

AIDS lecture July 30, 1987

Address

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 to the National Council of State Legislatures

Indianapolis, Indiana

July 30, 1987

---

It was four days since I last spoke publicly about AIDS.

This lecture was an extraordinary opportunity – to speak to the National Council of State Legislatures the very bodies that enact our state laws and to acquaint them with the things they ought to know about trends and problems in the management of AIDS so that they could show responsibility as legislators.

I began by giving the good news and that was telling them about the indicators of the state of health of the nation and how they seemed to auger well for the future. This included an all time high-life expectancy, something the Social Security Administration worries about, but which was definitely progress for me. Also, that our infant mortality rate was the lowest in our history, and one of the lowest infant mortality rates of any modern, industrialized country in the world.

I told them that 10,000 children would be born in the United States that day, and more children were starting out healthy and then tend to stay that way. Less than one per cent of those children – 2 new babies – will die within a month. That's two too many, but it was still a record low for our country.

I also talked about the declining death rate from heart disease, stroke, and most cancers. That was especially true for young people in the 30's, 40's, and 50's in their peak years of their earning power.

It was now time for a plug and I made it for all the people who work for these legislators in saying that behind all this good news was the excellent public health leadership we had at state and local levels. I particularly lauded the commissioners, the chairs of boards of health, epidemiologists, health economists, but especially my friends in state maternal and child health programs.

I also made it clear that these fine public servants could not have these things in regard to chronic disease, immunization, dental health, waste management, and so on, if they didn't have the understanding and support of their state legislatures.

Having said all that I had to turn to the bad news and that was the disease of AIDS – here for only six years, but in that short span of time, the total case-load had grown from 5 cases to 39,000. But they were more than case. They're people...human beings...and already more than half of them had died – some 22,000 – and the rest probably would.

I reminded the audience that we had no vaccine and probably would not until the end of the century. That latter statement was really condescending to my colleagues all of whom were more hopeful than I. I had never thought a vaccine would be easy and I didn't think we'd have it by the end of the century.

Without a vaccine nothing can stop the AIDS more effectively than a strong program of public education and information, but on this occasion, I said for the first time combined with counseling and testing. I then went through how AIDS is passed, but especially of how AIDS is not passed. Then for the special attention of state legislatures, I said that barring a child with AIDS from school or denying anyone with AIDS any medical or dental service was the worse kind of nonsense. At this point, I drew attention to the fact that a million and a half Americans were then infected with the AIDS virus and pointed out the difference between the contraction of an AIDS-related disease and being HIV positive.

These legislators deserved to know the partition; one of every four AIDS victims was an I.V. drug abuser, one-third of those folks were also homosexual and bisexual men, or to say it another way, over 90 per cent of the AIDS cases had been transmitted through specific sexual or drug-taking activities that people do voluntarily. If we could change the behavior of those two population groups – homosexuals and I.V. drug abusers – then this country would not have the AIDS epidemic it then had.

On then to heterosexual activity and the same four percent that the Centers for Disease Control were using as the prevalence. I had to lighten all this bad news by saying that if the individual is not engaged in high-risk sexual behavior and doesn't shoot drugs regardless of where they live and regardless of how old they are the chances of being an AIDS carrier are zero. Keeping people that way was my greatest concern as the Surgeon General. More good news with the bad, a lot of homosexual and bisexual men seem have to have heard an education message and high-risk sex practices have dropped from a high of close to 70 per cent to a low, 18 months later, of 41 per cent of the men surveyed. So, education does work, but again to emphasize new things, it's education plus counseling and testing that works even better. I cited Thomas Coates of San Francisco, who found that men who tested for the AIDS virus and received some counseling were much more likely to reduce their high-risk behavior than men we were not tested and counseled.

This was an era in the history of AIDS when we had the test, we had made the blood supply safe for transfusion, but we had sharply divided opinions about whether testing should be mandated, whether the contacts should be notified, indeed whether we should treat AIDS as the public health menace it was, or treat the disease politically, which had been the tendency for the past six years.

Because we were in Indianapolis, I used the state of Indiana to show a good case in point. Their State Board of Health had professional people working full-time on AIDS education and risk reduction programs, and they had been developed and carried out by a network of 14 community action groups around the state. Their trained personnel were also doing pre-testing counseling in a variety of settings, such as drug abuse treatment centers and clinics for sexually transmitted diseases. I.V. drug abusers and prostitutes and others who have multiple sex partners or who engage in high-risk behavior were getting the facts.

I would say that Indiana has a model program and I lauded President Reagan for inviting the Indiana Health Commissioner, Woodrow (Woody) A. Myers, Jr. to be one of the 13 members on the new AIDS Commission. He, I could personally attest, had a great deal to offer.

Back to information of help to legislators: AIDS has been with us only 6 years, and we have understood it as well as we do for only 2 or 3 years, but that is extraordinary progress in state after state nevertheless. There are so far this year, something like 500 bills dealing with all aspects of the AIDS problem that have been introduced in state legislatures – that was twice the number introduced in all the previous year.

More money was being appropriated not only for education and counseling and testing, but also for surveillance, research, patient care, and administration. And legislatures were putting into place new systems of maintaining accurate and confidential records of persons who are tested for AIDS.

That led me to say that they now had some serious things to think about, in reference to testing and confidentiality. I stressed that confidentiality did not prevent vital health information from being given to persons who had a need or a right to know. (spouse, child, hospital personnel, correctional staff, or entire schools systems) with AIDS, this “need to know” concept is even more significant, since AIDS is still a mystery and it is virtually 100 per cent fatal. These are two very compelling reasons for strengthening confidentiality to the point that people at risk will volunteer to be tested and for insuring that certain narrowly defined persons in the community – with a clear “need to know” for their own protection – are given that information. It’s not 100 per cent old-fashioned public health protocol, but it’s a lot better than many people were advising at that particular time.

We were still balancing a person’s need for privacy against the community’s need for protection. It was true in this stigmatizing disease that folks were avoiding the test for fear that knowledge of the fact of AIDS positivity would jeopardize their jobs, their housing, or their family life.

But there are occasions when AIDS testing ought to be done routinely and the information routinely shared with those who need to know. Because of male rape in prisons, the AIDS virus in a prisoner’s bloodstream could be just as deadly as a pistol in

his belt. Therefore, I believe -- along with President Reagan -- that all federal prisoners ought to be tested for AIDS and the results given to wives or others who will be with that prisoner during conjugal visits or after the prisoner's release back into the community. If it's good for federal prisons, why not for all prisons as well. That law will not change behavior nor will it change the environment for enforcement. I could not help to mention at this time that the first day we heard about pneumocystis carinii pneumonia -- only 5 cases -- but all occurring in homosexual males otherwise healthy, led me to suggest at the public health staff meeting that this would be a huge problem, if we found that the disease were indeed primarily among homosexuals because of forced sodomy in prisons.

I couldn't understand then and I don't understand now why the rest of the people at that meeting thought I was out of order.

Legislators should know, however, that even though prison authorities would like to know which prisoners are carrying the virus, they can't do much with that information since their facilities are already crowded to the legal maximum -- or worse. Some administrators in prisons have expressed the fear of additional violence, if the confidentiality of the test results were somehow breached.

Another entirely different story is one I can relate to well because it involves patients undergoing surgery. As a surgeon, I always felt that the medical staff had the right to know who was HIV positive and I was disheartened to hear stories of doctors, here and there, refusing to operate on patients known to be AIDS carriers. Some nurses left their assignment in operating rooms as well. For that reason, Secretary of Health and Human Services, Dr. Otis Bowen, and I agreed that AIDS testing ought to be considered for non-emergency surgical patients when it is deemed to be necessary by the physician.

*I suggested something that I thought would work very well. Hospital patients should be tested if they were non-emergencies and the front of the chart stamped HIV negative, if that were the case. No designation would be made of HIV positive patients. That means that the staff, especially in tough situations like the operating room would know which patients were HIV positive without any records so stating.*

Nine states now require that positive test results be reported. Most states want to know the names or other identifiers who test sero-positive. Colorado, for example, which had about 400 cases of AIDS all together, was the first state to require the reporting -- by name -- of people who test positive for AIDS. The citizens of Colorado know this.

Yet, Colorado continues to have a very high number of people who voluntarily come in to be tested. Records are confidential and no one, to our knowledge, has been adversely affected by the test so far. That's the key reason that Colorado has been successful.

In Minnesota the names of persons with AIDS are now being reported to the Department of Health and that Department in turn is offering "partner notification" services, on request, to anyone who wants to be fair with his or her sex partner, but can't get up the courage to break the news.

In seven states, police, fire, and rescue workers must be told if they've been exposed to a person with an infectious disease. AIDS in particular, is infectious, and I think that is also a good idea.

I expressed an uncertainty that I would not have expressed a couple of years later, and that was that we're not sure how to predict the spread of AIDS in heterosexuals. I queried whether this would remain a minor phenomenon or if we were on the threshold of a rapid expanding epidemic, such we experienced with homosexuals. It turned out not to be that bad, but certainly spread heterosexually.

Drawing to a close, I left the high-risk groups and talked about the breakdown by race and ethnic background and presented the facts of disproportionate positivity among Black and Hispanic peoples. I did call attention to the fact that in reference to health indicators I mentioned at the opening of this lecture, that while the minority community has to confront and contain the life-threatening disease such as AIDS that's hitting them with twice the effect that it's having anywhere else, we know from virtually every other health indicator, that minority Americans are not making as much progress in health status as the rest of the country does.

I announced two upcoming meetings, one next month in Atlanta, a two-day meeting with some 600 people invited from national, state, and community-wide organizations representing Black and Hispanic Americans. And another in September, which has been a long time in the planning-stage, will be a national conference for state and local personnel. The objective is to come up with minority health concerns, which was better than the non-strategy we've have now.

For the first time, I mentioned something that I talked about a lot later, that AIDS attacks people who have been on the periphery of health care –homosexuals, bisexuals, and I.V. drug abusers. Even though we have provided them with special clinics and special programs of one kind or another, they remained outside the mainstream of American health care. We desperately need to reach them and we discover we don't really know how to do it, and they don't voluntarily come to us.

I asked that the group share with me the commitment, to never give up, never give in, and never give way to fear or prejudice. And I maintain that living is what government is all about.

---

AIDS & operating room personnel  
AIDS & patients undergoing surgery  
AIDS testing of surgical patients  
AIDS transmission as a voluntary act  
Appropriation of money for education counseling & testing  
Barring children from grade school  
Chronic disease, immunization, dental health, waste management

Colorado's record  
Death rate from AIDS  
Death rates for heart disease  
Death rates for most cancers  
Death rates for people in the 4<sup>th</sup>, 5<sup>th</sup>, and 6<sup>th</sup> decades  
of life  
Death rates for stroke  
Denying medical service to HIV positive  
Individuals  
Disproportionate prevalence of AIDS in minorities  
Education  
Education plus counseling & testing  
Exposure of police, fire & rescue workers to  
infectious disease  
Federal budget for vaccine research  
Federal prisons vs. other prisons  
Growth of the caseload of AIDS  
Heterosexual AIDS  
Heterosexual transmission of AIDS  
Homosexual & bisexual males  
Homosexuals & I.V. drug abusers  
How you don't get AIDS  
How you get AIDS  
HIV positivity & social effects on society  
Increasing number of bills before state Legislatures  
on AIDS  
Infant mortality lowest in history  
Infant mortality one of the lowest in industrialized  
world  
Intravenous drug abusers  
Life expectancy for Americans  
Male rape in prisons  
Maternal & child health programs  
Meetings ahead re: minority health  
Minnesota's record  
"Need to Know" concept  
Notification of prisoner's future sexual contacts  
Occurrence of the virus in body fluids  
Other health deficits in minorities  
Prevalence of the virus in the United States  
Prison overcrowding  
Prison violence & AIDS  
Privacy vs. the community's need for protection  
Public health leadership in America  
Race & ethnic background of HIV positive  
Individuals

Record of the state of Indiana in AIDS control  
Refusal of professionals to give care to HIV  
positive patients  
Risk factors in AIDS  
State attitude toward AIDS testing  
State public health personnel  
Support of state legislatures for health  
Surveillance, research, patient care administration  
Testing and confidentiality  
Vaccine  
Various groups on the periphery of health care  
Voluntary testing

---

Otis Bowen  
Thomas Coates  
President Reagan  
Social Security Administration