Prevention and control of AIDS

An interim report of the American Medical Association's Board of Trustees

EDITOR'S NOTE: Because of the importance of AIDS to all physicians, we are printing this report of the AMA's Board of Trustees on AIDS, and three resolutions of the House of Delegates.
JAMES S. TAYLOR, MD, EDITOR

Responding sensitively, intelligently, and effectively to the growing AIDS crisis is one of the crucial public health problems facing the nation. Prevention and control of the disease must be an essential part of that response because there is, at present, no known cure for AIDS patients.

See also the editorial by Calabrese (pp 473–474)

Recommendations in this report have as their foundation an overriding concern for a judicious balance between the well-being of HIV-positive patients and the protection of the public health. These recommendations are based upon the best information and data available at present. The AMA will continuously monitor and analyze developments in AIDS and update AMA policy and recommendations as dictated by advances in knowledge.

Education continues to be the major weapon against spread of HIV infection. Physicians should assume the leadership role in educating themselves, their patients, and the public. Individuals in society also must assume responsibility for being well-informed and for actions that affect their own health and the health of others. In developing this report, the Board emphasizes the need for concerted and cooperative efforts by all members of society in the fight against AIDS. The recommendations outlined below are designed to help in successfully confronting this challenge to society's well-being.

Adopted by the AMA House of Delegates at the 1987 Annual Meeting, Chicago, Ill., June 21–25, 1987. Printed with the permission of the AMA.
Cleve Clin J Med 1987; **54**:477–487

Background

The current climate

It is estimated that five to ten million people are infected with HIV virus worldwide. AIDS has been reported in more than 100 countries. In the United States, HIV-infected individuals may number 1.5 million, approximately 35,000 of whom have been reported to suffer from AIDS and more than 20,000 of whom are dead.

The U.S. Public Health Service has projected that by 1991 there may be 323,000 reported patients with AIDS and as many as 200,000 of them may be dead by that time. In addition, conversion rates of seropositive people to AIDS status now appear to be higher than early preliminary estimates. Originally under 20% were thought to convert. It now appears that, without treatment advances, a much higher percentage will develop the disease.

Seventeen percent of the AIDS cases have been intravenous drug abusers; 66% have been homosexual/bisexual men; 8% have been homosexual male IV drug users; female, heterosexual male, and pediatric victims infected by the trans-

fusion of blood or blood products, sexual contact, or prenatally in the case of infants, account for the bulk of the balance.

Polls indicate that AIDS has become the highest priority health concern of the American public, ahead of heart disease and cancer. It has already caused changes in a variety of public attitudes. Sexual abstinence, monogamous relationships, and the use of condoms are being widely promoted in the media by public officials and many private organizations. IV drug abusers are being counseled to use clean needles and to avoid sharing needles. Education on the sexual transmission of the AIDS virus is being extended to school children. The nation is more sensitive to the rights of those afflicted with the disease to be free from discrimination, regardless of the manner by which they became infected.

Historical control measures for infectious diseases

A primary mode of transmission of AIDS is through sexual contact, and the control efforts for sexually transmitted diseases (STD) that have been instituted in the past are sources of analogies for prevention and control of AIDS. National programs to control STDs were established during the beginning of World War I. For the following 50 years, the focus was almost exclusively on the control of syphilis and its complications. During World War II, rapid treatment centers for syphilis and gonorrhea were established. Public health officials instituted limited contact-tracing, had the authority to close sex bars and clubs, to order tests for prostitutes, and most importantly, had effective therapy to offer. Widespread availability of penicillin led to the dissolution of the rapid treatment centers and of the clinical specialty, syphilology. Every state in the Union at one time required all persons seeking marriage licenses to be tested for syphilis. During the 1950s and 1960s, federal assistance programs continued to support contact-tracing, serological screening, and patient education.

In the late 1960s, public health officials were concerned about the rapidly escalating cases of gonorrhea, and projects were instituted to increase case-finding and contact-tracing. In 1972, financial assistance for STD control by the federal government was dramatically increased and, by 1982, gonorrhea accounted for nearly three-fourths of the federal STD dollar. During the 1970s, gonorrhea control efforts evolved through overlapping phases that included objectives to lower disease incidence and the occurrence of drug-resistant bacteria, focused screening on high-risk patients, intensified follow-up of treatment failures, and used patient counseling as a means of increasing compliance with therapy and improving contact-tracing. The latter was deemed especially important since the large numbers of gonorrhea cases precluded the intensive follow-up of each infected case that had been characteristic of the syphilis era.

In 1982, the World Health Organization/Pan American Health Organization (WHO/PAHO) identified the following key objectives for intervention to reduce STDs:

1. To minimize disease exposure by reducing sexual intercourse with persons who have a high probability of infection.
2. To prevent infection by increasing the use of condoms or other prophylactic barriers.
3. To detect and cure disease by implementing screening programs, providing effective diagnostic and treatment facilities, and promoting health-seeking behaviors.
4. To limit complications of infections by providing early treatment to symptomatic and asymptomatic infected individuals.
5. To limit disease transmission within the community through the above efforts.

These objectives were used as a framework for the current United States program regarding STDs, which consists of the following components:

1. Health education and promotion.
2. Disease detection through testing and other means.
3. Appropriate treatment.
4. Contact tracing and patient counseling.
5. Clinical services.
6. Training.
7. Research.

The challenge of AIDS control

It might seem reasonable to extend the experience in preventing the spread of other STD infections to AIDS. The objectives established by WHO/PAHO and the components of the current national STD program are certainly applicable to AIDS. However, AIDS presents a much different social problem than other STD infections. Since there is no cure for AIDS and no protection beyond avoiding or making safer intimate contact with infected individuals, those infected with the virus must be sexually isolated from uninfected persons. A condom barrier offers some but not complete protection. Avoidance of sexual contact and use of shared needles are the only sure protections.

Further, the stigma that accompanies a diagnosis of AIDS, based on fear and society's attitude toward IV drug abusers and homosexuals, presents a factor beyond the control of the infected individual or medicine. An HIV-seropositive individual who might live five years or much longer with no overt health problems, once identified in a community, may be subject to many and varied discriminations—by family and loved ones, by neighbors and friends, by employers and fellow employees, and by other providers of services.

As with prevention and control of all contagious diseases, prevention and control of AIDS involves two, sometimes competing, concerns. First, the person who is afflicted with the disease needs compassionate treatment, and both those who have the disease and those who have been infected with the virus should not be subjected to irrational discrimination based on fear, prejudice, or stereotype. Second, and of critical importance, the uninfected must be protected; those individuals who are not infected with the AIDS virus must have every opportunity to avoid transmission of the disease to them.

The need for a national policy on AIDS

Given the growing dimensions of the crisis and given limited national resources, it is imperative that a national policy be developed jointly by the public and private sectors. Such a policy must seek, in a cost-effective way, to achieve fundamental national goals: prevention, treatment, and cure—and adequate research in all three areas. A coherent national approach to this modern killer is needed: a comprehensive blueprint for a national response, not piecemeal solutions. Knowledge of the disease is now more than six years old and the growing magnitude of the problem has been apparent for nearly that long.

Such a national policy must have certain characteristics:

- The policy must be comprehensive, proceeding simultaneously on the fronts of prevention, treatment, and research.
- The policy must be coordinated between public and private sections and between the different levels of government. A national policy does not necessarily mean a federal policy: there are important roles at all levels of the health-care systems and at all levels of government. Nor does it necessarily mean uniformity: on certain issues different approaches should be tried to determine efficacy.
- The policy must be carefully balanced. For example, concern for the person with the disease must be balanced with concern for those who do not have the disease but who may become infected. Similarly, careful consideration must be given to directing scarce resources to increased prevention, even as increasingly large resources are necessarily devoted to research and treatment.
- The policy must be based on scientific information and medical judgments. Although policy choices must inevitably be made, they should be formed on the best available information and on the extensive public health experience in dealing both with AIDS and with other contagious diseases.
- The policy should be nonpartisan. Although it may be tempting to play on fears and prejudices, public figures and officials both inside and outside the health community should avoid exploiting the crisis for partisan political advantage.
- The policy should be capable of continuous review and modification as more and better information becomes available.

RECOMMENDATION 1: A Commission, modeled after the commission that made recommendations on the problems of Social Security financing in the early 1980s, should be consti-

tuted with representatives from the Executive branch of the federal government, the Congress, state and local government, and the private sector and directed to develop a consensus position for consideration by the Congress, the Executive, state and local governments, and private associations and institutions. The presidential commission announced, but not yet appointed,* by the Administration could be broadened to implement this recommendation. A high-level body with representatives from the different branches and levels of government, but operating to the side of the more formal political processes, may have the best chance of forging the necessary national consensus which can then become the basis for concerted and coordinated action by both the public and private sectors.

The special role of physicians and other health-care counselors

Because there is no cure for AIDS, effective preventive techniques are vital. This involves both those who are infected and those who are not. Those who are infected must be identified so that they will not unknowingly transmit the disease to others. Many who are not infected will need to change their behavior substantially to minimize their risk of infection by the AIDS virus.

The key to changed behavior is public education coupled with counseling that must be given by physicians and other health-care counselors.

Public awareness

The public is well aware of AIDS in a general sense. The attention of the media has been intensively focused on the disease. Translating general awareness into modifications of behavior is the challenge.

The groups that are most at risk for AIDS, e.g., IV drug abusers, homosexuals, bisexuals, and prostitutes, have reason to know they are at risk. Their contacts, however, may not know they are at risk and hence spouses, unborn babies, and premarital and extramarital sexual partners may become infected. Education and counseling aimed at the high-risk groups must be the first priority. The education should urge immediate counseling with a physician or other health-care counselor about the risk of AIDS, the uses of antibody testing, and preventive measures.

Also, it must be recognized that persons in these groups may not respond to education and counseling and, when they do not, more aggressive programs—such as expanded methadone maintenance programs or penalties for knowingly exposing others—must be considered.

Education aimed at the more general population is difficult for at least two reasons. First, reaching all Americans with an effective message can be expensive and not all people respond in the same way or to the same method of learning. Messages must therefore be tailored to the target audience in question. Second, preventive messages must necessarily deal with controversial subject matter. Widespread use of the electronic media—especially television—appears to be the most effective way to reach the general public. Accordingly, public-service advertising on the electronic media must be greatly increased and these announcements must be shown at times and in places where they will be viewed by those who need the message most.

The AMA will continue its efforts to place its own public service ads on national television. AMA's Tony Danza public service advertisement (PSA) directed at teenagers about abstinence and condoms, and other PSAs that the networks have agreed to use, are significant first steps. But, more must be done and it must be nationally coordinated.

RECOMMENDATION 2: The communications industry must develop voluntary guidelines for public service advertising regarding AIDS in consultation with the health-care community and government officials. The AMA intends to be a catalyst in this effort to immediately bring the communications and health-care communities together.

Counseling—and educating counselors

Perhaps the greatest need at the present time is effective counseling of both low-risk and high-risk populations by physicians or other health-care counselors. A massive education effort for physicians and other counselors is necessary as a first step. Complete and accurate information on the disease, the modes of transmission, the appropriate application of antibody testing, and effective ways to change behavior must be understood

* The Committee has now been appointed.

by counselors if it is to be properly communicated to patients. In conjunction with face-to-face counseling, printed materials—like the Surgeon General's recent 36-page report on AIDS*—should be widely disseminated.

Even more challenging than preparing physicians and others for generic counseling on AIDS is preparing these counselors to assist those who test positive and are infected with the virus. It is at that time that a change of behavior on the part of the person infected is most critical, and it is then that the most sophisticated counseling is required due to the emotional impact of the test results. There is no higher prevention priority than ensuring that the community of individuals who provide health-care counseling be given adequate tools to be effective. And the AMA, as the largest organization of physicians in the world, must take a leading role in this undertaking.

RECOMMENDATION 3: A conference should be immediately held between the AMA, other physician organizations, and public health officials at all levels of government to determine:

1. The types of education and training that are necessary for effective counseling.
2. The people in the health-care community who should receive this education and training.
3. The current resources available for such education and training.
4. Recommendations for providing additional resources, including consideration of the respective roles of medical associations and government at all levels.
5. Recommendations on how to update information continually as new scientific data are developed.
6. Recommendations as to alternative measures to prevent the spread of AIDS where education and counseling are not likely to be effective, particularly among IV drug users, through such programs as expanded methadone maintenance.

The AMA will promptly and widely report on the conference findings and assist in the implementation of the conference recommendations.

Voluntary and mandatory testing

Knowledge that a person is infected with the AIDS virus can be the crucial predicate to changing behavior. Thus, testing for an antibody to the AIDS virus, when used in conjunction with appropriate counseling (and when offered in the context of appropriate antidiscrimination and confidentiality protections discussed below), serves the important public health purpose of providing impetus for behavior changes that minimize the risk of transmitting the AIDS virus.

Clearly, the need for HIV-antibody testing has expanded beyond its original purpose, the screening of blood donors. Guidelines for the appropriate use of HIV-antibody testing must center on the following justifications:

1. To identify infected persons and to offer treatment where possible and to protect uninfected third parties.
2. To offer education and counseling that would modify high-risk behavior.
3. To solicit patient cooperation for locating and referring sex partners.
4. To obtain broadened epidemiological statistics on the prevalence of HIV infection in the population.

In addition, in considering the merits of voluntary versus mandatory testing, these facts about AIDS must be kept in mind:

1. AIDS is caused by an infectious agent and therefore is an infectious disease. Appropriate precautions, procedures, and policies should be applied to protect the community from the spread of the disease.
2. The extent to which the AIDS virus already has spread into the general population is not completely understood. Cur-

* Surgeon General's Report on Acquired Immune Deficiency Syndrome. U.S. Department of Health and Human Services, Washington, D.C. Issued October 1986.

rent projections are based on a number of unverified assumptions.

3. The transmission of the AIDS virus does not occur through casual contacts. Sexual contact, septic intravenous equipment, and the administration of infected blood and blood products are the main modes of transmission.

4. Heterosexual transmission of the AIDS virus, especially from males to females, does occur.

5. Seropositive pregnant females will transmit the virus to their babies in a high percentage of cases.

6. Health-care workers, especially those who perform invasive surgical procedures, and emergency room and laboratory personnel are at some risk when caring for AIDS patients.

7. No patient with a clinical case of AIDS has survived the disease. The disease has been uniformly fatal.

8. The disease, not its victims, is the threat from which society must be protected.

9. The confidentiality of the doctor–patient relationship is vitally important but not absolute.

10. Physicians have an ethical and professional obligation to behave in a scientifically responsible manner.

All of these considerations guided the Board of Trustees as it considered the issues that have been raised by the wide variety of proposals for HIV-antibody testing that are being discussed in society.

General conclusions

Except for individuals in the limited categories listed in Recommendation 5 below (blood, organ and semen donors, immigrants, military personnel, prison inmates) with regard to whom testing serves well-established and well-accepted protection goals, mandatory national testing should not, at present, be broadly extended.

Military personnel have traditionally been subject to mandatory immunizations and our defense forces, of course, must be as strong as possible. Prison inmates, because they are confined and have a higher incidence of high-risk individuals than the general population, require special protection. Immigrants should be tested so that we can focus on the AIDS problem already here, and the nation certainly has the right to bar entrants with communicable diseases. The need to test donors of blood, organs, and semen has never been questioned.

Public health authorities have advanced a plausible premise for their opposition to mandatory testing of homosexuals and drug abusers: such testing will only drive people underground and away from the health-care system. Public health authorities also have advanced a premise for not requiring mandatory testing of large segments of the general population, such as all those seeking marriage licenses of all those admitted to hospitals: such testing in low-prevalence populations would result in a high proportion of false positives, and would not be cost-effective, given the demand for voluntary testing and the shortage of testing and counseling resources for those who want them voluntarily or who will want them following effective public-awareness campaigns.

Until those premises are shown by superior studies to be incorrect, a policy regarding mandatory testing, which has been rejected by the vast majority of public health officials, including the Centers for Disease Control and the Surgeon General, cannot be recommended.

But certain high-risk groups should be regularly tested, with a right to informed consent and to refuse the test. Those groups are defined in Recommendation 6.

In addition, physicians and other hospital personnel involved in invasive surgical procedures who necessarily and unavoidably come in contact with the blood of patients, need to be aware of their risks. Limited regular testing of patients will assure that the CDC guidelines for the protection of hospital personnel are followed rigorously and will further assure that all patients receive prompt and full treatment. The Board emphasizes here that physicians have a long and honored tradition of tending to patients afflicted with

infectious diseases with compassion and courage. That tradition must and will be continued throughout the AIDS epidemic.

Because the risk to health-care personnel will be slight in most areas, any effort at mandatory testing of certain kinds of patients should be instituted after voluntary testing has failed and where a variety of factors, e.g. the costs and availability of proper testing and counseling as measured against the risk presented by the relative presence of a high-risk patient population, weigh in favor of mandatory testing.

The AMA does not believe it appropriate at this time to extend regularly offered testing to persons other than those listed, e.g., recommended testing should not be extended to all individuals anywhere who are considering marriage or to all persons in hospitals. Decisions about whether there should be generally recommended testing to other types of individuals should, at this time, be left to the decision of the local community depending on its own circumstances and the judgments of its own public health officials.

At present, each case of AIDS must be reported by the individual physician to state public health authorities either by name or identifier. Anonymous, or if carefully implemented, confidential reporting should also be extended to all confirmed instances of persons infected with AIDS virus but not afflicted with ARC or AIDS. Individuals who are seropositive for the HIV antibody are infected with the virus and can spread the disease as certainly as those with symptoms of AIDS. A sound epidemiologic understanding of the potential impact of AIDS on society requires the reporting of those who are confirmed as testing positive for the antibody to the AIDS virus.

Testing recommendations

RECOMMENDATION 4: Tests for the AIDS virus should be readily available to all who wish to be tested. The tests should be routinely subsidized for individuals who cannot afford to pay the cost of their test.

RECOMMENDATION 5: Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs and other tissues intended for transplantation in the U.S. or abroad, for donors of semen or ova collected for artificial insemination or in vitro fertilization, for immigrants to the United States, for inmates in federal and state prisons, and for military personnel.

RECOMMENDATION 6: Voluntary testing should be regularly provided for the following types of individuals who give an informed consent:

1. Patients at sexually transmitted disease clinics.
2. Patients at drug abuse clinics.
3. Pregnant women in high-risk areas in the first trimester of pregnancy.
4. Individuals who are from areas with a high incidence of AIDS or who engage in high-risk behavior, seeking family planning services.
5. Patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

RECOMMENDATION 7: As a matter of medical judgment, physicians should encourage voluntary HIV testing for individuals whose history or clinical status warrant this measure.

RECOMMENDATION 8: Individuals who are found to be seropositive for the AIDS virus should be reported to appropriate public health officials on an anonymous or confidential basis with enough information to be epidemiologically significant.

RECOMMENDATION 9: Physicians should counsel patients before tests for AIDS to educate them about effective behaviors to avoid the risk of AIDS for themselves and others. In public screening programs, counseling may be done in whatever form is appropriate given the resources and personnel available as long as effective counseling is provided.

RECOMMENDATION 10: Physicians should counsel their patients who are found to be seropositive regarding (*a*) responsible behavior to

prevent the spread of the disease, (*b*) strategies for health protection with a compromised immune system, and (*c*) the necessity of alerting sexual contacts, past (5–10 years) and present, regarding their possible infection by the AIDS virus. Long-term emotional support should be provided or arranged for seropositive individuals.

RECOMMENDATION 11: Patients should knowingly and willingly give consent before a voluntary test is conducted.

Resources

Only recently has Congress and the Administration begun to seriously consider the vast resources needed to deal effectively with AIDS. Federal funding for 1988 is expected to reach $1 billion. But that amount will not be enough. The AMA endorses the bill introduced by Congressman Waxman to increase resources for testing and counseling.

Testing for the HIV virus in America will require substantially more resources than are currently being made available. Trained counselors, materials for counseling, and research on effective counseling approaches, for the variety of population groups that need these services, are urgently required. Also, dependable testing facilities with sufficient capacity to respond to the epidemic are needed now. In addition, funds for research and care must be increased to fully exploit the nation's capacity to respond effectively to this crisis.

The key premise of a prevention strategy, when there is no vaccine, is behavioral change on the part of those infected and those at risk of infection by AIDS virus. It is therefore crucial that there be immediate and systematic studies conducted of how behavior of affected groups may have changed in recent years, and if possible, what factors caused the changes. Most particularly, it is necessary to study and evaluate the types of counseling that have been effective so that the techniques may be replicated widely. There can be little question that in a free society suasion and voluntary change, if effective, are far preferable to compulsion.

RECOMMENDATION 12: Public funding must be provided in an amount sufficient (1) to promptly and efficiently counsel and test for AIDS, (2) to conduct the research necessary to find a cure and develop an effective vaccine, (3) to perform studies to evaluate the efficiency of counseling and education programs on changing behavior, and (4) to assist in the care of AIDS patients who cannot afford proper care or who cannot find appropriate facilities for treatment and care.

Protection against discrimination

Antidiscrimination

The AMA believes strongly that AIDS victims and those who test positively for the antibody to the AIDS virus should not be treated unfairly or suffer from arbitrary or irrational discrimination in their daily lives. Last year, the AMA filed a friend of the court brief in *School Board of Nassau County* v. *Arline*, a case before the Supreme Court that addressed the question of how the federal handicapped antidiscrimination laws should apply to persons afflicted with contagious diseases. The AMA set forth a framework for the application of the law that the Supreme Court adopted, quoting verbatim from the AMA brief in its key holding.

A sound antidiscrimination approach does not allow reflexive discrimination against AIDS victims based on fear or stereotype or prejudice. Nor does it require that all employers or other federal-fund recipients automatically accommodate a person afflicted with a communicable disease. Instead, based on an individualized analysis of the nature and duration of the handicap and the nature and duration of the communicability, a federal-fund recipient must make a reasonable accommodation based on reasonable medical judgments, given the state of medical knowledge at the time. This sound framework for carefully balancing the two competing concerns—the right of the victim to be free from irrational acts of prejudice and the right of others to be protected against an unreasonable risk from disease—should also guide state antidiscrimination efforts.

A key question left open by the Supreme Court is whether a person who is not afflicted with AIDS or AIDS Related Complex, but who nonetheless tests positive for the antibody, is protected by the federal antidiscrimination law.

In order to encourage people to seek counseling, and testing if necessary, the AMA strongly urges that antidiscrimination laws at both the federal and state levels be clarified either by regulatory interpretation or statutory amendment to cover those who test HIV antibody positive. Allowing irrational discrimination against those who test positive serves no useful purpose: it only has the destructive effect of removing

those who are otherwise productive members of society from the work force or otherwise denying them access to an important aspect of normal life. While the federal law should continue to apply only to federal-fund recipients, state laws should be sought to prevent irrational discrimination by entities or individuals within those jurisdictions.

RECOMMENDATION 13: Antidiscrimination laws must be clarified or amended to cover those who test positive for the antibodies to the AIDS virus.

Confidentiality

The ability of the heath-care community to maintain the confidentiality of patient information and restrict its use to only those purposes essential for maintenance of health is, like clarification of antidiscrimination laws, vital to an effective program of preventing and controlling AIDS. Even if antidiscrimination laws were completely effective, which unfortunately is not likely, persons who test positive (such as those with ARC or AIDS) will suffer stigma. Thus, confidentiality is crucial.

The basic principle should be that access to patient information should be limited only to health-care personnel who have a legitimate need to have access to the information in order to assist the patient or to protect the health of others closely associated with the patient.

As with antidiscrimination laws, laws protecting the confidentiality of patient information should be on both federal and state agendas.

RECOMMENDATION 14: Model confidentiality laws must be drafted that can be adopted at all levels of government to encourage as much uniformity as possible in protecting the identity of AIDS patients and carriers, except where the public health requires otherwise.

Questions for the future

As the national debate on prevention and control of AIDS continues, other important issues will need to be addressed.

Research and data

There is an urgent and critical need for more scientifically sound data on the prevalence and spread of virus in the general population. At the present time, only those cases that meet the current CDC surveillance definition of AIDS are reported to that institution. Since AIDS is the terminal and fatal stage of HIV-infection, it represents only the tip of the huge HIV-infection iceberg. There are protean manifestations of HIV-infection ranging from infected asymptomatic to full-blown AIDS. How large the base of that iceberg really is—that is, how many people are actually infected—can only be estimated from the number of reported AIDS cases. That has been done by using a multiple (50 to 100 times the number of AIDS cases) that has been extracted largely from surveys done in high-prevalence areas. Yet this same multiple has been used to estimate the number of current and potential HIV-infected persons in low-prevalence areas and for that matter the entire country and even the world. The CDC itself is unsure about the accuracy of its estimates. Yet if economic and medical plans are to be made for the future, reliable projections must be available. How sufficient or exaggerated these plans may be depends upon the accuracy of current and future estimates of HIV-infected persons, particularly as to the extent of its spread into the low-risk heterosexual population.

Not only are accurate estimates of HIV-infected persons needed, but so too are reliable data on the rate conversion of asymptomatic seropositive persons to clinical illness, including AIDS, that requires increased medical care. This information is important for the formulation of plans for the future cases of potentially hospitalizable patients and the economic consideration thereof. HIV-infection has protean manifestations and death can result not only from AIDS itself, but from severe ARC or progressive CNS disease as well. In order to obtain accurate information in HIV infected persons on the rate of conversion from asymptomatic to clinically severe illness, baseline data on their serologic status must be obtained as early as possible—not after clinically manifest disease is present. The presence of HIV antibodies indicates not only current infection with the virus, but also that the patient is potentially capable of transmitting the disease. This follows from the fact that HIV integrates its genome into the host cell genome with the result that once infected, the patient remains infected for life and is, therefore, capable of lifelong transmission of the agent. The earlier the infected person is detected, the earlier he or she may be advised of this contagious state and counseled on how to avoid further transmission of this lethal virus.

RECOMMENDATION 15: Consistent with the proposal by the Secretary of Health and Human Services, a national study in various areas

of the country must be immediately undertaken to determine the prevalence and conversion rate of the virus in the United States population, and the study must be repeated at appropriate intervals to gauge the spread of the disease.

Warning to third parties

One of the more difficult issues for society is how to warn unsuspecting spouses or sexual partners of persons who test HIV positive. Such a warning would allow the third party to practice "safer" sex or to abstain from sexual relations with the infected person altogether. Given the life-or-death consequences, the unsuspecting third party should, as a general matter, be warned because there is no cure and because it may not be responsible to rely solely on the infected person to provide a suitable warning.

Physicians who have reason to believe that there is an unsuspecting sexual partner of an infected individual should be encouraged to inform public health authorities. The duty to warn the unsuspecting sexual partner should then reside in the public health authorities as well as the infected person and not in the physician to the infected person.

The AMA believes that mechanisms, analogous to those used by public health authorities to warn sexual partners about other sexually transmitted diseases, would be put in place to warn unsuspecting third parties about an infected sexual partner. Such warning may be appropriate whether the infected person is bisexual, heterosexual, or homosexual.

This problem raises the general question of whether anonymous reporting should continue to be the standard for persons who test seropositive. Our recommendation at this time is limited to situations where physicians or health officials already know the identity of the AIDS carrier and have reason to believe a risk to third parties exists.

RECOMMENDATION 16: Specific statutes must be drafted that, while protecting to the greatest extent possible the confidentiality of patient information, (*a*) provide a method of warning unsuspecting sexual partners, (*b*) protect physicians from liability for failure to warn the unsuspecting third party, but (*c*) establish clear standards for when a physician should inform the public health authorities, and (*d*) provide clear guidelines for public health authorities who need to trace the unsuspecting sexual partners of the infected person.

Sanctions for reckless disregard for the safety of others

A related question which must be explored is whether an infected person, who knows he or she is infected and who knowingly fails to warn a sexual partner of the infection, should be subject not just to tort suits, but to a proceeding brought by state authorities to sanction the individual.

RECOMMENDATION 17: Given the risk of infection being transmitted sexually, and given the dire potential consequences of transmission, serious consideration should be given to sanctions, at least in circumstances where an unsuspecting sexual partner subsequently finds out about a partner's infection and brings a complaint to the attention of authorities. Pre-emptive sanctions are not being endorsed by this recommendation.

Conclusion

The Board intends to review its evaluation of developing AIDS epidemic on a constant basis. Modifications of the AMA's positions will be made as the situation warrants.

Resolutions on AIDS adopted by AMA House of Delegates

Substitute resolution 18

Resolved, That the American Medical Association:

1. Institute an AIDS public awareness and information program,
2. Endorse the education of elementary and young adult students within the school system regarding the mode of transmission and prevention of transmission of the human immunodeficiency virus (HIV),
3. Address, through the Council of Ethical

and Judicial Affairs, the patient confidentiality and ethical issues raised by known HIV antibody positive patients who refuse to inform their sexual partners or modify their behavior,

4. Work with various state societies in seeking to delete legal requirements for consent to medically indicated HIV testing, which are more extensive than requirements generally imposed for informed consent to medical care,

5. Assist states in their efforts to take whatever actions are necessary to allow blood bank and health departments to share information for the purpose of locating and informing persons who have any transmissible blood-borne disease,

6. Seek greater involvement and adequate funding from the state and national levels for immediate development and implementation of AIDS/HIV educational programs,

7. Work with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with AIDS and AIDS-related conditions,

8. Lobby for federal, state, and local governments to allocate funds for AIDS education programs in schools, colleges, and new media, and

9. Expand its work with AIDS public service announcements to include messages on abstinence, condom usage, and safer sex for distribution to media that specifically target high-risk groups.

Substitute resolution 176

Resolved, That the American Medical Association:

1. Identify risk factors and guidelines for hospitals, medical staffs, and health workers appropriate to the care of AIDS and HIV positive patients,

2. Include in such guidelines policy that would enable physicians caring for patients with a positive HIV test to discuss with legal immunity and in a confidential manner these patients with other health-care professionals who are also involved in their care, and assist state medical societies in changing state laws where such informational exchange is now prohibited,

3. Distribute these guidelines widely and encourage medical staffs and health workers to work closely with their hospital administrations and governing bodies in establishing appropriate hospital policy regarding AIDS and HIV positive patients,

4. Affirm its support for the dignity and self-respect of all patients, and

5. Oppose all acts of medically unfounded discrimination against patients because of their medical condition.

Substitute resolution 29

Resolved, That the American Medical Association join with the Surgeon General and with the public health community in endorsing the use of condoms as one useful measure in attempting to contain the spread of the HIV virus among the population; and be it further

Resolved, That the AMA investigate the possibility of cooperation in setting up a foundation or coalition with the public health community and/or government agencies for the purpose of developing standards and producing tasteful public service announcements regarding condom use in limiting AIDS and other sexually transmitted diseases.