

AIDS lecture March 1, 1988  
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Prepared Statement  
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It was three days since I last spoke publicly on the subject of AIDS.

This was not a lecture, it was a prepared statement given before an officially appointed presidential commission appointed by President Reagan to study AIDS, the epidemic in its entirety.

I began for being grateful for the opportunity to appear before the Commission and discuss the prevention and education issues concerning AIDS and HIV infection. I congratulated them on the progress made thus far and then went into the release of my report in October of 1986 and what had been accomplished at that time. With the cooperation of the news media, the entertainment media, the administration and the congress, we had greatly increased the resources for the fight against AIDS and HIV infection.

Research and health care communities were working hard on the problems. I also said it was the highest level of such activity and commitment to a public health problem that I had seen in my lifetime. There was an increasing public awareness of this health issue and a strong desire to take personal and public action.

I confessed to my areas of special concern: needle sharing among I.V. drug abusers, and I gave statistics about sharing of drug injection paraphernalia that had alarming implications for both the drug users and their sexual partners; solutions were not readily obvious, because I.V. drug abusers led disjointed lives and many of them are functionally illiterate. We have to find the right combination of strategies to get people off drugs and away from contaminated needles.

Incidentally, for the user of this archive, I might say that I took time to study the broad behavioral attitudes of drug abusers in New York, London, Edinburgh, Glasgow, Dundee, and Amsterdam. With the exception of Amsterdam where I thought the behavioral patterns were very much like New York, the other European cities I visited didn't seem to have the same dysfunctional addicts attached to dysfunctional families and groups of society. It was an important difference that I wished we had had time and money to investigate in greater depth during my tenure as Surgeon General.

Additional drug treatment capacity was needed, but I also said that simply making dollars available would not translate into additional slots available for addicts. There needed to be sharing of expertise and programmatic experience among federal, state, and local governments working on close conjunction with community organizations and the professional provider community. Our only hope lies in the solutions that come from this type of collaborative activity.

I then turned my attention to my concern about the spread of HIV among heterosexuals, and expressed outrage at recent newspaper and magazine articles stating that there was no danger of heterosexual transmission from normal vaginal intercourse. I made it clear that it was just not true, but what was unknown was the level of the danger and time has proved me eminently correct.

Although I am sure that our statistics were underreported, CDC claimed 2092 cases of reported heterosexual transmission out of a total 52,249 adult cases, which was about 4 per cent. Excluding foreign-born individuals, most of those cases were the sexual partners of I.V. drug abusers. I said something I'd never said before in public and that it was that we knew from infected spouses of persons with hemophilia that HIV could be spread through normal vaginal intercourse. My concern was the potential for more rapid spread in the general population through casual sex.

To bolster my concern, I noted the reported increase of infectious syphilis by approximately 30 per cent between 1986 and 1987. The greatest increases were in Florida and New York, and California, which were also the areas of the highest HIV incidence. Relative increases in this cohort were greatest for females and heterosexual males of all racial and ethnic backgrounds.

This moment was taken to add a special word of praise for those dedicated to the compassionate care of people with AIDS and AIDS-related conditions – physicians, nurses, teachers, social workers, and others, especially, in the highest concentrated areas of AIDS cases.

I had to mention the concern I've expressed in other lectures about the instances in which health professions refused not only to treat persons with AIDS, but also turn away patients who came from the same high-risk behavior groups – homosexuals and bisexuals men and intravenous drug users.

In passing, I mentioned the small number, less than a dozen, of health care workers out of the seven million Americans so occupied and the size that all workers be required to follow CDC guidelines. I was aware during this entire presentation that I was talking to a presidential commission that had the power to do a lot of things that couldn't have been done otherwise, even if it was only by coercion and moral suasion.

I couldn't close without getting into the economics of the situation, and I went through the litany of figures, but added there were social costs that could not be measured, such as the loss of human capital often translated as lost wages and productivity. I also included the predictions from CDC of the costs in 1991, when there would be an estimated 145,000 persons with AIDS in

various states of a terminal illness. Challenge therefore was to give the country a way of caring for AIDS patients while preventing an escalation of costs.

Again, I emphasized to this particular audience that the critical point was one of complexities of AIDS in that it is an epidemic characterized by related issues, a number of them social (e.g., homosexuality, I.V. drug abuse). Therefore, we must develop our strategies to meet the specific dimension of each issue related to the epidemic if we are to contain HIV infection in this country.

Also, I confessed to having limited myself to a few critical issues to the exclusion of many others and expressed my concern that we needed to stop the epidemic in a way that was effective and yet, consistent with American law and tradition. That means we need good science and good education. The public must have a clear understanding of the threat posed to them by this disease, and that they are ready to fight back with the best weapon available – their intelligent choices about personal behavior.

I closed with sort of a charge to the presidential commission with high public visibility telling them that they had the ability to market good disease prevention, good science and good health practices to the public and the American people would look to their final report for a leadership vision of those things we must do to contain the HIV epidemic. Only in this way could the Commission serve the best interests of the American people.

Because of the nature of this presentation and the fact that each point is really an index point, there is no index.