

AIDS lecture September 9, 1987

Address

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Presented to the President's Commission on AIDS

Washington, DC

September 9, 1987

It had been ___ since I last spoke in public on the subject of AIDS. To be able to talk to the AIDS Commission about AIDS was certainly an opportunity and an unprecedented one. The people who spoke before me touched upon a range of epidemiological and biomedical issues regarding the pandemic. I laid out the focus of my remarks as being a number of concerns that had been brought to my attention as I traveled around this country and overseas.

I repeated that AIDS was still a mystery, that was fatal, and that people got AIDS chiefly be doing things that the majority of people don't do and don't like other folks doing. These three facts presented the people of the United States with a difficult and complex test of our national character. I tried to impress this group that those issues and the highly sensitive issues of law, ethics, economics, morality, and social cohesion really make purely scientific issues pale in comparison. I mentioned that in spite of the CDC guidelines we still hear – every day—of professionals who refuse to treat persons with AIDS or that they are suspected of having AIDS.

This was an example of the time that the good conduct of the vast majority did not release us from facing the un-professional conduct of a fearful and irrational minority. I reminded the Commission that we have a tradition in America in health that “no one is turned away”.

I relayed the issues for the cost of care for AIDS patients and who should pay that cost. This economic factor is probably not well known to most members of the Commission and I outlined the mixed system we had for the reimbursement in this country.

I talked about programs that we had paid by the American tax-payer that support material and child health, alcoholics, drug addicts, and syphilitics. They are part of the government's total commitment to provide for “the general welfare”. These programs are, in general, relatively inexpensive. On the other hand, AIDS is proving to be very expensive, then, of course, after consuming tens of thousands of dollars worth of medical care and social services, the AIDS patients dies.

I had to ask the question, would the American people continue to support such care as the AIDS case-load climbs and the costs rise, or will they ask for relief and support only second-class care for AIDS patients? How do we respond to that possibility?

In as much as previous speakers had mentioned the issue of individual privacy versus the need to protect the community, I asked the question of how much leeway did we have, as a free but responsible people? How much risk can the community tolerate in order to preserve the rights of individuals?

I pointed out that this was the heart of the debate over confidentiality in records. Again not knowing how much this Commission knew, I pointed out that it had been a long-standing practice in public health to get as much sensitive, health-related information as possible from the individual, in exchange for the guarantee of confidentiality. It was such a system that gave us the success in containing most infectious diseases, as we had done. However, I had to acknowledge, that no previous disease had been at once so mysterious, so fatal, and so resistant to therapy and vaccine prevention.

I stated that the public health belief that the assurance of total confidentiality was the key to having potential – and actual – carriers of the AIDS virus present themselves for voluntary testing and counseling.

I felt that I had to issue a warning that we had to be careful of taking an absolute position, and I used as an example my experience earlier in the year to being asked to look at sexual child abuse by the Department of Justice. Among the recommendations was one that advised health personnel to administer a number of tests – including a test for the presence of AIDS. In other words, we believed a health worker should check to see if the perpetrator in sexual abuse passed the AIDS virus to the child victim during the sexual attack. We needed to know that because the child with the AIDS virus should not receive, for example, the routine series of vaccinations that nearly every child in America then received. For the child with AIDS, vaccination itself could be life threatening.

In this situation, naturally the parents should be told if their child is sero-positive, and the family physician, if there is one. But should the school be told? Should the child's religious congregation be told? How much of the public had a "need to know" whether or not the child is sero-positive?

I then made it clear that the issue of confidentiality would never have come up, had it not been for the number of instances in which persons known to have AIDS had been fired from their jobs, had lost their insurance, had been evicted from housing, and had been sent home from school, and so on.

These reactions had been irrational, unfair, and discriminatory. What should we do about it? How can we deal with these inclinations toward discrimination?

And here we come to the crux of the arguments that I heard so frequently, that it is not discriminatory to deny housing or medical care or any of the other essential services to a

person who contracted AIDS while shooting drugs or engaging in sodomy. But the great march of public health policy over the past century in this country has been to reduce or eliminate altogether criteria for eligibility to receive essential public services.

Is AIDS the exception? And why?

And finally I pointed out as probably the most important point of all, we see more evidence every day that this disease is becoming the particular scourge of people who are young, Black, and Hispanic. Our country is only now emerging from two decades of turmoil, during which we have tried to correct the social injustices of the past. We have finally extended to Americans – regardless of race, color, creed, ethic, origin, relations, age, or sex – the birthright of freedom that is theirs.

Will the disease of AIDS – by itself – reverse this trend of history? We hope and pray that it will not.

The reader can see that I used the technique of asking questions, rather than laying down admonitions to the body that is now entrusted with providing the government with final advice on AIDS. So, I asked the question, how can this Commission contribute to the leadership that we need? How can they and I and every American insure that our country will not return to fear and hatred in the ways of a shameful past? As I've said so often, we were fighting a disease and not the people who have it.

Can we remain color blind in this war against AIDS? How can we make sure that we do?

I reminded the Commission that in my role as Director of the Office of International Health I had many occasions to speak with health ministers of other nations and was constantly reminded of the extent to which the United States is a beacon of good sense and good science for the rest of the world. Today especially, the world sorely needed us.

With the caveat of underreporting, I said that the World Health Organization count of AIDS in other than the United States had reached 14,600.

This had far-reaching complications because the President had asked the House of Representatives to appropriate the full U.S. contribution to the United Nations, especially to the World Health Organization

Disease knows no borders. Clearly, part of our success in containing the disease depended upon how well it will be contained elsewhere. For that reason, it would be self-defeating if the United States did not face up to paying its full assessment to the United Nations. We had to make the choice that was ethically correct.

I closed with the hope that the Commission would investigate these issues as well and come forward with guidance and good counsel when they deliberations were over.

American tradition that does not abandon the sick or disabled

Aspects of AIDS that color everything done & said
about the disease
CDC guidelines to the health professions
Child abuse & AIDS testing as a dilemma
Cost of care for AIDS patients
Criteria for eligibility to receive essential public
services
Denial of medical care by health professionals
Difficulty of taking absolute positions
Disease knows no borders
Ethical foundation of health care itself
Ethical imperative of paying our United Nation
dues
Extremely difficult & complex test of the national
character
Governments commitment to provide for the
“General Welfare”
International implications of AIDS
Irrational, unfair discrimination
Law, ethics, economics, morality, & social cohesion
Mixed system of support for health care
Origin of the disease of AIDS
Privacy vs. need to protect the community
Question of second-class care for AIDS patients
Reporting child sex abuse & AIDS testing
Resistance of AIDS to therapy & vaccine
prevention
Social implications & punishments for HIV
positivity
Social injustices & race, color, creed, ethnic origins,
religion, age, or sex
Social injustices of the past
Social prejudices against sodomy & I.V. Drug
abuse
Support of maternal & child health by American
taxpayers
Support of programs for alcoholics, drug abusers &
syphilitics by taxpayers
“The Need to Know”
U.S. contribution to the United Nations
United States leadership
United States as a beacon of good sense & good
science
Voluntary testing & counseling
World Health Organization figures on AIDS
prevalence