AIDS Lecture July 1, 1987

The Current Crisis in AIDS

By
C. Everett Koop, MD, ScD
Surgeon General
Of the
U.S. Public Health Service
And
Deputy Assistant Secretary of Health
U.S. Department of Health and Human Services

Presented before the Berlin International Medical Society
Harnack House, Berlin – Germany
July 1, 1987

It had been 13 days since my last presentation on AIDS.

One of the more interesting assignments I had during my two terms as Surgeon General was responding to the invitation by the United States occupying forces of the occupied city of Berlin to come and instruct not only Army personnel, but West Berlin civilian physicians as well about the knowledge we had of the AIDS epidemic. I was asked if I would object to contributing to international cooperation by also speaking to the civilian doctors in East Berlin. I, of course, accepted with alacrity

I think most people understood by this time that AIDS was a disease of immunodeficiency and that the symptoms that people had were those of an opportunistic disease, which had taken hold in the patient because of his or her lack of immunity to fight it off. I was not prepared for the differences I saw in AIDS patients in West Berlin and later in East Berlin. Those in West Berlin looked exactly like those in Washington, New York, or Philadelphia. Whereas, those in East Berlin essentially had only one opportunistic infection and that was tuberculosis. The reasons probably were that it was the most prevalent infectious disease around East Berlin at the time, that it probably was near epidemic proportions without the AIDS epidemic, but the presence of that immunosuppressive disease enabled the spread of the tuberculosis bacillus very rapidly. Indeed, we saw some of the same things years later in the United States where we had some increase in the incidence of tuberculosis because of AIDS. Where homeless people began to congregate in confined quarters with poor ventilation, we saw spread of tuberculosis itself in the absence of AIDS that we had not seen since I was a young medical student, 50 years before.

This lecture was given in the venue of Harnack House and was presented to the Berlin International Medical Society, which was military and civilian. The military command rotated and, at the time that I was there, the United States was in charge, but there were representatives of medical services of countries that had been our allies in World War II.

My task was to cover as much ground in as short a period of time as I could, so I began with the beginning of AIDS in June of 1981 and went through the reports of

pneumocystis carinii pneumonia, and later in the summer of 1981 of 26 cases of Kaposi's sarcoma, all of both diseases appearing in otherwise healthy homosexual or bisexual young men. I then speculated on immunodeficiency. I told how AIDS acquired its name and recited the number of AIDS victims in the United States at that time being 37,000 approximately; half of them already dead of the disease.

I indicated that our predictions were for an additional 23,000 to be added to those numbers that year and that by the end of 1990 the cumulative total in the United States should be over a quarter of a million.

I talked about the virus and the fact that although scientists had seen it, they didn't know precisely what it was and that we had narrowed it down to a human retrovirus and I talked about its specific designation as HTLV-III and acknowledged the work at the Pasteur Institute where they called it be a different name, but we now had agreed internationally on the single common name of Human Immunodeficiency Virus or H.I.V. I talked of the discovery of anti-bodies and how that led to the tests that were used to screen blood for transfusion and how we had the happy circumstance now, instead of four or five tainted units of blood per 10,000, we had only four contaminated units per million of transfused blood, which was as close to perfect as one can get in this type of endeavor.

That test had led us to believe that we were in a situation where there were between a million and a million and a half Americans walking around with the AIDS virus, although I believed it could have been between 400,000 to 4 million. I made it clear that these folks had the virus but were not necessarily sick with an AIDS-related disease.

This led to discussion of incubation, and the research going on in reference to vaccine development and drug therapy. The cost of this effort was about 300 million dollars in U.S. Federal funds that year, plus many millions more in state and private funds.

One experimental drug Axidothymidine, or A.Z.T. went through a "fast-track" approval process at FDA and was then being used to prolong the lives of victims particularly (at the time of this lecture) dying of pneumocystis carinii pneumonia. I expressed my own continued pessimism that we would have a vaccine before the end of the century, if then. Those predictions have thus far turned out to be correct.

Moving on to the transmission of the virus, I had to cover its presence in body fluids, which led to the description of sex practices among homosexual and bisexual men and the transmission of the AIDS virus by sharing the paraphernalia of intravenous drug abuse. At that time only 4 per cent of AIDS cases in the United States were heterosexual in origin. Then I went on to the partition in Black and Hispanics and reported as the only good news that there had been a noticeable drop in the number of men taking part in wholesale, anonymous, promiscuous sex, as evidence by a decline in the incidence of other sexually transmitted diseases among homosexual men, such as gonorrhea, hepatitis B, and syphilis.

I mentioned that the time had come to turn the educational efforts to heterosexual men and women, which really was the society at large. That led to the description of the Surgeon General's Report on AIDS and how it came about through the request of President Reagan and the manner in which I put it together, reported it to the Cabinet and released it to the American public by way of the press on October 22, 1986. Then to the message to the young people of abstinence and the message for older folks, mutually faithful monogamy, with the final message to people who wouldn't heed the other two, that all we had to offer was the use of a condom, which was really no more certain than the intelligence of the person that uses it -- certainly not 100 per cent protection.

Naturally, I had to talk about the differences of opinion in the United States on:

- Sex education for the young
- How to best to protect individuals who were HIV positive, or had AIDS, from unwarranted disclosure and discrimination, while at the same time protecting the public from infection.

This led to the public health perspective; the primary purpose of any action related to the AIDS epidemic was to prevent the spread of the disease. This included a broad range of options, some reflecting traditional, federal, and state roles, other went beyond the public health purpose and would have broader effects on insurance, employment, and other practices.

The current protection from disclosure of persons who were HIV positive included private actions such as physician discretion, the Hippocratic oath, state laws and federal laws and regulations

This led me to talk about the patchwork quilt situation with state laws and the numbers that were inconsistent with prohibited or mandated disclosures. Most states at the time of this lecture had not classified AIDS as a sexually transmitted disease.

I had to reveal to this audience the problem we had in the United States that potential or actual disclosure might "chill" voluntary testing, stigmatize the infected and possibly lead to actual discrimination. This was the only material in this lecture that was truly new. I revealed to the German audience that our current protections were mixed:

- State courts had uniformly ruled that infected children were entitled to attend school
- Only a handful of states had prohibited insurers from testing and denying individual health insurance to those infected.
- For employment, health care, and other services, legal protections varied state by state, which was usually dependent on the interpretation of handicapped

discrimination statutes in a few states, and in a few states, new AIDS-specific statutes.

- In the United States a federal statute known as Section 504 of the Rehabilitation Act prohibited discrimination against the handicapped by institutions supported by federal funds. A Supreme Court decision known as the Arline Decision meant that people with AIDS would be protected. However, the reach of that protection was unclear, but was certainly limited.

This was the first time in a public lecture I had gone into such detail about the protection of the AIDS patient and how that conflicts with public health custom in reference to the spread of any infectious disease. In protecting the American public from infection, the principle situations of concern included sexual partners, health workers, morticians and other high-risk occupations, prisoners (because of forced sodomy), customers of prostitutes, and assault victims. The latter were individuals who were intentionally infected, by sexual means, or biting, etc. A small number of such cases had received inordinate publicity that probably exaggerated the problem.

The protections for consenting sexual partners were minimal. Some states required, by existing sexually transmitted disease law, or special AIDS law, "contact tracing" for those who tested positive. But most relied solely on voluntary disclosure. The two largest testing programs, -- blood banks and military recruits—did not routinely provide for contact tracing.

Other protections of the public were mixed:

- Few statutes or cities tested prostitutes

- Most states against criminal assault theoretically applied to HIV carriers who bit or rape and there were several court cases pending.

- For high-risk professions, particularly health workers, protection depended primarily on practice rather than the law. There were guidelines issued by the Centers for Disease Control in that regard.

- The Justice Department had announced testing of federal prisoners. In addition, some states were doing that, but follow-up steps or other use of results remained unclear. Most local jurisdictions where I visited were hesitant to test because they did not have means of segregating prisoners and fear for the lives of those who might have been known to be HIV positive.

I could not avoid saying that the potential problem caused by this mixed type of protection was substantial, if the public was not protected and included not only infection of unsuspecting persons, but also a potential for backlash if governments were not perceived to be taking all of the prudent steps. (Some of those did not provide the protection that many people demanded for the infected.)

All this became more complication as heterosexual transmission of the disease increased.

This was also the first time that I introduced the controversy in the United States between those who favored mandatory testing and those who did not. The motivation of the former group was mixed, most of the public health people adhered to the latter stance. The two areas of the most heated controversy were premarital testing and the testing of hospital admissions. I went into the differences between old premarital testing, marriage licenses, etc., and pointed out the differences between the diseases of syphilis and AIDS. I also introduced the cost of such testing as being exorbitant especially when there was no subsequent program available except education. One side-light was that it was estimated that in the State of New Hampshire that was about to enact a law it would cost $100,000 to find a single HIV person in premarital screening. Hospital admissions mandatory testing was opposed by most public health authorities. A compromise plan was under discussion where only surgical admissions would be voluntary, but that was obviously inadequate for obvious reasons. It became real however, when doctors refused to operate without such testing and nurses were leaving their jobs. It was sad that knowledgeable medical staffs were not giving the best care to some patients because of the fear of HIV positivity.

I went into all of this detail because I was certain that these things were not being discussed in the German press and they were certainly not yet appearing with any regularity or clarity in the professional medical press. Yet many of the people to whom I was speaking would soon be back in the United States practicing where all these things existed

---

Acquired Immunodeficiency Syndrome
American & French progress with isolating the virus & naming it
AIDS & heterosexual activity
AIDS & intravenous drug abuse
AIDS antibodies
AIDS specific discrimination statutes
Arline Decision
Blood test for AIDS
Condom use
Criminal assaults & the law
Current protections embodied in the law
Derivation & history of calling the disease AIDS
Differences of opinion in the United States concerning education & the protection of individuals
Directions for avoiding transmission of AIDS
Disclosure of HIV positivity
Drop in homosexual promiscuity
Education as our main defense
Federal law

Handicapped discrimination statutes
Health workers & AIDS transmission
History of AIDS
Insurers & the law
Kaposi's sarcoma
New Hampshire's pre-marital testing
Partition rage between Blacks & Hispanics
Pneumocystis carinii
Pre-marital testing
Preparation of the Surgeon General's Report
Prostitutes & the law
Protections are mixed
Refusal to deal with AIDS patients
Research in drug therapy
Sex practices of homosexual & bisexual men
Special consideration for surgical patients
Special consideration in operating rooms
State law
Statistics of AIDS
Testing of federal prisoners
Testing of hospital admissions
Toxoplasmosis
Transmission of the AIDS virus
Vaccine development
Virus of AIDS

Azidothymidine (AZT)
Morbidity & Mortality Weekly Report (MMWR)
President Ronald Reagan
Section 504 the Rehabilitation Act
Surgeon General's Report on AIDS