I-N-D-E-X

I-N-D-E-X-(continued)

PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON SOCIETAL AND LEGAL ISSUES

The Hearing was held at the
INTERSTATE COMMERCE COMMISION BUILDING
HEARING ROOM B
12TH AND CONSTITUTION AVENUE, N.W.
WASHINGTON, D.C.

Wednesday, April 6, 1988

COMMISSION MEMBERS PRESENT:

ADMIRAL JAMES D. WATKINS (Ret.), CHAIRMAN

COLLEEN CONWAY-WELCH, PH.D.

JOHN J. CREEDON

THERESA L. CRENSHAW, M.D.

RICHARD M. DeVOS

KRISTINE M. GEBBIE, R.N., M.N.

BURTON JAMES LEE III, M.D.

FRANK LILLY, PH.D.

JOHN CARDINAL O'CONNOR

PENNY PULLEN, M.D.

CORY SerVAAS, M.D.

WILLIAM B. WALSH, M.D.

POLLY GAULT, EXECUTIVE DIRECTOR

P-R-O-C-E-E-D-I-N-G-S

9:02 a.m.

MS. GAULT: Ladies and gentlemen, distinguished guests, members of the President's Commission, my name is Polly Gault. I am the designated federal official, and in that capacity it is my pleasure to declare this meeting open.

Mr. Chairman?

CHAIRMAN WATKINS: Good morning. Once again, I'd like to welcome our witnesses and guests to today's hearings on societal and legal issues.

Yesterday, we heard some compelling testimony correlating the HIV epidemic to other societal problems, reminding us again that the HIV epidemic is not taking place in a vacuum. Our witnesses offered some creative solutions to the plight of border babies, and physicians and historians helped us look at epidemics of the past and the lessons we could learn from responses to them.

Today, we'll deal with the critical issue of the supply side of the drug problem. As you know, the Commission in its interim report issued some sweeping recommendations calling for treatment availability for IV drug abusers and setting forth a comprehensive program of research, prevention, and outreach education.

Yet, the drug problem which is connectively tied to the HIV epidemic is not monolithic, and therefor this Commission must join forces with the many commissions and boards seeking new ways to stem the flow of drugs in this country if it is to significantly impact on the HIV epidemic. To merely address the demand side of the drug problem would fail to acknowledge the overwhelming impact of the multi-billion dollar industry on the fabric of our country and the future of the HIV epidemic.

In addition, a number of legal issues have emerged in the context of this epidemic. A number of states have passed laws and more have introduced them creating civil and criminal liability for the transmission of the virus. Today, some of the nation's leading legal minds will share with us an analysis of those laws and make suggestions to effectively use legal strategies to help prevent further spread of the virus.

In addition, we'll discuss liability issues faced by vaccine manufacturers. The liability issues have been described to us as a significant obstacle to progress in developing an effective vaccine as quickly as possible.

Once again, I'd like to thank Dr. Burton Lee for his dedication to these issues and his diligent work in organizing this hearing, and I'll turn the chair over now to Dr. Lee for the remainder of today's panels.

CHAIRMAN LEE: Thank you, Admiral Watkins. Mr. Chairman, fellow commissioners, sometimes I wish we were serving on the Snail Darter Commission. The combination of issues with which we are dealing are staggering, and they go from problems related to the alterations of human sexual patterns to the war on drugs and drug abuse, a war which we are fighting on our own soil and a war that is claiming thousands of lives among our young people. If they are not killed or maimed, their lives are damaged in permanent ways. Many thousands will spend their entire productive lives in prison.

We must deal with these problems because AIDS sits in the middle and prospers in these environments. We learned yesterday that the patterns of drug abuse are switching from heroin to cocaine and crack, and that crack is used primarily within a sexually promiscuous setting. This makes our problem with crack use just as serious as it has been with IV heroin use. If anything, the crimes related to drug abuse are now more violent and there are more of them.

We look to our panels this morning to help us address these problems. This afternoon, we deal with liability issues, issues which have stymied the Institute of Medicine and the AMA and Congress, but they are terribly critical issues relating to the financial health and viability of many of our most essential institutions, such as our insurance industry. We hope that this AIDS lens will allow us to focus further light and heat on this problem, so that our legislative bodies may take constructive action.

I want to particularly thank members of our staff who have brought together the hearing book and the information which is before each one of our commissioners, Ms. Sherry Kaiman, Emily Cooke, Mr. Leo Arnaiz, Mr. Chris Hanus and Mr. Rob Mathias.

Lastly, may I ask my fellow commissioners a favor today? We have a full compliment of commissioners. We have full panels. Please limit your questions wherever possible to five minutes so that the panels can respond. If you exceed your time limit, fellow commissioners will not be able to participate. If we have time left at the end of the session, we can go back and explore more of your concerns.

DRUG ABUSE AND HIV/SUPPLY SIDE FEDERAL PERSPECTIVE

CHAIRMAN LEE: Let us start off with our first panel. We apologize for the fact that General Noriega is unable to be with us, but in his absence let us start off with Mr. Burke.

DR. BURKE: Thank you very much, Dr. Lee. While Mr. Noriega's not here, we have Mr. Juan Matta Ballasteros back in the United States now. I'm sure that it was a fairly traumatic thing for that person waking up in his villa yesterday morning in Tegucigalpa, Honduras, and going to bed in solitary confinement in a prison in the United States. Maybe that will send the type of signal that we're looking to send around the world to some of these traffickers who feel that --

CHAIRMAN LEE: Could you repeat that? Some of us missed that.

DR. BURKE: I'm sorry. While Mr. Noriega couldn't be with us this morning, we do have Mr. Juan Matta Ballasteros, the cocaine king of the Medellin cartel, who's been hiding out in Honduras -- not exactly hiding out, living in a luxurious villa for some time -- and he woke up in that villa yesterday morning amongst his luxury and comfort, and the U.S. Marshalls Service put him to bed in the middle of the United States in the early hours of this morning in solitary confinement in a prison cell. Maybe this is the type of signal that we need to send, hopefully more frequently, to these international traffickers.

I'd like to take a few minutes -- I have a prepared statement which has been provided to the staff which may make interesting reading, I hope, for you tonight, but probably would make a boring hearing this morning -- and just briefly go over some of the things that we're facing, especially with drugs coming from all areas of the world and coming from the confines of our own country. In doing so, I feel kind of like former General Chesty Puller at the Chosan Reservoir in Korea in the early '50s, when he gathered his commanders and said, "Men, the enemy is to our front and to the rear and on both flanks. The bastards won't get away this time."

We have drugs coming at us from every angle in the globe. We can take the four main drug areas that we worry about, the cocaine, the heroin, the dangerous drugs, and the cannabis, and you can put your finger on just about any point on the globe and find that it is either a transit point, production point, or a growing point for the drugs. You can touch just about any type of crime in the United States and internationally, and there will be some drug ramification there, some major part of the crime will have been initiated in some way or other by drug trafficking.

Briefly, heroin: heroin is coming at us, as many of the other drugs, from all directions. We have the very potent black tar heroin coming from Mexico. Opium growth there in Mexico is probably as great as it was ten years ago. It did recede for a certain period of time through an extensive effort of eradication in Mexico. That eradication effort is continuing, but also we have found that by hiding the growth better, by using more remote areas, it's been more difficult for the government of Mexico to efficiently spray the poppy fields.

We have opium being grown in Afghanistan, in Pakistan, and in Iran. Because of the war and the conflict over a number of years now in Afghanistan, it's been very difficult to have any type of control in that area at all.

Fortunately, I am happy to report that we are getting very excellent assistance from the government of Pakistan. They are raiding an increasing number of heroin laboratories every day throughout Pakistan. I myself, having served in Afghanistan and covered Pakistan and India a number of years ago, never thought I'd see the day that the government of Pakistan would be able to raid into the tribal areas of the Northwest Frontier. They are doing that now, and they are doing it with some effect.

However, the flow of heroin is still coming out of Southwest Asia. Southwest Asia probably is our number one producer of the heroin that we receive in the United States now. Not too far behind them, and apparently attempting to catch up, is the area of the golden triangle which we've all read about for a number of years. We are getting very high grade heroin out of that area. I just want to double check and see if I have the exact figures here.

In February, on the 10th of February of 1988, 1,280 kilograms of heroin were seized on the docks of Bangkok. That exceeded our previous estimate of the entire annual U.S. import of heroin from Thailand. It was hidden in a shipment of raw rubber destined for New York. It was an exceedingly huge amount. The amount of Southeast Asian heroin coming into the United States, the figures are in my report, are greater than they ever have been. It is an unprecedented amount of heroin coming from that direction.

Cocaine: about 92 percent of the coca is grown in either Peru or Bolivia. Both of those countries had previously had only growth there and conversion to coca paste, and in some cases coca base, up until a very short time ago. We now have Bolivia with major cocaine hydrochloride laboratories located throughout the jungle areas of Bolivia. Along the Brazilian border area where Brazil borders Peru, Colombia and Bolivia, the Brazilian forces have located a number of major hydrochloride laboratories.

In January I was in Bolivia. After flying for an hour and a half north of Trinidad, which is a fairly remote area in the Amazon basin, crossing jungle and basically water-logged grazing land at this time of the year, we found a deserted air strip. We located in the jungle there, a very well hidden laboratory that had been set up two years ago by a Colombian trafficker -- excuse me, by a Colombian chemist, at the behest of a Bolivian trafficker.

For a year, they had been producing about 200 kilograms of cocaine hydrochloride a day in that laboratory using 17 workers. They had tables set up about half the length of your rostrum. These were drying tables. They had wooden rakes. They had hundreds and hundreds of drying lamps, such as the type of lamps we have above us this morning, with which they were drying the cocaine hydrochloride.

I tell you this only to give you the impression that here, out in the middle of nowhere, having to bring in all the chemicals by plane or by boat and remove the finished product under very difficult logistical circumstances, they were still able to turn out this volume of cocaine. The scary part of this, if this isn't bad enough, is the fact that during the next few days the Bolivian forces that we were working with were able to come up with four or five similar size laboratories in the same general area run by the same people.

Now, I won't bore you with how this is trafficked up to the United States. I'm sure you've all read enough about it and seen enough in the press. It is principally routed through the Caribbean, and the southwest U.S.A. I've just returned from a tour, or finished a tour in Arizona, where I was concerned with the Mexican border area. The Mexicans are basically being used as an Atlas Van Lines for the Colombian cocaine traffickers.

The cocaine traffickers from Colombia move the finished product from South America to landing strips in Mexico. The Mexican groups take it over at that point and smuggle it north using their traditional marijuana and heroin smuggling routes. They move the drugs to the border in most cases by small aircraft, and then either using body pack -- or vehicles across the border. We used to find the peasants, the Mexican peasants, backpacking marijuana across 50 kilos or so at a time.

We now find them bringing the same size loads of cocaine across, leaving it in the desert on the U.S. side of the border to be picked up by pickup trucks and vehicles of the organization. It is then brought up to either Tucson or Phoenix. Then it is moved on to Los Angeles where the Mexicans turn it back over to the Colombian groups for further distribution in the

east. We have it coming through the Caribbean, through Florida, as you know, through just about every imaginable route.

Moving on to marijuana: we have still a significant amount of marijuana coming virtually by the truckload, out of Mexico. There has been some cut-back in Colombian marijuana availability. There has been a pretty aggressive campaign of eradication, aerial spraying by the government down there. The same in Jamaica. But, even despite these efforts, right now we are still getting from Columbia and Jamaica and Mexico and now Thailand a very significant amount of marijuana.

Now, we can't just sit and point our fingers at these countries though, and say, "Isn't this terrible," because we are also producing a tremendous amount of marijuana in the United States ourselves. We have an active program where we have about 46 or 47 states participating in a domestic marijuana eradication program. But, we are still producing probably at least 25 percent of the amount of marijuana consumed in the United States today right within our own borders.

The dangerous drug situation in the United States is one that I would suggest this panel take a very close look at and not just concentrate on the intravenous use of heroin and cocaine. Because methamphetamine is so popular they call it the poor man's cocaine. It's extremely popular. The number of laboratories as documented in my written statement will show you that there are laboratories concentrated all over the United States.

When you go into these laboratories, the people are cooking the methamphetamine or speed. Many of the places have used syringes with blood in them hanging off the ceilings where they've been thrown. Thrown against the walls like dart boards because the people are constantly shooting up this methamphetamine even while they're producing it in these sometimes bathtub-type laboratories.

Now, we have many of these bathtub-type laboratories for both PCP and methamphetamine across the United States. Unfortunately, we also have some very sophisticated laboratories that are being run by individuals in a very organized fashion. Many of these are associated with the major outlaw motorcycle gangs. These places are very well fortified establishments, booby-trapped and set up with explosives so that they can blow up their entire laboratory should the police raid it. The number of weapons we take out of these places are staggering. We have had to come to the realization that we have placed our own agents and the police who go into these labs in great danger, just because of the toxic chemicals that are present and the huge amounts of ether that are used.

I've gone into laboratories, so called laboratories, in houses in the middle of residential areas that had enough ether and other materials to have blown half the block away. This is a real danger and it's not one coming from outside of the United States. It's coming from right in the United States. So, again, I urge you to take caution and be a little hesitant in pointing our fingers constantly outside our own borders.

Quickly, in response to what we're doing here in the United States which you wanted to know about, our initiatives here, I mentioned the Cannabis Eradication Program. It is a federal, state, and local program where we do training and supply funding so that the local law enforcement people can go out themselves and locate the marijuana fields, conduct raids and destroy them.

It's a very, very labor intensive activity. When you raid one of these fields with 1000 or 2000 plants, there is a lot of cutting to do and the marijuana has to be hauled away. The fields are generally in remote, difficult areas to get to. The marijuana is wet and yet it has to be burned. It's a very labor intensive operation. But, we have most of the states, participating in this operation.

Regarding cocaine: our major investigations we are going after the people whom we really feel are behind these operations. We are trying to obtain as many indictments in the United States courts as possible against the principal Latin American, Mexican and other foreign traffickers who are responsible for bringing the drugs into the United States.

By getting indictments in the United States, even though we can't always reach these people to jail them immediately, we do put a crimp in their operations. They can't travel back and forth to make the arrangements that they would like to do. They're leaving their assets that they like to purchase in the United States very vulnerable to the asset and seizure laws.

Operation Pipeline is an operation in 38 states right now, and I wish I had the time to tell you how effective it is. It's objective is the training of State Highway Patrolmen, sheriff's personnel, and others who patrol the U.S. highways. When officers are making routine traffic stops, they're trained to be alert to certain signs that cause them to ask questions of the drivers and passengers.

The approach has been very successful in identifying cars that are laden with drugs or money supplying the U.S. drug network, throughout the United States. It's a very successful program and it has had the participation of most of the major highway police departments throughout the United States.

We have an operation right now in South America where we're working with local officials in a number of countries in a very major program. I won't be able to get into that in too much detail this morning, but we are going after the supplies through air, land, and water interdiction, and hitting at the laboratories, hitting at the production sites throughout South America.

As I mentioned the clandestine laboratories, we seized 682 clandestine, dangerous drug laboratories during fiscal year 1987. We have already taken off 308 this year, and that's about a 96 percent increase over this same time last year. It's just obvious to a lot of people there's a lot of money to be made in these drugs and a lot of people want to use them. That is why we're getting more and more of these laboratories. There's no question about it.

We also have a number of investigations going regarding heroin. We have a domestic monitor program where we supply money to local police departments to make small purchases of heroin throughout the country on a regular basis. We are able to test the potency of the heroin and determine the origin of the heroin. This program is just strictly to track and try to determine just what we are facing,
where the heroin is coming from and what the distribution system is through the United States.

We have a number of major investigations. One just culminated with the FBI in New York. It's an interesting story that was highlighted in U.S. News and World Report in this week's edition. Because of the joint operation between DEA and the FBI, a major Sicilian organization was taken down between the United States and Italy.

We are going after major organizations with the FBI in five major cities. We put our heads together and determined which of those organizations in those particular cities neither one of us had been able to get. We identified them and confirmed that they were major domestic trafficking organizations. We have put our resources together and we're combining forces to go after these groups.

I could sit here for the next hour or two and tell you about many of the activities I have identified in the written statement. I would like to say that in my government career, I just received my 30-year pin with the U.S. government, I have never seen the likes of the current level of cooperation, state, local, federal, and international. It's never been as high in my 30 years as I've seen it in the past four or five years.

There is rarely a single major investigation in any city in the United States that goes down that has not been the result of joint state, local, and federal help. I found as Agent in Charge in Phoenix, the press got a little tired of the long list that I would give them; the FBI, the U.S. Marshall Service, the Coast Guard, the U.S. Customs Service, and police departments and sheriffs offices that were participating in any particular investigation.

But, it is the one ray of hope that I do bring to you this morning. That, despite that magnitude of the problem, there are a lot of concerned law enforcement people out there working at it. I would stop my presentation with that and you may ask any questions you may wish to.

CHAIRMAN LEE: Thank you, Mr. Burke. Mr. Storey?

MR. STOREY: Thank you, Doctor. My written statement will be furnished later on this afternoon. Mr. Burke more than adequately described the drug problem itself and the production and the availability of drugs here in the United States.

This morning, I would like to limit my remarks to the enormity of the problem from our perspective as it relates to the organizations that are responsible for the importation and distribution of drugs in this country. The FBI became involved in drug trafficking investigations when we received jurisdiction in 1982. Up to that time, we had not actively addressed the drug problem from a program standpoint. Since that time, we've initiated numerous investigations directed at organizations responsible for the importation of drugs. It is now a separate program within the FBI. We have over 1000 agents working drug cases as one of our top five investigative programs.

The approach that we're taking is a little different in some respects than the traditional approach. We're looking more at the organizations that are responsible. We're talking about multi-billion dollar organizations that rival some of our major corporations here in the United States. We're looking at the entire enterprise. We're looking at it from a national and international level in cooperation with DEA as relates to the organizations.

To give an example, in Miami alone we've identified over 250 Colombian organizations responsible for the importation and distribution of cocaine. Now, they have three different groups. One group is responsible for the transportation. The other group is responsible for the distribution. And then they have other groups that are responsible for the laundering of the money that is generated from the sale of cocaine.

Mr. Burke referred to a recently concluded investigation involving the DEA and the FBI in New York and other cities throughout the United States. We've identified over 110 Italian drug trafficking organizations operating here in the United States. These organizations are already here operating, and of course they have contacts and associates and a source of supply in foreign countries.

In addition to that, we have the Mexican trafficking groups that are responsible for the importation of cocaine along with the Colombians with whom they associate. Mexico is used as a trans-shipment point for cocaine, and is the principal provider to the U.S. of marijuana, black tar heroin, and brown heroin. There's over 65 Mexican organizations operating in the United States. One organization alone, the Herrera group, has 5,000 members. We've had extensive investigations involving some of these groups. In one particular case in Chicago, we arrested over 117 individuals. But, that's just one organization.

In addition to that, you have the Jamaican groups, the so-called "posses." Now, that really gets into a local problem because of the homicides involved, the rivalries, the control of the trafficking activities. You have Cuban organizations. The Chinese groups are now becoming very, very prominent. The importation of Southeast Asian heroin is rising steadily. So, you have all these particular groups that are already here in the United States importing and distributing the drugs and then siphoning off the money, and a lot of the money, of course, is leaving our economy.

Our approach is long-term in nature. We by no means feel that by taking down organization after organization we're going to eliminate the drug problem in the United States, but we do believe that if we can neutralize some of these organizations, take away their power base, it will make a significant impact. Most of our agents are concentrated in the large metropolitan areas. We have what we call major distribution centers, of course, in New York, and Miami, Los Angeles, Chicago, Houston, San Diego.

But, of interest in some of these investigations, particularly the one last week, we had an Italian drug trafficking group centered in New York that allegedly involved the importation and distribution of heroin, but they had associates and contacts throughout the United States where this heroin was being distributed. For instance, we had a group in Greensboro, North Carolina that we arrested. In fact, on Thursday morning when the arrest took place, one of these individuals had a kilo of heroin in his possession.

Now, heretofore we did not have that type of intelligence information and were not aware of a group in North Carolina participating in heroin distribution. The same investigation also took us into Houston, Texas. We have had other groups that we've identified in Dallas, Texas; San Jose, California; Harrisburg, Pennsylvania. We've also made two arrests in Bethlehem, Pennsylvania.

So, this problem is not just -- and when I'm talking about problem, I'm talking about the organizations -- they're just not limited to New York and Miami and cities like Chicago and Los Angeles. It's truly a national and international problem and that's the way we have to approach it.

How can we do more to address the problem? Like every organization, law enforcement agency, we have limited resources. The problem is so enormous, we just don't have enough agents to effectively and efficiently address the problem. We have identified 250 Colombian organizations. We're only looking at maybe 20 of them. We have 110 Italian drug trafficking groups. We may be addressing 10 of them. With the Mexican trafficking organizations, we're only looking at another 15 or 20. With the Jamaican groups, we can barely address those particular organizations. We have maybe six or seven major investigations going on now throughout the country.

But, in order to effectively address these organizations we're going to need more resources at the local, state, and federal level. Thank you, very much.

CHAIRMAN LEE: Staggering statistics. Mr. Saphos?

MR. SAPHOS: I think it is probably unfortunate, Mr. Chairman, that the dopers will sleep a little bit better tonight after they hear how limited our resources are. But, thank you for inviting me here today.

CHAIRMAN LEE: Could you bring your microphone a little closer, please?

MR. SAPHOS: Yes, sir. Thank you for inviting me here today to address the relationship between our efforts to apprehend and punish drug offenders and the spread of the AIDS virus. I think that you all on the Commission have done a worthy job of documenting the relationship between the spread of the AIDS virus and the abuse of controlled substances in this country. I applaud that. I think it's appropriate, then, at this time, that you ask us what we're doing with your tax money to address the supply of narcotic drugs in this country.

I would like to start out by saying that there have been and continue to be some unquestionable successes in our war

on drugs, particularly if you measure our job as apprehending, prosecuting, and taking away the assets of those people who violate the laws of the United States. If that's the measure of what we do, we are unquestionably doing a better job each year with reduced resources.

If, however, our job is measured by how successful we have been at reducing the availability of drugs in the United States, then unfortunately the demand for drugs in this country -- the insatiable demand, in fact -- has outstripped our law enforcement resources. All the federal agencies contributing to the fight against drug abuse and drug trafficking have developed programs in an effort to formulate a national and international drug law enforcement strategy. Under the supervision of the National Drug Enforcement Policy Board, five standing committees have been formed to coordinate the supply reduction efforts of all federal agencies. These committees address the areas of international efforts: interdiction, intelligence, investigation, and prosecution. Each of these agencies is charged with the responsibility of formulating a dynamic strategy to address the changing threat of drug trafficking.

One of those committees is the prosecution committee, which is chaired by the Criminal Division of the Department of Justice. The principal goal of the National Narcotics Prosecution Strategy is to immobilize narcotics trafficking and money laundering organizations through a series of related plans designed to incarcerate organizational members, forfeit their assets, and divest them of their power to control drug trafficking within the United States.

To accomplish this objective, the limited prosecution resources of the federal government, as well as the unique capabilities of federal law enforcement agencies, are directed at the most significant national and international targets where successful prosecution has the most lasting impact on the success of the overall strategic objective.

Simultaneously, however, a successful prosecution strategy depends on adequately trained and equipped state and local prosecutor's offices to maximize the impact of the federal plan within every locale of the United States.

This strategy, therefore, focuses on a variety of interrelated activities, including but not limited to the following: to extend the efforts to reduce the supply of illegal drugs in the United States to the maximum extent possible by increased proactive targeting of major traffickers responsible for narcotics importation and distribution in the United States; attacking other significant, local and regional narcotics threats as identified by the federal, state and local law enforcement authorities and to maintain a federal enforcement presence in

every district of the United States; lastly, to continue to work with state and local narcotics enforcement authorities and expand the efforts to assist them in narcotics prosecution at the state and local levels.

In order to accomplish this, we have set up a system of priority goals for the National Strategy. They are as follows: The first priority goal is to extend the efforts to reduce the supply of illegal drugs in the United States to the maximum extent possible by increased proactive targeting of major traffickers responsible for narcotics importation and distribution in this country.

I believe that Mr. Storey and Mr. Burke have already testified as to some of the successes of that targeting program. Strategy two is to give assistance to state and local prosecutive efforts and to continue to work with those officers and enforcement authorities to expand efforts to assist them in narcotics prosecution at their level.

Strategy three is to attack within the regions other significant local and regional narcotics threats as identified by the federal, state and local enforcement authorities and to maintain a federal enforcement presence in every district and every state of the United States.

This is but a part of our law enforcement plan to address the supply of drugs in our communities. However, with that there is a recognition, I think, that this plan alone, to address the supply of drugs coming into the United States and the organizations responsible for the manufacture and distribution of drugs, is but one role that law enforcement has in this country.

Another role has to be in addressing demand reduction. There is a component for law enforcement in that role as we're increasingly recognizing. That is, there are certain portions of our population who will not conform their conduct based upon information that their conduct is self-destructive and anti-social. There have to be real sanctions applied, realistically, appropriately and surely against those persons, certain persons, to convince them that their conduct is inappropriate.

Until we come up with a system of appropriate sanctions and sufficient resources to apply those sanctions, there will be a segment of our population who will not conform their conduct and who will continue to be a threat group for the AIDS virus. Thank you.

CHAIRMAN LEE: Thank you, Mr. Saphos. Mr. Rosenblatt?

MR. ROSENBLATT: Thank you. The United States is currently faced with a narcotics trafficking problem that is virtually out of control. This problem threatens the health and safety of our nation, and unfortunately seriously jeopardizes the future of our youth. As you know, our national anti-narcotics efforts are the highest national priority, and even as I speak, the U.S. Customs Service and our federal, state and international law enforcement counterparts are in the process of implementing a narcotics strategy that is international in scope. This strategy aggressively attacks the narcotics smuggling threat and focuses on detecting, identifying and intercepting shipments of illegal drugs as they move from the departure zone in source countries along smuggling routes to our nation's land, air and sea borders.

At the forefront of this effort is the United States Customs Service who, as the lead agency for federal interdiction efforts, has jointly developed along with the Coast Guard, Drug Enforcement Administration, Immigration and Nationalization Service, the National Narcotics Border Interdiction System and Department of Defense and other federal enforcement counterparts a comprehensive interdiction strategy. This multi-year road map seeks to disrupt the flow of narcotics into the United States by attacking the transportation link between narcotics supply and demand.

This strategy is fluid and capable of responding to changes in smuggling methods and trends as they occur. We feel that this narcotics interdiction strategy is by far the most concentrated multi-faceted effort the United States has ever undertaken in our war on drugs.

The National Interdiction Strategy compliments the other supply side narcotics reduction efforts. These efforts consist of intelligence, investigations, prosecution, international drug control and interdiction are dependent on one another and, taken together, offer a concerted supply reduction effort.

Customs has initiated several programs recently which, in addition to supply reduction, we hope will have a major effect on demand reduction. As a 25 year veteran of law enforcement, I personally feel that law enforcement in and of itself will only provide a holding action for the drug menace. It is the supply/demand/reduction, getting to our youths of today for the next generation or two that is going to curb this problem.

In line with that, we have initiated, along with the Department of Justice, a Zero Tolerance program which was initiated by Customs in San Diego in 1986 with the cooperation of the U.S. Attorney Pete Nuaz. He prosecutes every individual who smuggles any traceable amount of personal use narcotics in the

United States. This is sending a message to all those who enter the borders of the United States. "We will not tolerate any traceable amount of narcotics coming into this country. We will arrest you. We will see that you are prosecuted, either in federal or state court."

We cannot be a permissive society and on the one hand say that we are going to put the big traffickers in jail, take their assets and the so-called user or small dealer, we're going to give them a license to continue on. Due to the success of the Zero Tolerance Program in San Diego, Customs initiated this program nationwide, again in cooperation with the Department of Justice and with the approval of the National Drug Policy Board.

The mandate directs that all Customs officers arrest all narcotic violators, regardless of the amount and seize their travel documents. The various offices are presently coordinating with the U.S. Attorney's offices to gain their support for the program nationwide. Not only are the violators arrested, but their conveyances are seized.

We hope this sends a clear message to the public that they better think twice about attempting to cross our borders with any amount of narcotics. Notwithstanding these sanctions, individual vehicles and conveyances found to contain simple drug paraphernalia are also seized. Consistent with our Zero Tolerance Program, we intend to launch, on April 15th, 1988, an initiative named National Paraphernalia Interdiction Program for Enforcement, or as we have to have in the federal government acronyms for everything, we're going to call it Operation PIPE. Kind of fitting when you take a look at some of this drug paraphernalia.

What we'll do is instruct our offices throughout the country to mount a concerted attack on the importation, exportation, manufacture and distribution of illegal drug paraphernalia. We intend to work closely with the state, local, and other federal agencies.

Just recently, this past month, Commissioner, von Raab, accompanied Customs agents who executed search warrants in New York and New Jersey which resulted in a large seizure of drug paraphernalia, also the seizure of hard narcotics and the arrest of five individuals. Similar actions also have been taking place already by other Customs offices and criminal prosecution convictions are anticipated.

This all came about as a result of the 1986 Anti-Drug Act, which makes the manufacturing and the importation and distribution of drug paraphernalia a violation of federal law. In connection with this program, we plan to initiate a public awareness program to express the theme that drug paraphernalia

breeds drug abuse. I feel that it also breeds what we are talking about here today with this Commission.

Although the Zero Tolerance Program does not significantly reduce the amount of narcotics, nor will our drug paraphernalia program necessarily reduce the amount of narcotics, it does penalize the users and it transmits a message throughout the United States that the federal government is committed to a total zero tolerance type program.

Since the inception of this program in San Diego, over 1,400 individuals have been arrested. Of these, 722 individuals have been convicted and disposition is pending on over 700 others. In addition, 42 individuals have failed to appear and warrants have been issued for their arrest.

As we all know, intravenous drug users are one of the traditional high-risk groups for infection and transmission of the AIDS virus. Although cocaine in the form of crack has become a major problem among drug users, heroin continues to be the drug of choice among intravenous drug abusers. There has been a significant increase in heroin seizures by Customs in the past several months. In the first few months of 1988, seizures of heroin increased 34 percent as compared to the first month of FY '87.

Mexico continues to be the primary single country supplier of heroin to the U.S. over our Southwest border. To combat the increasing narcotics threat from Mexico, Operation Alliance was initiated along this Southwest Border. Drug seizures on the Southwest border have increased dramatically as the result of the cooperative efforts of federal, state and local law enforcement agencies involved in Operation Alliance. In fiscal year of 1987, only 52.6 kilos of heroin were seized by Customs and Immigration officials on the Southwest border, compared to 27.4 kilos seized in FY '86.

Nationwide, we see, as I said, a 34 percent increase. This is is my projection if we continue with the seizures of heroin at the rate that we are presently during the first two quarters of this year. Unfortunately it's likely we will set a record of seizing by U.S. Customs and other agencies involved with us on cooperative interdiction cases involving over 1,000 pounds of heroin. I think we have the makings of another epidemic with respect to heroin abuse, almost similar to what we had with cocaine in the early '80s.

Despite these successes, heroin continues to be a menace. What the Customs Service and the other federal agencies involved in the interdiction efforts strived for is the reduction of narcotics availability. However, this effort alone cannot stem the tide. It has to be a well-balanced, well-coordinated

attack headed by the National Drug Policy Board and the strategy that we've set forth. It also means a coordinated effort between supply and demand reduction. It is my fervent hope that one of the points that this Commission makes is an increased effort on demand reduction. Thank you.

CHAIRMAN LEE: Mr. Rosenblatt, I like your attitude. Captain Trainor?

CAPTAIN TRAINOR: Good morning, Mr. Chairman, members of the Commission. It's a pleasure to appear before you to address the Coast Guard's drug interdiction operations and to present our role in the effort to stem the supply of illegal narcotics from entering the United States. I'll also provide information on seizures we have effected which involved drug types that are related to the IV drug users and, by extension, to the HIV epidemic.

Mr. Rosenblatt has adequately covered the drug interdiction strategy of which all the members at this table have played a major role in developing. The strategy has a number of goals. In principal, we want to intercept illegal drugs. We want to deter the traffickers, want to disrupt the flow of drugs to the United States, force the traffickers to alter their operations to avoid detection or to raise the risks so high they'll abandon drug trafficking on the maritime region, (the Coast Guard's principal area of operations over and above the maritime region). That's the ultimate goal.

Since 1973, the Coast Guard has been involved in interdiction of drug traffickers at sea. During that time, we've seized 1,636 vessels and arrested 8,855 persons. We've interdicted nearly 29 million pounds of marijuana and 60,000 pounds of cocaine, combined value of over $26 billion, an enormous sum, an enormous amount of drugs.

As I was talking to Mr. DeVos earlier, we really consider our actions just a holding action. I'm echoing Mr. Rosenblatt in that regard, because we believe that until the ethic of the country turns around, until it becomes anti-social to use drugs, that all we're doing is stemming the supply, and the supply is almost overwhelming.

We have only interdicted a very small amount of heroin in the number of years we've been interdicting drugs. Our cases include three vessels which resulted in arrests of nine persons and 52 pounds of heroin at a value of $2.8 million. A joint effort between Coast Guard and Customs in New Jersey last month was the most recent involvement in a heroin seizure.

We're continuing to seek innovative ways to stop the flow of narcotics into the United States and we're proud of our

achievements. Our drug interdiction responsibilities and operations in the Caribbean basin continue to expand with the invaluable assistance of the Department of Defense, Customs, DEA, State Department as well as cooperating nations. Budget reductions have impacted on our ability to maintain the strong interdiction posture we feel is necessary. However, we will continue to work closely with these agencies I mentioned and also responsible international communities to build the most effective interdiction system our resources can support. Thank you.

CHAIRMAN LEE: Thank you very much, Captain Trainor and this entire panel. Dr. Conway-Welch, do you want to start off?

DR. CONWAY-WELCH: May I defer for a moment?

CHAIRMAN LEE: Sure. Dr. Lilly?

DR. LILLY: I gather that you're all in agreement that there is no way to attack supply that will be totally successful? You cannot interdict supply entirely with any amount of effort.

MR. ROSENBLATT: Well, it depends upon the level of effectiveness that you're talking about, Doctor. I think we've all said that each component of the strategy plays a very important part. If we can reduce the supply in foreign countries and also reduce the demand, it narrows the universe that the interdiction agencies have to play with. It also allows the investigative apparatus to concentrate on lesser organizations.

DR. LILLY: But you started out with an "if" there, "If you could."

MR. ROSENBLATT: Right now, there is no way interdiction can cut off the supply. There's just too much of it.

DR. LILLY: I must say I had rather come to that conclusion even before your presentation this morning. In fact, about the only thing I have to say is that this Commission has already come out with some rather strong recommendations on the subject of trying to cope with demand. That's also a very difficult problem and I'm not sure that anyone knows exactly how to stem demand anymore than you know exactly how to stem supply.

Therefore, it seems to me that one of the things we have to realize is that there is always going to be some level of use of illegal drugs in our society. Coming back to something that one of you said and that many other people have told us, that education -- again, we have to fall back on education of our young people to hope to get anywhere at all. And even there, realize that we're not going to be totally successful. There is

no way that we can totally stamp out illegal use of drugs. That's all I have to say. If you have comments on that, I'd --

DR. BURKE: I think I can agree, Doctor. The point is that you can put all the warnings you want to on cigarette packs and people are still going to smoke cigarettes. We can warn the public and warn each other and so forth about how much cholesterol there is in a steak and I'm sure there are a lot of us that will still go out on Saturday evening and throw a steak on the barbecue that's well marbled and so forth.

But, as far as doing something about the supply, what we need to do very much while we're waiting for the education process to catch up as far as it can, is we need to pull this whole circle together. You've heard from several components here today. There are other components that are very important in this process and that is in the reduction of the supply itself.

We have the State Department that has a very active program internationally where they're doing crop eradication. They have eradication programs in a number of countries around the world. They're supplying money for equipment and conducting training through the DEA and other agencies for foreign law enforcement agencies and to foreign AID type agencies to reduce the growth of the illegal crops, the opium and the marijuana and so forth, and also try to work with some type of an income substitution program.

Then you go through this entire circle of interdiction, of the investigations and so forth and you reach the prosecutorial system. Then you have to reach the court system. And if each one of us are very successful in our own agency's missions, what do we end up doing? We dump a whole lot of people on the doorstep of the U.S. Federal Prison System which cannot handle them.

So, what we have to come to grips with on this whole thing in terms of the supply problem is totally closing that circle and not just looking at it in one segment or the other. And for each one of us who sit here today, the rivalries are not among each other as far as whose going to make the arrests, it's who can get the most dollars out of the Congress to carry out the mandates that our agencies have received. We have this entire process, this entire circle that we're up against.

DR. LILLY: We've asked for a good bit of congressional support for treatment, for example, of drug users. Is that more or less efficient than an attack on supply?

MR. SAPHOS: I think that you can't take out any one component of the overall national strategy and say, "Look, we can do away with this, the nation doesn't want it," or say, "If we

take all the rest of the resources from every other component and give it to this component, there will be a solution to the drug problem of the United States."

As I'm sure you're aware, the drug problem in the United States is too complex, it's too sophisticated for any one simplistic answer, more airplanes, more boats, more crop eradication. No one thing is going to end the problem, as you pointed out.

I'm not, however, so pessimistic as to think that the problem won't be cured. I don't think it's a short-term problem and I don't think it's going to end in the next 10 or 15 years. But I'd say within 20 years we're probably going to be a non-drug abusing nation in a sea of drug abusing nations all around us.

DR. LILLY: We were told yesterday by one of the witnesses that, in fact, that might happen but that if it does happen it's because the ethos of this country will have changed and not necessarily because of the active measures that are taken. It will be simply because it will become the norm of the nation not to believe that that will do anybody any good to take drugs.

MR. SAPHOS: This is sort of a philosophical argument. Do active efforts by people like you cause the norm of the nation to change or is the norm going to change if we just sit back and watch and by the measure of the pendulum it will change? I think it's going to take very active efforts from all elements of the community, all elements of society to make the norm change. I don't think it's really a function of education, nor is it simply a function of law enforcement. It's a combined function of many, many components, including education and law enforcement, among others.

MR. ROSENBLATT: If I may, Doctor, demand reduction is relatively a new phenomena in the war on drugs. The law enforcement component has been at it since probably the early 1900s in an active way. We've learned a lot of lessons and let me just give you one that's recently from our experience.

We talked about the Southeast Florida problem. We immediately move all kinds of personnel down there, to some extent exposing the Southwest border. Well, one of the things that many of the agencies and maybe all of the agencies did not do in addressing the Southwest border in implementing Operation Alliance was to take resources from Florida and move them over to the Southwest border because all they would have done is go back to Miami.

All I ask is a cautionary note, in at least the way I understand your comments. Yes, build up the demand reduction,

but not at the expense of law enforcement's effort. At some point in time, the demand reduction emphasis dollars may overshadow what we're trying to do in the supply reduction. It has to be a balanced format.

CHAIRMAN LEE: Thank you.

DR. LILLY: Doctor, could I ask one more?

CHAIRMAN LEE: Frank, we're really going to have to move on, unless you're dying to --

DR. LILLY: I did want to ask Mr. Rosenblatt just one more thing. The business of confiscation of passports of people who come in with narcotics. I remember reading a little bit about that in the paper and I'm wondering about the legality of that.

MR. ROSENBLATT: Counsel, do you want to answer or do you want me to?

MR. SAPHOS: I'll be glad to. It's perfectly legal, sir. When the United States Customs Service apprehends a person crossing the border in violation of the United States laws, they're empowered to seize not only those things which are contraband, but those things which are evidence of a violation. A person's travel document not only proves his identity later in court (as a matter of fact it's the very best proof -- I've got your photograph or the violator's photograph or signature and other biographical data), but it also proves that the man has, in fact, traveled in international commerce.

So, if an officer of the Customs Service apprehended somebody and didn't seize his passport, he's probably remiss in his duty. The Department of Justice absolutely endorses that.

CHAIRMAN LEE: Dr. SerVaas?

DR. SerVAAS: I was doing research on marijuana 40 years ago and I remember then reading all about these countries in Northern Africa where they had very stiff laws against marijuana. I think there it was called hashish. They were able to keep it down and their reason was they couldn't afford the hospitals to put the mental patients in after they've been on drugs for a long time.

My question is, if they can prevent use of drugs and were successful even back then, why can't we? And how is Russia handling the drug problem? What penalties do the Communist countries use and what is the extent of their problem in Russia?

Is the KGB more effective, Mr. Storey, than the FBI and is that at all because they don't have a free press? This is to Mr. Saphos. My friends who are doctors in Miami say that the prison guards are themselves drug addicts and are able to get drugs into the prisoners while they're in prison. Do you have a problem with how we handle the drug addicts once you arrest these people for trafficking in drugs where they're able to get their drugs from the prison guards?

And Captain Trainor, I want to know from you, do you ever think it's bad enough that you need to call in the Marines? Does anybody think about that and could our press do any better than we're doing -- I mean maybe not just the press, but the media in portraying drugs maybe not as seriously as we should be taking drugs? Do you think our media is in any way at fault? All those questions.

DR. BURKE: Maybe we can go right down the table and try to answer each quickly here. First of all, I find it very difficult to believe that you were researching anything other than high school books that many years ago. But in any event, as far as the hashish and the different countries, different laws: there are very stiff laws in many countries and that varies throughout the world. In a couple of the Southeast Asian countries right now where a small amount of heroin means the death penalty, there are very few people who are smuggling heroin through those countries. There's obviously a relationship between crime and very swiftly carried out punishment.

Now, as far as the Soviet Union, they have been interested as far back as the early 1970s -- I know this for a fact because I visited the Soviet Union at their request and briefed them on drug activities and trafficking through the Soviet Union as a transit route. They have come down very hard on it. There are overtures right now between the Soviet Union and the State Department and the DEA regarding training for their people, their investigators and so forth. So, I think they recognize that to some extent or other, and I don't know that we fully know how wide that is, they do have a problem. I'll pass on now to the other gentlemen as for your other questions.

MR. STOREY: It's a little difficult for me to compare the FBI with the KGB.

DR. BURKE: I'm interested in this answer.

MR. STOREY: But one of the approaches that the government in Russia is taking concerning the alcohol problem, there's so many alcoholics in Russia, they just stopped selling vodka. So, there's no freedom of choice as far as the people are concerned. They can't purchase the vodka to drink.

If we were able to have that type of enforcement here, I don't know how we could enforce it. But their approach to the problem in Russia is much more direct than our approach. There's other areas involving the FBI and the KGB which I won't go into. Thank you.

MR. SAPHOS: The Soviet Union is encountering a more substantial drug problem than ever before. They are now, as of this year, announcing for the first time that they do have a domestic abuse problem. In fact, we have photographs of the Soviet Customs in Moscow literally climbing all over the Aerofloat coming out of Afghanistan to intercept drugs.

They have to send a substantial western population to a place where hashish is the strongest in the world, and which has bargain basement rates for both heroin and hashish. I would presume that they would have domestic consumption problems very similar to those we had when we sent our troops to a place with bargain basement heroin and hashish.

The question concerning prison guards, as to whether they are in fact drug addicts, I do not believe that is correct. As you know, however, the Bureau of Prisons is under the Department of Justice and the Department of Justice, for all of its agencies, has initiated a program of drug testing for its employees in sensitive positions, including all of us sitting here at the table, and persons who carry firearms, persons who have jobs requiring a security clearance, persons who drive other people and vehicles and things of that nature. Prison guards are certainly covered within that program.

We are not instituting the program essentially because we believe we have a problem among our personnel. In part, we're having this program because we believe we should be instrumental in convincing the institutions of society that drug testing is a good idea. If we think it's a good idea, then we ought to put our own conduct where our mouth is and show that we're willing to be tested for the abuse of drugs or for the absence of abusive drugs.

DR. SerVAAS: Mr. Saphos, I can bring you a physician of impeccable credentials who treats drug addicts in Miami who treats prison guards, among others, for drug addiction. This comes from a very good source.

MR. SAPHOS: Ma'am, I certainly can't say that every person who is employed by the Department of Justice is, in fact, drug free. To the best of my knowledge, I'm the only supervisor in the Department of Justice who has had to prosecute one of his employees for possession of controlled substances.

I think that we are perhaps no better or no worse than the rest of the population, but perhaps unlike other institutions in the rest of the population, we're aggressively addressing it right now. We're instituting testing programs right now. We're instituting rehabilitation programs right now. And if people don't clean up their act, we're going to institute firing programs right now.

MR. ROSENBLATT: Let me add to that, if I may, Ma'am. The drug testing program initiated by the government fortunately happened to start with Customs. It started with new hires. We had a lot of problems convincing the people and the courts that drug testing was important for a drug free society. I think we've gotten over that hurdle. But at the same time, we're now branching out into random drug testing within the federal establishment as well, to send this message out. That's not to infer necessarily -- I'm seeing Dr. Lilly's shaking of the head -- of convincing people.

But I am kind of perplexed by this term "war on drugs." Although I was a youngster when the big war was fought, I recall stories from my parents and relatives that the war brought about rationing, it brought about temperance of a lot of things that we did without for a short period of time. I'm not so sure that this is a War on Drugs. Going back to your comment about the media, I think the media is very supportive in stopping this insidious and enormous problem we have. It's convincing the general public out there that has a concern, but I'm not sure that it's at the 112 degree level, the boiling point.

We've had mothers and women develop MADD, Mothers Against Drunk Drivers, a very effective program. Until we have the people out there saying, "We're willing to do without this or that liberty for awhile," are we really going to have demand reduction in this country to where the children themselves actually turn in, for the betterment of themselves as well as their friends, people who are dealing in drugs or on drugs. That's what a war is all about.

CHAIRMAN LEE: That's well said, Mr. Rosenblatt.

DR. SerVAAS: Captain Trainor?

CAPTAIN TRAINOR: Yes, we have called out the Marines. As a matter of fact, in the most appropriate sense, we've called out all the DOD. The Marines have provided OV-10 surveillance aircraft, they've provided communications, they've provided some night vision goggles. The Air Force has provided E-3 surveillance aircraft, the Army has provided the Black Hawk helicopters and other communications equipment.

And in particular, in the relationship the Coast Guard has with the Navy, Admiral Watkins, the Navy has provided ships to carry Coast Guard law enforcement detachments at sea. Those law enforcement detachments have the full authority of the Coast Guard in boarding ships at sea. The Navy also provides E2-C aircraft, some to the Customs Agency, some to us, and some they're flying on their own, and the P-3 aircraft surveillance aircraft.

So, in the most appropriate sense, all DOD forces have provided in this war on drugs. The most appropriate sense I emphasize and underscore. None of DOD agencies are law enforcement agencies. We don't want to have a country -- at least I don't think we want to have a country where we have Army, Navy, Air Force making arrests on the streets of New York, Miami, Washington, D.C. as other countries that are military dictatorships. The current one we're having problems with right now is Panama where the military have the authority that the law enforcement agencies you see at this table have.

So, the military does have a role, they have a strong role in the drug interdiction process. It's a supportive role, however, and they're providing that role.

CHAIRMAN LEE: Thank you. Dr. Walsh?

DR. WALSH: First, let me commend all of you for looking so well in what has to be a most frustrating war that you are fighting. I'm very encouraged with what I have heard this morning. But I would like to ask a couple of questions because we are running into the problem of limitation of resources. We're in political campaigns where lots of things are being said, but where new policies may well result.

Tell me this first. Do any of you have a feeling that using the penalty of lessened foreign assistance which has been bandied about publicly so much would help or hurt the cooperation you're getting from the foreign governments with which you're dealing?

DR. BURKE: Let me give it a try. It's one of the nice sticks to have in your back pocket, but it's got to be used very sparingly because when you've just got a country going and you've got them moving forward and you set these quotas and goals and so forth, you have to take a look at the whole perspective in the sense of what they're trying to do. They may not have the sophistication, they may not have the resources, they may not have the will of the people in the countryside, if you would, to actually implement those programs as quickly as we would like to see them implemented.

I think sometimes if we took a look within our own borders, we could see some of these countries that we're getting ready to hit with a stick turn around and say, "Well, look, are you going to cut off aid to California because you've got two or three counties up in Northern California that are almost totally out of control in the production of cannabis?" That's the best answer I can give you, Doctor.

MR. STOREY: We've been able to develop very good working relationships with some foreign governments. The Drug Enforcement Administration, of course, has direct responsibility for that. But the case that we concluded last week, for example, we worked very closely with Italian law enforcement authorities in Italy and also in Sicily. When we made our arrest here, they made simultaneous arrests in their country. So, there are some very good working relationships throughout the world with foreign governments.

CAPTAIN TRAINOR: I agree that you have to make judicious use of this authority to cut off the aid to countries. In fact, since the publicized U.S. position against Noriega has come out, we have interdicted two Panamanian flag vessels with the cooperation of the Panamanian government. So, that's a small example of a law enforcement cooperation that we still have in spite of the problem that we have with Noriega.

DR. WALSH: Then I gather you all encourage it as something that could be in the back pocket but not necessarily an up-front policy. Now, secondly, I'm encouraged by what appears to be a great spirit of cooperation between multiple agencies, and we all know in this den of bureaucracy in which we live that that's very difficult. It has been advocated by many politicians that perhaps we should have a Manhattan Project approach, an overall single czar to ensure coordination and so on between all agencies and make it a more uniform law. Do you have any feelings on that?

MR. SAPHOS: Yes, sir. There have been, to my knowledge, at least twice, bills introduced on the Hill advocating a drug czar. We believe that the mechanism that we have in place right now is an adequate mechanism to coordinate the efforts of the agencies involved with the war on drugs, and that is the National Drug Policy Board.

The National Drug Policy Board, under the supervision and the chairmanship of the Attorney General, brings together all those cabinet chiefs in whose purview there's some degree of attention to the drug problem. And, in a consensus atmosphere, it develops the policies of the United States. It's within that supervisory role that in part this spirit of cooperation has been accomplished, and also the cooperation now between the law

enforcement and supply reduction and the demand reduction and treatment side of the house.

As I said in my testimony, I don't believe that demand reduction is merely a function of the health professionals. It has to be a function of other components including that of law enforcement, and as part of our renewed mission I think we have to get behind that as best we can.

CHAIRMAN LEE: Do you detect from your appearances before the Congress, more than lip service where one party criticizes the other or they criticize the Administration? Do you have a feeling that there is any unanimity in the Congress on providing you the support you need?

Because, I know that reduced budgets on drug enforcement have been criticized on a political basis, yet the Congress, for example, voted six more F-18s than the Administration asked for while taking money away -- while accepting the reduction in budgets to some extent in the war on drugs. Do you detect any sentiment in Congress that would make you feel that they really appreciated the seriousness of what you are facing, and we are facing as a country, or is it just political dialogue?

MR. ROSENBLATT: I personally believe there is unanimity within the Congress as there is within the Administration. It's a question of numbers versus all the competing priorities, with the large debt that we have -- that has to be addressed -- a multitude of different things that you and I are familiar with.

You also have to keep in mind that the 1986 Anti-Drug Act was passed and there was an enormous amount of money that was distributed both on the supply and the demand side. There is a current proposal, the '88 Anti-Drug Act that's been proposed in Congress in the Senate.

One must be wary of how much resources are thrown to us at any given time, because our system is only able to absorb so many and bring them on board, train them, and get them out there effectively. But, I see for the first time during the last four or five years, a big push on the war on drugs and putting the money where our mouth is, collectively between the Administration and the Congress. Maybe, my colleagues have a different view of that.

CAPTAIN TRAINOR: I'd like to respond. I'm not so sanguine, to be honest with you. Certainly, in the '86 Anti-Drug Abuse Act we did receive a number of resources along with all of the other agencies. But, we took a $103 million cut in the '88

budget, which came through the continuing resolution. Maybe not enough attention was paid to all the tenets in that budget.

But, that cut has forced us to cut back on our operations at a level of about 55 percent, and that's a severe cut. That could be an anomaly. It could be a hiccup in the system. We'll have to wait and see what the '89 budget actually looks like as it's approved by Congress. But, if that was not an anomaly, then the Coast Guard and its interdiction forces are in serious trouble and the country is in serious trouble.

MR. SAPHOS: With the exception of the Coast Guard, all of us here at the table have had increased budgets for the last three years. If the question, however, is, has the increase been adequate to address our perceived needs, probably not. Could we use more? Absolutely.

If you gave us everything we asked for, could we then answer Dr. Lilly's question and stop the supply of drugs in the United States? Probably not, but we would probably do a better job in doing that which you chartered us to do, which is to apprehend those people who are violating the laws of this land and to punish them for their conduct and take away their wealth.

DR. WALSH: One last question, very brief answer, Burt, if I may. That is, do you have any information or figures on whether there is actually a reduction of demand on the part of what we would call our youth, which would be our next generation? Has there been any really concrete --

DR. BURKE: Well, there are some figures which I've included in my testimony, but they come from NIDA. NIDA is primarily the organization that's responsible for gathering these figures. The only problem with these, I think that we're working off of a 1981 survey on the heroin addicts in the country which I think at best is at least half of what it really is. We have a high school survey recently that shows a diminishment in the amount of marijuana being smoked.

But just like any other type of survey, whether it be a political survey or a census or whatever, you have to again put those in perspective. There are not many junkies hanging around the telephone waiting for NIDA to call them to ask them how much heroin they're using. We have extreme limitations.

The high school kids, obviously, are very reticent in many circumstances to answer positively that they're using drugs no matter how confidential they think their answers might be. A lot of them are afraid that maybe mom or dad are still going to get that information or the school people will. On the other hand, there are some who probably don't use it who feel that they have to answer yes just because of peer pressure.

DR. WALSH: But, in other words, you don't see any lessening of demand at all?

DR. BURKE: Well, it may be there, but I'm not sure that we have the measurement tools right now to determine that.

MR. SAPHOS: If it exists, if there's a good sign, the high school senior survey is showing it. The high school senior survey is showing a measurable decrease in consumption among those people surveyed. But those are the people that stayed in high school. They're not the people that dropped out. Those are the people that are living at home, not the people that hit the streets.

So, we're saying that that is a good sign that the low-risk group seems to be responding, but the high-risk group appears to be increasing in its consumption.

CHAIRMAN LEE: Thank you. Cardinal O'Connor?

CARDINAL O'CONNOR: Thank you. Thank you very much for what you're doing, not just for this testimony, but for the dedication of your professions.

A very quick horror story as prelude to this question, particularly since you told us a number of horror stories, Mr. Burke. On Christmas Day, I stood by the bedside of a 26 year old who died because of an IV drug abuse acquired AIDS virus. Three months before, his 33 year old brother had died. Four months before, his 20 year old sister, three in one year. In my judgment, not one died of AIDS except accidentally. They died of drugs. We haven't been taking that same attitude toward drugs that we're now taking toward AIDS.

I'm very, very sympathetic to this Commission's efforts in regard to AIDS and persons with AIDS and in preventing transmission of AIDS, but far, far more people have died through drugs than have died thus far through AIDS.

That leads to my first question. What would be your positions in regard to the distribution of clean needles in an effort to prevent the transmission of AIDS? Am I correct in understanding that this constitutes being an accessory to a violation of drug laws?

MR. SAPHOS: As a matter of law, I do not believe that's true. But I also would not suggest that it's a good social policy for you to go to an Alcoholics Anonymous meeting and distribute clean shot glasses either, although drinking out of clean glasses is always a good idea and certainly well recommended. I think that your message may be mixed between

encouraging the consumption of alcohol at that meeting and encouraging people to use clean glasses.

I'm not trying to diminish this problem or to make light of it. But I believe that the risk of sending a mixed message to the population concerning our priorities and what type of conduct we condone and what type we encourage and the benefit of possibly decreasing the number of people who catch AIDS from dirty needles to be measured.

I would suggest to you that one of the things that you might examine is the actual efficacy of such a program. I believe that there is a social situation involving the heroin abuser and the IV drug user which actually does involve the sharing of needles that you're not going to address.

Also, I believe that the conduct of those persons is so incredibly self-destructive already, to their own knowledge they are being self-destructive, that your chances of conforming their conduct in this very limited area -- "Okay, go kill yourself, go murder yourself with heroin, but for God's sake use a clean needle while you do it." I don't think that they're going to get that particular message, sir.

CARDINAL O'CONNOR: Your answer is much more gracious, cautious and prudent and much more charitable than mine. I think it's a reprehensible approach to the whole situation. Secondly, some years ago when drugs were just bursting on the national scene, '70 to '72 particularly, I was a so-called drug abuse officer of the cruiser/destroyer force of the Atlantic Fleet. I took a very dim view of the use of marijuana and was distressed that the days seem to come that a number of our commanding officers considered this little more than a casual infraction.

It seems to me that through the years, I have seen this casual approach to marijuana then deteriorate into the use of harder drugs. Have you experience along these lines? Would you reject that or would you comment on that?

CAPTAIN TRAINOR: If I may answer and take the military point of view, and pick up on another answer we had before about urinalysis. That is true. I had the same experience in the middle '70s as I was going to sea. There was the casual use of marijuana and the military did not take strong steps against those users, and that deteriorated into harder drugs. I think what is evident in the military reflects what is evident in society when promiscuousness exists in any form.

The military made a grand turnabout when I returned to sea again in the middle '80s, after we instituted a urinalysis test. Believe me, the use of marijuana and the use of hard drugs had diminished to become a negligible problem. If this country

would get on the ball and go into urinalysis full board, not only in the federal government but in the private industry, if the private industry would take their own sense of responsibility and put some teeth into what they are saying, then the problem of use of narcotics, not only in the work force but in private lives when it could be detected in the work force and would threaten their livelihood, would be severely reduced because urinalysis testing would have a major effect on turning this social sense of acceptability to drugs right around.

The U.S. industry, U.S. governments at all levels, have to take this step and we've got to get off the stick of worrying about people's rights because the whole fabric of the country is deteriorating with the use of drugs.

CARDINAL O'CONNOR: My final question is very brief. May I ask if any of you has the experience to know what would be the average penalty for drug hustling at any level? When you spoke of someone in jail for ten years, what is the probability of his spending ten years in jail?

MR. SAPHOS: In 1986, sir, there was a gross amendment to the penalty laws in the federal statutes, which in most instances mandated minimum mandatory penalties for a majority of drug offenses. Included in that, I might add, is the drug offense of civil possession. One of the things which is relatively unknown, and it's a shame, is that it is against the federal law in the United States for any person anywhere within the territory of the United States to possess any amount of drugs. It is a federal law violation. Now, that law was amended in October of 1986 to include what we think of as the "yuppie penalty" and that is a minimum mandatory fine of $1,000 for possession of any amount of drugs anywhere in the United States. We think that's a very good idea.

CARDINAL O'CONNOR: If you give people clean needles, you don't give them clean needles for crocheting, you give them clean needles then to violate the law.

MR. SAPHOS: I'm sorry, sir, I didn't catch that.

CARDINAL O'CONNOR: I'm saying if it is against the law to possess and use drugs, then it would seem to me that if I give clean needles to someone for that purpose, I'm an accessory after a violation of the law.

MR. SAPHOS: I'm not sure, but I think if you tried to transport those needles in interstate or foreign commerce, Mr. Rosenblatt would seize them from you as being drug paraphernalia.

MR. ROSENBLATT: If I may, you're talking about sentencing and I can't help but relate some experience with large

municipalities and their court system. It's just a fact of life that the dockets in your New York Cities, your Miamis, Chicagos, are overloaded compared to the number of judges, magistrates, juvenile judges, whatever you want to call them, and there's a lot of plea bargaining going on. Many, many drug violators at the local level don't see the inside of a jail for any extended period of time, except overnight, when they're bailed out until their fourth or fifth offense.

I'm not saying necessarily we have the facilities, the jail facilities to house all these people. But at the same time, we've got to come to grips with possibly changing some of the things that we have gone along in a laissez faire attitude if we're talking about a war on drugs.

CARDINAL O'CONNOR: May I conclude by simply asking you not a question but if you would reflect upon this. You have been very conscientious in emphasizing education. Might I ask that you modify that to talk about motivation? Education can be merely information. It's like sex education. I think we have a sufficiency of information, including information about drugs, but the motivation not to use, if that can come through the education programs it could be very helpful. Thank you very much.

CHAIRMAN LEE: Thank you, Cardinal O'Connor. Ms. Gebbie?

MRS. GEBBIE: Part of what we've been exploring in a lot of ways over a number of hearings is how to construct the conversations to learn the most about all of these issues. You're clearly involved in the enforcement side of laws. My next question may involve the switching. I ask you to step outside of doing what you're doing now and look at this from a different perspective.

We've had witnesses suggest that under the present structure we will never succeed at all, that there's too much money being made in the business of selling drugs for us ever to finance enough enforcement to get there and that a very radical solution, such as decriminalizing drugs and getting out of this enforcement model into some other model is what is necessary. Parallels are drawn to prohibition and what happened in an attempt there that apparently totally failed. It is hard to figure out how to have that discussion in a sensible way. I think it would be helpful to us to hear how each or any of you react to that idea.

MR. ROSENBLATT: I'd like to answer that question by asking you how many times a year you fly on an aircraft, commercial aircraft? Two, three, four times possibly?

MRS. GEBBIE: Have you noticed the schedule of this Commission?

MR. ROSENBLATT: Yes. How would you like to have legalization of drugs and have the pilot in command of a 747 high on drugs? So long as it's legal.

MRS. GEBBIE: Well, we have alcohol legal but I still don't think we let pilots fly while they're drunk. So I'm not sure that's a fair answer to the question.

MR. ROSENBLATT: Unfortunately, if we were to dig into the private sector on alcohol abuse, particularly in some of the professional jobs, I think you all would be shocked.

MRS. GEBBIE: I'm not taking a position on the issue.

MR. ROSENBLATT: I understand that.

MRS. GEBBIE: I'm trying to do some exploration. I think we maybe have some other parallels of things that are legal that maybe ought not to be legal. I'm trying to look at what is an alterative --

MR. ROSENBLATT: I think the price, eventually -- if you were to legalize it and put the private sector, the price would go so high that there would still be a black market utilization in a short period of time of drugs. I'm not sure you would really be solving any problem. I think we'd be letting ourselves into a further degradation of our society and our social morals.

MR. SAPHOS: I think that the metaphor with prohibition is appropriate in some ways. I would point out then if it is appropriate, that following prohibition it's my understanding that consumption of alcohol -- the number of persons in the United States consuming alcohol following the repeal of prohibition increased 300 percent. I'm not too sure that we're ready to face that with controlled substances if that is an appropriate metaphor.

Secondly, I don't believe that legalizing alcohol, or decriminalizing consumption of alcohol, has assisted us in addressing alcohol abuse by children and I don't think we're ready to face that in the United States. I don't believe that decriminalizing alcohol or legalizing the consumption of alcohol has assisted us as parents in giving messages to our own children to say, "We think certain conduct should be prohibited, notwithstanding whatever the government tells you or whatever the government doesn't tell you on that sort of thing."

And with drugs, I'd like to have the extra impact of saying to my children, "And besides what you hear from me, if you do it you'll probably go to jail, you'll probably get your car taken away from you, you probably won't get the good job that you want. People aren't going to lend you money," things like that.

MR. STOREY: I'd like to make another comment too. Legalizing gambling did not take organized crime out of controlling gambling operations and influencing legalized gambling operations or taking over casinos. So, the mere legalization of an activity does not eliminate the criminal aspects of that activity.

CHAIRMAN LEE: Mr. DeVos?

DR. DeVOS: You're a pretty tough bunch of guys down there and I'm glad you're around. We're all wrestling with the same problem. I just want to have you think with me on the demand side of this thing. All of you sort of concluded that while it's not a one-armed struggle, we've got to do all of it, that the demand side is where it's at.

Now, you're all experts in this and you've been in the front lines of this war. Maybe you can help us arrive at some recommendations as to what we can do to reduce the demand.

We always hear education, education, education. The first thing I got on this AIDS issue is that we've got to get educated and we've got to educate everybody. But as the Cardinal points out and I've used in many a speech, education without motivation means nothing. We've got a whole bunch of very smart fools out there. These are not stupid people, they just aren't motivated to do the correct thing.

Motivation, from my experience, works from two points of view. One is fear and the other one is faith. I hear all of you continuing to recommend a higher level of the fear factor. We've got to have better courts, tougher enforcement, longer jail sentences so that we treat the fear side with lots of power.

The other one is the building up of faith in people so that they can have hope that they can build a happier, more productive, more secure life. Now, I want you to tell me if I'm off-base, but if we're going to work on education with motivation, then we're going to have to work on fear and faith. You make them have a desire to keep that car, have a nice home, where they can get up in the morning and be able to look themselves in the eye instead of being half shot all of the time.

Now, Ms. Gebbie over here gets into the criminalization/decriminalization of it. I've never thought of it in those terms, but the only reason it comes up is that we

don't seem to be doing much that we're gaining on the other way. That's where the frustration comes. So the feeling, therefore, is that we don't just decriminalize it, but that we make it available -- as we do in some cases now -- to people who are hooked, but stop the pushing because the money that's involved, every guy who gets in on it has got to find another customer to keep himself supplied. So, we stop this powerful sales force going. Now, that's where the fear factor comes in again.

I want to just add one other thing and that's the major accountability. I think it's a part of the whole disease in this society. There's a wonderful myth out there and that relates to AIDS or drugs, that somehow this Commission, our government, some bureau, the police are going to be able to correct every problem. We've developed it in this country, the quick fix or the quick cure. If you get sick, you get a shot. If you get syphilis, you get a shot. Whatever you do, there's something that will fix it.

But to me, the motivation begins at the core. Only you can fix you. I don't hear much talk about it. We hear people come here, they talk about we need more money, we need more force, but how do we get around to saying, "You are accountable for your life. Your actions have consequence"? That, to me, is what you come down to and that means individual accountability and responsibility. Now, you spend a lot of time on this and if you're going to get down with the demand and help us get down the demand in a specific recommendation, how do we accomplish that?

CAPTAIN TRAINOR: If I could pick up on your fear and faith dialogue, I think that the high schools present a good example. It seems to me those students that have faith are those students that join in the Just Say No organizations that Nancy Reagan has sponsored. They have faith in the system. I think even without it they probably would be good kids and would go on to be the ordinary American citizens that we respect and entrust our country to.

Those kids that are fearful, they're fearful of social ostracism, not being accepted, they're fearful of rejecting a strong individual who pushes drugs on them. They need a little crutch. The crutch that I see that works is the urinalysis. I'm not advocating, necessarily, urinalysis at the high school level, although we may come to that.

But I am advocating urinalysis at the work force level so that their parents have to undergo a urinalysis. Even those parents who may be still a little fearful that it's not accepted in their work force can say no to drugs because they say, "Hey, if I take drugs, I'm likely to have a urinalysis check any day now and I'm going to be out of a job. So, therefore, I can't take drugs." It gives them the opportunity of that crutch, maybe

to substitute a little for their lack of personal strength or self confidence that allows them to say no on principle. It does give them a little crutch and it does give an opportunity for not only the employer but the good employees to live and work in a work force that is as clean of drugs as possible.

DR. DeVOS: Well, I appreciate that. That comes down to a clean recommendation to say, "We endorse testing in the work place on a sporadic basis to make sure people aren't on it," as emphasizing the fear side of this business to get people off it. That's something you can put in a piece of paper and say, "Do something."

I always get confused because we've spent 90 percent of our time on ten percent of the people in this country and somehow we act like all the other people just don't exist. We've got to find a way, in my view, to make the 90% role models instead of just kind of letting them get lost in the shuffle.

MR. ROSENBLATT: Let me throw out a suggestion for you.

DR. DeVOS: We've almost made heroes out of the kids who are peddling the drugs.

MR. ROSENBLATT: I would advocate drug testing also with the schools. I go a step further. You use faith and fear and maybe I've become a cynic in this job of mine, but I go based on how I was raised, sort of like the reward system. If I did something wrong, I got rewarded out in the toolshed. If I did something right, I got some benefits from it. Why not set up some scholarships -- we spend a lot of money in this country on drugs. Why not set up some scholarships relative not only to academics but staying clean and to be a role model for others. Students that do a lot within the school system on saying no to drugs.

DR. DeVOS: I'm with you. You're going to make heroes out of the kids who are doing it right and they become the examples to follow. Those are constructive things, along with the fear. You can't remove the fear or you won't force them over there.

MR. ROSENBLATT: Yes, but I wouldn't want to give a scholarship to a student and later on find out that particular individual was on drugs and that's why I'm advocating testing in the schools as well.

DR. DeVOS: I'm supporting both. But I see testing as the fear side and the other ones over on the faith and reward side for good conduct.

MR. ROSENBLATT: Well, there are certain rewards, sir, that our society does give, but we give them so regularly that I think we've confused whether these things are rights or privileges. The state of New Jersey and the state of Oregon have now recognized that driving an automobile is a privilege, it's not a right. They will withdraw that privilege to people who abuse drugs, which is a darn good idea.

In Oregon, it was started by a high school principal who was driving with his 15 year old child and another child passed him. His 15 year old son said, "That boy was intoxicated in high school yesterday, I bet he's intoxicated again today." The guy was driving in a reckless manner. His father felt a need to respond to that and he said, "We only trust driving to people who can show that they have the good judgment to accompany this privilege with responsibility and in my household you will not get a drivers license unless you show the good judgement to get that privilege." That's a reward.

When I was in high school, the thing that I wanted most of all was to get to know Suzie who sat next to me in math class a lot better. I thought having a drivers license and access to an automobile was the way to do that. I wanted that reward very badly and I would conform my conduct almost anyway you wanted me to to have that reward.

I suggest that that's a very good idea and I suggest that we examine the rest of those things which we do in the federal and state systems to determine whether or not they're rewards which we should give to drug abusers, whether or not we should give them scholarships to college under our loan programs, whether or not we should allow them to travel internationally and to represent the United States in other countries, whether or not we should lend them money, whether or not we should license them to be physicians and to operate Customs warehouses and to fly aircraft if they're drug abusers. I think we should look at the -- or you should, sir, perhaps look at the entire spectrum of rewards that our society gives.

DR. DeVOS: I think now you're talking. That's what I like to hear.

CHAIRMAN LEE: We'd better move on. Dr. Crenshaw?

DR. CRENSHAW: You may have seen me thumbing through this book. I trust you are familiar with it. I found it quite an education in the area of supply side of drugs.

While I'd appreciate your general comments on the quality of this tome, what I'm particularly interested in as we talk about the challenges we have here in the United States is the international political aspect of it. I wonder what kind of

help and how much help negotiations among political leaders, with perhaps economic sanctions in our hip pocket if necessary, but negotiations among the key representatives of governments throughout the world would help you in your work.

If what it says here is correct, and I'll read you a very brief excerpt, "The international narcotics industry is, in fact, not an industry at all but an empire, sovereign, proud, expansionist. This underground empire, though frequently torn by internal struggle, never fails to present a solid front to the world at large. It seeks to extend its dominance by any means".

"Legitimate nations combat its agents within their borders but effectively ignore its power internationally. The United States government, while launching cosmetic wars on drugs and crime has rarely attacked the empire abroad, has never substantially diminished its international power and does not today seriously challenge its growing threat to world stability."

Noriega is obviously an example and some efforts are being launched to do something about it. But what could be done in this arena? Do you have any thoughts on it or any recommendations that could help you in your work in addition to what you've mentioned, which is more widespread urine testing, tougher penalties to discourage people from entering the business?

DR. BURKE: Well, Doctor, if I might start out the responses on that one, I've been reading that book for about two years. I haven't finished it yet and I keep getting angry and throwing it at the wall. It's getting pretty battered right now, because frankly I know all the players that are talked about both on the good side and the bad side. There are a lot of exaggerations in it and so forth. So, don't take that as a bible, please.

DR. CRENSHAW: All right.

DR. BURKE: The author might get mad at me, but it's worth the reading for a lot of reasons I'm sure. But international cooperation, is one of the key things that really helped us get ahead. Initiatives not just in this current administration, where there have been plenty, but the administrations over the past number of years. The relationships that have been built up throughout the world by law enforcement officers alone in getting together and working together. DEA alone has offices in 64 countries around the world and we have FBI legal attachés around the world. We have Customs people assigned to various posts around the world.

In each one of these countries, the individual officers who have been assigned there have been able to build a personal relationship over the years that may have started out at an agent level, the working level. Right now, the people that I started working with -- I have 16 years overseas in the international narcotics arena -- the people that I worked with at that time are now ministers of interior or senior officials in the police departments and so forth. So, we're able to take these types of relationships and turn them into meaningful action.

When I started this morning and talked about Mr. Matta getting here, Mr. Matta didn't get here by magic. Mr. Matta got here yesterday by a tremendous amount of planning by the U.S. Marshal Service and some very excellent assistance by a number of foreign governments.

We are very prone to blast Mexico. There is, no doubt, a tremendous amount of corruption in Mexico. There is, no doubt at the same time, that hundreds of Mexican police officers have died in the war on drugs, two of them as recently as two or three weeks ago in a town near Ciudad Obergon where they went and fought it out with some very heavily armed traffickers.

There are police officers in Mexico and many of these countries that are renowned for corruption, that we can go to and we can work with and we continue to do so on a daily basis and trust them.

The amazing thing about the situation in Panama is that it continues to be, even today, one of the countries we're getting excellent cooperation from, as was mentioned just a little earlier. Following the indictment of Mr. Noriega, the Panamanians turned over to us a Cuban trafficker. Mr. Noriega was being accused of being in bed with the Cubans. They turned over a major Cuban trafficker who had just been indicted in Miami. They put him on a plane and shot him over to Miami for us.

Beneath all this political rhetoric very often, and beneath the international tensions that take place between countries, there is a lot of cooperation going on even as we speak.

We received a call about two weeks ago through our consulate in Hong Kong from the People's Republic of China. The officers in Shanghai, the investigative officers had found a load of heroin being shipped to the United States, to San Francisco. The traffickers were very ingenious. They had taken an entire huge shipment of goldfish and killed a number of them and sliced the cadavers, if you will, open and inserted heroin in them in condoms and put them in and sewed them back up. Very labor

intensive, obviously. They intended to ship those to San Francisco.

The arrests were made in Shanghai, they contacted us and said, "Would you like to make a controlled delivery to San Francisco with us?" So, two Shanghai police officers joined the DEA agents and were brought in -- Customs assisted us out in San Francisco and a controlled delivery was made to the receivers, the intended recipients of that heroin in San Francisco. All those people were arrested. At the same time, Hong Kong authorities, Australian authorities, Malaysian authorities combined to make arrests in those countries.

For years, DEA agents and predecessor agents in BNDD in Syria were the singular contact the United States government had with the Syrian government a number of years ago when relations were even more strained than they are now.

So, the role of international law enforcement is one that really supercedes a lot of political considerations. It does not always appear to be that case on the surface. We have, thankfully, the type of relationships at the top level where we can get the President and we can get the Attorney General to go down, and it does not always show up in the press releases that come out and so forth, but they can sit down with foreign government leaders and really, if you will, talk turkey to them. Maybe the press releases don't reflect it, but the increased support and assistance that the law enforcement agencies enjoy following those trips really do produce results.

DR. CRENSHAW: This is really valuable information because the impression given by this book and other things I've read is that there's a feeling of sabotage or undercutting in the drug enforcement area. I raise it because if there's anything we can do to make recommendations that could give you more strength or support from above, share that with us and the Commission will do what they can.

If what you're saying is that there isn't a feeling of less than full support and there's no sense of sabotage or frustration, then I need to know that also. And that would be the best news of all. Anybody else have any comment on that?

MR. SAPHOS: I think perhaps that book was written at a time when within the law enforcement community there was a perception that we were relatively isolated in this fight against drugs and that the other agencies of the government who should be taking some responsibility and showing some leadership were not doing so. I don't think that's as true now, if it ever was true then. I think that through the National Drug Policy Board and other vehicles, we do have a concept that the Department of

State, for instance, is behind us in the efforts we're trying to make in the international arena.

They are dealing with the United Nations right now to write a convention which is a multi-national agreement against drug trafficking internationally. They are highlighting our relationships with foreign nations, the demand that those people make consistent of efforts against narcotics trafficking. I think that's true of many, many other agencies of the federal government. I don't think the cops feel anymore that we're on the walls of the Alamo and all by ourselves and no one's passed the ammunition as much as we felt when that book was written.

DR. CRENSHAW: Thank you.

CHAIRMAN LEE: Dr. Crenshaw, we have an appointment shortly after 11:00 and we have to get through. Ms. Pullen?

MS. PULLEN: Mr. Burke, what does our government know about the cooperation and involvement of the governments of Cuba and Nicaragua in drug exporting to the United States?

DR. BURKE: There have been a number of trials that have taken place over the past couple of years in Miami that brought out that certain Nicaraguans were involved in trafficking. There has been testimony to the fact that Cuba has been used as a safe haven in terms of a safe area to fly over for overflights of the Cuban airspace on the way into making drops of drugs and so forth in, say, the Bahamas.

There have been reports and information given that certain Cuban Navy officials have allowed boats to enter certain areas in Cuba in a safe fashion, resupply, maybe transfer their drugs to other boats and move on.

I do not think, and I could be corrected here, but I don't know of any real evidence that we have that there is a national policy on the part of their government to support that activity. And I think that if you look at Cuba that it would seem strange that it would be, when you look at the overall goals of that country, that that is a policy of the government.

As with many other countries, as with many law enforcement people in the United States who have been arrested there are corruptible people in just about any country. There are probably naval people, if you will, in Cuba who have the contacts and so forth and have the ability because of certain jurisdictions that they have to allow aircraft or to allow boats to go through their area of control safely. The same thing probably happens in Nicaragua.

MS. PULLEN: Mr. Rosenblatt touched on this briefly, but I'd like to get back to it for a minute. In Illinois we found several years ago that judges who were involved in narcotics prosecutions were continually approaching the legislature, asking for penalties to be reduced for various types of drug crimes based on their feeling that the penalties were so stiff that they were letting people who were obviously guilty off with plea bargains or even acquittals in order to avoid the minimum penalties. The legislature fell for that and did reduce penalties very substantially.

I am encouraged to hear that Congress has, in a moment of wisdom, adopted at least the beginning of what looks like a stiff minimum penalty for possession. Would any of you please comment on the situation of judges once the law enforcement officials bring cases into court with adequate evidence, the attitude of judges at the federal and, if you have any awareness of it, at the state level and what we can do about it?

MR. SAPHOS: I think that there has been a general perception of the branches of government, executive, legislative and judicial, that the executive and the legislative have been more quick to recognize the threat to our society and our national security that drugs and drug abuse poses and the judicial has been a little behind the power curve. So, a couple things have happened.

We have minimum mandatory penalties, which means that if you have certain quantities of certain substances, you go to prison without a chance of parole for a minimum amount of time, up to a minimum mandatory penalty of life imprisonment without parole for certain offenses.

That was the perception by the legislative branch that perhaps the judicial branch wasn't getting the message.

MS. PULLEN: Could I interrupt you one second? Would it be helpful if we had laws that allowed the prosecution to demand a jury trial as well as laws allowing the --

MR. SAPHOS: The prosecution can, in the United States federal courts, demand a jury trial.

MS. PULLEN: In the federal courts? Good.

MR. SAPHOS: Yes, ma'am. And occasionally we, to our embarrassment, are asking for them. We think that perhaps -- judges are just like the rest of us, just brighter and divinely appointed, and perhaps you all and other well-informed people can reach the judiciary and can inform them of the national priority and significance that we place on this, your expectations of what their conduct should be and what kind of penalties they give.

And perhaps if more parents started going to court and watching the system and telling the courts and the judiciary what they expect of them and how they're disappointed in them, then perhaps we'll get a better response from the judiciary, or a more appropriate response.

DR. BURKE: I'd just like to echo that the judges do represent all of us. Some of them are very liberal. My definition of a liberal is a conservative who hasn't been mugged yet. We have a lot of very liberal judges who came in under previous administrations and I have seen them change over the years. They get very tired of seeing the same people in front of them.

We have a reputation in the district that I just came from of the courts being fairly lenient. Yet one of the judges who is considered very lenient I think has become fed up with what he's seen in the drug trafficking. As recently as three weeks ago, he sentenced a trafficker in a 200 pound cocaine case to, on the first count, life imprisonment and $1.5 million fine and to the second count, 20 years imprisonment on top of life and a half a million dollar fine. That frankly sent shivers through that district in terms of defense attorneys and defendants.

MS. PULLEN: I hope it sent shivers through the pushers, too.

DR. BURKE: That's the defendants. That's whom I'm speaking of.

MS. PULLEN: Well, the ones who haven't been brought in yet.

DR. BURKE: Right.

MS. PULLEN: Thank you, that's encouraging.

CHAIRMAN LEE: Admiral Watkins?

DR. CONWAY-WELCH: Excuse me, I didn't get my question.

CHAIRMAN LEE: We're not over yet. Do you want to go now?

DR. CONWAY-WELCH: I would like to ask one question.

CHAIRMAN LEE: Okay.

DR. CONWAY-WELCH: Several of you have alluded to cooperative ventures with your various departments interdepartmentally. Is there an organization whereby the heads

of your various departments meet regularly to share information, cooperate with each other, plan overall strategies that are then implemented and at what level is that? Is that at the Attorney General level or --

MR. SAPHOS: Yes, ma'am. At the top it is at the Attorney General level and the Cabinet level. It's through the standing committees of the National Drug Policy Board, it works down to the working staff level too. We meet more than monthly.

DR. CONWAY-WELCH: And is that efficient? Is that working as far as you're concerned?

MR. SAPHOS: It's working better everyday. Is it perfect in its implementation, no, but it's getting better everyday.

DR. CONWAY-WELCH: Are there recommendations that you could share with us, in writing, not now, that might assist in making that more effective? Are there suggestions that you might be able to --

DR. BURKE: Create some better human beings. That's about all. I think people really are concerned, but you get all levels of concern. I didn't mean to be smart about the liberals, but you have people who have not yet had this problem touch them.

The question was asked earlier about the members of Congress, you have a Charlie Rangel who every time he stands up or goes and visits a country to talk about drugs, they shake because he is concerned. His area is hard-hit. He has been beating the table for years. Senator DeConcini and a number of the key congressmen and senators, they're the ones who are the backbones. Most of the bills that you see, they're the ones that are taking a leadership role. Many of the others are concerned, but they frankly haven't had the problems hit them between the eyes yet.

When you talk about MADD, the Mothers Against Drunk Drivers are the mothers who had kids killed. And until this hits home a little more closely to a lot more people, all of us are going to be kind of wallowing in this thing.

DR. CONWAY-WELCH: I understand what you're saying. My question though really relates to what mechanical relationships exist and if they can be enhanced in any way and if you have suggestions for that enhancement that might be appropriate for us to be able to assist you in that way, we certainly would appreciate seeing them.

CHAIRMAN LEE: Admiral Watkins?

CHAIRMAN WATKINS: A number of years ago, some of the laws, posse comitatus, for example, were adjusted to allow certain actions by the military in concert with the drug enforcement agencies. Are there now any constraints in the law that you know of that impede the most effective execution of the national strategy against drugs?

Let me bring up one. For example, when the Vice President ran the special interdiction operation several years ago, we amassed probably more military forces than we ever have in the war on drugs. It was focused heavily on a cooperative effort between the government of Colombia and the United States. In addition, there were in-country operations, going after the 400 plus laboratories in the jungles. We put forces off the coast of Colombia along with Colombian forces. We did a lot of work, the Air Force, Army units, everyone involved for a sustained period of time.

The equipment used by the drug peddlers in Colombia were some of the most sophisticated electronics in the world, listening to all the communications, being able to focus their attentions where we were not.

So, it seems to me that one of the things which we recommended in our interim report was that you've got to go after this on a sustained basis. By sustained it means on all sides of it. So, if the sustenance isn't there on the supply side for a period of time, it seems to me that we don't do the job thoroughly.

Had we been able to provide sustaining equipment under security assistance, for example, to Colombia or in Bolivia, wherever we're working in cooperation with foreign governments, that those equipments could be used by the locals and they could be trained by our people. But unfortunately, that isn't within the security systems laws of the country.

The question is, do you think something like this could be provided for the cooperative effort with foreign countries in security assistance for the drug war, using the kinds of military equipment that are necessary to do the interdiction in country, along with our teams to go in and train them to do their own work, would be useful?

DR. BURKE: Admiral, we're working with Lieutenant General -- retired and now back in active duty, Lieutenant General Olmstead, Assistant Secretary of Defense. The key problem here, very frankly, is budget.

The willingness to help is there. I was at SOUTHCOM with the SOUTHCOM commander just a couple of months ago. The

willingness is there to assist wherever possible on the part of the military. They have their own budget constraints right now.

We have active programs going on in Latin America right now. The biggest problem we're having is equipment. There are something like 134 helicopters that are being surplused right now by the military. We're trying to pick up maybe 10 or 20 of those to support our operations. The bureaucratic system of trying to go through that in itself, the red tape is very difficult. But it's primarily a funding problem because it's not just a matter of acquiring those aircraft and that type of equipment. We need the pilots trained to use it.

Right now we have six helicopters, six Hueys in the Bolivia area, going on these laboratory raids. We need the pilots trained, we need the fuel. We very often cannot get fuel into these locations. It's a logistics nightmare. Any part of this could be overcome through the budget process --

CHAIRMAN WATKINS: Its monetary resources, it's not constraints within the law?

DR. BURKE: No, sir.

CHAIRMAN WATKINS: The next question is on prison over crowding. We hear reports that basically in the high drug related crime areas that the prisons are already 100 plus percent of capacity. In fact, we're rolling people out of prison early in order to roll others in. And we're also informed that 60 percent of the adult males in jail today are there for drug related crimes. I think there's an indication of some discouragement on the part of the American people that locking up sounds very tough, but letting them out early again for repeated drug related crimes seems to worry people.

Do you have any comments about prison over crowding and repetitive drug related crime? Are we really achieving deterrent or do these people go out and pick up their cash of $10 million they brought in on the airplane that they dumped into the mud down in Southern Florida? So, what have we really done?

MR. SAPHOS: Your observation concerning prison overloading is appropriate, sir, and right. It seems to be a problem that the American public has just not come to face -- that is, our prisons are overcrowded, they're expecting us to do a job for them and we can't do it unless we can take the people out of society and put them someplace.

Also, I think it's an unfortunate observation, but there are certain human beings, sir, that pose such a substantial risk to the safety of this society that we're going to have to

warehouse them for the rest of their lives. Either that or we're going to have to put them to death. And the American public is going to have to realize that that is a reality. Those people must be removed from their community and must be placed someplace where they can be held very expensively for the rest of their lives. We're not doing it.

So, what sort of deterrent is it when a judge says, "You're going to jail for ten years," but all of us in the courtroom know that that person is going to be back out on the street --

CHAIRMAN WATKINS: But so does the individual. What I'm saying is, is the wait for the $10 million not sufficient incentive to say, "I'll go to jail for five years and take my --"

MR. SAPHOS: Down in Miami I was going to have prestige plates on my car that said, "Crime Pays." Certainly.

CHAIRMAN WATKINS: Well, is there some recommendation we could make that isn't so staggering? Is there some direction that we can go in to allow the law enforcement officials like yourself to have some hope that when you're talking about tough lock-up that we expect those people to be -- having shown that they're irresponsible citizens, to then stay in for the length of time without coming back at us again?

MR. SAPHOS: Yes, sir. One of the things you can consider doing is, from the federal level at least, let us keep the money and use it. Drug law enforcement is actually a money-making proposition for the federal government. Mr. Rosenblatt and I, for three years, worked on a task force in South Florida and for every person that worked there, no matter what their job was, whether it was secretary or chief of the task force, whether they worked there for two weeks or three years, we made $2.5 million.

The Drug Enforcement Administration last year seized $150 million in excess of its own budget, as I recall. But we can't use that money. The money goes back into the general Treasury of the United States. It's released for very limited purposes such as refurbishing cars, compensating law enforcement on the state level, and the states can use it for law enforcement purposes once we give it. In fact, they're required to, before we can give them the money, but we're not. That money goes back in the federal Treasury, it doesn't educate children, it doesn't hire agents, and it doesn't build prison space for us.

One of the things you can consider doing is letting us keep that money. I might add, as far as the prisons are concerned, we constantly hear cited the very high cost of prison construction. There's no doubt about it. But do we really need

the regulations that say there have to be X number of TV sets and so much carpeting per square foot for each prisoner? Are we building Holiday Inns or are we building prisons?

CHAIRMAN WATKINS: You're implying that you are frustrated by a number of things. It seems to me it would be useful for this Commission to know what those frustrations are and ask that Mr. Saphos might link up with the others here at the table and send us a recommendation saying, "Here's the kind of thing we think could be done immediately."

If we were told in the military to set up a reasonably humane sort of facility to house people for a period of time, we could probably build it with the Seabees in two weeks and it would probably stay there for two generations. So, it seems to me that there are things that could be done in the near term for something less than the full-blown cost of granite from Vermont to build the penitentiaries.

But if it's such an urgent problem it seems to me that it's time for some urgent actions to give the American people a feeling that by taking these tough actions, we're not going to see those faces back on the street again spending the money that they got which is tax free. And urinalysis is a very key issue but it also has to be part of an integrated program. The military just didn't test. The military had an integrated program of drug prevention and drug rehabilitation. They had a compassionate approach that said a one time failure does not throw you out but gives you an opportunity to go through a program and if you are not a recidivist, you'll stay with us, and the large majority stay.

Now, with that and the drug testing program, we went from 55 percent marijuana use of 18 to 21 year olds down to less than three percent. And it's now a negligible issue because you've got peer pressure on the side of the command. What we're looking for is peer pressure on the side of the work place, for readiness, efficiency of that work place. Peer pressure on the side of the school administration because the students themselves feel that association with colleagues who are spaced out is not something they want.

I would like to know if we could follow up on Captain Trainor's idea, is there an integrated approach to the education process on substance abuse which could include a urinalysis program that would be humane, that would be fair, but have the carrot and stick approach to it. Who has looked at that and drafted that kind of a concept, including the very important tool of testing, which as we know was the real turning point in the military, along with the other actions I mentioned?

MR. ROSENBLATT: Admiral, if I may ask a question. You used the term -- and I'm not disagreeing with you and I don't want to seem to be controversial, but you used the word "fair" again. What seems to be fair to the people, what seems to be fair to this group.

We've got an epidemic. We're not going to be able to please a lot of the population out there. We've got to put this concept of fairness in perspective to the epidemic we have out there. That fairness, to some extent, may have to go for a short period of time on this war on drugs. Thank you.

CHAIRMAN WATKINS: There's one way to get at that and maybe the way to start is something that's going to be realistically saleable. Fairness means that there's a responsibility on both sides of the equation. That's all I'm talking about.

MR. ROSENBLATT: I agree with you, Admiral, but we've been playing with this testing program now for close to 20 years. If we don't have an idea of what we're doing by now, another 20 years in deciding what fairness is going to be about, we're liable to be -- it's liable to be snowing cocaine in two years here if we don't get with the demand side of this equation. No disrespect intended, Admiral.

CHAIRMAN WATKINS: But then I don't understand what your recommendation to the Commission would be along these lines.

MR. ROSENBLATT: Drug testing in the private sector, drug testing in the schools, drug testing in conjunction with licenses, in all walks of life as Mr. Saphos was talking about. We have proven test methods. Unfortunately it's got to be regulated. You've got to insist that people do it. If you're going to ask for volunteers to be fair, to be palatable, it's not going to work. You're not going to have people knocking down your doors to come and get tested. They're going to have to be mandated to be tested in order for them to work. If they require a license to be a doctor or a license to be a lawyer or license to be a pilot, they've got to go through testing. You can't ask them for their permission if they want to fly. It's got to be part and parcel of the whole package.

CAPTAIN TRAINOR: I think we're in agreement. The only difference is that we're into zero tolerance. We're not willing to forgive one time. People want to volunteer and come forward and ask for treatment, that's one thing. But if they are tested and found guilty of drug abuse, then they're going to pay the penalty, whether it's take away your license, take away your job, take away your scholarship.

CHAIRMAN WATKINS: But why isn't that something that can be applied -- isn't it fair that if a person comes forward and asks for help you give them the help, if that the person is not a recidivist, that person gets a kind of an "A" for coming forward and coming out of the drug abuse problem?

CAPTAIN TRAINOR: I think that goes to show we're in agreement. You're right.

CHAIRMAN WATKINS: That's what I meant by fairness.

CAPTAIN TRAINOR: We're just going to define "fair" a little bit.

CHAIRMAN WATKINS: How much has been done on this, to package it in an integrated way and say, that's what the Say No to Drugs issue should really be expanded to perhaps, something a little more aggressive? Has that been proposed?

DR. BURKE: Admiral, it is in many areas, because there are things that are going on in the country. There's something that we started up called the Sports Awareness Program and it's using the High School Coaches Association throughout the United States and it's setting up these athletes as role models for the kids. Those programs are ongoing. They're small in the sense of our bureaucratic input into them, but what we've taken is a few staff people who have gone out and taken an organization such as the National Coaches Association and they've run with it. We've given them a few ideas, we've given them a little bit of support and they take that out throughout the country. So, we've been fairly doom and gloom here for the last two and one half hours. I can tell you, as a final note, maybe to lighten it up a little bit, that there is hope out there because there are people who are very concerned. And not only concerned, but who are doing something. I think this Commission's support to something like the National Coaches High School Association or at least giving that association and their activities some credit and some support would be very beneficial.

CHAIRMAN WATKINS: So we need to have your thoughts. If you can send those to us separately, we'd appreciate it because I think we have to get focused on some specific recommendations we can make and we may be on the verge of finding something here that we can propose.

CHAIRMAN LEE: One final comment. Forfeiture. I hope that you forfeit the pools, the houses, the jewelry and the designer dresses on the female companions, the fur coats, the bank accounts. Now, this is so incredible to me that I had to make this statement. I hope the American people listen and I hope they back you up in taking all of these monies away.

Thank you very much, gentlemen. We have to go to an appointment. We'll be back in ten minutes.

(Whereupon, at 11:25 a.m., a recess until 11:39 a.m.)

DRUG ABUSE AND HIV/SUPPLY SIDE STATE AND LOCAL PERSPECTIVE

CHAIRMAN WATKINS: We'd like to bring our next panel up, please. This is on drug abuse and HIV/supply side, state and local perspective.

Inspector Rodolfo Thomas, Street Enforcement Unit, Narcotics Section, Detroit Police Department.

Mr. Mark Cunniff, Executive Director, National Association of Criminal Justice Planners.

Mr. Malcolm MacDonald, Interim Director of Program Services, Texas Adult Probation Commission.

Mr. Jack Yelverton, Executive Director, National District Attorneys Association.

Welcome. I'll turn the Chairmanship of this set of hearings over to Dr. Lee, who just arrived in the room.

Dr. Lee.

CHAIRMAN LEE: I defer to you, Admiral.

CHAIRMAN WATKINS: We'll have the first statement, then, from Inspector Rodolfo Thomas.

INSPECTOR THOMAS: Good afternoon. The Detroit metropolitan area is ranked number six in the nation among large metropolitan areas. The Detroit Wayne County population of 2.4 million people represents 25 percent of Michigan's total population.

CHAIRMAN LEE: Could you speak a little closer to the microphone, so we make sure we can get it?

INSPECTOR THOMAS: Combined with the two adjoining counties, Southeastern Michigan is composed of more than four million residents or about 44 percent of the state's population. The City of Detroit is located on an international border with Windsor, Canada, only a five minute drive across the Ambassador Bridge.

This testimony or report concerns a national threat, not from our neighbor to the north, but a threat crossing a border over 2,000 miles away. Cocaine, heroin, and marijuana are as common on the streets of metropolitan Detroit as they are in those far away countries in which they are grown. How these drugs reach the streets of the city is not the subject of this report. The effect they have on the quality of life of the citizens of the city is nothing short of a national disgrace.

In reference to IV drug abusers, approximately 25 percent of the people with AIDS are a direct result of the IV drug abusers or their sexual partners, and 70 percent of the heterosexual cases in Michigan are sexual partners of IV drug abusers. In Detroit and Wayne County, heroin and cocaine continue to be the major focus of law enforcement activities in narcotics for the area. Although cocaine continues to increase across all indicators, currently the majority of all police activities continues to shift more exclusively to cocaine targeting.

The major method of distribution in the City of Detroit and several other cities is on street corners in broad daylight, using young teenage males as agents. This method of distribution gave rise to a major drug ring known as Young Boys, Incorporated. Young Boys, Incorporated, or YBI, became the status symbol of success for black teenage males on the streets of the city of Detroit. Members of this highly organized drug distribution organization were paid $250 to $300 per day to sell drugs on a high volume street corner. This method of drug distribution is a story in itself, and has become the major method of selling drugs, using youth in the 13 to 16 year old range.

Crack cocaine has, in the short time it has been on the market, created problems which have never before been a concern of law enforcement officials. These problems have required that new and innovative approaches be developed.

Through a series of trend analyses and recent studies in which I have been involved, it has been determined that the average heroin purity level in Detroit is approximately just over one percent. One might gather from this figure that an admitted heroin user is probably addicted to the mixes or the involved cutting agents rather than the drug itself.

Another interesting trend is that the majority of heroin abusers in the Detroit, Wayne County area are between the ages of 30 to 35, or roughly 44 percent of the drug abusers. Ages 26 through 29 made up approximately 21 percent of the heroin users, while the age group of 36 to 44 year olds made up 22 percent of the heroin population. These figures are primarily based upon the admissions and arrests and treatment facilities.

In Detroit, three out of every four heroin admissions were black, while 24 percent were white. Included in this study was the fact that 10 to 11 percent of all admissions used heroin for five years or less before entering treatment facilities. Another 19 to 29 percent used heroin between six and ten years, while one-third or 33 percent of admissions used heroin for between 11 and 15 years before entering treatment facilities.

It would, therefore, seem reasonable to state that heroin seems to be largely concentrated in the age cohort which began their use between 1965 and 1974, and who are between the ages of 30 and 44 years old. The IV drug user in the Detroit area, based on the facts I have presented, is older and virtually stable. Although the number of IV drug users does not appear to decline, it has through the years remained very constant.

The IV drug user in the Detroit, Wayne County area can and should be educated in the problems associated with the Human Immunodeficiency Virus epidemic. Solutions such as the needle giveaway program would obviously require the full cooperation of law enforcement personnel and public health officials. Drug users would no doubt be fearful that they would be arrested the moment they walk out of the door.

How can we as law enforcement agencies authorize someone to take a legal instrument and use it for an illegal purpose? Based upon local ordinances, we would be conspiring to violate the paraphernalia statutes. However, just as recently as two weeks ago, the Department of Social Services began issuing free condoms to all recipients of medicare. This could possibly be an alternative solution to the IV drug abusers who remain very suspicious of any police involvement.

Currently in Detroit, the most crucial problem facing the city as well as the nation is that of cocaine; more specifically, crack, which is cocaine freebase. As you all probably know, cocaine hydrochloride is utilized in a process in which the cocaine base or alkaloid has been freed from the ions of salt. Crack is commonly sold in small quantities and first appeared in Los Angeles and Miami.

Crack is described as a white coagulated powder, resembling slivers of soap in appearance, and is manufactured by converting cocaine hydrochloride back to the base using baking soda and water instead of the volatile chemicals previously used in freebasing. Crack is sold in pellets, usually two to three a vial. One pea sized pellet, an average dose, weighing approximately 125 milligrams sells for around $20.

More recently, we have discovered the sale of $5 and $10 "rock cocaine," which are either smoked in a pipe or crumbled into a tobacco or marijuana cigarette, more commonly known as

"151s." Mid-level dealers obtain cocaine hydrochloride, process it into a cocaine freebase in home style laboratories and distribute their finished product themselves. Some laboratories also provide rooms where crack can be smoked. These establishments are known as "crack houses."

The most frightening facts concerning crack are the purity ranges, which are approximately 92 percent in the City of Detroit, giving rise to a quick and early addiction. Usually, the high experienced by one smoking crack lasts approximately 20 minutes and immediately after experiencing this sudden rush, the crack abuser acquires a need to repeat his prior sensation.

In Detroit, we are experiencing females, including the prostitutes, addicted to the drug who may enter the so-called crack house and submit to sexual acts with 20 to 30 males in any given day. The sexual permissiveness and multiple sexual partners of those addicted to crack present an alarming danger to society. This is where the heterosexual relationships would tend to foster the spread of the AIDS virus.

Due to the highly addictive nature of the crack cocaine, it is not uncommon to find our young people, 13 to 15 years old, with a $75 to $100 a day habit. This exhibits a great disparity between the ages of those first time users of IV heroin and the abusers of cocaine.

Presently, I am the Commanding Officer of the Special Operations Section of the Detroit Police Narcotics Section. I am responsible for the street enforcement, corner operations, as well as the mid to high level drug conspiracy operations. I have first hand knowledge of what has been happening in the City of Detroit. I'm out there with the crews and I see this potentially -- this AIDS virus as just becoming enormous, especially with the cocaine problem.

Recently, the Department implemented a step-up in the crack-down on crack. As of December 1st, we executed over 1,000 raids. We arrested over 3,500 defendants. One thousand of these were felonies. We confiscated over $1.5 million in narcotics proceeds, and over 1,000 firearms.

Our subsequent problems, as you've already heard, I'm sure, is the overcrowding of the jails, the plea bargaining, the limited sentences. Real deterrence emanates from the prospect of swift apprehension and conviction. In this case, perhaps special prosecution teams would do more to deter drug related crimes rather than to increase severity of the penalties, which few are very likely to suffer. That's all.

CHAIRMAN LEE: Thank you, Inspector Thomas. Mr. Cunniff?

MR. CUNNIFF: Admiral Watkins and members of the Commission, thank you for giving us this opportunity to testify before you.

Many of the persons with whom the criminal justice system comes into contact may have AIDS or carry the AIDS virus, but display no discernable symptoms. Indeed, not only are the employees of the system in the dark about whether or not the person has the virus, chances are the defendant is equally in the dark as to his/her exposure.

The way in which AIDS manifests itself within the criminal justice system is primarily through drug abuse. Drug abuse has been a persistent problem that the criminal justice system has had to address and to date has found no effective way to control.

A measure of the impact of drugs on the Justice System can be found in the publication, "Drug Use Forecasting: New York 1984 to 1986," by Eric Wish. This study revealed that 56 percent of the male arrestees from Manhattan in 1984 tested positive for opiates, cocaine, PCP or methadone. The follow-up survey conducted in the fall of 1986 evidenced the percentage of male arrestees testing positive had increased to 85 percent.

This phenomenon is not unique to Manhattan. In drug testing studies conducted in seven other cities, Indianapolis, Washington, D.C., Phoenix, Portland, New York, San Diego and Houston, high drug positive percentages were also found.

Though alarming in the context of the AIDS epidemic, these statistics also revealed that opiates, usually injected intravenously, surfaced in 21 percent of the arrestees in 1984 and 23 percent of the arrestees in 1986. Therefore, the major surge in drug usage occurred with cocaine. In 1984, 42 percent of the arrestees tested positive for cocaine, while in 1986 the positive test rate nearly doubled to 83 percent. Although the IV drug user clearly represents a major risk in the spread of AIDS, that group is still a minority among the drug using population. The impact of drug abuse on the spread of AIDS, however, will be catastrophic if non-opiate drug abusers change their method of intake from such practices as smoking or ingesting to intravenous injection.

Many of the persons arrested by the police, including those arrested for felonies, are in secure custody for only a short period of time. The amount of time a person is held in custody between arrest and the appearance before a judicial officer for bail setting varies among jurisdictions based on the codes of criminal procedure, but most arrestees make that

appearance within 24 hours. Very few arrestees are held over for 48 hours or more pending that appearance.

If arrestees are not able to make bail, they are detained in the local jail. Only a small fraction will stay in jail until their trial, however. Nearly 80 percent will attain their release within 20 days.

Overall, less than half of those persons convicted of a felony go to prison and nearly 25 percent of convicted felons are sentenced to jail, generally accompanied by a term of probation. The balance of convicted felons receive a term of straight probation, that is, with no accompanying term of incarceration. For persons convicted of felony drug trafficking, the imprisonment rate is much lower, only 27 percent go to prison. Many more drug traffickers go to the local jail, 40 percent. It should be pointed out that these statistics apply to persons convicted of a felony and generally less than 25 percent of felony arrests survive as felony convictions.

These statistics are presented to point out the reality of processing felony arrestees through the criminal justice system. This reality should be instructive in developing strategies you may recommend for the criminal justice system in dealing with defendants with the AIDS virus. While many IV drug users are arrested, they are not isolated from the general population for any great length of time, nor are they isolated from one another.

Furthermore, while reference was made to drug testing in this testimony, that testing was voluntary, not mandatory. Indeed, the results were confidential and so were not used in subsequent case processing. Compulsory testing for drug abuse or the AIDS virus for arrestees in a pretrial status is fraught with legal obstacles.

Though prior to adjudication the criminal justice system is not in a position to compel change in the behavior of arrestees or to isolate arrestees with the AIDS virus, it does have a captive audience for a sufficient period of time in which public education about AIDS can be conveyed. Consequently, strategies directed at public education, including information on where interested individuals could go for more information, including testing, could be effective in reaching a high-risk population. Such strategies would require coordination not only among the justice agencies, but also with public health agencies, especially where arrestees seek follow-up information.

As for arrestees who are convicted, strategies directed at compulsory testing and treatment are feasible as the criminal justice system does routinely impose special conditions on convicted felons. The success of such efforts would be highly

dependent upon the cooperation of the judiciary as well as the willingness of government to make the resources available to implement such programs. It is important that the prospective targets for such programs not be restricted to state prisons. As noted earlier, only a minority of convicted felons are sentenced to prison. Far more are sentenced to local jails and community based supervision, such as probation.

Where programs of compulsory testing are considered, it is important to state explicitly the purposes of such programs. Clearly there is the need for correctional officials to know whether or not specific inmates pose a potential health hazard to correctional employees as well as to other inmates. Furthermore, informing convicted felons who have tested positive for AIDS as to the precautionary measures they should take in preventing the spread of the virus to others is also a reasonable goal.

Other purposes of such programs, however, can quickly lead to controversy. For example if the purpose of such testing were to quarantine persons testing positive, considerable resistance could be expected and legitimate questions would be raised about the appropriateness of using the criminal justice system to implement such programs.

The criminal justice system exercises considerable power, but that power revolves around the deprivation of liberty for those convicted of crime. The system's power is much less potent in compelling people to change their behavior while free in the community. Instilling in the individual a sense of what is right and wrong is a societal task wherein the criminal justice system is but one of many institutions that needs to play a role.

There are very real limits to the capacities of the criminal justice system to manage, much less solve, the drug trafficking problem. The activities of the criminal justice system directed against drug trafficking is analogous to swimming against the tide much energy is expended, but very little progress is being made.

The most effective weapon in the war against drug trafficking is to attack drugs at their source and, in most instances, that is more a problem of diplomacy than of criminal justice policy. Drugs such as opium and its derivatives, as well as cocaine, are grown outside the borders of the United States. Consequently, only the Federal government has the authority to take action in this area. State and local governments have no jurisdiction outside their geographic boundaries. The Federal government in the form of the State Department must exercise greater effort in convincing governments in countries where drugs are grown to eradicate such growth. In the context of the

AIDS epidemic, IV drugs must be specifically targeted. Thank you.

CHAIRMAN LEE: Thank you, Mr. Cunniff. Can I urge the subsequent panelists to precis your remarks, if you can, into a five, six minute time frame? Mr. MacDonald?

MR. MacDONALD: Hello, I'm Malcolm MacDonald with the Texas Adult Probation Commission. I am here today as the immediate past president of the American Probation and Parole Association.

I have provided to you two documents. One is my written testimony and second is the American Probation and Parole Association's position statement on AIDS. You should have been given both of them just recently.

Essentially, I'd like to summarize my written testimony by stating probation and parole's capability to manage parolees and probationers who are involved with IV drug abuse. Technology currently in use in probation and parole throughout this country is case classification.

This process of case classification assesses the risk the offender poses to society and also the need for services to solve the problem that got the offender involved in the criminal justice system in the first place. These risk and need assessments look at the offender's companions, sexual dysfunctioning, drug use, alcohol use, family and marital relations, and other factors. All of this information can highlight and alert the officer to information which will identify high risk behavior, which is associated with the spread of the HIV.

In addition to case classification, there is a system of client management classification. This is a proven system developed in Wisconsin and used throughout the country and promoted by our own National Institute of Corrections. This system looks at different strategies for supervising offenders, based upon their stability, capabilities, and pro-social values, or lack of pro-social values.

The combination of these two systems enable officers to adequately supervise people within the community who may be either persons with AIDS or persons who have serious drug abuse problems. Current technology in probation and parole also includes intensive supervision programs. These include: intensive probation, electronic monitoring and home confinement, specialized case loads, residential community corrections.

The one that I'd like to highlight to you is the specialized caseloads for drug offenders or for persons with

AIDS. Specialized caseloads are characterized by an officer carrying a limited number of offenders on the caseload; 40, as opposed to typically 150 to 200 offenders. This reduced number allows additional time for attention to the offender.

The officer also is highly skilled in dealing with the problem that is being addressed through this specialized caseload. If there were to be caseloads of persons with AIDS, it would be anticipated that the officer would be: 1) fully knowledgeable about the AIDS disease; 2) able to persuade community resources to be responsive to the needs of persons with ARC or AIDS; and 3) able to provide counseling, including alternative healing modalities and other intervention strategies including curfew restrictions when appropriate to lead the offenders to take responsibility for their high risk behavior and to make changes.

Another issue is community resources. There are projections in this country that there are 750,000 IV drug abusers who are using IV drugs on a regular basis, and another 750,000 who use them on an occasional basis. The volume of community resources available to treat this problem are not even adequate to treat those who are not in the criminal justice system and not with AIDS. When you complicate the availability of treatment resources with a client who has both AIDS and is involved in the criminal justice system, availability drops even further. I'm sure you've heard testimony from the National Institute of Drug Abuse on this issue.

I would like to inform you about the National Institute of Justice's research, AIDS Issues in Probation and Parole. This research is currently in the process of being generated into a final report which should be out this summer. Essentially, what we're discovering is that there are very few training programs for probationers and parolees who are IV drug abusers. There are training programs for staff on the issue of transmission of AIDS.

Of the 125 probation and parole agencies which responded to the survey, 76 could not answer the question concerning the number of confirmed AIDS cases which were on their case loads. Only eight agencies indicated that they had ten or more cases. Again, this report will be issued by in the National Institute of Justice and their staff will detail more information concerning this project.

I've provided you with seven recommendations made on behalf of the American Probation and Parole Association. They essentially involve the National Institute of Corrections and the Bureau of Justice Assistance providing the American Probation and Parole Association with the resources to deliver a nation-wide training program on AIDS issues in probation and parole. This training should include information concerning case

classification and client management classification so that the type of strategies used for our targeted populations will be effective.

We need a network of health specialists to actually provide training on the transmission of the disease to the 50,000 probation and parole officers in this country. They, in turn, can transfer that information to the 2.5 million people on probation and parole in this country.

Another recommendation before you is for the Bureau of Justice Assistance to include under its Justice Assistance Act funding, specialized case loads for persons with AIDS as a model project in this country.

The National Institute of Corrections funds the National Institute of Sentencing Alternatives on a program of training on AIDS issues for residential community corrections managers. This program should continue to be funded and delivered. Its initial delivery was highly accepted.

Finally, we look at the issue of routine and mandatory IV testing for probationers and parolees, and there's not support for that, across the board. I can certainly go into further discussion during questions and answers on the justification for that position.

CHAIRMAN LEE: Did you say there is or is not?

MR. MacDONALD: There is not support.

CHAIRMAN LEE: There is not.

MR. MacDONALD: For mandatory or routine testing of probationers and parolees. Again, on behalf of the American Probation and Parole Association, we appreciate the opportunity to present information to you today.

CHAIRMAN LEE: Mr. Yelverton?

MR. YELVERTON: Thank you.

CHAIRMAN LEE: Thank you, Mr. MacDonald.

MR. YELVERTON: On behalf of the local prosecutors of this country, I'd like to express our appreciation for this opportunity to discuss briefly with members of the Commission our policy relative to drug control issues, what our association is doing and what we think others can do. A nationally syndicated columnist recently wrote that in the war on drugs we are a nation of whimps, a "mushy" democracy. "We invoke blustery rhetoric of mortal combat, and employ tactics appropriate to a crack-down on

a bingo epidemic in the parish basement." I could not agree more.

In our exasperation, some are suggesting that we throw the full force of our military might into drug enforcement, even sending troops into jungle hideouts of South and Central America to attack cocaine dealers. The columnist that I just quoted suggests that we don't need to go to the jungles of South and Central America to engage the enemy, that enemy is on the streets of America today. How, he asks, can we expect Mexico to stop narcotics from crossing our 2,000 mile frontier, when the United States government can't stop drug trafficking in the shadow of the nation's capitol. I could not agree more.

Certainly, the judicious use of our military services is appropriate, as is the adoption of a tough, no nonsense foreign policy demanding total cooperation in the eradication of drugs. The additional beefing up of federal enforcement capabilities is also appropriate.

But, effective drug control methods demand bold innovative approaches that require us to go well beyond the use of the military to assist in the interdiction of illicit drugs, to go well beyond the signing of eradication and compensation treaties with other nations and to do a great deal more and increase the enforcement capabilities of our federal enforcement agencies.

While these efforts are important and we strongly support them, when all is said and done we must look to the local communities of America for a lasting solution to this frightening specter of drug abuse and its consequences. To really begin a lasting solution to the drug problem, attitudes must be changed; the attitude of our adult population, the attitude of our young adults, and the attitude of our children.

First, we must adopt a zero tolerance for drug use. The place to start changing attitudes is with the generation that is still at its mother's knee, still in pre-school, and still in beginners sunday school class. Our ultimate goal in this approach is that the next generation of Americans will be so conditioned that when they reach young adulthood and adulthood, anyone using drugs will be considered a pariah and totally ostracized socially and professionally.

But, I have little hope that we can instill zero tolerance for drugs in our children as long as people who hold themselves out to be responsible adults and citizens and parents are using drugs. The zero tolerance stance that we support is one that will mean that a few public officials, doctors, lawyers, businessmen, actors, and star athletes, will have to spend some time in jail. That will send a very emphatic message that will

demonstrate without equivocation that we are dead serious, and it will certainly begin to change some attitudes about drug use.

We recognize that putting people in jail for the use or possession of relatively small quantities of drugs is drastic by today's standards. It was not too many years ago that penitentiary time was frequently given for the possession of only a trace of marijuana. Had we not gone soft, had we stuck by the policies adopted back then, we wouldn't have the drug problem we have today.

To change attitudes about drug use, we must get serious. We must reexamine our state and federal statutes and our court decisions to determine what must be done to meet the extraordinary challenge facing this country today. And states must seriously consider adoption of little RICO statutes, modeled after the federal law to effectively deal with criminal conspiracies. They must adopt effective and efficient drug asset forfeiture statutes. They must adopt effective electronic surveillance statutes, and they must tighten the bail procedures for drug dealers.

Drug dealers should be given no quarter, and our policy also requires the reexamination of some of the court-concocted guarantees such as the exclusionary rule and others. We must quit putting drug dealers back on the street after they're convicted. At a minimum, people on probation or parole from drug sentences should be revoked and sent to jail without delay upon violation of the conditions of their release, especially where those violations are drug-related.

Our policy will admittedly mean that a few more jail cells will have to be built, a few more court rooms made available, and that a few more police officers and prosecutors be hired. But, to even begin making a serious difference in drug abuse, local communities must be given significant federal assistance.

The U.S. Department of Justice has developed a five year plan, a plan that they call the National Narcotics Prosecution Strategy, which will redirect federal resources to activities that the federal government is uniquely suited for. That is, the investigation and prosecution of international and national drug cartels.

While we support this strategy, the withdrawal of federal investigative and prosecutorial resources will exacerbate an already critical situation by leaving a serious enforcement void in many communities, a void which cannot be adequately filled without major financial assistance in the form of federal grants.

Last December, our National Center for the Local Prosecution of Drug Offenses brought to Washington 40 seasoned drug prosecutors, most of them unit chiefs from the largest jurisdictions in the country to discuss their common problems. They cited first and foremost the lack of adequate manpower, both prosecutorial and investigative. And related to this, a lack of training and experience among those engaged in this endeavor.

Next, they cited the lack of pre-trial and post conviction jail space. They cited the tolerant attitude toward drugs by courts, legislatures, and the community in general. They cited the problem of recruitment of youngsters to assist in peddling narcotics and the explosion of serious drug-related crime.

Finally, they cited as an inhibiting force the existence of interagency rivalries and jealousies which seriously impede coordinated, concerted, broad-based action against drug traffickers. There's a footnote here, I'm happy to say, that a bill has just recently been filed by Senators D'Amato and DeConcini, and we understand joined by at least 65 other senators, which will provide $1.5 billion for comprehensive state and local drug control grants, and $750 million for federal drug control efforts in addition to what was recommended by the President in his budget.

Rest assured, the local law enforcement community will be working hard to convert all the political rhetoric we've been hearing for a number of years into cash for local assistance. Having said this, we recognize that money is not the complete answer.

Through our National Center for the Prosecution of Drug Offenses, a project which is funded through the Bureau of Justice Assistance, we're encouraging district attorneys to fully exploit their leadership role in their community to become a catalyst for the development and implementation of bold, comprehensive, community-wide anti-drug programs in addition to aggressive prosecution policies and practices. There are communities that have taken steps in this direction, and we know that some of them are already achieving some successes.

One of the objectives of our National Center is to find and document the success of these innovative programs and to provide training and technical assistance to those prosecutor offices desiring to learn by example. We already know from experience that any significant success in this effort will require the total dedication and cooperation of all of us serving in the criminal justice system as well as the constant attention and action of Congress and our state legislatures.

I sense that Americans have had just about all they can tolerate of this drug mess, that we have finally become sufficiently concerned about the problem to begin doing something about it. I believe that what we need now most of all is strong leadership, nationally and at the state and local level. I hope I'm not wrong. Thank you very much.

CHAIRMAN LEE: Thank you, Mr. Yelverton. For the sake of the commissioners, Mr. Yelverton's name is not on your list, but he is Executive Director of the National District Attorneys Association.

MR. YELVERTON: Mr. Chairman, excuse me. We'd also like leave to file at a later date a written statement for the record.

CHAIRMAN LEE: We would appreciate that. Mr. Creedon?

COMMISSIONER CREEDON: One of our witnesses yesterday, I believe he was from the Rockefeller Foundation, suggested that if at some point the efforts that we're now making are not successful that we should give some consideration to decriminalizing the use of drugs.

I wonder whether we're at that stage now, whether we are. It seems to me that the testimony that we have received thus far suggests that. If indeed there is a war on drugs, and we've been talking about a war on drugs for a number of years, we're not winning the war despite the best efforts of people such as the ones who were here just before you, doing their best to stop it on the supply side.

We went through this with prohibition years ago, trying to make it illegal to drink. It didn't stop anybody from drinking. As you suggest, you have young kids on the street corners in Detroit and New York and every other major city in the country, who can make more money in a day than they could make in a month working at a regular job. It takes them out of school. It dispirits them for the future.

The present system involves organized crime being at every level of society, corrupting the judiciary, corrupting government officials, doing all kinds of damage to our cities. In addition, the whole drug need is responsible for much of the crime we have on our streets. It's such a complicated problem.

Maybe throwing more money at it will help. I mean, I applaud what Senator D'Amato and the others are doing, but we're throwing a lot of money at it now. I just wonder what your reactions are. In other words, at what point in our attempting to deal with this as a societal issue do we say, "Well, we have

to take a different approach. We have to put the distribution of drugs in the hands of the government and let people get it, so they don't have to commit crime to get it every day".

I'd like to start with Mr. Thomas and just kind of get reactions. I know many of you -- I mean, this is your livelihood. Your job is to deal with the criminal aspects of drug distribution and abuse, but you're the ones who are closest to it. Would we be worse off as a society? Someone suggested yesterday that if this were done there might be an increase in use to start because it became available, but eventually the real key here has to be education.

As Mr. Yelverton said, we simply have to educate, especially our young people. It begins with the parents. Can we educate them better when it's criminal or when it's available?

INSPECTOR THOMAS: I think by decriminalizing drugs we're going to create a world of walking zombies. There is no way I would go along with the idea of decriminalization. I think we need to expand most of our monies and efforts towards education. There is nothing that is going to ignite any movement toward decriminalization, because we've seen this in regards to the methadone program in Detroit. We started to deal with the heroin users. We gave them methadone, and now they're taking methadone orally and they're selling methadone. We're not solving anything by decriminalizing or giving them a drug. I think this is only going to worsen the problem.

MR. CUNNIFF: We're getting back to basics here. Those of us in the criminal justice system are left to deal with crime as it is defined. Crime is whatever the legislature defines as being a criminal offense. The legislative process is basically a political process and given the current environment legalization is not a very viable alternative. Any politician who proposes it will face a very tough reelection campaign.

Aside from the political problems, I would caution that decriminalization is not a panacea. Even if we legalize it there would still need to be a very heavy role for criminal justice in regulating whatever was legalized.

COMMISSIONER CREEDON: Oh, undoubtedly.

MR. CUNNIFF: In the context of the AIDS epidemic I would urge the Commission to focus on those drugs which have a correlation with AIDS, and that is mainly opiates.

COMMISSIONER CREEDON: They all seem to have a correlation with AIDS. We first thought, well, it's just the IV drug use and you get it through the needles. But the drug users

seem to be sexually promiscuous, and so they pass it through that method as well.

MR. MacDONALD: Several comments I'd like to make. One is that in many places in the country it is decriminalized already, so we have experiments underway. You could even go to rural East Texas, and find places where the use of marijuana is no longer considered a criminal offense, be it defacto or based on the inability of the system to respond.

In Alaska -- certain drugs, such as marijuana, are legalized for personal consumption. Whether you have a society of zombies walking around in Anchorage, I don't know. I know that's not the case in rural East Texas.

COMMISSIONER CREEDON: It's too cold up there.

MR. MacDONALD: We live with paradoxes constantly. You know, we subsidize farmers not to grow certain food and we have people starving to death. I think the drug problem is always going to be with us. Americans are tolerant of drugs. We are tolerant of alcohol, tobacco, nicotine. We are tolerant of various kinds of drugs, and in the normal distribution of society there will always be a percentage of our people who will go to the extremes and abuse drugs.

COMMISSIONER CREEDON: Yes, but alcohol and tobacco are not illegal. Secondly, they are not causing the kinds of societal problems that are being caused by drugs.

MR. MacDONALD: And it seems like the a serious problem being caused by drugs is the illegal economic activity. The murders that are done by persons on drugs are typically not drug addicts who are murdering other crazed drug addicts, but the suppliers of that drug. It does seem that it is the economic problem with drugs that's causing a major problem.

For us in probation and parole, there is very rarely a drug addict who hasn't started off with alcohol. And if we want to take examine what use leads to what abuse then we have all sorts of evidence in our field that says alcohol leads to drugs, which leads to the criminal problem.

COMMISSIONER CREEDON: So, should we criminalize alcohol?

MR. MacDONALD: We've tried that once. I just think there's a tremendous amount of success that we've seen with the AIDS epidemic on the power of education and information. We've seen this in the smoking of cigarettes, how that's become less popular in this country through a tremendous education effort. It seems to me that through a tremendous education effort on how

drugs lead to dysfunctioning, people can be persuaded to avoid the abuse of drugs.

We see it in probation and parole constantly, thousands and thousands of people leaving drug abusing life styles and becoming productive. We're not 100 percent successful. I wouldn't say that, but thousands of people leave that life style and return to normal mainstream society.

COMMISSIONER CREEDON: One of the government officials who recently came back from South America indicated that the government people in South America, are pleading with the United States to stop the demand for drugs. Because, they cannot have a democracy in those countries because of the corruption that exists because of the demand for drugs in the United States.

MR. YELVERTON: I think that any public official or other presumably responsible citizen who advocates the legalizing of drugs is irresponsible. And I don't equate marijuana in rural Texas, to crack in the Bronx.

COMMISSIONER CREEDON: Nor do I.

MR. YELVERTON: It's tough. So is finding the cure for AIDS tough. So is finding a cure for cancer and multiple scleroses. It was tough as hell when the Japanese bombed Pearl Harbor in 1941 and wiped out our fleet. As a result of that, we had to adopt some emergency measures to get by under the circumstances.

And that might be just exactly what we've got to do now, because I sincerely believe that we've never been threatened as a nation so much since 1941 as we are today with this cancer that's eating us internally, our life, and killing our children, corrupting our officials, and turning us into very irresponsible people to say the least.

COMMISSIONER CREEDON: I think much of it is affecting the under class. Some of the testimony we had yesterday was about the under classes, in the major cities especially. It's affecting the under class more than the upper class, although there's a lot of drugs everywhere in this country, everywhere, in every high school in this country.

CHAIRMAN LEE: Thank you, Mr. Creedon. I am going to cut the questioning off here after one more hour. So, I hope the commissioners keep that in mind.

MRS. GEBBIE: The various things that we've heard sometimes are hard to put together. We hear different panels on different days and we don't get them all together. We heard this morning kind of a nice cooperative tale of six federal agencies

happily working together to stop drugs. They made references to the need for education and for the treatment side. It wasn't clear how involved they were with organizing that.

You folks represent local level activities. I think it would be very helpful for us to hear either how satisfied or dissatisfied you are, that when it comes right down to a city or a county or a local area, you really have an opportunity to participate in the organizing and planning of both the supply and demand side programs that might have the effect we want.

I get very concerned about the zero tolerance kind of thing. That sounds very good. Yet for some of the under class kids, I have trouble seeing how saying no's going to work when they see all the money in the hands of the dealers. You've got to coordinate the just say no parts with a myriad of other things.

Is that happening locally? Are we really pulling all the pieces together so you have a part of decision making and feel like you're in control of what's happening or is it very random, what should we be doing to improve it?

MR. CUNNIFF: As a planner, I have to admit that there's very little planning that occurs within the criminal justice system. Where it does occur, it's generally within an agency. But one of the realities of the criminal justice system is that it's made up of independent agencies headed by either independently elected officials basically at the city or the county level. So, for instance, the County Executive cannot tell the Sheriff what to do, cannot tell the judges what to do, and so on. You have to get a diverse group of individuals from difference agencies together and get to consent not only to what needs to be done, but also how it will be done, who will do it, who will pay for it, and will it be a top priority for everyone. That's a very difficult process.

Not only is there not much planning within the criminal justice system, but it's almost non-existent when you talk about coordination between the criminal justice system and the health system or the education system. Everybody tends to work in their own arena. So, given that as a reality, I think it's very difficult to go into a jurisdiction and talk in general terms.

I think the burden on the Commission here is to come up with some very specific recommendations. And if we're talking about treatment, what can we do with regard to treatment? We're talking about testing, what does testing tell us, what doesn't it tell us and how should we use it, and try to keep the agenda very, very specific, because the more general it is, the less success you're going to have in getting anything accomplished.

MR. MacDONALD: I would like to add that I complement the Bureau of Justice Assistance which in the recent funding cycle emphasizes a comprehensive approach to the drug problem.

The American Probation and Parole Association, for example, received a grant to do training on interdiction and intervention strategy for drug abusers. What the bureau recognized was that you cannot enhance one segment of the criminal justice system, without causing a problem for another. If we were to put more money into prosecution, then there needs to be more courts, more corrections to respond to it. And by corrections I mean the broad view of probation and its alternatives. There needs to be that sensitivity about the interrelatedness of all the components of the criminal justice system.

The Bureau this go around in drug funding has put a major emphasis on the system-wide approach. I concur with Mr. Cunniff that the amount of planning that goes on in cooperation has a lot of room for improvement. I also would endorse that cooperation between criminal justice and the health agencies needs to be fostered because we find very dramatically opposing policies.

For example, in Vermont, the prison system distributes, through its medical arm, condoms to inmates. In Texas, that's not allowed. It's against the law. So, you get very different philosophies even within the medical and the correctional communities.

MR. YELVERTON: I agree that not enough is being done on the local level to bring all the essential elements together. We're just now ourselves beginning to do this.

As I said, we're encouraging elected district attorneys who we feel in most instances have some great leadership, significant leadership role in all the communities in the country, to get them to bring together the civic groups and the ministers and the people who are responsible for our school curricula and to be the catalyst for changing attitudes at the local level because it can be done.

Look what happened at the grassroots in the MADD movement. Things got done because mothers were tired of their kids being slaughtered on the highway by drunk drivers. And we can do the same thing from a grassroots level with this situation if we have the proper leadership at the local level.

I really lose patience with hearing over and over and over again what it's going to cost to solve the problem. Whatever the cost and however much money it takes, we've got to do it. We spend billions of dollars on other things that are not

as important. We spend billions of dollars on defense, we spend billions of dollars building super highways to get people to the beaches on the weekends. We've got to spend whatever it takes to solve this problem.

MRS. GEBBIE: Are we allowed one question each today?

CHAIRMAN LEE: I hope we can speed it up a little faster than this.

MRS. GEBBIE: Okay. I have a couple of other questions. I'll provide them in writing.

CHAIRMAN LEE: Mr. DeVos?

DR. DeVOS: I'm going to pass. I'm not going to redistribute my time, I'm just going to cut my time out.

CHAIRMAN LEE: Dr. Crenshaw?

DR. CRENSHAW: I'll redistribute mine.

CHAIRMAN LEE: Ms. Pullen?

MS. PULLEN: Mr. MacDonald, in the statement that you provided us from the American Probation and Parole Association, is the boldface print sentence, "Specialized caseloads have unique applicability to the managing of offenders who have the AIDS related complex or AIDS and may be in need of additional supervision/services." Does this include asymptomatic HIV infected persons or just those who have been diagnosed?

MR. MacDONALD: What I'm suggesting there, Commissioner, is just those who have been diagnosed with ARC or AIDS.

MS. PULLEN: Why?

MR. MacDONALD: Targeting specialized caseloads for asymptomatic offenders implies some sort of mass screening. This Association does not support mandatory or routine testing on the entire probation and parole population. Targeting specialized caseloads for persons who may be engaging, or who have engaged, in high risk behaviors would place the emphasis on the behavior and not on health status.

But specifically what's being suggested here are for the populations who have AIDS or ARC to be considered for special treatment/supervision which is more expensive than regular supervision. Resources will always be limited and therefore targeted appropriately.

MS. PULLEN: I would encourage you to widen that.

CHAIRMAN LEE: Thank you, Ms. Pullen. Dr. Walsh?

DR. WALSH: A couple of just very brief questions for either Inspector Thomas or Mr. Cunniff or both of you. I wondered if you could tell us -- I think you mentioned, Mr. Cunniff, the fact that many of the prisoners or people that you test coming in for a criminal offense are on methadone. Do you have any idea of, number one, the percentage of those people who are on methadone who are continuing to behave in a felonious way? And secondly, is there a significant number of them that are repeat offenders?

MR. CUNNIFF: I'll answer in a general way and I can send you a document that will give you a more specific answer.

DR. WALSH: All right.

MR. CUNNIFF: Those on methadone are in the minority. They're not an overwhelmingly large class of people.

DR. WALSH: That's good.

MR. CUNNIFF: They are largely poly drug abusers. For instance, they may be using methadone because they're in a methadone treatment program and they are be using PCP or something else to get their kick. Drawing from memory, I'd say it's probably in the area of five to seven percent of those who are testing positive for drugs.

Are they repeat offenders? That's not an easy question to answer. The criminal justice system has a lot of data but what it doesn't always have is conclusive information. When we have somebody before us who's arrested, in custody of police or in the jail, we don't know what their prior arrest history is until we get their "rap" sheets back from the state. The Code of Criminal Procedures in the states vary. For instance, in the state of New York, you need the rapsheet before you go any further. In other states, you don't need it until you get to sentencing. So, we don't know what their prior history is at a given point in the process. It's very difficult to get that kind of information on demand.

DR. WALSH: But are you implying that a significant percentage of those on methadone treatment, while they may avoid heroin, are using other drugs to get their kicks?

MR. CUNNIFF: We haven't got any data to tell us how much abuse there is, but with those that were going through the testing program in the seven jurisdictions I mentioned, methadone was not a very large part of the action.

DR. WALSH: One other question. I wondered what your attitudes would be, on the fact you pointed out that 85 percent of the people coming to jail were drug users? And also the fact that a random test recently done at Ryker's Island, of which you may be familiar, in which some 43 percent of 50 persons tested were HIV positive and that they were within the percentage of drug users, as you say. But that they remain in Ryker's Island an average stay of 47 days and then go out on the street. The first thing they look for is a sexual contact.

What is your attitude toward criminal penalties for these people who do that? I mean should they be stopped or should there be -- statutes that are already on the books, should they be utilized to prevent these people from just indiscriminate sexual behavior if they're known HIV positive?

MR. CUNNIFF: One of the problems we get into here is what to do with this kind of information if we can get it? We do not have much of a track record in this regard and the legal ramification could be very problematic. When they're in jail, we have much more supervisory control over them than when they're released into the community. It's possible to state limitations on sexual activity as a condition of probation, but how would we monitor sexual contacts with other people? It can't be done.

The burden of proof would be on us. Now, I mean I'm not an attorney, but I suspect you would have a very difficult time trying to make the case in court given the evidentiary procedures that would need to be followed. So, in terms of looking to legislation to solve the problem, I think we're going down the wrong path.

DR. WALSH: Yes, because the problem is where yesterday we had this discussion about social contracts and people having a moral responsibility. I think that's fine except when you're an IV drug user you're not conscious of moral responsibility.

MR. CUNNIFF: We can hope to know that they knowing it, we can tell them that they could spread this disease to their loved ones, and we can tell them here's what they need to do to prevent that from happening, and this is where we get into the tie-in with the public health system. The criminal justice system is not made up of doctors or nurses. We need to have that tie-in with people who have the expertise in this field and the knowledge of where the resources are to treat them and to monitor them.

DR. WALSH: Thank you.

CHAIRMAN LEE: Thank you, Dr. Walsh. Dr. SerVaas? Not the whole pad of paper, Dr. SerVaas.

DR. SerVAAS: Just three pages, short pages. Mr. Yelverton, my question is for you. We heard from the former panel, it was Captain John Trainor of the Coast Guard. As I understood it, industry should do more drug testing, to identify those with drug problems so they could help and counsel them.

Are there good urinalysis tests? What do they cost? Another panel member suggested taking teenagers drivers licenses away if they were caught using drugs. In line with that, could we make available a simple, accurate, inexpensive urine test that parents could buy? They wouldn't violate any civil rights if they tried to keep their own children alive. They could withhold the family car, the drivers license or their allowances or anything else. Would that work?

If Bobby Kennedy's son, if he did die from an overdose, it could happen to any of us. What could you recommend that mothers could do to mobilize nationally like MADD did for drugged drivers?

Indianapolis, Indiana, at IU, our faculty member developed the breathalizer at the School of Medicine and the lawyers were always saying it wasn't any good. It was a very good test. Do you have that same problem with urinalysis where the lawyers keep us from recognizing the value of that urinalysis test like they did for years in the breathalizer test? Do you have that problem?

MR. YELVERTON: Well, I can't tell you -- I'm not an expert on urinalysis. I can't tell you for certain which tests are more accurate or what the cost is. But certainly, like certain other things that we use in the investigative field, it might not be perfect but it's helpful.

Let's take urinalysis, for example, where you have a parolee and you bring that person in and you give that person a test. You don't have that person in a court of law before a jury. You're not talking about providing something beyond a reasonable doubt. You're looking for a preponderance of the evidence. And if that urinalysis shows he's on dope, he should go back to jail. Now, what else did you ask me?

DR. SerVAAS: Well, if I had a child and he was 16 and driving the family car would it be against somebody's civil rights if there were an inexpensive, at the drugstore test I could get? I'd say, "Look, Johnny, you take this test or you don't drive my car tonight," and that would be okay because I think I would take care of him. I could counsel him and I am

responsible for the car if he crashes or dies, I'm responsible to bury him.

MR. YELVERTON: Well, I don't know. I've never heard that suggestion, that parents give their kids tests before they go out in the family automobile. I personally think it might work but I would not give my kid the automobile if I suspected that that kid was using drugs in the first place. I wouldn't require a urinalysis to take the keys or his drivers license.

Now, they have a program in New Jersey, it might have been mentioned here before, where the state is going to start, if it has not already, taking the drivers licenses of kids who have violated these type laws. I suspect that it's going to be very effective because one thing the kids do not want to do is lose their driving privileges.

DR. SerVAAS: Well, it's hard to take a car away from a 16 year old. Do you have 16 year olds?

MR. YELVERTON: Well, I did.

CHAIRMAN LEE: It's not hard, it's easy. You take the keys away.

DR. SerVAAS: But the question about how you would recommend mothers to form a MADD organization like Mothers Against Drunk Driving.

MR. YELVERTON: Well, it's an attitude problem. Driving while drunk is an attitude problem. We all used to do it. I used to do it. I don't do it anymore. I mean judges and lawyers and prosecutors used to drive under the influence of alcohol, some still do. But I can guarantee you that the attitudes have changed to such an extent that it is just not something now that's socially acceptable and certainly not professionally acceptable.

It's an attitude problem. It's an attitude that has to be changed in the legislatures, it has to be changed in the schools, it has to be changed in the churches and it has to be changed in the homes. When those attitudes change, then all of the things that I've suggested, the legislation and all of the other things, the funding, all of those things will happen.

DR. SerVAAS: Does anyone on the panel know what it costs? I overheard an industrialist say they couldn't afford to test for drugs in the plant because it was $44.00 each person every time they test. Is that true? Is it that expensive for urinalysis?

MR. MacDONALD: Urinalysis is used extensively in probation and parole. Last year in Texas, we estimate that we took 35,000 urine tests. It ranges anywhere from a simple screen for one drug of $.75 to a screen up to the GCMS system which is a confirmatory system that might cost $65.00 for that test. But the mass screening that we do for drugs such as marijuana, can be done as cheaply as $.75. It's based on volume and other factors. But there's no average cost of $44 of which I am aware.

MR. CUNNIFF: The EMIT technology is a fairly inexpensive technology. The cost is driven by the number of drugs for which you are trying to test. But again, your purpose for testing needs to be specific. For example, there's a program in the South Bronx at Lincoln Hospital. It's a drug treatment program where everybody is routinely tested and the person who's running the program, Dr. Michael Smith, defers to the protocols of the referring agency. If the probation department wants to know about the first dirty urine, Dr. Smith sends it right back to them.

In his treatment program Dr. Smith expects to see a dirty urine or a couple in the first month. It just happens. That's how you walk the clients through those initial dirty urines to get them clean over the long haul.

DR. SerVAAS: Is there much danger of false positives?

MR. CUNNIFF: Well, given what Dr. Smith is using it for, he's not worried about it because he's not kicking the people out of the program on the first dirty urine and he's not surprised when he sees it. I mean he's disappointed, but he walks through that with the client and he'll tell them, "You can't come in tomorrow. You come in Thursday and we'll talk about it then. And if you give me a clean urine then, we'll keep on going."

Now, if the purpose is leading to revoking somebody's probation sentence, you had better have the confirmatory tests to be sure the that initial screening was indeed accurate.

DR. SerVAAS: Thank you.

CHAIRMAN LEE: Thank you, Dr. SerVaas. Dr. Lilly? The prior panel and this panel has spelled out this problem very clearly to us. Admiral Watkins, would you like to wind it up?

CHAIRMAN WATKINS: The question was asked about coordination between law enforcement, public health and education entities to carry out what I sense is generally thought to be appropriate procedure. Because you're at the grassroots level, what is the mechanism for the collaborative effort between the federal state and local levels? How well is that coordinated?

What's the flow of information down? What's the integrating function for rapid exchange of information? I'm just asking the question so we can be specific in our recommendations.

MR. CUNNIFF: Admiral, if I can interject here, I'm not a believer in "comprehensive planning" because realistically it involves too much major political gamesmanship, to get everybody to agree on the grand goals. I think you have a much more achievable task if you have a specific objective that you're going after.

For example, trying to get the health department to work with the criminal justice system, for example to do some kind of screening or education program in the jail, but be very specific. Take the city of New York. They have a lot of experience now with AIDS in the community. How do we bridge that expertise with the criminal justice agency that has these people in their control for a period of time to either educate them or test them or treat them? By being very specific I mean, don't try to get the whole Board of Health to meet with the entire criminal justice system to talk about doing something about AIDS. In that instance we could be there for a year and still not make any progress.

This is based on our 20 years of experience with planning in the criminal justice system. Planning is a relatively new field in the system. And the more specific it can be, the much higher the probability is that you will succeed. The more vague it is, the more difficult.

CHAIRMAN WATKINS: But what are you recommending to the Commission? Would this take resources to do or is it just a matter of leadership getting together and working the problems out? In other words, do we need to offer incentives and demonstration projects in various states to carry out that function or is it really not a federal job, it's just a matter of using common sense locally and getting on with it? I'm trying to figure out what you want us to do to perhaps get on with this very specific approach, let's say in the prisons.

MR. CUNNIFF: More money is not necessarily the answer. Money may help grease the tracks, if you will, to get people to move, but what you're basically talking about is a reallocation of resources or refocusing of resources. If the health department has the resources already, and the expertise, you need to match that expertise up with people who are coming into contact with a high-risk population, namely the IV drug abuser. That's what we come in contact with.

But the criminal justice system is very ignorant to date in terms of the nature of AIDS. How do we begin to educate the system and how do we begin to interface with those clients

that come through the system into whatever slots we want to put them, treatment, prevention, education?

CHAIRMAN WATKINS: But that's clearly within the purview of the states to affect such an effort along the lines you've just discussed.

MR. CUNNIFF: It would be primarily at the local level. The states would have very little to say about this.

CHAIRMAN WATKINS: But who has to move it?

MR. CUNNIFF: Again, one of the problems with this country, and it's one of its strengths as well, is that a lot of responsibility resides at the local level.

CHAIRMAN WATKINS: We agree and we put a lot of emphasis on the local level. In fact, we've worked hard to find funding to move directly to local levels. So, are you asking the Commission to make some recommendations to enhance that collaborative effort at the local level very specifically focused?

MR. CUNNIFF: I would, again, urge the elected officials to take this problem more seriously than they have to date and to mobilize the resources they currently have available. If the message going out is to say, "We're going to put together a federal program to try to do something about this problem," they'll wait for the federal program to get developed and be funded. Where if the resources may already be in place, it's a matter of redirecting those resources.

I think what the Commission can do is begin to give people a more concrete idea of how they could begin to mobilize those resources. Where are the problem areas and how can we effectively interface with those problem areas?

CHAIRMAN WATKINS: Have you given us the information to do that in your formal statement or do you have additional information that you could provide us?

MR. CUNNIFF: I'm not an expert in AIDS, Admiral. I'm basically giving you my insight from watching the criminal justice system for the last 20 years and how you have a reasonable chance of affecting some kind of change.

But I would defer to the American Probation and Parole Association. They're in contact with a good number of the IV drug abusers because that's where these people are sentenced.

CHAIRMAN WATKINS: What do you think we can do, Mr. MacDonald?

MR. MacDONALD: Well, one thing that is taking place right now is the National Institute of Justice's AIDS program track. They've come out with a book, "AIDS and the Law Enforcement Officer", and several other publications and will be coming out with a publication on AIDS carriers in probation and parole. These publications not only talk about policies within our correctional programs, but talk about medical information about AIDS transmission. We in the criminal justice field have one focal point of contact with the U.S. Department of Justice National Institute of Justice. There's a clearinghouse number.

So, what has been a tremendous benefit to us is to have one place to go to in criminal justice to get information. If I had to also go the Department of Human Services and to another federal agency to get information, I would be disjointed, distracted and it would take more time to gather that information.

So, the model that's set up through the National Institute of Justice is quite effective for getting some of the best information to us. In the paper, I presented some specific recommendations. For example, the Bureau of Justice Assistance should fund this specialized caseload model program. By the Bureau putting in X amount of dollars and having five sights in the country implement this type of program, it serves as a model, an impetus, an initiative for many other states and jurisdictions to follow. So, that modeling role that the federal government can fill is a needed service. And then there's some research efforts on the applicability of case classification and client management classification to the AIDS crisis.

CHAIRMAN WATKINS: Would all these tend to move towards a greater potential to collaborate locally between law enforcement, public health and education to give maximum punch to those three elements in dealing with drug abuse?

MR. MacDONALD: Federal modeling of cooperation between Health and Criminal Justice does motivate local agencies to cooperate. The publications of the National Institute of Justice demonstrate this cooperation and have motivated cooperation at the local level.

MR. YELVERTON: May I address that just a moment? I think, Admiral, that coordination has got to be handled on a little higher level than NIJ. I think the coordination has got to be handled by Cabinet officials who can make things move down below.

For example, we have and have had since the fall of 1979 an informal working group comprised of the leadership of my association, the National District Attorney's Association, the National Association of Attorneys General and high level

officials in the U.S. Department of Justice, put together specifically to resolve prosecutorial conflicts between the federal, state and local prosecutors.

The Attorney General makes that meeting. It's a quarterly meeting. He always makes that meeting and when something is agreed on, it's done. I think that this is a model for a working group comprised of top level officials, cabinet level officials at the federal level and other leaders at other levels to bring those people together perhaps in a working group and move things along.

CHAIRMAN WATKINS: Would you provide us with some information on that collaborative effort and perhaps some thoughts on its expansion to other areas more focused on this law enforcement, public health, education issue, maybe there's something there that we could recommend. If you feel that it would be useful, we'd like to look at that.

MR. YELVERTON: We'll be happy to address that in our written statement.

MR. CUNNIFF: Admiral, if I may interject here, one of the key roles you could play as a Commission is to define who is the high-risk person out there with the AIDS virus. Now, my assumption was that it's the IV drug abuser. You've been getting testimony that's saying cocaine users are also a high-risk group. That information is news to me.

I think we need to be very specific in terms of who is at high risk of having this virus and how do we begin to identify it and not get caught up with the entire drug problem because you can be sidetracked very quickly on that. If we're talking about cocaine or PCP or whatever, they certainly are problems, but how does that problem relate to the AIDS virus? I think that's one thing you need to be very clear on and, again, tying it back to what do we know about the virus and where are the resources that can tell us how to interface with that population.

CHAIRMAN LEE: We're going to reconvene at 1:30

(Whereupon, the meeting was adjourned at 12:58 p.m., to reconvene this same day at 1:33 p.m.)

A F T E R N O O N S E S S I O N

LIABILITY FOR TRANSMISSION OF THE VIRUS

CHAIRMAN LEE: Let's start the session now on liability for transmission of the HIV and we will start off with Mr. Larry Gostin, Executive Director of the American Society of Law and Medicine, and any other title you may wish to cover.

MR. GOSTIN: Thank you very much. I won't begin with a number of formalities because of the short amount of time and you do have a full set of evidence with appendixes which allow me to cover much more --

CHAIRMAN LEE: We appreciate that and we'll enter all of this in the record.

MR. GOSTIN: Good. The burden of my evidence is going to be very simple and straight forward and, I think, self-evident. And that is that the law must carefully follow the weight of scientific and medical research and that in examining personal control measures it should not succumb to political pressures or unjustified public fears. And that it is only by very close attention to public health research that the law can focus on the real risks of transmission and avoid irrational responses based upon fear and improbable outcomes.

I thought it would be helpful not to adopt a format where I slavishly say that you should adopt this particular criminal law and you shouldn't adopt another. What I propose to do is to propose a framework for how this Commission could, and I believe should, assess the whole range of personal control measures. I believe this structure can be helpful in examining most of the public health interventions that you are considering. My proposal involves four different principles and I'll set them out.

The first that the public health measure must be focused toward a significant risk of transmission. Significant risk is a key phrase which should be measured by the severity of harm and the probability that the harm would occur. Public health law should focus on behaviors which are well established as primary modes of transmission. If public health measures are designed to prevent unprotected sexual acts, needle sharing, exposure to large amounts of blood, then they deserve serious consideration. But interventions which are designed to prevent casual contact such as contact in schools or a job are inappropriate because then they don't follow traditional public health services research.

In the middle are activities like spitting and biting or splattering of blood which, in my view, are very marginal. There's been no documented case of transmission of HIV through these mechanisms, except for three cases reported by the CDC involving soaking of health care workers in blood and I would not regard them as the primary mode of transmission of the virus. Therefore I think that personal control measures aimed toward those areas should be viewed with extreme caution. Highly coercive or invasive policies designed to prevent such behaviors should be suspect.

The second criteria is that the public health response must be efficacious in preventing a primary mode of transmission. The intervention must be reasonably likely to impede the spread of the HIV, not simply symbolically getting tough with it. That there must be some demonstrable medical or scientific evidence that this form of intervention is actually going to impede the spread.

For example, compulsory treatment for syphilis would be one measure which might be very effective because we have simple antibiotics. But because we have no definitive treatment or definitive vaccine for AIDS, highly coercive measures toward that end appear to be less justified.

The third criteria is that the public health response must not pose economic, practical or human rights burdens which are disproportionate to the public health benefit. Even efficacious policies should not be implemented if they're prohibitatively costly and impracticable to implement and overly burdensome of human rights. So, for example, if one were talking about widespread use of isolation or widespread activities against various groups such as IV drug users or prostitutes of a highly coercive nature, even though they might be efficacious, if they impose too great a toll on human rights, privacy, liberty and autonomy then they ought not to be considered.

The fourth is that the public health response must be the least restrictive necessary for achieving a compelling public health objective. Policies that are recommended should not be over broad and should be narrowly tailored to achieve important public health goals. This is a very standard constitutional principle.

Policies should only be applicable to those where there is a likelihood that the person is going to spread HIV by their behavior through high risk behaviors. Policies should not be focused on those who simply harbor the virus and are unlikely to transmit it by their behavior.

I am distinguishing between penalties or personal control measures based on a status, that is the status of a

person being infected with HIV, as opposed to control measures based upon the behavior if the person is likely to do something where there is a serious, probable and immediate risk of harm. Policies should also infringe on personal rights to privacy and liberty as little as necessary to achieve the public health goal.

So, in summary, the public health strategy that I think the Commission ought to recommend is a policy which prevents a mode of transmission which is well established by research, efficacious, not disproportionately burdensome of human rights, and is the least restrictive alternative. If these criteria are all fulfilled, then I think the policy, even a strict personal control measure, deserves careful attention for what we're trying to do is create a balance. And I think that a person's primary right is his or her right to health, and the government's primary obligation is to protect the health of the community.

It does no service to vulnerable risk groups to safeguard their civil liberties at the certain cost of their mortality or morbidity. Therefore what we want to do is to distinguish those clear policies which go to the heart of the epidemic from those which are not founded upon scientific research and are based upon political pressures remote possibilities or irrational fears.

Let me try to apply this four prong test to the area of the criminal law. There are essentially two means of imposing criminal penalties for HIV transmission. The first means is use of the general criminal law, that is without any need to adopt any new statutes. And the second means is to try to implement or to enact certain public health statutes which provide for specific public health offenses.

We did a study at our group at Harvard School of Public Health for the United States Assistant Secretary for Health where we examined all these things and I'd like to go into them. First, let's look at the general criminal law and how likely and probable it is to be an important factor in the goal that this Commission has of impeding the spread of AIDS.

The criminal law prohibits certain intentional or reckless behaviors which may cause physical harm. There have been a multitude of criminal cases brought, but very few convictions around the country. There have certainly been over 50 criminal charges brought against persons with HIV. These charges range in seriousness so that they go from cases like the Morris case where there was repeated sexual relationships without informing the partner to other cases like donating blood to a blood bank knowing that you're infected with HIV, to biting, spitting and then splattering of blood.

If we apply the test that I mentioned earlier, it would seem obvious that you immediately have to distinguish those cases which are concerned with sexual transmission or needle sharing transmissions of HIV from those where it may involve things like biting, spitting or splattering of blood.

The great majority of cases brought to date, I think often by over zealous prosecutors who are very sensitive to the political pressures on them to look tough, have been involving low risk behaviors; that is spitting, biting or smattering of blood. This is so despite the fact that there's never been a documented case of transmission through this mechanism (except for the three CDC cases) and the fact that it is a very, very remote possibility that HIV would be transmitted in this way.

We do have one federal court case, The United States versus Moore, where a person was charged and convicted of assault with a deadly weapon for biting a prison guard. The United States District Court upheld that conviction on the grounds that the person who had AIDS was, indeed, somebody who had the propensity to have a deadly weapon.

I was an expert witness in another case, the state against Haines in Indiana, where a man, finding out that he had AIDS, had cut his wrists and was in anguish unconscious on the floor. The police officers and emergency workers came in, knowing he had HIV, and applied pressure to the wound with their bare hands and short sleeve shirts. A very ill trained, uncautious approach to say the very least.

He was in an unconscious state, awoke and then immediately said, "I want to die. I've got AIDS," and then when they refused to leave him splattered his blood over them saying, "I want you to find out what it's like to die of AIDS."

He was charged on three counts of attempted murder and the jury convicted him on all three counts of attempted murder, which shows the very strong potential for using very Draconian criminal law in this kind of case.

It so happens that very recently we appealed to the trial judge saying that it was wholly inappropriate that the criminal law should be used in this way. And the judge has now directed a verdict of battery rather than attempted murder and set aside the jury's verdict. He was sentenced to eight years imprisonment. Nonetheless, we continue to see a whole range of cases based upon the proposition that an AIDS patient is a loaded gun ready to shoot. Well, in my view the purpose of the criminal law in a public health context should be preventive and not punitive or retributative. And that such long prison sentences do appear punitive.

Moreover, if we regard a person's behavior, anything that a person does in the course of human anguish, as if they were a loaded gun that means that the same behavior that you and I may do out of human anguish which may be a trivial behavior, become very serious in the eyes of the criminal law. We are holding AIDS patients up to a standard of behavior which the rest of the population is not held up to because of their disease.

What should the public health goal of the criminal law be? Clearly, in my mind, it should be focused in favor of trying to prevent transmission. Use of the criminal law in case of biting, spitting or splattering of blood is unlikely to do this for a couple of reasons. First, severe criminal penalties are unlikely to deter or prevent transmission because an AIDS patient is dying and a long criminal sentence, a Draconian criminal sentence, is not likely to deter any behavior.

Secondly, the behavior is not premeditated. We're dealing in many of these cases with sheer human anguish of discovering that a person is HIV infected and not the usual attempt of a premeditated, intentional attempt to cause death.

Third, even if a serious conviction did prevent cases of biting or spitting, and I think there's no documented evidence that it would prevent such behavior, but even if it did it would be unlikely that preventing such behavior would have any meaningful impact at all. Indeed prosecutions of this kind probably would not prevent transmission in a single case of HIV because the behavior is such a low risk behavior. Not that it's not serious or that we shouldn't treat it as a battery, because whenever we bite or spit it is a battery. But what I'm addressing myself to is the use of use of a "loaded weapon" analogy or "attempted murder" analogy. These cases are more complicated than pulling a trigger on a gun.

The area where we are most concerned in the criminal law is sexual transmission. Clearly this is much more serious and it's in line with the epidemiological research about viral transmission. I don't believe it's right that a person who has HIV should be immune from the criminal law. Sexual behavior capable of viral transmission can be just as dangerous as other behavior that the criminal law seeks to prevent. If a person with knowledge intentionality and premeditation wants to kill another person using viral transmission, then, of course, I think that the full use of the criminal law would be applicable. But the cases to date that I'm aware of did not involve people wanting to kill other people, but they involved a much more complicated issue of sexual intercourse.

Sexual intercourse in relationships do not fall neatly within a criminal law model. Motives, the risk, the blameworthiness is not so simple as in the criminal law model of

trying to kill. You can't often characterize a sexual relationship whereas one person is a deliberate criminal, a deliberate murderer or attempted murderer and the other person a helpless victim. Most sexual relationships do not involve those kind of simple views of how the world is.

Moreover, proving guilt beyond a reasonable doubt is very difficult in our constitutional system. What went on in the privacy of a sexual encounter which could have taken place many years ago? Did the person know he harbored the virus? Did he inform a sex partner? Did he have safer sex? Has the partner had other unprotected sex or use of shared needles? So the sheer difficulty of proof beyond a reasonable doubt in our constitutional system will make the criminal law not a particularly strong candidate for trying to prevent transmission of this epidemic.

There is another way, of course, to try to look at the criminal law and that is by use of criminal public health statutes. We spent a great deal of time on this in our report for the Assistant Secretary for Health. Basically in nearly half the states in the United States there are provisions which make it a criminal offense to knowingly transmit a sexually transmitted disease without informing the partner. You don't need to show intentionality or causality or any of the other difficulties. You only need to show that it happened. But in most cases it's just a slap on the wrist. It's a misdemeanor.

In my view, it is not unreasonable for society to try to draw a bright clear line between acceptable behavior, which it will tolerate, and behavior which is unacceptable and that it will not tolerate. And that a misdemeanor or a small public health crime is not an unreasonable thing for society to impose upon truly dangerous sexual relations.

However, in many states, the great majority, these public health crimes do not apply to HIV. The reason is because HIV in most jurisdictions has not been classified as a sexually transmitted disease. Rather HIV has been classified as a communicable disease or a special reportable disease. Thus, these sexually transmitted disease statutes do not apply to HIV in most jurisdictions.

You might come to consider whether or not these public health statutes should apply. If you do, I would urge you to look at it as merely a misdemeanor and not a serious offense for many of the reasons I've given. But I want to give you several reasons why such laws may well not protect the public health.

First, these sexually transmitted disease laws have been around for quite a number of years and decades now, and they are falling into disuse among virtually all of the states.

They're widely regarded as a failed experiment. So that we can't take any solace from history in reimposing them now in relation to AIDS.

Second I fear that it could discourage cooperation with vital public health programs because the surest way for a person to avoid criminal prosecution would be not to know if he or she was infected with HIV. If the person were not tested or counseled, it would be very unlikely they could be charged or convicted for knowing transmission. So that these laws could provide an incentive not to know, which would run against the thrust of what I take to be your fine proposal for voluntary testing and counseling with informed consent.

Criminal sanctions might also impede partner notification programs because to be fully truthful with counselors and partners might be to admit to the fact that a criminal offense had been committed. In addition, policing of sexual offenses has always been intrusive and arbitrary or it certainly potentially could. The entire edifice of the criminal justice system could be bought to bear, grand jury investigations, search warrants, police surveillance of homes in relation to sexual -- inherently private sexual acts.

I fear that the use of the criminal law might undermine public health goals and our confidence in using public health strategies as the main aspect in fighting this epidemic. Finally, states are increasingly considering public health crimes as felonies with very stiff penalties and particularly using these against vulnerable groups traditionally legislated against like prostitutes. I think that there's a legitimate concern that retribution and punishment is overwhelming our concept of public health prevention as a motive for these statutes.

Criminal court cases and statutes and other personal control measures may appear to be getting tough with AIDS. But in fact a Presidential Commission recommendation that they be used more widely would be unlikely to impede the spread of HIV and could divert our attention and resources from policies that do make a real difference -- focused education, testing, counseling and treatment for drug dependency. So I would conclude by simply saying that if we carefully follow the straight forward message of public health research, and we do not seek to be punitive, retributive, and not seek to adapt our policies to political pressures or irrational fears, we will certainly be much more likely to impede this tragic epidemic.

CHAIRMAN LEE: Thank you very much, Mr. Gostin. The next witness is Dr. Donald Hermann, Professor of Law and Professor of Philosophy and Director of the Health Law Institute, DePaul University College of Law.

DR. HERMANN: My topic today is the availability of legal doctrines and measures to address transmission of Human Immunodeficiency Virus both through private law provisions as well as public law actions. I've provided you a fairly extensive written discussion of these matters so let me just, perhaps, summarize that statement and save time for more specific questions.

I think in the area of civil actions, private actions for transmission, there are sufficient analogies to other areas of law and authority for resolving conflicts in this area. In relation to transmission by means of blood and blood products, particularly in cases where blood has been received after the development of the antibody test, it seems to me that there are ample doctrines such as the theory of negligence, negligence on the part of facilities where blood is received which hasn't been tested, which provides adequate basis for recovery. The requirement of informed consent with regard to the window of opportunity for infection provides an alternative basis for liability when a recipient otherwise might have availed themselves of measures for donor directed blood or had their own blood reserved for transfusion.

For blood received prior to the development of the antibody test, it seems that there are distinct difficulties in obtaining any kind of recovery. Most of the decided cases have refused to find liability, these cases have been decided on the basis of laws which provide that -- providing of blood is a service, therefore removing blood from the area of warranty or strict liability. And cases finding that generally providers of blood who conformed to the FDA recommendations prior to the development of the antibody that or took no measures prior to those recommendations, that those providers were not negligent and therefore have no liability.

As I said, I think in any case where, after the antibody test was recommended, blood has not been properly tested, a suit based on negligence should provide a sufficient basis for recovery.

In the area of sexual transmission, again there are analogies to cases involving transmission of syphilis and a series of cases involving transmission of herpes. The doctrines of battery and negligence have provided a sufficient basis for recovery. There, of course, are difficulties because of the plethora of defenses available to individuals sued for transmitting a sexually transmissable disease such as assumption of risk on the part of a partner who knows that an individual is or might be infected and contributory negligence for engaging in needle sharing or sexual activity where both parties have equal opportunity to know the risks.

Very similar doctrines would be available in the area of IV drug use. Of course, there are serious problems of proof involved in showing that one particular contact the resulted in infection. And the length of time for development of positive antibody adds to the difficulty to establishing a causal connection between a particular transaction and infection.

In the area of the transmission during childbirth there are a great a number of cases recognizing suits for wrongful birth where a party, even a parent, is held liable for actions that have resulted in a child being born in some way handicapped or defective as a result of the failure of the parents to take proper measures to prevent injury to a child. And here I think that a father, knowing he was HIV positive and that he presents a possibility of infecting the mother, and proceeds to cause a pregnancy resulting in an infected child, that father would be subject to such a suit.

Finally, the other area of possible liability for transmission is in the work place and the issue is the extent to which the employer conforms to the recommended guidelines of the various government agencies overseeing the particular work type activity. In the area of the public law it seems to me that there are three areas of possible activity with regard to transmission. The mental health law, public health law and the criminal law.

In the area of mental health law, there are certainly a number of mentally ill individuals who are infected with the HIV virus and whose mental illness may make them dangerous with regard to their sexual or drug related activity. Their mental illness whether independent of or related to their HIV infection may produce an inability to understand the significance of their activity and its possible effect. In addition to that, there are certainly cases of people who have been infected with the virus where the effect of the virus is to have produced dementia and in other cases to have triggered AIDS related psychosis. And in those cases, too, it may be appropriate to consider the use of the mental commitment law where the showing of the person is, in fact, mentally ill and as a result of that mental illness is dangerous or unable to care for themselves.

The public health law, it seems to me, also offers a series of approaches to dealing with transmission. Obviously the most effective and well recognized is the process of education and counseling. It seems to me a second level of activity in order to more effectively reach individuals who might be infected is a process of voluntary contact tracing. And then it seems to me, finally in the third area, where individuals who are infected and who are known to persist to engage in activity likely to transmit the disease after counseling and where less restrictive measures are ineffective in eliminating dangerous

activity, the possibility of isolation under the provisions governing the isolation of those with communicable disease or sexually transmitted disease, should be considered, or possibly there should be consideration of adopting additional legislation specifically providing guidelines for isolation of persons infected with HIV who present an established danger of likely transmission to others through engaging in dangerous activities such as IV needle sharing.

In addition to these measures, obviously, the possibility of guaranteeing places where activity likely to transmit the disease is being engaged in. And again, it seems to me the statutes in existence provide a means for dealing with this, alternatively specific legislation could be developed directed to this issue in relation to HIV. But again, it seems to me, the less restrictive means should be exhausted before any more restrictive approach is taken.

Finally, the area of criminal law is available and it seems to me it provides probably the least effective and least appropriate measures, although there certainly are provisions in the criminal law which exists and can be used in appropriate cases. Professor Gostin mentioned the provisions specifically directed at knowing transmission of sexual transmitted disease. But as we look at the criminal law, generally, I think it's important distinguish the offenses for which general intent is sufficient as opposed to specific intent offenses. That is, offenses involving someone who simply engages in activity knowing that it's possible that the virus will be transmitted as opposed to activities that are engaged in for the very purpose of transmitting the virus. Most of the suits that have been filed have been based on assault a general intent offense. And it seems to me that the assault model is one that is most appropriate to consider in this area and moreover there is a precedent of prosecution of individuals for transmission of syphilis; the view is that it's sufficient that the person knowing that they're infected intended to engage in sexual relations, aware that there was a risk of transmission.

It seems to me extremely difficult, however, to maintain actions where the assertion is clear intent to transmit the disease as the way purpose for engaging in the action. And it would seem to me most cases of where such intent is present that it would be more appropriate to consider the public health law measures of isolation because simply placing this person in a correctional facility involves moving such a person into another population where they are likely to pose the same threat. The public health authority provisions aimed at isolation to prevent transmission seem to be much more effective.
Alternatively one may consider the availability of the civil commitment remedy where there's a showing that a persons conduct in intentionally transmitting the disease stems from some kind of

mental disorder. So I think that is a general overview and, perhaps, it would be appropriate later to consider some of these specific issues.

CHAIRMAN LEE: Thank you, Mr. Hermann. The next speaker is Major Paul Capofari, Office of the Judge Advocate General, Department of the Army in the Pentagon.

MAJOR CAPOFARI: Thank you, sir. Sir, my written submission to the Commission emphasizes, and I'd like to start out by emphasizing, the criminal law and imposing criminal law sanctions is a small part of the Army's and Department of Defenses' HIV policy. Essentially criminal law and the criminal law sanctions are a last resort when all other actions fail to produce responsible behavior.

The goal of preventing the spread of HIV is best achieved, not by new laws, but by education, counseling and making support available. Existing criminal laws, specifically aggravated assault, can punish those who criminally expose others to HIV. Aggravated assault is a battery with a means likely to produce death or grievous bodily harm. Article 128 of the Uniform Code of Military Justice is how we prosecute soldiers for aggravated assault.

Now in addition in the military we have the military orders. As our regulation, which I've provided the Commission requires, Army commanders must take a solider who has tested positive for HIV and give him a lawful order to inform his partners and to take precautions before he engages in sexual activity. A violation of this order can be punished under Article 90 of the UCMJ. And the Navy and the Air Force will have similar regulations in the near future.

We found that violation of an order is an effective tool for a number of reasons. First, it provides notice. That is, the soldier is on notice as to what conduct is being prohibited, the dangers that that conduct poses and the precautions that must be taken. So it's a knowing violation.

The second advantage we find is that it forces the commander to become involved with the soldier, to counsel the soldier, to make available to the soldier the support systems that we have available within the military and so it aids in prevention. And quite frankly, the third reason is a type of charge for violating an order is very easily proved in court. You simply show that an order was given and that the soldier violated the order.

The Army has had successful prosecutions for exposing others to HIV and we have other cases ongoing right now. These cases involve heterosexual conduct where an HIV antibody positive

soldier, after warnings, engaged in intercourse with unsuspecting partners. Our two convictions thus far both involve sergeants. One was for aggravated assault, the other conviction was for violating orders. I'll answer any questions that you may have.

CHAIRMAN LEE: Thank you very much, Major Capofari. Next witness is Mr. Robert Weiss, prosecuting attorney from Genesee County in Michigan.

MR. WEISS: Thank you, Mr. Chairperson. When I received the invitation from this Commission to speak last week I was somewhat surprised. I appreciate the invitation, however, because I think it's important that any commission or any legislative body have input from those of us who are in the street implementing policy decisions on a day-to-day basis. Although I cannot bring expert medical opinions to you, I can describe how things work in the real world.

I was thrust into this area some three years ago when I became the first prosecutor in the country to charge an AIDS carrier who spit at a police officer with assault with intent to commit murder. It is not something you look for, it's not something that you figure is going to happen. But when you're confronted with such facts, you proceed with what you believe is an appropriate response.

The case subsequently was reduced to resisting arrest. We did not appeal that reduction based on some other legal problems with the case, for instance the defendant was intoxicated at the time and, as you've heard, there were some intent problems. So we didn't feel that this was the case to make law on in the area. But we in the field of prosecution are faced with this growing problem.

I think it's interesting that Mr. Gostin and I are at opposite ends of the table because we certainly -- I have trouble dealing with some of his recommendations on a day-to-day basis. Some of the things that I heard him say today are the same arguments I heard relative to drug abuse and drug use in the '60s and the '70s. You don't punish, there aren't consequences for your actions. Instead, you rehabilitate them. That has not worked, and today we're drowning in our drug abuse problem. So I think that approach does not work in the real world. There must be consequences for those who violate somebody else's rights and privileges, and we must go about dealing with that.

We're not talking about -- and I want you to understand the field of prosecution, and I speak obviously for myself, but I notice that you had Mr. Yelverton here this morning. We are not dealing with people who have the disease and who are not exposing it other people. I don't hesitate to endorse what every other person testifying before this Commission has said. Obviously,

the long term way to deal with the problem is to find a solution to this deadly problem; to find a cure and to find a way to deal with the problem. But in the short term, if you are aware that someone is violating somebody else's rights and using the disease offensively, then I think we, as a society, must deal with that antisocial behavior. And I think that that's what we're about.

It's difficult to be in the forefront of this problem, but I'm glad that you have asked me to address the problem. And if I can be of some help, I would like to address those problems. Thank you.

CHAIRMAN LEE: We should be off to the races with this panel. Some very interesting issues here. Mr. Creedon and Mr. DeVos have told me they had to leave early, so we give them the opportunity to start off the questioning.

DR. CREEDON: I don't have to leave that early, but I will be glad to comment. As a lawyer I hesitate to say this, but from the standpoint of the Commission I don't know that the issues of criminal liability are that important. I think the lawyers and the judges and the judicial system can deal with them in an adequate way. The legislatures can. I really agree with what has been said, in other words, the real problem here is one of education, of finding a cure, of finding a vaccine. I'm not in any way trying to minimize the problems that will arise under the criminal system or under the civil system. But in relation to the functions of this Commission, I don't think we should spend a lot of time, myself, on those aspects of the problem. And with that, I will pass.

CHAIRMAN WATKINS: Well, Mr. Creedon, we do have in the charter from the President the requirement to report to the President and to other members of the Cabinet as well as other state and local officials our recommendations on any legal ramifications of the HIV on society. The degree to which we feel we can address the legal issue is, of course, another matter. But I do think that we certainly have to listen to the various legal issues and I would think this one, because it is a social issue as well, we have to be very careful before we leave it unaddressed.

DR. CREEDON: Well, to the extent that we have to address it under the Presidential Order, I certainly agree that we must address it. But all I'm saying is that in the scheme of things I do not regard, and I'm a lawyer, I do not regard the legal issues here as the important issues that have to be addressed.

CHAIRMAN WATKINS: We note your comment. Thank you.

DR. CREEDON: Thank you.

CHAIRMAN LEE: We have another distinguished legal mind on this Commission, Mr. DeVos. Do you have any --

MR. DeVOS: I pass.

CHAIRMAN LEE: You pass? Then we'll go to Dr. Primm who hasn't had a chance yet today.

DR. PRIMM: I want to pass now, Mr. Chairman, and I'd like you to come back to me, if you would?

CHAIRMAN LEE: We will do that. Dr. Conway-Welch? Nobody wants to tackle you guys.

DR. CONWAY-WELCH: I'm organizing my thoughts. Give me just one minute.

CHAIRMAN LEE: You want us to give you some time and we'll come back to you?

DR. CONWAY-WELCH: Okay.

CHAIRMAN LEE: Dr. Lilly, are you prepared?

DR. LILLY: Well, I'll huff and I'll puff. It seems to me that a large percentage of the attention that is going to be paid to this type of, case of at least quasi-intentional transmission -- again as some of you pointed out a question of intentionality is a very difficult one to deal with under the best of circumstances. On the other hand, there is the question that continuously comes up of what about recalcitrant people who will not do what they should do? And it seems to me that most of the suggestions I've heard on this story is, you tried the least difficult measures first and if they don't work, you go to stronger and stronger ones. And there does have to be a limit to what one can do. But the question of where you draw that limit is what's at issue here.

Secondly, the considerable majority of this discussion comes up in the context of prostitution. And those are not the only circumstances, but they are, indeed, the main circumstances. And I think that that complicates the issue, to say the least.

I don't have an awful lot to say on the subject, except that I do feel that you don't jump immediately to the death penalty. You start a little place short of that in trying to encourage people to behave the way one would like them to behave.

MR. GOSTIN: Can I mention something about the prostitution issue, because it's a very important one and none of

us have addressed it and I know that there a number of judges around the country who have been considering this?

I did a study for the National Institute of Drug Abuse about at what stage the criminal law could intervene to compulsorily test or compulsorily counsel somebody. It's clear that under the Schmerber Doctrine, (a blood test case decided by the Supreme Court) that you can't test a prostitute until she has been formally arrested and charged. Before a lawful arrest and charge the criminal law has no jurisdiction over them. However, once they've been formally arrested and charged and certainly after they've been convicted, there may well be things that the criminal law could do. I know a couple of very innovative judges who, at that stage, instead of imposing a criminal punishment, are putting as a condition of bail or as in lieu of sentence a requirement that the person is tested, counseled, supervised on a continuing basis for a period of time. And it seems to be something that both the convicted person and the courts have found to be useful. It's not a heavy punitive method, but it is a way to proceed so that you just simply don't, turn your back on the problem and then send her back onto the streets.

DR. LILLY: But on the other hand, in what sense is that not sending her back on the street -- her or him, on the streets?

MR. GOSTIN: What you're doing is, you're sending her back with a whole different area of counseling, support, supervision.

DR. LILLY: Well, in a sense, then what we've done is what Major Capofari has done, which is to give this person in a sense orders. You have told the person what the situation is and what the proper behavior is from now on, thereby establishing the right to further prosecution, if those orders are disobeyed, in a sense.

MR. GOSTIN: Well, I think that's a fair analogy, yes.

DR. LILLY: Right.

CHAIRMAN LEE: I like this orders.

Mr. Weiss?

MR. WEISS: I find it difficult that we're trying -- that I hear someone trying to move around punishment. If someone --

DR. LILLY: No, I'm not trying to move around punishment.

MR. WEISS: I'm not talking to you, I'm talking about the response. The punishment is something that we should not use in the system.

DR. LILLY: I didn't hear that in the response.

MR. WEISS: Well, I heard that from Mr. Gostin that we should not be using punitive measures in this area. If someone is violating somebody else's rights, knowingly doing that, then there ought to be some punishment. Our whole system is based on that.

Unfortunately there was a period of time in our legal system when we tried to be rehabilitative. We weren't very successful then and we are not very successful now. But given the resources that we have within the system, the place where rehabilitation ought to take place in the criminal justice system is in the juvenile system. That's where you have a chance to make a difference. It's not happened. The same thing is not going to happen here.

You can talk about rehabilitation, but I can tell you that with the resources we currently have to deal with in the system, it's not feasible.

DR. LILLY: Would you like to define a punitive measure, perhaps?

MR. GOSTIN: It's clear that say in the prostitute example that the criminal law is punitive it's not a voluntary mechanism. If a person's been convicted, the criminal law is doing something which is coercive to the extent that it's compelling the person to be counseled, tested. It's requiring them to attend medical or psychiatric or psychological treatment and it's supervision.

There is some element of punishment there, but it does seem to me that it's particularly unseemly and unproductive for public health, and particularly for a commission that's primary objective is public health, to be concerned with long periods of incarceration for terminally ill people. I've explained in my evidence why I think that's likely to be unproductive from the public health point of view and not a deterrent. And also what it does is it just simply puts somebody who is dying into a prison sentence -- a prison atmosphere for the rest of their life where they may, indeed, continue to spread the virus and I think serve very little public health purpose. Besides which I think that many of these kinds of prosecutions are very much a lottery. That is, that the most vulnerable, isolated individuals come to the attention of prosecutors where the great majority of instances of transmission in the community go unnoticed.

As I say, I don't think it's right for us to simply turn our back on dangerous behavior. I'm not suggesting that at all. I think it's something we need to attend to. But I think that it is wrong to think that very long draconian prison sentences are the way that we can solve this essentially public health problem.

DR. LILLY: I'd like to ask a slightly different question then. We've talked about the responsibility of the HIV infected prostitute for spreading the infection. I'd like to ask about the responsibility of the customer for accepting spread of the infection and wondering if it isn't one of the functions of the education that we keep talking about giving people, to make the prospective customer aware of the danger and some responsibility devolves then upon the customer to protect him or herself.

MR. GOSTIN: Yes, there was a case in Florida where an HIV positive prostitute very recently was charged with a very, very serious felony. And the person who attended the prostitute not only wasn't admonished, tested, counseled, but his name wasn't even disclosed because of the circumstances.

I think there is a difference between prostitutes and those who visit them. But on the other hand, I think the disequality in attention has become alarming and I think we certainly need to consider both sides of the coin. We need to educate people that are going to prostitutes, using prostitution services is very, very dangerous for their public health and we're much more likely to achieve our public health objectives that way.

CHAIRMAN LEE: Mr. Hermann?

DR. HERMANN: It's probably best not to limit the consideration to prostitution but to all sexually related offenses and have some provision for testing people convicted of such offenses such as rape and other sexual offenses and to consider the possibility of law similar to that which dealt with sexual psychopaths where there's repeated behavior and subsequent convictions which would provide for the power to isolate the individual in order to protect the general public where there's demonstrated failure of the educational counseling activity to have proper effect.

MR. WEISS: Well, I'd like to respond to that. I agree with your comments. The question becomes how many victims are there before the system reacts? You say that there's counseling and then you put the person back through the system. Take rape, by persons infected with AIDS, for an example. How many rape victims do you need before society is going to step up and

address that issue? It seems to me that it ought to be dealt with the first time, and the person ought to be isolated. Society ought to be rid of that person for a period of time.

Now, I'm opposed to the death penalty, which may shock many of you. I am opposed to the death penalty because I don't think the system works that well. But I am a firm believer in isolation if you have somebody who is antisocial and is out there transmitting a disease.

We as a society have to deal with that, and we have to deal with it properly. We cannot -- counseling may not work. So how many more victims are we going to have before we deal with that?

DR. LILLY: Well, I think many of us feel that a rape conviction by itself is an extremely serious problem and the question of the presence of AIDS is a bit of a plus or a minus in that situation. So I'm not sure that is where the big argument is in the rape conviction.

MR. WEISS: The other thing I would like to respond to is something I've heard since the day that I charged the spitting case, and I have seen it in other prosecutions coming along the line. I hear the phrase from so-called experts that there are no documented cases in which the AIDS virus has been spread by saliva, yet I note that when I go to my dentist, he's wearing gloves and a mask. When I go to other health professionals who I have respect for, I notice they are taking similar precautions. Yet I hear other experts saying there are no documented cases.

So, for those of us who are out there trying to deal with it on a day-to-day basis, there is a gap there that we don't understand. We are led to believe that there may be some threat. Otherwise, why are people -- taking all of these precautions?

DR. LILLY: Hepatitis virus is one reason.

MR. WEISS: Exactly. We had a police officer in Flint, Michigan, who got hepatitis when he was searching someone. Put his hand in the pocket and got stuck by a needle. Now, if an officer can catch hepatitis in this manner, why can't AIDS be transmitted the same way. Fortunately, there is a vaccine for the hepatitis.

CHAIRMAN LEE: Can we go on to the next -- Dr. Primm?

DR. PRIMM: Yes. Major Capofari, has the Army now tested everybody in the Army?

MAJOR CAPOFARI: Yes, sir.

DR. PRIMM: And my concern is the rate per 1,000 among certain ethnic groups in the Army. For example, among blacks, the last report that I can recall both men and women on active duty, 4.7 of every 1,000 of those enlisted personnel tested were positive for the virus. For black officers five of every 1,000 tested were positive for the virus. And that is, I guess, junior grade and field grade and general grade officers were all tested. If they were no longer married and in the service, 6.6 of every 1,000 blacks tested were positive for the virus. Now, that was as of November, 1987 and these statistics supposedly were done in 1986, and I'm sure since that time there have been considerable numbers of others tested and I'm sure that the difference is very high. Now, I'm wondering how can a commander -- you have been a commander in combat. You wear the combat infantrymen's badge --

MAJOR CAPOFARI: No, sir.

DR. PRIMM: You're a paratrooper.

MAJOR CAPOFARI: It's not a combat infantrymen's badge.

DR. PRIMM: That's not?

MAJOR CAPOFARI: No, sir.

DR. PRIMM: Well, it looks like that from here. I guess I need to get closer to you. But you're a Ranger and you're a paratrooper. So how -- and a commander you've been in a platoon leader and so forth. How then can you monitor these kinds of HIV numbers of positivity in terms of their sexual behavior or whatever they're doing on active duty in the armed services? I'd like to hear that.

MAJOR CAPOFARI: Well, normally a commander and a level commander I'm speaking about has about 100 men in his command, and so he would not normally have more than -- I would not assume that he's had that many in his unit. I don't have the statistics broken down by race. I know that we've had 1476 positives out of 1.1 million tests and we estimate there's about 850 soldiers on active duty right now that are positive. So you would not have that many soldiers in your particular unit if you were a company commander. When I say monitor, I merely mean the commander gets involved in making sure that this soldier knows that his medical condition is going to be taken care of and that we've got help available for him, that he does have to take certain precautions because he could infect others and that the doctors, the mental health professionals, the other services that we have are available to that soldier. But the commander does not go out of his way in watching that soldier at all particular times. The soldier goes on with his normal duties as his medical condition permits.

DR. PRIMM: Yes, but Private First Class Morris that someone cited here today had sexual intercourse with three different individuals, I think two women, and a man, and he was convicted and then later on it was overturned, is that correct?

MAJOR CAPOFARI: Sir, Private Morris, we should point that out, hasn't been convicted of anything.

DR. PRIMM: Is that right?

MAJOR CAPOFARI: His case was taken on an interlocutory appeal. There hasn't even been any evidence presented in Private Morris' court-martial which should resume next week. Now, he has been charged, but I think we're all willing to point out he hasn't been found guilty of anything. There's been no evidence presented, although there's been a lot of publicity about his case. The other two sergeants that I mentioned have been convicted and their cases are final and the sentences have been judged against them.

DR. PRIMM: But my question is how can you monitor the behavior of the number of individuals who are HIV antibody positive that are on active duty? Someone had to tell the commander for him to bring charges against Morris and the other two sergeants. In other words, either their sexual partners or someone-- and they had to know from some kind of way that Private Morris was infected. How could they know that if there is confidentiality practiced in the armed services? How did that message get to the lovers? Do you follow me?

MAJOR CAPOFARI: Yes, sir. In the case of Sergeant Stewart at Fort Sill, Oklahoma, his girlfriend found his medical records and opened them up and saw it right in there.

DR. PRIMM: You mean soldiers carry their medical records around with them?

MAJOR CAPOFARI: He had just come back from the hospital and he had been --

DR. PRIMM: I see.

MAJOR CAPOFARI: -- accessed once again to see how his medical condition was. Sergeant Sergeant at Fort Sam Houston, Texas, his commander from Hawaii was reassigned to Fort Sam Houston and saw Sergeant Sergeant out on a date with one of the privates there on post. And was concerned about "do these people know?" I know because I used to be his commander. He surfaced it. In Private Morris' case, allegations of homosexual conduct were made, and that's what brought the case into the public arena. Once the publicity occurred women that he had been with came forward.

I think the point on these cases and how they come up is the point that Mr. Weiss is making. As an Army prosecutor these cases are thrust upon you. You don't get a lot of chance to make studies and do a lot of ivory tower looking at all this. All of a sudden you've got a case and you've got to prosecute it because you're down there enforcing the law. And that's how these cases have come up in the Army.

DR. PRIMM: What then is the Defense Department doing about protecting the confidentiality of health records of persons in the armed services who are found to be positive for the antibody to the virus? I think that's an important issue.

MAJOR CAPOFARI: Yes, sir. And the regulation which I've provided to the Commission requires that the same type of privacy that applied to that information be applied to other medical information and the regulation uses a nice phrase, "it's only to be released on a need to know basis." I'm not going to tell you that it hasn't happened that people have gossiped about, people have rumors. It's something we have to work on.

DR. PRIMM: What do you do in the service, when someone working in the health field violates the confidentiality of a patient and tells somebody else? I mean what happens to that person? Do you have any sanctions for an individual, a physician, a corpsman or --

MAJOR CAPOFARI: Yes, sir. They would be subject to the same range of sanctions as anyone else who commits a violation.

DR. PRIMM: Then why wasn't the commanding officer of the sergeant who saw him out with a date and knew about his antibody status, prosecuted under the military code of justice?

MAJOR CAPOFARI: Because I don't think he did anything wrong, sir. I think what he did in that case --

DR. PRIMM: He violated that sergeant's confidentiality by saying that he knew he was positive, you just said that, right?

MAJOR CAPOFARI: Yes, sir. And he went back to Sergeant Sergeant's present commander and said, "Do you know this guy is out there dating the privates on post." Sergeant Sergeant --

DR. PRIMM: But that's the point. That's the point I'm trying to make and that is a violation.

MAJOR CAPOFARI: I think that balancing the violation, that violation versus the violation that Sergeant Sergeant was doing, he did not receive any punishment.

DR. PRIMM: Okay. That's all the questions I have. But I think the Commission understands the point that I'm trying to get at here. How can we have confidentiality and then violate the confidentiality and turn somebody in? And I don't think that should happen and especially in the military.

DR. WALSH: Benny, if the man's company commander is the assigned counselor, there is no violation of confidentiality.

DR. PRIMM: Yes, but this was not the man's company commander. This was a sergeant under whom he had served at one time or another and saw him dating a private and then goes and tells somebody else. I think that's clearly a violation. I mean that's no different than if I saw someone who I knew their antibody status and they were dating somebody and I would go tell them. I mean do you do contact tracing in the Army like that? Are you monitoring people like that in the armed services?

MAJOR CAPOFARI: Sir, I know we'll have a court-martial next week out in the Presidio of San Francisco that came about because a corporal who was positive confided in his close friend at the supply dock where they worked that he was positive. And then his friend constantly was receiving calls from the corporal's girlfriend and he finally confronted the corporal and said, "Hey, have you told her, you know, about your medical condition?" And the Corporal said, "No, I haven't told her." And so his friend went and told the commander and that began up the criminal case which will be, as I say, taking place next week out in the Presidio. And I don't think that friend violated any kind of confidentiality compared to the danger the corporal was posing to his sex partner.

DR. PRIMM: Okay. Would anybody else like to comment on that issue? Mr. Gostin.

MR. GOSTIN: Well, I mean, it's -- I don't think I can comment on the specific case, but I do think that Dr. Primm's point is very well taken that the armed services do not have a clear doctrine of confidentiality within their code which they will enforce.

What worries me is the privacy issue. I almost have visions of a sex police where there are people whose job it is to determine what kind of sexual relationships are going on. I must say I feel discomforted by it, but I understand the public health danger and wish that it could be achieved without violations of privacy and confidentiality.

DR. PRIMM: Thank you very much.

CHAIRMAN LEE: Dr. Welch?

DR. CONWAY-WELCH: In some of the previous panels we've heard the problems of what happens after someone is charged and convicted; the problems of plea bargaining, short sentences and easy parole. Are we begging the issue when we look at what kinds of sanctions are appropriate for the HIV positive person who has exhibited disruptive or uncontrollable behavior and we move them into the judicial system and then they come out on the other end abruptly and prematurely? Are we kidding ourselves that that would be a useful mechanism to go through if you took the position that these people should be isolated when, on the other side of the coin, we know that plea bargaining and reduced sentences, are a major problem in our system and the buildup in the courts, is also a major problem? Could any of you comment on that?

DR. HERMANN: I think your questions suggests why it's more appropriate to think of the use of powers under the public health law for isolation of persons whose behavior justifies such action, because the public health authority can detain those persons indeterminately until there is a determination made that the person no longer presents a danger. On the other hand, the criminal justice system is backward looking and fixes the penalty according to the seriousness of the offense. And, as I said, the offenses that generally can be charged in conduct related to HIV transmission are those general intent offenses such as assault which have generally shorter sentences. And the sentence really bears very little connection to the real concern created by the presence of HIV in the person whose engaging in the contact likely to transmit the disease.

I think in providing these powers of isolation and in exercising them, there should be a heavy burden on the public health authority to determine that their application is are necessary and appropriate and that there is a factual basis for making any isolation determination.

MR. GOSTIN: May I just add, you raise, I think, the real and important question about what you do with a person who has AIDS and who is in the prison system. Now, it's certainly true that there are two variables you need to look at. One is their dangerousness if you let them out of the prison system. That is not a unique question to AIDS. I think that whenever parole officers are considering probation or early release of some kind they have to consider whether there's going to be a danger and they have to try to minimize that danger; rape or murder are no less serious than somebody who goes out and may continue to have sexual relationships.

So I think we need to do that. If we're going to let somebody out early, I think that careful supervision, counseling, testing and so forth may be justified. But the reason that people are let out early leads to the second factor. You're dealing with somebody who is terminally ill and in need of treatment, care and support; nursing care which the prison system simply is not capable of doing. So in my judgment it's certainly a rational balancing to say that the prison system is no place for somebody in their last months or years of life. People with AIDS who are dying are probably the least likely of the people to transmit the virus. A person who is asymptomatic is more likely to be dangerous.

I also want to just comment on Don Hermann's point about use of isolation because we've not discussed that at all. I do address it in detail in my written evidence in the Appendix because of the time I didn't emphasize it verbally. But I think that there are many, many strong objections to the use of isolation, not the least of which is the fact that it is forward looking in that we have to predict who is and who is not going to engage in dangerous behavior in the future. That prediction itself, which is not on the basis of any previous behavior, is a very, very difficult thing to do. That is the first problem.

The second problem is the fact that it is indeterminate. There is no definite period of time for isolation. Third, that we have to develop means; where are we going to put people who are isolated? For how long are we going to put them there? On what basis? How can we predict what they're going to do in the future? I think it raises a whole grave area of difficult problems and I would just draw your attention to that section of the evidence rather than going into it in depth here.

MR. WEISS: I would like to comment, if I might, on that. I think the isolation suggestion by Mr. Hermann might be an excellent alternative. The problem I think you've got to be very careful, of is creating a type of revolving door for these people. This problem is analogous to the one created by revisions in the mental health code of Michigan and the due process that has been given to mental health patients. What you find is a revolving door of people who are going in and out of the system, and I think to a large extent it's created a problem of street people and homeless people who society still has to deal with. We moved them out of a mental institution and said, "Okay, now fend for yourself," and they're not capable of doing that.

So I think that by looking at one solution you've got to look at it all the way down the track and recognize that at some point you're going to have to deal with it. As a criminal

justice person I don't care if that person is in isolation, prison, or wherever, as long as he or she is not a threat to society. And I think that's our primary concern in the area, that they're not out doing it again.

CHAIRMAN LEE: Dr. SerVaas?

DR. SerVAAS: I wanted to ask Major Capofari and Mr. Weiss their opinions about how we protect the girlfriends and the wives and what you know about how we handled the syphilis epidemic before we had penicillin. It was my understanding that we did all the testing because we didn't want genital syphilis babies and we were protecting the women whose husbands would be out catting around and getting the treponema and spirochete that would burrow through the uterus and into the baby and you had these horrible deformed babies. But they're no more deformed than the AIDS babies. And if we're going to have 20,000 of the babies, I don't understand, and I'd like your opinion of what Mr. Gostin is saying, to the effect that for syphilis we had penicillin but we don't have that for AIDS. We certainly have a way to identify those who are spreading the virus now and causing the same kind of epidemic of babies.

How can we justify saying that for syphilis -- we have penicillin. We were testing for syphilis long before we had penicillin. And what do you do now for confidentiality on testing your soldiers for syphilis?

DR. HERMANN: Incidentally, the question you raise has some answer under many state statutes which provide the opportunity to inform and in other states place an obligation on the part of a physician to inform a spouse of someone who is infected with a sexually transmitted disease. More generally I think analogies can be made to the opinion in Tarasoff v. Board of Regents of the University of California which relates to the responsibility of a psychiatrist to inform or to protect the intended victim of a patient. And I think a similar case exists where there is an identifiable party such as a sexual partner, a spouse, or an IV drug user with AIDS who indicates an intention not to inform such an individual as a sexual partner or IV drug use buddy or to take precautions to prevent transmission of the virus. There should be an obligation on the part of a physician to warn a spouse, to inform a spouse of the other spouse's condition so that measures can be taken to prevent further infection.

MAJOR CAPOFARI: The Army policy, ma'am, is that the spouse is told by the military. If the military member comes up positive, the spouse is a health care beneficiary under the military. We encourage the spouse to tell. If they don't, we will call them in and inform them.

For other frequent sexual partners, we follow whatever the state law is in that particular jurisdiction. If a single soldier came up positive, whether or not we told his girlfriend would be dependent on state law.

DR. SerVAAS: I think one of you made the remark, and I think it was you Major, that we have a vaccine for hepatitis. But I don't know if you knew that we don't have a vaccine for non-A/non-B hepatitis. It can be fatal and it's prevalent.

MR. WEISS: What I was talking about was the police officer who got stuck with that needle and, fortunately, there was something for that officer. But it very well could have been terminal.

DR. SerVAAS: The other kind of hepatitis.

MR. WEISS: Absolutely. And I think that's a whole other area that should be looked into safety precautions for police and other emergency people. We hear that concern every day. Responding to a scene of a crime where there's blood all over. What they're walking into, that is a concern of police personnel everyday.

CHAIRMAN LEE: Dr. Walsh?

DR. WALSH: I think that you can see the complexity of the charge that the Admiral told you about that this Commission has.

The problem that I find here again goes back to the issue of public health. Many of the attorneys that we have heard, as well as many of the physicians, want this treated as a public health problem, yet many of the public health officials that we have had before us do not want to invoke the very powers or statutes that they have available to them because of the--not only the vigorous assault of the civil libertarians, but also for fear of being brought to court by lawyers who believe in violations very strongly of confidentiality, discrimination, one thing or another. And we are expected out of this morass to come up with a set of recommendations.

Now I am gradually myself, coming to the feeling that Mr. Weiss' approach has somewhat more logic than the approach of doing nothing. As he cited the permissiveness of the '60s towards criminals, not only drug users, did nothing but produce more criminals. The concern for the rights of the defendant, to my mind, sacrificed for years the rights of the offended and we're just now starting to recognize that there are really obligations that we have to those who are the victims of crime.

To me someone who is sero positive and has been counseled and knows that they are potentially infectious -- and I'm not interested in whether it's one in 200 times. That doesn't make a damn bit of difference to me because it's the same -- you used the term of the Saturday Night Special one of you did. Every time a Saturday Night Special is used someone isn't killed, they just might be wounded. But maybe one in 200 times someone is killed. And I think the same thing applies here.

And I wonder could you give us a set of recommendations, for example, in a step-wise form, of when it is appropriate and proper to impose a criminal penalty? I accept the fact that, it would be great if we could counsel everyone, but we don't have enough counselors. And I don't think we ever will have because to train them costs money. We have no way of evaluating whether counselors any good.

I don't know how the Army determines whether a commanding officer is a good counselor or a bad counselor. And this to me would be a problem, even for the two or three people he counsels.

But if you do counseling, if you do take all the other precautionary and supportive measures, I don't see that it's a problem of whether we can monitor behavior or not. The individual has an obligation to monitor his own behavior and if he doesn't monitor that behavior and he is a danger to society, what is wrong with imposing some type of criminal penalty?

I know in our conversations with, for example, the homosexual community which has done a great deal about bringing about behavior change I've been told by several members of that community that they do counsel and they do urge very strongly, the corrections of behavior. But they fall short of saying we would urge criminal prosecution for that rare one because it's always a rare one, you know. It's never a lot of people that violate the law except we can't keep the jails empty. But not even the rare one is reported for fear of violation of confidentiality if he chooses not to report himself as being an irrational sexual behaviorist.

What is the answer? What are we to tell the President of the United States if we are to contain this disease? We're not going to have a vaccine for ten years, if then. We're not going to have any magic cures that we can see. So what can we do when behavior is not voluntarily controlled? That is when we must turn to the law, but if the law then says, "Well, that's a public health problem," what do we do? What actions do we take? What recommendations do we make? I mean it's fine to say that people have been successful in behavioral change, but unless you're 100 percent successful there's a danger. What do you do?

DR. HERMANN: But it seems to me the experience of the armed services shows the proper use of the criminal law where you have well documented cases where people have engaged in the very kind of behavior likely to transmit the disease and there's clear proof of that. It seems to me that the civilian criminal prosecutions that have been brought are involve biting and spitting where there is a great deal of criticism from the medical and scientific authorities because the conduct being charged is not an effective means for transmitting disease. I think these prosecutions have had the effect of producing criticism and concern about the use of the criminal law. But it seems to me that that doesn't mean they are not proper cases for criminal prosecution where someone knows their status as HIV infected and continues to share needles in IV drug use, where a person knows their status and they continue to engage in unprotected intercourse. But it seems to me it's going to be -- it's difficult to imagine that this is going to be an effective means generally to address the problem of HIV transmission.

I think as experience of the armed services shows, there are going to be relatively few cases where a prosecutor will be able to show clear knowledge, by the HIV infected person of their status and the likelihood of transmission, conduct likely to transmit and actual transmission. That is why I think that the public health powers are a much more appropriate response, that the public health authorities are much more likely to be effective in this area than will be powers exercised under the criminal law. Most of the cases prosecuted are presented to the criminal law authorities to deal with as a result of a complaint. But I don't think that it makes sense to look at the criminal law as a likely device for producing effective response to controlling HIV transmission.

DR. WALSH: I understand that. But you see you have state health offices who refuse to recommend, for example, that a disease be called communicable but only make it reportable because that way they don't have to use the law that's on the books. But at what point does society benefit from that type of cowardliness by a state health officer? I mean, you have to turn somewhere.

DR. HERMANN: It seems to me this Commission should be recommending to public health authorities that they effectively develop regulations and procedures --

DR. WALSH: All right.

DR. HERMANN: -- for dealing with these kinds of cases. But I don't think the recommendation should be that the criminal law authorities should take it as a particularly heavy part of their charge to combat AIDS through assault and other criminal prosecutions. I think that prosecution should occur

where there is the kind of conduct that shows blame-worthiness, kind of conduct to which the community response is one which supports criminal prosecution. But I would not recommend putting major resources in the prosecutor's office to combat AIDS.

DR. WALSH: No. No. But 95 percent of the proposed legislation before the Congress today is to protect the potential offender in the situation with AIDS. And the few that are down there that would protect the offended will never get out of committee.

Now, what is this Commission supposed to do in view of this legislation because we're going to make it more and more difficult because federal law will supersede, perhaps, some of the state laws. I'm not enough of a lawyer to know whether they can do that. Some of the statutes that are being proposed go to great lengths to protect every confidentiality, discrimination, the whole bit, some of which is legitimate and some of which is not. But it seems to me the health of the public is losing in this fight.

MR. GOSTIN: I think it's very important to dispel the notion that the reason that public health officials are not implementing statutory powers is indifference to civil liberties. I don't believe that civil liberties are more important than public health. But the reason that we are not implementing these powers is because there simply is no data, no research, to indicate that they would be efficacious.

The reason that we do not impose sanctions on persons with HIV is not a civil liberties point, it is precisely a public health point. The United States Public Health Service, the World Health Organization, any large major public health authority that I know has never recommended widespread use of the criminal law.

DR. WELCH: No, no.

MR. GOSTIN: -- or isolation or anything of the kind. And their reason is because they don't believe it would work.

The reason that they implement confidentiality and anti-discrimination legislation is two fold. First, they believe that insuring confidentiality and anti-discrimination would be one way to insure that there is complete use of public health programs for testing, counseling and behavior change. That it is a long tradition within public health that people and health care data should remain confidential, precisely because we want to encourage cooperation in public health programs. The same point is true with anti-discrimination legislation. But there is the additional point made by the Supreme Court which said that we don't want to stigmatize somebody because they have the status of

being infected. What we have to do is separate the status of infection from the actual behavior. So I think that it is quite rational the approach that public authorities have taken.

MR. WEISS: I enjoyed your comments, Doctor, and I made a promise to myself when I came here today that I was certainly not in a position to make recommendations to this august body as to solutions.

DR. WALSH: But you are. We want them.

MR. WEISS: And I'm here more to identify the problem. But one of our problems in proving a criminal case is showing knowledge on the part of the person who is transmitting that disease. It seems to me that this problem -- we're just in the infancy of the problem. If you talk about the progressions that I read and the numbers that I read, it's going to be astronomical in a short period of time. Similar to the drug problem that we're facing today.

It seems to me that we have to start testing antisocial people as they come into the system. We have to do drug testing as part of a booking system so that infected persons know that they, in fact, have the virus, or have the potential to transmit it, and are informed and are counseled at that period of time. No criminal charge concerning the virus is involved at this point. These people have been arrested for something else, for instance prostitution. Prostitutes are at a high risk of transmitting the disease, as are other assaultive, antisocial people who may be infected. We should identify these people and let them know they are carriers and then have state statutes enacted so that these people know they are walking with that gun.

DR. WALSH: Well, that's what the military does. But, you see, we have little or no opposition in this country 25 or 30 years later to urine testing for drugs in the work place or anywhere else. But we have universal objection to testing for HIV as a condition for employment or in the work place or as a condition for insurance. I'm not advocating that myself because of many other reasons. But how long is it going to take before we have the acceptability by society that this poses potentially as great a threat as drugs do? I mean that's the question. How long do we wait for help?

MR. WEISS: My response to that is we'd better be addressing it right now.

CHAIRMAN LEE: Ms. Gebbie?

MRS. GEBBIE: Thank you. First, just a brief clarification to Mr. Weiss. The reasons dentists are wearing gloves isn't because of saliva, it's because of blood in the

mouth. It is the blood exposure that is the reason for the precaution related to both hepatitis and HIV infection. And I'd be happy to talk about that with you some more later.

I tend to disagree with Dr. Walsh that we've had confusing testimony on this. I think again where we stick to the same question we get very consistent answers from lots of people about which kind of laws to use in which kinds of situations and what the conditions of those statutes ought to be. And even the issue of taking action at the front end I think we hear very consistently, although we hear some differences.

The more I've listened today the more the problem is with the support system. It's not with the law, it's where we're going to find enough staff to treat the people properly whether we shove them in prisons or whether we do something else, and you've already said that.

All that by long way of preface, I guess, to the issue that we do have some differences in public health laws in this country. We have some differences with the way people administer them, but generally agreement about taking action when cases are needed. But Mr. Gostin's paper points out not all the statutes are modern, not all the statutes meet the tests of various content.

We have had debates in other areas then. If the state laws are inconsistent and maybe not modern enough, one of the quickest ways to fix that is to move to a single federal statute that would override. That would, in public health, be extremely unusual, because our public health laws reside at the state level. But I think it's only fair that we include this in our discussion if the panelists see any merit in taking that kind of an action here to alleviate the outdatednesses or whether taking that major precedent setting step in public health would be inappropriate and we simply have to concentrate on fixing them up at the state level and then using them properly with proper guidance. And I'd like some discussion on that.

MR. GOSTIN: I'd like to answer that, if I may. I would answer yes and no. I think that traditional infection control statutes (that is use of isolation, public health criminal offenses and the like) should remain with the states, the reason being exactly the perceptive reason you gave. Public health has always as a matter of constitutional law and tradition been a state prerogative, not a federal prerogative.

MRS. GEBBIE: I should hasten to add as a state health director I'm not real excited about the possibility of changing that system. But I just want to hear some experts.

MR. GOSTIN: Yes. But I do think that there is an important role for the federal government and for federal legislation in an AIDS specific sense. I would certainly think it would be very beneficial to provide for monies for education and counseling and statutory powers for confidentiality and anti-discrimination on a federal level. I feel it strongly for two reasons.

The first is that at the moment I regard the position on confidentiality and anti-discrimination in the states as nothing short of a doctrinal mess. That is, if you have very basic questions about confidentiality and duty to warn, like whether you notify a spouse or an emergency worker, that if you go from one state to the next state that the answer to that very basic question will be different in one state than it will be in another. And I think that's unfair to the AIDS patient and to the health care provider, particularly.

More importantly, even within a state a health care worker will not know the answer to those basic questions, the distinctions between confidentiality and duty to warn. And, indeed, we will have to go into a morass of legal detail and our report for the U.S. Assistant Secretary draws this out about how if you classify a disease in certain ways, you can have more confidentiality than if you classify it in other ways.

STD statutes have very strong protections of confidentiality but because, as we know, AIDS is not in most states classified as a sexually transmitted disease. Therefore, I agree very strongly with CDC that there is insufficient protection of confidentiality.

The same thing is true with anti-discrimination. If you then go back to the August, 1987 CDC report from its Atlanta conference, it recommends very strongly in favor of a federal role in anti-discrimination and confidentiality. I know because I work with the World Health Organization at the moment, they are also interested in developing some kind of a uniform standard and principle in those two areas so that we have a bedrock below which we cannot go. So I think that in those areas there is a strong justification for a federal role.

MRS. GEBBIE: But not for clarifying the inconsistency or lack of modernity in the isolation or public health order side of those --

MR. GOSTIN: Yes, exactly. For that I think what we need, and I proposed and you'll see it in your appendix in the Milbank Quarterly is that we need uniformed model guidelines for state legislation. We had a revolution in this country in civil commitment in the 1960s and the 1970s because the laws were outdated, profoundly unfair and the Supreme Court and several

federal courts through a decade showed that those statutes were very, very bad and outdated. And within a decade every state in the country changed their civil commitment laws.

I think that we need no less of a revolution in relation to public health statutes, but I think what we need to do is perhaps a strong recommendation for reform from this Commission at the state level followed up by model guidelines and model legislation would be the way forward.

DR. HERMANN: But I think the analogy to the mental health law provides good evidence of why this matter should remain in the states. True, there was general revision of the mental health laws in the 1960s and 1970s, but a number of states have found that these revisions of the law resulted in release of patients, wholesale release of patients who suffer from serious mental disorders. The revisions of the mental health law do not provide authority for the mental health department to confront these people's needs. That is why we have seen over the last five or six years revisions in the mental health laws in a significant number of states to address the problem of mentally ill homeless people.

I think that the activities in the various states that have been taken may be appropriate to a particular population and the special character of individual states as well as provide an opportunity to have a number of experiments to address various HIV issues and to explore different approaches to in confronting various problems. This will produce solutions, solutions that will be more beneficial, than trying to impose some standard solution throughout the United States at the present time on most of these issues.

Nevertheless, I think the issues of discrimination and confidentiality are areas where there is accepted general opinion and federal action may be appropriate, particularly regarding discrimination. And I think those matters may be appropriately considered from a federal statement. But it seems to me the general public health law, both the statutes and regulations dealing with the broader range of HIV issues, should be developed in ways that are appropriate to the particular jurisdiction.

MAJOR CAPOFARI: Well, I think the military, obviously, has a very big interest in uniformity, we are an organization with camps, posts and stations in all 50 states. We say we're going to follow state law, that creates a very confusing situation. On the other hand, I guess just speaking personally, that does create the need for a lot of extra lawyers. As a military lawyer, I want the extra assignments.

It is in the military's interest to have standard laws all over. As Mr. Gostin said, we have different -- much

different regulations at Fitzsimmons Army Hospital in Colorado than we do at our hospital in San Francisco because the state laws are so different.

MRS. GEBBIE: Mr. Weiss, do you prefer state law or federal law?

MR. WEISS: No. I have nothing to say, but to have a politician and a lawyer say nothing, it's impossible.

My only concern is that we have seen it in the drug area. And again, I relate back to that. We have seen that the drug problem is not a local problem. It's a national problem. Yet we're trying to fight it with local resources. The same thing is going to happen here. As this problem escalates, localities with limited resources and limited dollars will be forced to fight this problem. The problem is truly national. And I think that's why the federal government needs to get in it as far as resources.

MRS. GEBBIE: Yes. Thank you.

CHAIRMAN LEE:

DR. CRENSHAW: I have read recently that in non-AIDS sexually transmitted diseases, that five percent of the sexually transmitted disease carriers are responsible for 80 percent of the cases of sexually transmitted diseases, meaning that a very sexually active small group has an enormous impact on our society.

Yesterday we heard from a panel on learning from history. And it seems to me that apropos of Dr. Walsh's comments that we're hearing such emphasis on the rarity of the patient zero or some of the individuals that you've alluded to, that have been prosecuted, whether they're rare or whether they're not rare we really must act promptly and effectively to prevent many others from becoming infected as a result of antisocial behavior.

One of the things that I'm hearing a debate on that I really think there's much more agreement on then meets the eye is the issue of rehabilitation versus punitive action. I'd really be surprised if all of you didn't feel that whatever we could do for rehabilitation ought to be done and tried. I don't hear someone saying, "no rehabilitation, thrown them in jail." And I think I heard from you, Mr. Gostin, that you wanted other issues approached first and then felt that someone who was sexually intentionally exposing someone else to a deadly disease has to be stopped in some fashion.

The one area that I know everybody agrees on is that since we don't have a cure or a vaccine, prevention is our only

hope. Here's what puzzles me and it's not going to be a direct question, but I would invite comment. Sex offenders are historically the most difficult to rehabilitate successfully in the field of sex therapy. And I'm suggesting that we need to work harder, try harder and become successful, just like we must in the area of substance abuse where progress is being made. But basically they are one of our greatest problems in effective rehabilitation and therapy. Even in the most aggressive programs the recidivism rate is incredible.

I haven't yet seen a sex offender come to therapy to get treatment because he's afraid of getting AIDS from the victim but perhaps one day this will motivate a few to stop. Short of that, we're really frustrated in terms of how effectively to intervene on a long term basis with these patients. And yet with prevention as our only tool, we're still at a point of debating whether sex offenders should even be tested against their will and then we add to that other antisocial behavior involving drugs and so on and so forth. Then we get to the point that I read in your testimony, Mr. Gostin, that contact tracing has no value when there is no cure. Where prevention is our only hope, it seems to me that that is also our only hope. And even though you represent people once they are infected, and I appreciate your efforts to protect their civil rights, my concern goes for them before they were infected and what we might have done for them to prevent them from entering that category where we can do relatively little.

These are my concerns. I sometimes feel like I'm an Alice in Wonderland when I hear some of the arguments and reasoning that applies to this epidemic. One example would be you pointed out that sexually transmitted diseases have very powerful confidentiality provisions and yet you're not recommending that AIDS be classified as a sexual transmitted disease. Instead you're recommending new legislation. It seems to me that we have many resources on the books that have been very thoughtfully developed over a long period of time that are being completely disregarded. So that's not a very clear question. It's more of an expression of frustration, but I'd appreciate comment.

MR. WEISS: Your comments about the sex abusers is extremely apropos because for a great period of time the criminal justice system felt, as you said, that a person needed help, needed counseling, needed to be dealt with in a rehabilitative setting. About five or six years ago that came to a sudden halt when the, and I may be wrong on the name, the American Psychiatric Association, came to the conclusion that you just mentioned and that is, that sex abusers are not being cured. The criminal justice system should not be turning back to rehabilitation because it has not worked. We need to punish and then counsel. If that works, terrific. I think your comment that

sex offenders are difficult to rehabilitate is accurate. When someone is antisocial, punish them but also see if you can't work with that person to turn them around. Their chances of success are not very good.

DR. CRENSHAW: Well, as I said, I don't think these approaches are mutually exclusive. Major, did you have any thoughts?

MAJOR CAPOFARI: From a criminal justice point of view (as a prosecutor) I would go all the way back to Mr. Creedon's comment at the beginning. The development of the criminal law will come along and I don't necessarily think that the Commission needs to recommend new criminal laws in this area. We can use the existing laws to punish those for whom it's appropriate and put the resources more toward prevention and education hoping that that helps us check the spread.

DR. HERMANN: I think your point about the significance of contact tracing as part of counseling education programs is well taken. I think it simply comes down to a matter of whether there will be cooperation by the persons who are diagnosed in providing the information and, secondly, whether this type of contact tracing is cost effective. Alternatively, whether it's more effective to engage in general education programs in trying to communicate safe sexual practices generally as opposed to spending very valuable and limited resources in a very expensive program of contact tracing to accomplish the same result on a more limited population. I really think a cost benefit analysis needs to be done, but I don't think contact tracing particularly voluntary contact tracing should be ruled out as a possible public health measure.

With regard to the other point, it certainly seems to me that legislatures should either determine that they're going to classify HIV and the related conditions under the sexually transmitted disease or communicable disease regulations or alternatively they should develop parallel provisions for reporting and establish the variously needed measures for isolation and quarantine that may be specific to the particular disease caused by HIV.

For example, the state of Illinois has adopted specific HIV measures and has provisions for a judicial order for isolation in a case of a person who continues to engage in behavior likely to transmit the disease. This particular provision does not exist in other statutes dealing with sexually transmitted disease or communicable disease statutes. So in a sense special protection for the civil liberties of HIV infected persons is provided in this specific HIV legislation which may be, I think, the reason that the legislation and regulations have been generally found acceptable to the citizens of the state.

DR. CRENSHAW: Mr. Gostin, do you think that AIDS, HIV related diseases should be classified as sexually transmitted diseases? I know in New York it is not and many other places.

MR. GOSTIN: Well, I don't think it's that simple. I'm very critical of the very rigid differentiations in current public health statutes that you actually have to say that this disease is sexually transmissible, this disease is communicable, this disease is specially reportable. And that by putting it into the straight jacket of one of those classifications, very profound and large legal consequences come to bear.

I don't think it is true to say that STD statutes are well thought out, tried and true. Our study I keep coming back to documents in great detail for the Assistant Secretary that amalgam mess, if you will. That they go back to an earlier time when public health values and public health understandings were much different. They have an infamous history of incarcerating tens of thousands of prostitutes in the so-call syphilis epidemic in what was widely regarded as a failed experiment. I'm very critical of those statutes. I think they do not provide clear due process rights. I think it's very likely that if isolation was used under one of those antiquated statutes, very likely the Supreme Court would find that it was unconstitutional for the same reasoning it did for many of the civil commitment statutes.

So I think that it is absolutely essential that before we even think about using these laws, we have to start to update them. And I think it's no coincidence, by the way, if it's crossed any of your minds, that after eight years experience with the HIV epidemic that we've yet to have a case worldwide of a serious use of isolation. There seems to be a profound public health consensus, not only in America but across the world that that's not the way to go.

DR. CRENSHAW: So the fear about the sexually transmitted disease category is the isolation issue, not the diagnoses of whether it's sexually transmitted or not?

MR. GOSTIN: Well, unfortunately, AIDS like hepatitis B is a blood-borne disease. It's partly sexually transmitted and it also can be transmitted in other ways. And when we develop these kind of categories we haven't recognized that you couldn't place a disease within one classification or another classification. The important thing is whether or not the person has a communicable disease, what the modes of transmission are and what the best ways of stopping the transmission are. I don't think it would be wise to recommend classifying AIDS under the current STD laws when those laws are so ill thought out.

DR. CRENSHAW: Last and briefest question is what exactly would you recommend be the actions taken on a prostitute who has been tested, has been arrested, is known to carry the disease and who is found the next day practicing her trade? What specifically would you approve of?

MR. GOSTIN: I won't be cornered by a particular case because there's so many multiple factors. But certainly prostitution is a criminal offense in the country, in most states except for Nevada. Which, by the way, Nevada licensed its prostitutes and tests them for HIV positivity. There's also a great deal of evidence that it is the prostitute herself who is more concerned with safe sex than her client.

DR. CRENSHAW: What exactly would you recommend?

MR. GOSTIN: Well, basically I would recommend that we would charge them with prostitution. I would then consider instead of putting them into prison, as I've said earlier, to test them for the virus, to counsel them, to supervise them.

DR. CRENSHAW: I'm trying to specify a situation. She's been tested. We know it. She's back on the streets.

MR. GOSTIN: Right. Then she's committed a criminal offense and you have to prosecute her for it.

DR. CRENSHAW: Okay. Thank you.

MR. WEISS: This is where we may disagree. I think that person needs to be taken out of society for a long period of time, and a misdemeanor statute for prostitution is not going to do that.

DR. CRENSHAW: How long does that take someone out of circulation?

MR. WEISS: Maybe it's isolation through the public health --

DR. CRENSHAW: No, no. I mean a misdemeanor --

MR. GOSTIN: A year or less.

MR. WEISS: In Michigan it would be 90 days or less. So that doesn't accomplish a thing. That does not protect the potential victim. There needs to be some statutory authority for us to deal with the problem of people who knowingly expose others to the disease. That the general statutes don't work. We'd have to charge assault with intent to murder again. We need to have state legislatures looking at the problem of developing state statutes that deal with the knowing transmission of that disease.

Michigan is about to introduce a statute, and I presented a copy of that with my testimony. That may not be the exact answer, but it's a vehicle to get where we ought to be going.

DR. HERMANM: The case of the prostitute is a perfect example of where the public health authority should have regulations dealing with this disease to provide for isolation until such time as it is determined that the woman no longer will be engaging in activity and transmitting the disease.

MR. GOSTIN: I mean I vigorously dissent from that because, as I pointed out, it's exactly what we did in syphilis where we rounded up tens of thousands of prostitutes, put them in isolation for an indefinite period of time. The great censuses of the public health literature is that that was not effective, it was punitive and it was a failed experiment.

I certainly think that we need more than the mere statement to suggest that that's what we need to stem the tide of the epidemic. We've gone that route, we've gone that route in Japanese internment camps. You simply cannot round people up in our constitutional era consistent with Supreme Court jurisprudence and put them away for indeterminate periods of time.

DR. CRENSHAW: I don't hear anybody suggesting that.

DR. HERMANN: I don't think that was the case. It seems to me --

DR. CRENSHAW: No, not at all.

DR. HERMANN: -- that the hypothetical that was presented was very definite. It's not the same as rounding up all prostitutes who are HIV positive. Don't you think that that person who has been engaged in the criminal conduct of prostitution, counseled and continues to engage in such conduct likely to transmit the disease should be subject to public health control? It seems to me that's very different than saying all people are subject to isolation because they're infected and a prostitute.

MR. GOSTIN: Yes, but all the prostitutes who were HIV positive and continuing to practice their trade would be similarly situated.

MR. WEISS: Fine. Then they ought to be out of society.

DR. CRENSHAW: Do you think they should continue to practice their trade if they're infected?

MR. GOSTIN: No, I don't, but I think we've got prostitution laws and we should enforce them. But I don't think that indefinite isolation of the HIV positive prostitute population with compulsory screening because that would be the logical outcome, would be sensible in light of our historical understanding of what public health measures are effective and what are not.

MAJOR CAPOFARI: We also have felony statutes and that's what the conduct you described is, it's a felony and it should be treated as such and punished as such.

MR. WEISS: But it's difficult for us to sustain that burden of proof in the real world. And this may be an area where you want to make a recommendation that something be done to deal with that, whether it be civil or criminal, to get that person out of society. That's what we need to do. And that's where Mr. Gostin and I disagree, obviously vehemently. That person -- let's think about the victims. That person should not be allowed to go around and perpetrate that deadly illness on other people.

DR. CRENSHAW: Thank you.

CHAIRMAN LEE: Ms. Pullen?

MS. PULLEN: We have had so many panels where the panelists either all agree with each other or handle each other with kid gloves. I don't have a question for you, I just would like to express appreciation to all of you for coming before us today and for speaking clearly and standing up for what you believe so that we could have a clearer definition of what these issues are. I think that it is a very important issue to come before us and you have enlightened us considerably with your little mini debate. Thank you.

MR. GOSTIN: Thank you very much.

MR. WEISS: Thank you.

CHAIRMAN LEE: Admiral Watkins?

CHAIRMAN WATKINS: Mr. Gostin, we were admonished by an earlier witness that when we got into this whole area of liability we'd better focus on very narrow areas, get very, very specific or we're not going to get very far and we're going to get embroiled in too many complications. So let me get very specific. Do you think a woman who has been raped should be able to obtain the sero status of the convicted rapist?

MR. GOSTIN: I have dealt with that question, so it's a very --

CHAIRMAN WATKINS: You can't answer yes or no?

MR. GOSTIN: I mean, like most professors I can give you reasons why and why not. It doesn't offend me if the person is compulsorily tested when they're a convicted rapist. It does not offend me at all. But I don't think it would gain a great deal of value.

CHAIRMAN WATKINS: So that would not be, from your point of view, legally objectionable?

MR. GOSTIN: That's right.

CHAIRMAN WATKINS: Let me ask you another question then. Should an individual who knows that he is HIV positive be required, have a responsibility even under your own rules of having justified scientific basis for this, including the method of transmission, should that individual then have a responsibility to tell the other sexual partner or partners?

MR. GOSTIN: I think so.

CHAIRMAN WATKINS: If it's evident that that individual then is not willing to do that, does the doctor then have the responsibility to at least inform the known partner? Not getting into the tracing, but let's say in this case it's a spouse?

MR. GOSTIN: I think that the law should provide a power and authority for the doctor to inform in that kind of case, but should not require disclosure. So I think that the law should say that if there is a third party who is in intimate danger and the sex partner refuses to inform, the doctor has full legal authority to inform.

CHAIRMAN WATKINS: And is then free of any other liability against him for breach of confidentiality?

MR. GOSTIN: Precisely.

CHAIRMAN WATKINS: Is that something that the federal government needs to get involved in or should get involved in or is that then relegated to the states under the concept that the states should take care of that rather than the federal government?

MR. GOSTIN: In my personal judgment it is better coming from a federal jurisdiction to have that kind of a balanced and sensible approach. And the reason is because I think on that kind of a fundamental ethical and legal question, you should not have wide disparities from state to state.

CHAIRMAN WATKINS: If the federal government were to get into this kind of statute then, would you again admonish us to remain very specific?

MR. GOSTIN: Yes.

CHAIRMAN WATKINS: Are there any other comments from the other panelists on this set of questions and answers by Mr. Gostin?

DR. HERMANN: I think the matter should remain with the states with regard to the physician's wider obligation to inform a third party who is known as an intended victim. It seems to me that this area is really only being developed in the last few years in a limited number of states by courts and state legislatures which have not addressed the matter outside of the very specific statutes dealing with sexually transmitted diseases.

The state of California Supreme Court has addressed the matter of the psychiatrist's duty to protect an intended victim. That court had to consider the matter twice and issued two opinions. And in the second opinion the court looked to alternative measures other than informing the intended victim that could protect the intended victim from the patient.

I think that the matter is complicated enough that it should be left to the states, but that the states should be encouraged to address the matter and specifically provide whether there's a duty, obligation or simply a power on the part of the physician.

CHAIRMAN WATKINS: Why do you two differ on this issue to the extent you do?

DR. HERMANN: Okay. Well, I think the reason why I think the matter should it be left to the states is that this is within a general context of physician/patient relationship which is governed by state law and while federal legislation might be enacted to deal with a physician treating and HIV patient such action would leave the state to deal with the general issue of patient confidentiality and take out of that context this one specific disease and provide a special rule that might be contrary to the obligations of a physician with regard to other diseases.

CHAIRMAN WATKINS: Now the question is if you have a federal statute that deals with confidentiality, could this come under that confidentiality statute?

MR. GOSTIN: I mean, actually I see Don's point and I think that it has great force. And I think the important thing

is to establish the principle. The reason I would tend to go with the federal statute is precisely for that reason, Admiral, is that I think it's the federal government's responsibility to insure strong confidentiality and that in the course of doing that it would be sensible and rational to clearly delineate where confidentiality could and could not be breached.

CHAIRMAN WATKINS: Mr. Weiss, do you have any comments?

MR. WEISS: No. I would not. I guess I would agree that it should be federal because then you'd have a uniform policy, and I think it's probably a good policy. I would assume the AMA would have a position on that that would be --

MR. GOSTIN: I mean, I might add that I did draft a bill for Senator Kennedy, a federal bill, to do just that on confidentiality and anti-discrimination. And that bill was strongly endorsed by the American Medical Association, the American Public Health Association and the Medical Nursing Association. So it does have apparent strong support for some federal role in this area.

CHAIRMAN WATKINS: It's my personal feeling that when we move in one direction on confidentiality it seems to me that inside that system we ought to provide the flexibility and balance for those that in the interest of public health must go another direction. It seems to me that in the doctor/patient relationship, we need to get the flexibility to make certain determinations under special circumstances that obviously would have to be justified if raised in court.

MR. GOSTIN: Yes.

CHAIRMAN WATKINS: I think it's just a matter of practice. I don't know if you agree with that.

MR. GOSTIN: I heartily endorse it. That's why I think that in formulating such a recommendation there are essentially three ways to go, and I would take the middle road, just the one you've suggested.

One could create a duty to warn which would, in its way, also be inflexible because the physician would then be liable if in his or her good judgment he decided not to. On the other hand, one could just have strict confidentiality and not have any regard to third parties in danger. But if you take the middle course, which is the course in this bill that I suggested and the one that I think you're endorsing is where you give a power, an authority on the part of the doctor so that if the doctor does want to inform in those circumstances, he or she would not be liable for so doing.

CHAIRMAN LEE: Dr. Walsh, you wanted to follow up?

DR. WALSH: No. I was just asking because of some of the legislation that has been proposed at the federal level on the converse side would you recommend that this Commission following the same line of reasoning oppose any legislation that penalizes the doctor for notification of a patient's sexual partner in the event the patient refuses to give permission because such legislation has also been proposed?

MR. GOSTIN: If the legislation penalized the doctor for breach of confidentiality where the doctor could clearly show that there was an identifiable third party in clear and intimate danger, then I think that would be unwise and you'd be justified for saying it was unwise.

DR. WALSH: You'd justify the approach. All right. Of course I think that's important, to finish up on the Admiral's point, because I agree with the Admiral 100 percent there has to be some flexibility in any --

MR. GOSTIN: It's important not to lose sight of the principal reason for doing all of this, and that is because we want a very strong federal protection of confidentiality. And that is the underpinning. From there we go on to those clear and justifiable cases where confidentiality can be breached.

CHAIRMAN LEE: Dr. SerVaas, would you like to make one clear point?

DR. SerVAAS: Just one clear point. Mr. Weiss, we had testimony from Dr. Tom Vernon, who is the Executive Director, of the Colorado State Health Department, where they have done 30,000 tests with not one breach in confidentiality. And after our testimony, checked with all of his people there. The man who actually runs the thing told me how advantageous it is to do contact tracing where a man has to admit that he's HIV positive if he goes and tells his contacts. But if the state does it for him, he's very relieved because it doesn't identify him. And I hadn't thought of that before as a very efficient way and they got 17 percent positive on the contacts that they picked up as a result of the state of Colorado contact tracing. And it sounds like a bad word, contact tracing, but we've been doing it for years in syphilis very effectively and still do. I think that other states can see what Colorado is doing and they're coming along now and doing it Colorado's way. And I think that we can't have that advantage if we suddenly burst in with a federal law that is going to apply to every state.

I had two comments and questions. One of them was made by Admiral Watkins very well with the problem related to the duty to warn. The other one has to do with the confidentiality that

was brought up by Dr. Primm. And I have always felt that the physician, irrespective of what the lawyers think, did really have an ethical duty to warn in this situation where one is dealing with a fatal disease. And I'm trying to look up my ethical positions on this and I would like you to see if this panel agrees with me. I came across the John Stuart Mills poem on liberty and I am led to believe that the legal profession does accept the principle of harm as being the final limitation on liberty. Would you agree with that?

MR. GOSTIN: Yes.

CHAIRMAN LEE: Thank you very much. This panel has been marvelous and we will continue to wrestle with these problems and we will probably be back to you. Thank you very much.

(Whereupon, at 3:45 p.m. a recess until 3:46 p.m.)

LIABILITY FOR VACCINE DEVELOPMENT

CHAIRMAN LEE: The next panel is on liability for vaccine development. This is a problem with which the Institute of Medicine particularly has wrestled with as has the pharmaceutical industry.

Can we first hear from Ms. Wendy Mariner, who is Associate Professor of Health Law at Boston University, Schools of Medicine and Public Health.

MS. MARINER:: Thank you. I am very pleased to be invited here this afternoon.

CHAIRMAN WATKINS: I like your name, Ms. Mariner.

MS. MARINER:: Thank you. I thought you might. My father was in the Navy. They wouldn't let me in. I got some recruiting calls from the Navy, actually, when I was young.

This afternoon I have three simple points to make, which I think I can do fairly briefly. The first is actually a question and the question is: is there really a liability problem? I shall argue that if there is, we haven't seen it yet.

Secondly, if there is a liability problem, that the solution is not to shield manufacturers from all liability for adverse reactions to vaccines without a serious reason why they should be treated differently from producers of other vaccines and drugs and other products. And finally, that the real problem may be whether there will be an affordable vaccine for the world population. That is, an economic and distributional concern.

First, the question of whether there is, in fact, a liability problem. Why are people worrying about liability for an AIDS vaccine which is admittedly many, many years in the future? Vaccine manufacturers worry, and adverse reactions to vaccines always occur, and we need to decide whose responsible for those kinds of injuries. And legislation has been proposed and, indeed, enacted in California to change existing law. So we need to know whether such proposals are necessary and useful or whether they're counter productive. But, as I suggested, I think there is a real question as to whether a liability problem exists.

So far there's no evidence that is publicly available that vaccine manufacturers are, in fact, incurring substantial losses in litigation. In fact, there have only been, at most, 25 to 30 reported decisions involving vaccines in the last 20 years and manufacturers win more cases than they lose. And they're winning more in the last several years.

If vaccine manufacturers are, in fact, paying a substantial portion of their revenues for settling claims for adverse reactions to vaccines it would be helpful and I think important for this Commission to see the numbers on that. Only then will we be able to determine whether, in fact, they are seriously burdened by liability for adverse reactions to vaccines. The point being at the moment if the system isn't broke, we don't need to fix it.

The liability problem may, in fact, be a problem of perception. Manufacturers and some public health officials tend to decry the public fear of adverse reactions to vaccines, understandably. But spokespersons for some of the pharmaceutical and vaccine manufacturing industry seem to fear even lower risks of liability. After all, there are very few adverse reactions to vaccines and only a fraction of those who suffer adverse reactions, in fact, sue. And of these, fewer than half at best win any kind of compensation. So a manufacturer's risk of liability is only a fraction of the risk of injury from vaccine.

It seems that the magnitude of the risk is in the eye of the beholder. If it's my risk, it's substantial. If it's your risk, it's insignificant.

The second point is if there is a liability problem or a liability problem does arise, then granting a special exemption for AIDS vaccine may, in fact, raise more questions than it answers. Those who believe that there is a serious liability problem may propose shielding vaccine producers from liability for adverse reactions as a solution. What may not be widely recognized is that special immunity from liability would be a major change in the law. That is, those who argue for immunity from liability are asking for an exception to the general rule.

If an exception is warranted, then it must be because there's something special about the people who make AIDS vaccines or about the people who take them so that they deserve special protection.

I've not found any special characteristics of AIDS vaccines that are relevant to liability. There are some, as I've argued, that may be relevant to testing, but not necessarily relevant to liability. And I've yet to hear -- I would like to hear any reason why AIDS vaccines, therefore, should be treated differently from all other vaccines or all other drugs or all other products. The point being, if we make an exception we have to have a good reason unless we are prepared to make changes for the rest of the liability system. There may be good reasons for this, but we need to know what they are.

The possibility of immunity from liability deals with only one concern surrounding vaccine development and that is protection of the producers. But it doesn't do anything to promote vaccine development for the future and neither does it provide any protection to persons who may be seriously injured as a result of vaccination.

It's possible, as a worse case scenario, that even if we granted vaccine producers total immunity from all liability we would end up with no more and no better vaccines than we have today. Immunity from liability does not answer the question of what action to take to encourage vaccine development, which is certainly what we wish to do with respect to HIV infection and AIDS. We ought to ask whether an exception to liability will, in fact, accomplish this. Tort law has been around for hundreds of years. It's certainly not perfect; I would not be one to argue that. But I think we have to think very carefully about whether it should be changed for a special group without a good reason.

The third and last point is what I think may be a real question, particularly for this Commission, and that is whether there will be an affordable vaccine for the world population. In the United States there is a lot of evidence that vaccines are not especially profitable products. Companies that produce both drugs and vaccines have, in recent years, begun to increase the proportion of their research and development funds in drugs and diagnostics, not in vaccines. What seems to be forgotten is that this trend existed long before anyone noticed the liability issue. That is, there may be economic problems with vaccine production, economic obstacles and disincentives to the development and production of vaccines.

For example, vaccines are only taken once or maybe three or four times in a person's lifetime, not continuously like drugs for chronic conditions, for example. The price of vaccine is low compared with the price of drugs. In particular outside

of the United States there's no significant market that can afford to pay current U.S. prices in hard currency for vaccines. Even if manufacturers could obtain financial assistance from state and local government or other organizations who pay for the vaccines, I doubt that there would be any way that we would be able to provide enough vaccine for Africa, for example, without some form of public funding. It's my understanding that no United States manufacturer currently sells any vaccine to the UNICEF and WHO global immunization program.

Much of the early research on vaccines has, of course, been paid for by the federal government and this is especially true for the development of AIDS vaccines. Looking at the size of the government's investment in vaccine development we ought to ask the question whether the public -- both the population and the Treasury would be better off if the government took over production of vaccines. If AIDS vaccine is going to be too expensive for <u>any</u> reason, then perhaps it's time to think about whether the government ought to produce it.

In summary, I would urge the Commission to recommend against shielding manufacturers from liability for adverse reactions to AIDS vaccines unless and until we have solid evidence that there is a liability problem and that special immunity will solve it without leaving both injured persons and manufacturers of other products out in the cold. And second, I would urge the Commission to consider whether, if vaccine production becomes too expensive for the private sector, the federal government should assume responsibility for producing vaccines. Thank you.

CHAIRMAN LEE: Thank you, Ms. Mariner. It looks like we may have another promising panel here. From the other -- in the black trunks, Mr. Paul De Stefano, Chief Corporate Counsel for Genentech, Inc. Visiting Professor of Philosophy at Dickensen College.

MR. DeSTEFANO: Thank you. And I do appreciate the opportunity to talk to you. As you mentioned in introducing Wendy, the Institute of Medicine two and a half years ago published the results of a study on what it viewed as a crises in the vaccine industry in the United States, that is the increasing number of particularly pediatric vaccines which had simply a single supplier in the United States, the threat of more and more manufacturers dropping out of the vaccines business and disincentives to the development of new vaccines in the United States. While the focus of the study was primarily on pediatric vaccines, most of the same concerns exist with respect to the potential development of an AIDS vaccine within the private sector.

Ms. Mariner asked the first question of whether there is a problem. Well, it's true that there's no hard evidence that there is a present problem in terms of the percentage of manufacturer revenues that are going to satisfy claims based on vaccine injuries, it's equally true that the problem is one of perception and that is the reality today is that potential manufacturers of vaccines, particularly researchers in the biotechnology area, are simply making the decision not to allocate corporate resources to the development of new vaccines.

I've watched in our company while potential recombinant hepatitis and herpes vaccines have sat on the shelf for years as the company has simply made the decision that we can't afford to take those vaccines into development.

Rightly or wrongly, to the extent that industry continues to perceive that as a problem, the result will be a very real one. It will be that there will be fewer entities out there doing research into a potential HIV vaccine and it means that those that are will increasingly license them out rather than take them to development themselves. Small companies which don't have a base of hundreds of products to which they can add a 100th of a cent on the cost of each unit will see the threat of liability - and more importantly than the threat of liability the costs and disassociation and disruption that go along with litigation even without ultimate liability - as a game in which they simply don't want to play. And if they don't want to play the game, plainly and simply our chances for coming up with a vaccine are decreased.

As to the question of why treat an AIDS vaccine differently or at least why treat vaccines in general differently, I think there's a fairly simple answer. As far as vaccines in general are concerned, unlike Pinto gas tanks or ski lifts or canned peaches there is a public benefit that goes along with widespread vaccination. If I'm vaccinated, not only am I protected, but you may be protected as a result of decreasing your risk of infection from me and you may even be protected as a result of a shedding effect depending upon the nature of the vaccine. That's different, I suggest to you, than traditional consumer goods.

But the real reason why I think an AIDS vaccine ought to be treated differently is simply that AIDS itself is different. It may be true that there is nothing qualitatively different about the entities that will manufacture an AIDS vaccine. It may be true that there is nothing qualitatively different about the individuals who will take an AIDS vaccine. But there is some something dramatically different about AIDS and the threat that it poses to society. I don't think that we can all sit around and talk about what a dramatic <u>public</u> health risk we're faced with without recognizing that there are going to be

some public costs; we should appreciate that the limitations on liability that industry is talking about are not complete insolation of a potential manufacturer from liability for injuries resulting from a vaccine. It is elimination of liability where there is no fault.

Our proposal is that manufacturers be shielded from strict liability in tort for vaccines which are: (1) approved by the FDA as being safe and efficacious; (2) for which there was full disclosure for the FDA during the course of clinical trials. That is: there were no potential side effects or adverse reactions which were hidden from the FDA; (3) which are sold in accordance with FDA labeling, and; (4) for which known defects are disclosed to the potential consumer.

Ms. Mariner points out that tort law has been in existence for hundreds of years. While that's generally true, the notion of strict liability in tort has not been. Strict liability in tort basically came into existence in California about 25 years ago. The case was called Greenman versus Yuba Power and it was a reflection not of fault on the part of the entity that was held strictly liable, but simply a shifting of economic burden recognizing that manufacturers as a result of availability of insurance and simply the possibility of adding additional costs to the widgits that they were selling were better able to bear the costs of a harm than an individual who may be harmed was.

Things have changed dramatically as far as the availability of insurance in the United States. And that takes away one of the assumptions that underlay the agreement. Because there is this additional public benefit with respect to the development of an AIDS vaccine, I suggest the considerations that went into Greenman and the evolution of strict liability are equally absent.

And finally, as to the question of whether we're talking about something that is dramatically different in treating manufacturers of an AIDS vaccine differently, let me suggest that a number of states have over time carved out exceptions of exactly the sort we're discussing. California for almost 30 years, for example, has had protection not only from strict liability but even for simple negligence for the administrators of mandatory vaccines as a means of providing incentives for public health nurses and for others, to get involved in the process of making vaccines available to a broad public. Other states have similar provisions recognizing needs of that sort on a case by case basis.

What we're proposing with respect to an AIDS vaccine is less than California has had for almost 30 years with respect to all mandatory vaccines, but it is more in that we are asking for

consistency from state to state, and that will come solely through federal action.

In conclusion, I recognize that focusing on legal considerations at a point where we don't even have a vaccine in sight may seem like putting the cart before the horse. But we can provide some incentives for at least private industry to be actively involved in research and development if we look for -- if we propose legislation that will: (i) provide protection just for strict liability in tort for an FDA approved vaccine, (ii) sold and manufactured in accordance with labeling requirements, and (iii) as to which there has been full disclosure. In those cases where there is negligence on the part of a manufacturer or where a manufacturer has not provided full disclosure to a consumer of a vaccine, we continue to believe that the traditional tort principle should apply and that liability without dollar limit should be available to a potential plaintiff. Thank you.

CHAIRMAN LEE: Thank you, Mr. DeStefano. For the sake of the subsequent discussion, let me throw out some statistics which have come to my attention. Of the $13.50 for a DPT immunization, about $12.75 is liability insurance. I have been told by the Chairman of Bristol Myers that the minimum amount of money he would like to have in the bank if he was going to get into the AIDS vaccine game would be $150 million.

I would like to know why Congress put a cap, as I understand it, on liability for the flu vaccine and I would like to know why there are only two companies out there that are willing to get into the vaccine game in the United States of America. Now please correct me and let's start off with Mr. Walsh.

DR. WALSH: Ms. Mariner, I want to be sure I heard you correctly because in the reprint with which you provided us of your previous article you urged no fault compensation as an answer. You also, while not enthusiastically agreeing with the reasons for driving vaccine production out of the United States, you conceded that that had been a result.

I think if I interpret your paper correctly of two things. One, not a sufficient margin of profit and second was the fear of large compensation awards. Now, did I understand you correctly that your position has changed, that you find there is no need to advocate the same type of thing for the development of AIDS vaccine? I mean would you advocate no compensation or no fault compensation for the development of AIDS vaccine on the part of government?

MS. MARINER:: I certainly did advocate no fault compensation specifically with respect to the pediatric vaccines

as ultimately arose with the National Childhood Vaccine Injury Act. And I think that there are, and have been, very special reasons for that, the most important of which was the fact that those vaccines are required for children and the notion that one had an obligation to take the vaccine essentially precluded that person from making a credible argument that there was a choice.

So, yes, I certainly advocated it for that. I also certainly thought manufacturers' fears of liability exist. My question has been, whether that fear is well founded and whether that fear does, in fact, drive them away from vaccine production. I acknowledge the fear and I also acknowledge that there are problems with the conduct of litigation. I'm certainly the first to acknowledge that. My concern is that if we eliminated liability issues altogether, we might have no more vaccine than we have today because it doesn't go to the vaccine development question, it doesn't deal with the economic incentives for producing new vaccines.

Now, for AIDS, interestingly enough, in spite of concerns about liability we have several companies working very hard trying to put together new AIDS vaccines. There are two already in clinical trials. There is another in the pipeline that I know of and there are more that are in the laboratories being worked on. We certainly have a rather substantial research effort in this field.

DR. WALSH: Yes, but your fear, as I think you stated, is that the result will be the same problem we're facing with AZT in which the vaccine will become so expensive in order to protect what Dick Gelb has obviously told my colleague Bert Lee that he would need $150 million in the bank just in case. And I wonder about the legal ramifications. Now you take an AIDS vaccine, say it's not required. Well, if I go because I feel that I want -- at my age it's no danger anymore -- but supposing I were younger and wanted to live a carefree life and went and voluntarily said, "Well, I'll take the AIDS vaccine and wow I can really go." That doesn't excuse the company from liability if the vaccine doesn't work or if I get something -- some bad side effect from the vaccine under what you're saying. And so the company -- we don't know how many more companies would be experimenting with vaccine development if there was a no fault compensation law.

I agree with you to the extent that I don't think we should have no fault compensation just for AIDS vaccine. I'm against any legislation that's just for AIDS, not only vaccine. I'm against home health care, I'm against all of the things that are just for AIDS because there are many other problems besides AIDS and many other vaccines besides AIDS. But I just was confused between what you had written in 1986 and what you're saying in 1988, which is the danger of writing. And I just wanted to be sure that I understood because to me I hate to see

vaccine development driven abroad and I hate to see more vigorous development of the AIDS vaccine taking place in western Europe where you do have no fault compensation. And I don't know what will happen whether we license that vaccine here.

Again, you're lawyers. Supposing they find it in France or Germany and we license it here for distribution by an American company. Would they require no fault compensation -- would they require protection or would you sue the German company? If an American company is licensed to distribute a vaccine developed abroad?

MS. MARINER:: If an American company produced and distributed it?

CHAIRMAN LEE: They sue deep pockets, Bill.

DR. WALSH: Yes. In other words, they would sue us, right?

MR. DeSTEFANO: You might very well find both sued.

DR. WALSH: I see.

MR. DeSTEFANO: And the question of who was ultimately liable resolved by an indemnification clause in the agreement --

DR. WALSH: In the agreement. I see. Okay.

MR. DeSTEFANO: --between the hypothetical licensor and your licensee. I can tell you from the biotechnology industry's recent experience with other vaccines. The first recombinant vaccine on the market is Chiron's hepatitis vaccine. But they were unable and unwilling, as they've testified in California, to develop it themselves and as a result licensed it to Merck.

Genentech's potential recombinant hepatitis and herpes vaccines, because of exactly the concerns we're discussing today, were licensed to Smith-Kline.

DR. WALSH: Well, doesn't Merck have a recombinant hepatitis B vaccine?

MR. DeSTEFANO: Yes, licensed from Chiron.

DR. WALSH: Yes. That's right.

MR. DeSTEFANO: What happened was that -- since Chiron was unable to take it to market itself, they went to a "giant."

DR. WALSH: Oh, I see. Yes. Right.

MR. DeSTEFANO: They went to a company that had hundreds of products on the market and could better spread the risks of that vaccine.

The same thing is happening with respect to AIDS research, at least recombinant AIDS research right now. You see a pairing between the small companies that are doing initial research and large --the Merck's, the Smith-Klines, the Lederles, American Cyanamide, the Connaughts. And what that does is really two things in my mind. It decreases competition and I don't mean in an antitrust sense, I mean in a "more people out there working" sense. The second thing it does is it kind of embeds a commitment to whatever path is taken.

If you enter in a licensing agreement that says "we've got a license with respect to GP-160," for invariably that agreement will have a due diligence clause. And if hypothetical small company A licenses a product to hypothetical large company B and large company B has an obligation to use due diligence in research and development of that product, it will keep developing that product perhaps at the expense of other potential products simply because the alternative will be to lose its license and to lose whatever payments it may have made to the licensing party.

DR. WALSH: Well then do you two agree or disagree that this Commission should at least give consideration to the recommendation of no fault compensation in its report even if we went to the extent of saying we think it should hold for all vaccines, not only AIDS vaccine, but we are only recommending on AIDS vaccine. That's our charge. But we could broaden the base of that. And you refer to two pieces of legislation in here, the pediatric legislation. Wasn't that passed?

MS. MARINER:: Oh, yes.

DR. WALSH: Yes, that passed. Sure.

MS. MARINER:: And it was funded this past December.

DR. WALSH: Yes. And is that a model which we could look at that would be applicable to AIDS vaccine or should we look for something else?

MS. MARINER:: I think that's not an obvious model to the extent that it relies on presumptions about what adverse reactions are actually caused by a vaccine. That element would not serve particularly well so that one could use the model if you used actual causation as a determinate, but that's highly problematic with a brand new vaccine and thereby in some sense it defeats the purpose of the compensation program if one of the purposes is to be efficient and quick.

DR. WALSH: Of course, the problem that I see with advocating no fault compensation for an AIDS vaccine is if one looks at it primarily as a sexually transmitted disease there is significant number of people in this country which would say they didn't want tax money, used for that purpose. So we may not get anywhere with it. So that's why I think it has to be a broadened base. It has to be for all vaccines almost. It can't be just for AIDS. It'll die.

MS. MARINER:: That's right. I have certainly argued that AIDS is a special problem and that AIDS vaccines have special problems for understanding their development and testing them. That's quite different from saying liability for AIDS vaccines should be treated differently,(and persons who manufacture them) and persons who receive them because if we set up something special for AIDS vaccines, one inevitably must ask why not for all vaccines that are voluntary? And if for vaccines which provide a benefit, why not for drugs? And if for drugs, then why not for medical devices? Certainly those categories of products produce benefit.

DR. WALSH: Except that vaccines are economically, as you've stated here, have proved their economic worth in what they save everybody.

MS. MARINER:: Oh, yes.

DR. WALSH: That's the one reason that it would hold for vaccines as opposed to everything else.

MS. MARINER:: I think this Commission would do a great service by examining whether there is, in fact, a need. If you are able to obtain the kind of data that Dr. Lee has and are able to verify that, in fact, this dollar amount is required as opposed to being an amount that one picks out of the air to protect against the possibility of all possible liability, it would be extremely helpful in order to make some kind of reasonable determination about whether there is, in fact, a financial problem and whether there are, in fact, clear disincentives from liability, or whether the disincentives are grounded in other more serious problems.

DR. WALSH: Thank you.

CHAIRMAN LEE: Very interesting.

Dr. SerVaas?

DR. SerVAAS: Do we have some information or did I miss it in your testimony about what Dr. Walsh was talking about history of no fault for polio and measles and the pediatric vaccinations where once in a blue moon there is an accident? And

have we had any legislation in any state where these people are protected?

MR. DeSTEFANO: Well, we have federal legislation in effect now. The negotiations leading up to this legislation recognized that we have a fairly accurate picture of what sorts of adverse reactions result from each of the mandatory pediatric vaccines and also recognized that we have a history of what sorts of awards juries have made or settlements have been reached with respect to each one of those adverse reactions. And so what that legislation does is, to over simplify it, is to provide an injured person, someone who believes that they're injured as a result of receiving a vaccination of the scheduled vaccines and who has an adverse reaction that's on the schedule, to make an administrative claim rather than a claim in litigation for compensation in essentially a non-adversarial setting. It's not completely non-adversarial. And they're given a choice to either accept that settlement or later to go through traditional litigation in federal court. So that is a federal model.

The advantage of using that model with respect to an AIDS vaccine is that the model is there. And I don't mean to down play that politically. The disadvantage is exactly what Ms. Mariner has said, and that is here we have vaccines that have been in existence for a long time and the schedules make some sense because we have a history of (a) what goes wrong and (b) how much people get when that thing goes wrong.

We are doomed to being somewhat arbitrary if we add AIDS to that list. Arbitrary first because it may not be a mandatory vaccine, but more importantly because we won't have those years of history as to what sorts of things go wrong. And certainly some people have suggested that an AIDS vaccine may get relatively quick treatment from the FDA and as a result be through the clinic more quickly than most vaccines have been. And others that the most serious adverse reactions from an AIDS vaccine may be ones that don't appear for more than a year or two or three. They may be five or seven years off.

California has a statute called AB-4250 which is specific to an AIDS vaccine. And essentially provides, with respect to certain types of defects in a vaccine which is manufactured by a California manufacturer, that traditional strict liability will not be available. Manufacturer liability will be limited to circumstances in which there is negligence or a negligent failure to warn.

It's similar to the federal legislation in the sense that having taken away the right for you to sue for strict liability, what I give you is the right to file a claim against a fund (which has not yet been funded). Again, presumably in a non-adversarial manner. But I'm on the state commission that's

trying to come up with ways to fund that fund, and I'm afraid we're quite a ways away from reaching a consensus.

DR. SerVAAS: Thank you.

MS. MARINER:: For your convenience, there's a very brief summary of each of those pieces of legislation in the paper that you have that I wrote with Gallo.

DR. SerVAAS: Thank you.

CHAIRMAN LEE: Thank you.

MS. MARINER:: But I couldn't have said it better.

CHAIRMAN LEE: Dr. Lilly?

DR. LILLY: First of all, I'd like to know we've been talking about vaccines which are FDA approved so far. I'd like to know just what is the status of liability during development and testing before a vaccine is licensed for general use?

MS. MARINER:: Well, there is no difference in theory between one's liability for adverse reactions whether the vaccine has been approved or not. But there are two practical difficulties. As a practical matter there are almost no cases involving clinical trials. Are you aware of any recent ones? There are virtually none in this country and there were only one or two in Canada that involved rather bizarre events having nothing whatsoever to do with vaccines. Having to do with cancer and the like.

DR. LILLY: I'm asking this largely because it seems to me that the development of a vaccine against HIV infection, it's really a horse of a different color. We're talking about a totally different magnitude of a problem. That even if I have something in a test tube right now that everybody agrees that makes perfect sense that that is likely to be a good vaccine, it's still going to be a long time before I know whether it is or not.

MS. MARINER:: That's correct.

DR. LILLY: And it's going to involve many, many steps. Then given that, it seems to me that it does broaden the problem, doesn't it?

MR. DeSTEFANO: If I may, let me say that my sense of industry concerns is that there isn't a great deal of fear about liability in the clinic, although as Wendy says, the liability standards are in theory the same. In practice there are so few cases. There are a number of reasons, among them you have a

much more immediate one-to-one relationship with a subject in a clinical trial and as a result it's a little bit easier to convince a jury or a plaintiff's lawyer that the informed consent that was entered into was really informed and you have someone actually signing something rather than just faced with a label which in real life they may very well not have read. So occasionally there will be an adverse reaction, in some cases very serious ones. Typically medical bills are paid for, not because it's clear that there's a legal obligation to do so but that's just one of the trade-offs you make when you go into the clinic. And occasionally there will be a settlement but claims almost never come to litigation.

DR. LILLY: Point number two. Our government is, indeed, I think putting a good bit of financial incentive toward the development of AIDS vaccines, is that not true? And I'm just wondering to what extent that influences ultimate liability questions?

MS. MARINER:: If you mean now the funding for basic and epidemiologic and other research, yes it certainly is although that's not entirely new, perhaps the magnitude of the contribution may be greater than in the past. So far it has not influenced liability in any way at all, certainly not in theory, and I don't know that anyone has suggested that it should. The concern sometimes has been that government might therefore have a greater interest in controlling the distribution of the resulting vaccine for the investment, but that remains a suggestion to date.

MR. DeSTEFANO: I'd agree. And in some cases the funding that has been available at least to private industry -- and I'm talking more at a state level than a federal level now -- has strings attached which have made that funding unappealing for private industry.

For example, California has made money available for private industry to fund research and provided that there will be a royalty of X percent on any product which results. Until one knows what a vaccine is going to look like, what your market looks like, how much it costs to produce, what you can sell it for and so on, agreeing to a royalty of a fixed percent may very well mean that you can't sell your product at a profit. And so there have been companies in California that have declined to take the funding that's available. But I don't think that's influenced anyone's liability concerns, although I mean it may have provided some disincentives for small start up companies to simply get into the business in the first place.

CHAIRMAN LEE: Ms. Gebbie?

MRS. GEBBIE: I'm finding it very hard to frame a question that would lead toward what we might recommend at this point. I have seen several different conferences and articles. I think the Institute of Medicine continues to look at this issue and explore what might be done. As I listen to the two of you the sense I get is a general agreement that something appears to be necessary in order to assure that we move toward vaccines and that people who get hurt get helped in a way that is both sensible and not harmful to the institutions that develop vaccines. Now, that's not a quote from either of you. That's sort of a mish-mash of it because in both cases as I look at written materials I see a lot of if this, then this and if that, then the other and so on. I don't really sense a common conclusion of two or three crystal clear things that just jump off the page.

You've been a little clearer on your proposals, I think, from industry than I've heard Ms. Mariner.

MR. DeSTEFANO: Well, I can offer you a couple to try and focus and see which ones are controversial. The first is that there should be a federal legislative response. That alone is somewhat controversial in that tort law has historically always been a creature of the states and today we have a particularly a "state's rights" oriented administration and that is not a inconsequential hurdle.

MRS. GEBBIE: As you give each one, let me just check a couple of points on it. You believe it should be federal just because this is a big issue and it would take too long to solve it in each state?

MR. DeSTEFANO: I believe that the process of going of through state legislatures will result in dramatic inconsistency from state-to-state. If you're trying to provide equitable and reasonable incentives for research for vaccine innovation, recognizing that vaccines, if not actually sold in each state, will almost certainly be sold to residents of each state. You have an interstate problem and you have to come up with an interstate solution. And the only way to gain that consistency is through federal legislation.

MRS. GEBBIE: Ms. Mariner, is that how you view it?

MS. MARINER:: Well, that is, I think, precisely why manufacturers of all kinds have been pressing for federal product liability protection for many years. And I would suggest that if we get into making recommendations about federal legislation for vaccine manufacturers we would have to consider whether it's appropriate therefore to support the product liability bill that is supported by other manufacturers. It would be very difficult, I think, to start suggesting specific federal legislation for

every different product that is on the market. As much as I am worried and concerned about getting out appropriate therapies and vaccines for AIDS, I feel it's my function to point out not so much what the Commission's recommendations should be , but what is entailed in accepting particular recommendations.

MRS. GEBBIE: So if that one were accepted, it would be either because we were willing to extend it to everything in sight or because we thought we could make a sufficient case of why this was special?

MS. MARINER:: Yes.

MR. DeSTEFANO: Let me follow up on what Wendy just said. When I was working in Sacramento on AB-4250, the California approach to limiting liability for an AIDS vaccine, I had a real civics lesson. One of the biggest liabilities that I faced was that representative of the California Manufacturers Association were sitting behind me, supporting me. And the opponents of what I was trying to do were therefore able to say, "You see, we're talking about Pinto gas tanks. We're not talking about just vaccines." I believe that we are talking about just vaccines.

The second thing that I would propose is that we recognize that vaccines are different. They are different from pharmaceutical products in general and they are certainly different from other consumer goods. And the reason is the public versus private benefit that I indicated before.

If I come up with some means for lessening the number of broken legs on ski slopes, I've provided essentially a private benefit to people who ski. If I come up with a vaccine against AIDS, I believe that the benefit provided is qualitatively different and that there is a public benefit as a result.

I am of two minds with respect to the question of dealing with AIDS separately or together with other vaccines. The public versus private benefit argument goes to all vaccines. The extent of the public threat that we're faced with is dramatically different from AIDS. I don't know what the dollar extent of the threat of diphtheria is in the United States today, but I haven't heard numbers bandied about that come anywhere close to the numbers that are associated with AIDS. And as a result, I can well understand a solution that focuses just on AIDS either because we believe the trade-offs weigh more heavily in favor of an AIDS vaccine than other vaccines or simply because politically it will be easier to get that solution enacted than it would be if we try to deal with vaccines as a general class of products.

MRS. GEBBIE: Where do you stand then on that point?

MS. MARINER:: Well, it strikes me that it's a question of what we are willing to do to get an AIDS vaccine out and if the suggestion is that we have to change the law to be able to produce an AIDS vaccine, then I think we have to think seriously are we willing to pay that price.

What I have not heard is an argument about the need for changing vaccine manufacturer's responsibilities for vaccines. The argument is normally phrased in terms of reluctance to produce vaccines given the current future concerns about liability. In other words, that vaccine manufacturers will not produce vaccines unless they are exempt from liability. It is not a question about whether they should or should not be responsible. Therefore the question is are we going to accept the option that we have to protect them from liability in order for them to produce vaccines? I don't know the answer to that and I don't think anyone outside the industry does.

MRS. GEBBIE: How do those of us outside the industry supposedly charged with making a smart decision get at the information that would let us have that answer and would you outline for us exactly the information we need to divine to get there? I think you've tried, but again I have trouble tracking this into an outline that I can remember.

MS. MARINER:: Yes. Well, I think there are two kinds of information that would be extremely valuable. One is empirical evidence about the number of claims that manufacturers have to face to determine whether or not there's a realistic concern there, because we need to know what the facts are. You must ask the industry. Ask Paul, he'll tell you.

MRS. GEBBIE: In general how many claims on all vaccines or how many do they anticipate on this new vaccine --

MS. MARINER:: I would certainly ask both. In fact, I have a whole list of questions that I am ready to ask the industry on myself. If you would like to see it, I'd be happy to give it to you.

MRS. GEBBIE: Are those questions in your written testimony?

MS. MARINER:: I beg your pardon?

MRS. GEBBIE: Are those questions in what you've given us?

MS. MARINER:: No, I'm sorry, they're not. They're in draft form for some research I'm about to undertake.

MRS. GEBBIE: It seems to me critical that we see those questions then and maybe you could just talk about them a little bit but provide them to us in writing.

MS. MARINER:: Certainly, I'd be happy to.

CHAIRMAN WATKINS: But will the answer to those questions be forthcoming? We've had a lot of discussion about this in the past for other purposes, not on vaccine development. But are the questions that we can get answers to without a great deal of pea under pod discussions?

MR. DeSTEFANO: I don't speak for the PMA, I don't speak for any other pharmaceutical company. I'm not even sure at the moment that I'm speaking for anyone other myself, up to and including Genentech. I recognize that there is a problem in that we could get representatives of 12 actual or potential vaccine manufacturers in front of you, each of whom would say "without legislation of the sort we're talking about we're getting off of the vaccines bus," and we're still left with a question of whether you believe them. I understand that may sound fairly incredible particularly if you stare them in the eye and say, "How much profit did you make off vaccines last year," and they mumble and they say, "Well, we made quite a bit."

On the other hand, we have some objective experience that tells us who it is who is going into the vaccine business today. Not so much who is actually in it today in terms of manufacturing DPT vaccine, for example. But who is going into it.

We view recombinant technology as being very, very promising with respect to the production of future vaccines. Look at the biotechnology industry and see what they're doing. See whether the products that are coming out of that industry are, in fact, vaccine products. The answer is generally no, exceptions are where one of the biotechnology companies is willing ally itself with a traditional pharmaceutical company. And that's the Chiron/Merck model.

That is one bit of objective evidence that you can look to. As far as what sorts of claims we estimate with respect to an AIDS vaccine, it's an impossible question. It's a question that we're wrestling with in California today to try and decide how much money we need to put into this fund so that we can have a fund against which victims of an AIDS vaccine could claim without having a vaccine, without knowing what the side effects are going to be.

MRS. GEBBIE: But this almost begins to sound like a whose going to blink first. That is, does the public sit around and just say, "You'll never buffalo us into changing the law. We're just going to wait until the manufacturers say, 'ah heck,

we'll go invent it anyway because it's an intriguing idea and we might be able to make some money off it and we'll run the risks,'" or does the industry hold tight and convince everybody else they'll never move so we'll change the law based just on this staring match. That's what this feels like that there really is no yardstick. Even if we got all those questions answered that Ms. Mariner is going to give us, I'm not sure we would be any further ahead of being able to say whether or not the situation is going to change in a week or a month or a year. It does feel to me like a standoff.

MR. DeSTEFANO: And I understand why it appears to be a standoff. And like most things that look like poker games, there are risks. One of the risks is that you wait for industry to blink and while you're waiting for them to blink, we have another 40,000 people, die.

MRS. GEBBIE: Or we take another option that Ms. Mariner I think alluded to. I think the state of Michigan still manufactures some of their childhood vaccines.

MR. DeSTEFANO: Certainly.

MRS. GEBBIE: As a public entity through their state public health department. We could say okay we'll put the money we were holding out for private industry into a public sector place and just do it.

MR. DeSTEFANO: Certainly.

MRS. GEBBIE: And bypass. I'm not sure that's a good option either, but that is certainly an option.

MR. DeSTEFANO: And although that goes beyond the testimony that I offered today, my sense is that if we're talking about disincentives for industry to act, anything up to and including involving the state at that level and getting the state involved as a means of eliminating strict liability because, of course, the state has sovereign immunity, would solve the problem. One could imagine all sorts of policy arguments about why we do or do not want the state involved in that process. But if the bottom line is that companies can get a reasonable return on their investment or at least a shot at a reasonable return on their investment I think that the incentives will be there.

CHAIRMAN LEE: Admiral Watkins?

CHAIRMAN WATKINS: It sounds as though we're really on the horns of a dilemma on this one. It needs the attention of the Commission. I just have one question, Mr. DeStefano. In your California arrangement that you find to be contractually unattractive you used a percentage for example that you would not

buy into because of the unknowns that might impact. Isn't there a way to sit down with the state officials and work up a formula that's related to those future obstacles and set up a mechanism that recognizes that there are certain phases of the contractual relationship, when we get to these points we make these adjustments? And what is fair in this formula we renegotiate it because it's a brand new area. Isn't there a way to divine that thing in a new way and perhaps a counter proposal to the state some other formula that makes more sense from the developer's point of view, from the researcher's point of view?

MR. DeSTEFANO: Well, there certainly should be. I think the problem is that there isn't an awful lot of trust between the state on the one hand and at least some people within industry on the other. For example, one could imagine a funding mechanism that instead of saying "and you'll pay a royalty of ten percent," (which might cause me to say I may not be able to make a profit) instead said you will pay a royalty at an amount to be calculated at some point in the future, but not exceeding that which would deny a reasonable rate of return to the manufacturer." And a manufacturer may still look at that and say, "You know, I don't trust the state you know, I may want 12 percent and they may want eight percent and we're not a utility, we're a --"

CHAIRMAN WATKINS: Well, why can't you break that down into your own internal auditor's approach that they would take and tell them to come up with a formula that they would accept? Expand that generality to something more specific that would be tailored to the particular vaccine development effort.

MR. DeSTEFANO: It <u>should</u> work; I just haven't seen it work because the questions that you see asked imagine a corporate management committee sitting around trying to decide on what its research priorities will be for the next year and then five years and saying, "Well, we have limited resources. We have a shot at one product which is going to have a potential 30 percent return on investment and we have a shot at an AIDS vaccine. Gosh, we'd like to do the AIDS work because the public benefit is tremendous and there may be a Nobel Prize there and we may get rich. But on the other hand, you know, it looks pretty certain that we're going to have a 30 percent return on investment on the other and what will our shareholders think?" And you end up with the answer to the question almost by necessity.

CHAIRMAN WATKINS: Well then clearly we're at the point where we're driving off shore at a higher rate and we're not coming to grips with a more aggressive and flexible national system that's putting the maximum resource into this? So maybe getting back now to Ms. Mariner's point, when we have these situations within the military there's a number of things you do to expand the base of research work. And you do things with

small business set asides, you do things with government owned contractor operations. We've done that on numerous occasions we've had unique situations where American industry will not get in the game. So the question is should there be a government owned contractor operated expansion of vaccine development for AIDS recommended for the country? Put a sunset clause on it, you do it for five years and then pass it back into the system to let it continue? And use the existing resources that are out there in research that can come to the fore and be somewhat protected under the government ownership for the period of time. And what you have to give up is something you'd have to negotiate. I don't know what would have to be given up in the process. Perhaps not as much as you think.

MR. DeSTEFANO: If I may, the dilemma that I see with what you're proposing is that what you're doing is giving the entity that you're talking about creating exactly what want. If the government gets into the vaccine manufacturing business, it will do so without the threat of strict liability in tort. Under the Federal Tort Claims Act and the doctrine of sovereign immunity your entity may not be liable for certain types of negligence. It will not be liable under any strict liability theory. We're asking for the same thing.

If what you're talking about is creating an entity that will, in effect, give us a kick so that we feel competitive or threatened and go out and compete with you, we're not competing on an equal footing. You have something dramatically important that we don't. You have eliminated the need for insurance while we're out scrounging around for insurance or looking for a way to self-insure.

CHAIRMAN WATKINS: But if we can't get into your files, then maybe this is the only avenue we have. If we're serious about an expanded and urgent effort on vaccine development for the HIV, then you're almost focusing us into a cul-de-sac on the issue. I mean what I'm trying to do is find out is there another way to go here? Maybe we have to move in that direction rather than --

MR. DeSTEFANO: Well, if that is the direction you go, it will be because you've recognized that private industry which is faced with these insurance and liability concerns can't compete and that the only entity that can is one that doesn't have those insurance concerns and doesn't have those liability concerns.

CHAIRMAN WATKINS: But you say it's liability concerns and there are others who have said it's the economic concern and that liability concerns aren't that clear. There's more perception, perhaps, and fear than reality. That's what Ms. Mariner says.

MR. DeSTEFANO: Well, they are economic concerns, although I agree that right now all we can do is prove that the perception is something that's influencing people. I'm not sure that I can prove that dollars out of pocket are influencing anyone.

For example, Genentech does not have a vaccine on the market today, so I can't tell you that it is actual liability that we're faced with that is causing us to make decisions. It is the fear of liability that is causing us to make decisions.

CHAIRMAN WATKINS: Ms. Mariner, can you comment?

MS. MARINER:: I think you've stated it very well, Admiral. To your point about competing on an equal footing, government could certainly compete on an equal footing if it were to assume liability or create a compensation program that would provide for persons who may have adverse reactions to any vaccine it produces. But I think that it may very well be time to think about that as an option. Government production or contracting for production of vaccine has not been seriously discussed for many years. It would take some doing. There are a lot of details to work out. But I think it is a possibility that deserves serious consideration.

CHAIRMAN WATKINS: Certainly could be studied and worked between the various private entities that would be interested in being the contractor for the government owned operation under those circumstances. I mean, this is the same thing we've done in other fields so it just seems to me the precedent is there. But to get this thing moving it seems to me we have to do something rather than stand around and about liability and the fact that we're seeing migration into other nations from this country in something that we ought to be a leader in.

MS. MARINER:: The good news and the bad news about AIDS vaccines is that we have time to think about that.

CHAIRMAN LEE: I agree with Admiral Watkins there. Dr. Conway-Welch?

DR. CONWAY-WELCH: A short last question. My apologies for not being here earlier. Six health science centers have commenced vaccine development at very early levels. How are they impacted at the current time over this liability issue? Are they proceeding forward hoping things are going to work out? Are there currently things in the pipeline that are going to solve the problem? How do you relate the situation of those six academic health centers with what we're hearing, at least with what I've heard you state?

MS. MARINER:: We mentioned earlier, I believe, that we don't see in theory any difference in liability applicable to clinical trials and than applicable to an approved vaccine. But as a practical matter there have been very few cases and it would be very difficult to establish a causal relationship between a vaccine that's undergoing certainly phase one trials and an injury.

In addition, as Paul as pointed out, there very often is a relationship between the investigator and the subjects so that perhaps the subject would be reluctant to sue or investigators might take care of small injuries. I don't think that there is indeed a specific concern about clinical trials as distinguished from ultimate distribution.

DR. CONWAY-WELCH: I see.

MR. DeSTEFANO: I've spoken to people associated with Vanderbilt and I know that Vanderbilt has asked itself that same question. I believe that each of the six have secured some sort of indemnitification agreement from the vaccine manufacturer in the event that claims arise.

DR. CONWAY-WELCH: During this trial phase?

MR. DeSTEFANO: During the clinical trials. But as Wendy said, we and they perceive the claims as being unlikely or at least small, limited for example to medical treatment if there's a problem.

DR. CONWAY-WELCH: And that's a separate issue then as to when it would go on the market or when it would be opened up for broader --

MR. DeSTEFANO: Absolutely.

MS. MARINER:: They also have a fairly lengthy written consent form which may obviate the issue.

DR. CONWAY-WELCH: Thank you.

CHAIRMAN LEE: The title for this hearing is liability and what is happened in my view is that the legal profession and the tort system has brought the entire thing to a screaming halt. We have driven vaccines overseas. Now, what are we going to do about this when Congress is composed mainly of lawyers? We have a problem and I appeal to the American people. Wendy Mariner in her article here which Bill Walsh has pointed out to me has suggested legislation that would go around the tort system. I can't see anyway except to go around the tort system, go around the lawyers, put caps on this.

The pharmaceutical industry isn't scared of this liability problem. They are terrified of the liability problem because it can destroy their company, as we have seen. So you two are lawyers. This Commission isn't going to solve it.

If I could write it, I would say let's get around the system and advise that a cap be put on and that the tort system be called to account. Thank you. Is there a response?

MR. DeSTEFANO: Would "ouch" be appropriate?

CHAIRMAN LEE: It would be helpful.

MR. DeSTEFANO: I personally agree. And I think my reticence with respect to Admiral Watkins' proposal is that I too see the solution to be to go around the tort system as opposed to going around a broader system, that is the initial assumption that private industry or private industry working with government is better than government alone being an alternative to private industry. It may just be a philosophical bias, but I think that by going around some of the problems that the tort system poses, either putting caps on recovery or on limiting the types of suits that can be brought, sufficient incentive will exist that industry will go there and do the job if it can be done.

MS. MARINER:: Two quick points. I would love to see the tort system shaped up. But we tried that with malpractice reforms and it didn't do us very much good, I'm sorry to say. So we may find ourselves in the same situation: perhaps the tort system is not the problem we should be attacking.

A different question is what would be left if we were to eliminate tort liability entirely for manufacturers. It would be, in essence, reliance upon the Food and Drug Administration's approval process. And as much as I respect the FDA, I'm not convinced that that should be the only basis for being able to assure that the drugs and vaccines that we have are as safe and effective as they should be.

CHAIRMAN LEE: I thank you. It seems though that we're getting to the point where the cost to society is getting to be too big. If a neurosurgeon has to pay $120,000 a year in New York City to practice medicine, that means when he does a subdural he has to charge $15,000 instead of $3,000. And the system is getting too costly. It has no solution. I'll let Admiral Watkins terminate the sessions.

CHAIRMAN WATKINS: Well, having solved this issue for our Commission work -- first we want to thank you both for coming today. It has been useful and, again, echoing what Ms. Pullen said earlier, I think when we have the debate between the

witnesses in dialogue with us it's more important than rounding any of the rough edges off. So we like to see the rough edges stand out. It's helpful to us in the debate and I think it sharpens up the issues and, again, I think the panels this afternoon have been excellent in that regard. In closing I'd like --

CHAIRMAN LEE: And the winner is --

CHAIRMAN WATKINS: In closing I'd like to thank our panelists for two very thought provoking days of testimony. We've heard a great deal regarding lessons of past epidemics, the devil devastation of the drug epidemic when combined with the HIV and the potential usefulness of criminal and public health laws in stemming the epidemic.

We'll carefully review all of this testimony as well as follow-up with our witnesses today, and that will include the two of you, in preparation for our final June 24 report to the President.

I'd like also to thank Dr. Lee again for giving us the incentive for this particular set of hearings and helping prepare with our staff the very effective set of presentations and witnesses.

The Commission's next hearings will address the international aspects of the HIV epidemic. They're to be chaired by Dr. Walsh and they'll be held at the Pan American Health Organization on April 18 through April 20. These hearings today now are adjourned.

(Whereupon, the hearing was adjourned at 5:01 p.m.)