PRESIDENTIAL COMMISSION ON THE HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

HEARING ON AIDS IN THE WORKPLACE

The Hearing was held at the
Indiana University Executive Conference Center
850 West Michigan Street
Indianapolis, Indiana

Tuesday, May 10, 1988

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9:00 a.m.

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

CHAIRMAN WATKINS: Good morning. We'll start the next set of hearings today on the subject of AIDS in the workplace. And I'm very pleased to be able to turn the chair over this morning to Mr. Richard DeVos, CEO, Chairman and founder of Amway Corporation, who is in the middle of these issues in the workplace himself and his own corporation has done a superb job and I think Rich is extremely well qualified to take over and run this set of hearings. So without further ado, I'll turn it over to Mr. Richard DeVos.

MR. DeVOS: Good morning, everybody. Today the Commission on HIV epidemic will address the issue of AIDS in the workplace. We want to welcome you here and especially thank our witnesses who have taken time from their busy schedules to discuss this very important issue with us.

I hope you relax and realize it's just a matter of trying to get information. This is not a court. Sometimes it must seem like that. All we're trying to do is get differing viewpoints so we can come to some conclusions.

Today's hearing will focus on the impact of AIDS on American business, industry and on the state and local government work force. Issues involving the federal sector will be discussed at the Commission's May 16th hearings in Washington, D.C.

AIDS has become a critical issue for U.S. business as the epidemic continues to spread to every geographic region of the country. The impact on business will be felt in two ways; either directly through employees or their dependents becoming infected and with the attended cost that comes from that in the corporate health programs, to say nothing of the loss of the personnel and their efficiency, or indirectly through higher taxes to cover the costs of those receiving public assistance for treatment of the disease.

During today's hearings we will be addressing the needs and concerns of both management and employees. We will hear about successful workplace polices and we'll be asking our witnesses to identify specific ways to best address the human, economic and medical aspects of this disease within the workplace setting.

We'll be hearing testimony from a number of the distinguished figures in the country who have been closely involved in AIDS and workplace concerns. Our first panel will present an overview of the impact of AIDS on business and industry. Witnesses include: Mr. B.J. Stiles, President of the National Leadership Coalition on AIDS; Mr. Edward L. Morgan, Assistant Vice President for Corporate Relations at Allstate Insurance Company, and; Mr. Jim Klein, Manager of Pension and Employee Benefits for the U.S. Chamber of Commerce.

Before we begin I want to submit for the record testimony from the Citizens Commission on AIDS for New York City and Northern New Jersey and policy statements on AIDS adopted by the AFL-CIO.

MR. DeVOS: I would like to remind the witnesses that in the interests of time we're asking you to limit your oral presentation to five minutes. After each of you have given your presentation, we'll proceed with questions from the Commissioners and we'll try to limit them, too. Try.

Gentlemen, if you would begin. And, Mr. Stiles, we'll begin with you this morning on your prepared comments and then we'll begin the dialogue after we go through all three of you.

MR. STILES: Thank you very much, Mr. DeVos. Admiral Watkins, Ms. Gault and Commissioners, thank you very much for the work you have been doing. You followed --

MR. DeVOS: Would you get your microphone a little bit closer so those in the back can hear you. Thank you.

MR. STILES: I didn't want to bark at you.

MR. DeVOS: That's all right. I've been barked at before.

MR. STILES: And probably will be again before the work is finished. Thank you very much for this invitation. My name is B. J. Stiles. I am President of the National Leadership Coalition on AIDS. We will be one year old only a few weeks before you will be one year old. Probably we may last a little bit longer, than you at least in terms of statutory responsibility. Fortunately, you have a mandated expiration time, and a final report you have to complete and then you can continue to do the work that each of you were doing long before you came on this Commission.

Our organization began to form approximately two and a half years ago when representatives of the private sector, having attended numerous public and private meetings discussing the HIV

epidemic, felt that though there was growing expertise -- medical and scientific and fiscal -- beginning to be attentive to the epidemic, one thing that seemed to be lacking then, and I regret to report I think is still lacking unfortunately is a sense of clarity and public commitment to the discussion and resolution of the challenges posed by this epidemic. And therefore, about two years ago representatives of a number of industry associations, several corporate executives from insurance and other companies, started discussing what the role of the private sector might be trying to provide a visible and more coordinated effort in response to this epidemic.

Our initial planning meeting attracted about 60 people representative of 40 national organizations, but most agreed that the subject was too narrow. That is, we were convened around the subject of whether there could or should be a private sector clearinghouse in response to the epidemic. Most of the participants in that meeting said there are already several clearinghouses, and there will be more. What is missing in this epidemic is leadership.

That group of people and their successors met three times to consider what representatives of the private sector might do. We formed a national organization a year ago in May.

My written testimony summarizes some of our activities and several of my colleagues today will report on specific projects that we have been involved in. I am the 26th representative before this Commission of organizations that, in fact, are members of the National Leadership Coalition and I think that number alone will suggest that we have tried to be aggressive and responsive and collaborative.

In our one year's experience I'd like to highlight two or three things that I think we have learned and that we consider to be critical about this epidemic. As my colleagues will report throughout the rest of the morning, when a corporation or business begins to deal with this epidemic one does better when you plan ahead of time. If you wait until there is an incident or a fear of an incident or have a particular reason why you are concerned about the presumption of someone in your work force who may be HIV positive, your response may be helpful, it may be constructive, it may be balanced, it may even be effective, but it will not be nearly as effective and balanced as if you planned that response well in advance of a particular incident, much less a confrontation.

We and our members, and I think virtually every business leader in the country, are discovering that the sooner one plans, the wiser one plans. Not only the wiser one plans, but the more effective, the more balanced and the more focused will be the response of that business or that corporation.

Secondly, I think we're all learning that the better response is one that is comprehensive. This epidemic requires a planning process which represents of virtually every segment of the work force and as much of the working community as possible.

As Andrew Smith, the President of the Pacific Northwest Bell Telephone, emphasizes how their company in Seattle, Washington -- a region not yet dominantly associated with this epidemic -- responded. They did so by working with representatives of the employee work force, which included an organized group of employees of Pacific Northwest Bell who are gay and lesbian employees. Mr. Smith and his corporate colleagues, in turning to employees, deliberately sought the advice of those persons presumed to already be knowledgeable about health matters within the homosexual community and particularly those persons on the forefront of responding to the HIV epidemic in Seattle.

To plan wisely in response to the epidemic does require, obviously, the combined resources of human resources, legal, communications and every other segment of the work force. It also requires that we have employees present and those who represent the fears and the anxieties of the workers themselves.

Plan soon, plan broadly, obviously plan legally..... though in many communities that raises questions because some employers often are unsure of all the laws that pertain when trying to sort out how to deal with confidentiality on one side and the rights of the public to be protected on the other.

It seems to a number of us that we have a long way to go yet before we have a simple, clear and full understanding of the full, legal context in which we operate when we approach AIDS in the workplace. However, the real issue that confronts every business person, as I suspect it has confronted each of you as Commissioners, is the question of timing. When is the right time? When is it too late, when is it too soon for each of us to become clear and balanced and committed in order to make a positive contribution?

My colleagues on this panel and others throughout this morning will provide evidence of how leaders have bitten the bullet, how people have reacted wisely and how people have created programs and policies that are constructive. However, these individuals are not the tip of an iceberg; unfortunately they barely represent the smattering of community leaders across this country who have yet taken action. And, tragically we're still on the threshold of the epidemic; unfortunately we will move through the hallways and into the main rooms far faster than most of us expect.

In the eighth year of the epidemic we have just passed over 60,000 diagnosed cases reported. If the projections of the Centers for the Disease Control and others stay on target, as tragically they have been very close to target in the last few years, within the next 24 months we will have dealt with 270,000 cases of diagnosed AIDS. That's a large number of men and women in our neighborhoods, our communities, our churches and our business offices and our workplaces to begin to deal with. Again, if we want to deal with them wisely, cost effectively and compassionately, that will require resources that are yet barely visible.

I am extraordinarily pleased to be a part of an organization that tries to represent the diversity of American life; corporate leaders, business leaders, health and social welfare leaders, academic leaders, religious leaders, gay leaders and a number of other persons who have acted positively in response to the epidemic. But I think they are acting, as I hope that respondents to this Commission will react, because we are convinced that the epidemic is serious, it is urgent, it is costly and, most importantly, because it is widespread and it is on our doorsteps.

This is not an epidemic that shall be restrained to any single segment of the American population or to any geography, although there are populations and geographies that are disproportionately and seriously affected. It is an epidemic about which we need to be literate, about which we hope we can act rationally and about which we must begin our work immediately.

Thank you for what you have done to help make the factors of the epidemic clear. Thank you for your rationality and your candor, and your commitment to present a report to this country that will say that this is an issue of extraordinary importance and urgency. Thank you.

MR. DeVOS: Thank you, Mr. Stiles.

MR. DeVOS: We go to Mr. Morgan.

MR. MORGAN: Thank you. Admiral Watkins, Ms. Gault and Commission members, Allstate is honored with the opportunity to provide testimony at this public hearing on AIDS on the workplace. I'm not here as representing an employer with a great deal of expertise in the issue, but rather as a concerned employer that has been involved with looking at and addressing the AIDS in the workplace issue.

The Allstate Forum on Public Issues was established in 1987 to provide a platform where leaders of diverse parts of American society could be invited to address pressing and

critical issues. Its intent is to respond to the need for business to take a leadership role and to recognize that government alone cannot solve all of society's problems. The Forum's goal is to forward the action toward solutions and resolutions of major problems as they exist in contemporary American life. Last summer, in response to a call for action from the Surgeon General, Allstate chose AIDS in the workplace as the first issue to be dealt with by the Allstate Forum. It was the first national discussion and workshop dealing specifically with the issue of AIDS in the workplace.

As a first step, Allstate askedFortune magazine to conduct a survey of the nation's business community to determine their opinions and policies on AIDS. I think the Commission has received a copy of this report.

One of the findings of the survey showed that only one in five U.S. corporations had or were developing policies dealing with AIDS in the workplace. Because AIDS has such a major human and fiscal impact on American business, it became apparent to us that companies large and small must deal with the issue as soon as possible, preferably before an AIDS case actually arises within the workplace.

More than 250 executives representing 150 major corporations and organizations met in Chicago last October to listen to experts on the issue at the first Allstate Forum entitled "AIDS: Corporate America Responds." Incidentally, Mr. B.J. Stiles played a key role in helping us put together both the program and the panel.

As a result of the first meeting, task forces were established in the areas of human resources; medical/corporate health services; government/legislative relations; legal; corporate communications and corporate philanthropy. Task force representatives of 78 corporations and organizations met during a three month period to gather data and develop AIDS in the workplace guidelines for employers.

Some of the questions these task forces dealt with were:

1: How should a company go about developing such a policy?

2: What should it include?

3: What form should it take?

4: What else should companies do in dealing with the AIDS issue?

Their recommendations were compiled in what we believe is the first comprehensive national report dealing with the issue of AIDS in the workplace written by and for the business community.

I'd now like to take a few minutes to cover a few of the guidelines that were developed by the Forum's task force. Bear in mind, these are not Allstate's recommendations, but rather recommendations that come from businesses that had expertise and had experience on the AIDS in the workplace issue. They're contained in this report entitled "AIDS: Corporate American Responds. A Report of Corporate Involvement," a copy of which I believe you also received.

One of the major recommendations in the report notes that AIDS polices must have the active support of senior management. They should also be the product of a task force approach which includes representatives from such areas as corporate communications, medical, employee relations and human resources, legal, safety, affirmative action and corporate philanthropy. Where applicable, a company task force should include members from management and labor unions. Outside medical and legal experts should also be called upon for guidance. The task force should analyze workplace risk with respect to the nature of their individual business.

Consulting with other employees and community groups can provide additional perspectives. The ultimate goal should be to develop a policy that provides safety and fairness for the workplace and, compassion for persons with AIDS. Overall, the report points out an AIDS policy should include the following.

Number one. It should develop a communications program for employees designed to minimize fears and help prevent the spread of AIDS by explaining the facts of AIDS and AIDS transmission. Such a program should also help explain the company's AIDS policies.

Number two. It should treat employees with AIDS in the same manner as any other employees with life threatening illnesses.

Number three. It should allow affected employees to continue working as long as possible, provide reasonable accommodations and job modification, where appropriate, and maintain eligibility for all company benefits.

Four. It should discourage testing for the HIV virus within the employee population.

Five. It should guarantee confidentiality of all medical information relating to AIDS.

Six. It should provide for referral of affected employees to appropriate company and community resources and experts for consultation and treatment.

Seven. It should encourage creative corporate philanthropy with respect to AIDS, especially in the areas of research, education, care and treatment, and technical assistance.

And finally, the AIDS policy should be consistent and tailored to the needs of individual companies.

These recommendations and many others were developed as a result of the task force process and we believe they can be of great value to both large and small corporations and organizations.

We have responded to requests for more than 25,000 copies of the report and the requests continue to flow in at a rate of more than a 100 a week.

Allstate printed the report and we have been providing single copies to companies and organizations at no cost. There is a charge which covers the printing and handling of the report for multiple copies. And we have received many requests for large of quantities for different seminars.

But we believe the reports deserve an even wider distribution. We believe the federal government could help by reprinting the report and making copies available through its publications catalog. The Labor Department might consider distributing it through its regional offices. Other government departments, such as the Department of Health and Human Services and the Department of Education, could also assist in the dissemination of the report. We believe the information in this report is valuable, it doesn't need to be redone. Essentially, our name can be removed and the report can be reprinted by the government and sent out. And we think that it's very, very important that this information gets out to organizations as quickly as possible. Allstate is pleased to have had the opportunity to play a part in helping to address the AIDS issue in the workplace and we appreciate the opportunity to testify before you this morning.

MR. DeVOS: Thank you. And we appreciate the work of Allstate in moving forward on that project.

MR. DeVOS: Mr. Klein?

MR. KLEIN: Thank you. Mr. Chairman, Admiral Watkins, members of the Commission and Ms. Gault, my name is James Klein. I'm Manager of Pension and Health Care Policy for the U.S.

Chamber of Commerce. I am pleased to be here today to testify on this most important issue which the Commission has been charged to investigate. Because the full text of my statement will be filed for the record, I'll simply try to highlight and, in the interest of time, touch on the most important issues.

It's a particular privilege for me to serve on the same panel with B. J. Stiles and Ed Morgan because, certainly the National Leadership Coalition on AIDS and Allstate have been two leaders within the business community that have made tremendous strides in helping employers understand the many issues that they need to understand about AIDS. And they've been both a tremendous help to me personally.

A complete description of who the Chamber's membership is, is shown on the inside front cover, of my statement, and I'll refer you to that in order to understand it in greater detail. But I only draw attention to it in order to make the point, since it is not always known, that although most of the large companies in America are members of the U.S. Chamber of Commerce, in terms of sheer numbers we are predominantely a small business organization. And I believe that's particularly relevant to the questions at hand because small firms, perhaps even more greatly than larger companies, have a tremendous need for advice and guidance on how to deal with workplace issues including, of course, AIDS.

The personal human dimensions of the suffering caused by AIDS cannot even begin to be calculated. Employers, like all individuals, have an obvious concern for preventing and ameliorating that suffering. But concern about halting an epidemic such as AIDS also takes on additional dimensions for employers. Among those considerations involve legal questions, financial concerns, the employee benefits concerns, employee relations matters and, of course, public relations issues, as well, especially for those companies that have a good deal of interaction with the public.

For many of us who deal with AIDS issues regularly, it may be difficult to appreciate that in many communities there still is very little known about AIDS. The infrastructure of those communities, the health system, the education system, local government agencies, businesses and the media simply have not yet had to gear up to deal with AIDS. In most communities individuals and businesses have not yet been confronted with the reality of AIDS among friends, coworkers and employees. Regrettably, it appears that that experience will soon change as more and more cases of AIDS occur outside of those few metropolitan urban areas that have seen the greatest number of AIDS cases thus far.

This underscores the need to engage quickly in education efforts to overcome misunderstandings or lack of information that will hinder the ability of individuals and businesses to respond appropriately to the great number of AIDS cases that we will see in the near future.

Where businesses are beginning to ask questions, I've found that most of the questions they've put to the U.S. Chamber have fallen into one of three categories: legal issues, employee benefits issues and employee education efforts. A sampling list of the most frequently asked questions appears in my written statement and, of course, those questions are by no means an exhaustive list. But just to highlight them quickly, among the legal questions we most frequently hear: Is an AIDS infected individual considered to be handicapped under federal, state or local law? If so, what are the reasonable accommodations that employers must make for handicapped employees? There are also lots of questions about confidentiality, also what legal remedies are available to management if employees refuse to work alongside a person with AIDS? And then, of course, employers just want to know what the relative advantages and disadvantages are of promulgating written polices or guidelines to deal with AIDS or other catastrophic illnesses.

Some commonly asked employee benefits questions include: Should AIDS be treated the same or differently than other catastrophic illnesses? Should there be limitations or exclusions in benefits plans and, if so, what type? Do company health plans cover prescription drugs, mental health benefits, experimental treatments, nursing home and hospice care and the like? Also the relative merits of self insuring or purchasing insurance.

Questions that we increasingly find employers asking themselves, and in turn us, regarding their proper role in education programs are no less probing. These include: If AIDS cannot be transmitted in normal workplace settings, is it even appropriate for a company to address the issue of AIDS with their employees? If the company wants to do so, what is the most appropriate way to do so and what is the most suitable format and what are the best materials to use and speakers to have?

Not all of these questions can be easily answered, but the Chamber is determined to help our constituents -- businesses -- address these questions as best as possible. Accordingly, the Chamber has taken several steps toward this end.

The U.S. Chamber's Board of Directors adopted unanimously a policy statement on AIDS which appears in Appendix A of my testimony, which urges our members to engage in educational efforts on AIDS and to consider the adoption of policies on catastrophic illnesses.

We have also devoted considerable attention in our broadcast and print media to this issue. The Chamber's morning news program, Nation's Business Today, which is carried on the nation's largest cable network, has run several segments including a special four part series on AIDS. The Chamber's magazine, Nation's Business which is the largest monthly business publication in the country, has run numerous stories on this issue, some of which are found in Appendix B to my statement.

Reflecting the composition of our membership, the Chamber's communications efforts have focused extensively on the concerns of small and medium sized businesses.

The Chamber's educational activity has now entered an even more in-depth phase. The Chamber will be publishing shortly a book,AIDS: Am Employer's Guidebook, which I have written, that focuses particularly on giving small businesses, local and state chambers of commerce, and other trade and professional associations necessary information and materials on AIDS.

Additionally, the Chamber will be offering seminars on AIDS on the workplace starting next month at our Institutes for Organization Management, which is a continuing education program for local and state chamber of commerce and trade association executives.

I would like to turn in, conclusion, to the Commission's request for specific recommendations. And I suppose we have, in general terms, three.

First, the Chamber urges the Commission to use its position to convince private and public sector leaders to devote resources to educate the public about AIDS. Myths and misunderstandings can only be overcome by a strong commitment to give the public the information it needs to understand the facts.

At the same time, the Chamber strongly urges the Commission to resist any effort that would require employers to sponsor education programs or to adopt specific corporate policies. We note with great concern that in California legislation has been introduced that would mandate employers to provide AIDS education to employees and to promulgate written AIDS guidelines containing specific provisions. The Chamber certainly hopes that such legislation does not pass at the federal, state or local level.

As much as we support these education efforts, and I hope one thing that has come through loud and clear in my remarks is that the U.S. Chamber is doing a number of things to encourage employers to undertake such efforts, we believe that it would be a mistake to mandate something that really should be strongly

promoted on a voluntary basis. A mandate fails to recognize the varied degree of employers' abilities to impart educational information to their employees and this is especially true when dealing with an issue as complex and evolving as the AIDS epidemic.

A second important function that the Commission could fulfil is to encourage that in every way practicable AIDS in the workplace should be handled like any other catastrophic illness. Whether it is a question of modification of employee benefits plans or permitting access to medical records to allow a better management of AIDS cases, AIDS should be handled to a no greater nor lesser standards than other illnesses. This, we believe, will help foster an environment in which employees, employers and the public at large understands the seriousness of the epidemic without overreacting to it.

Finally, recognizing that the scientific facts about AIDS are rapidly evolving, we believe it would be wise to avoid the hasty adoption of rules or policies that are inflexible and might be ill suited to dealing with this epidemic as it changes in the future.

The battle to defeat AIDS and the myths that accompany it will require vigilant efforts by both the public and private sectors. The Chamber stands ready to contribute its effort to help corporate America respond to this important challenge.

Thank you very much.

MR. DeVOS: Thank you, Mr. Klein.

MR. DeVOS: Thanks all of you for your prepared statements. We will now go to a period of discussion with the panel members here. And we'll just dialogue together. You should each feel free to respond if it's in your area, and dialogue between yourselves if you wish. And we're going to start this morning with Frank Lilly down on my left and we'll let Frank take the ball and run with it.

DR. LILLY: Mr. Klein, I'm interested in the very last part of your comments where you're proposing that we -- I'd like a little fuller explanation because it went by me very fast and I didn't entirely seize all the nuisances where you were suggesting that there are a lot of things we need to wait on because we don't know enough. I'm not entirely sure exactly what you're referring to there.

MR. KLEIN: Just in general terms, the fact that since there still seems to be so much unknown or developing in terms of our medical and scientific knowledge, for example, questions about AIDS dementia or the risk to an individual with AIDS in

terms of their own being prone to opportunistic diseases and so forth that we would just caution, as policies are being developed, against drafting them in such ways that would be so concrete or inflexible that if the medical facts as we know them now should change, that companies and others would not be able to respond appropriately.

DR. LILLY: Well, I'm worried about that because it seems to me that there an awfully lot of things that need approaching immediately and --

MR. KLEIN: Very definitely.

DR. LILLY: -- I would hate to see issues that we desperately need policies on be postponed simply because there may be new information. There may be new polices, too, for that matter. How do you communicate with the lower echelons of your organization?

MR. KLEIN: Well, we don't consider them the lower echelons because they're our members. They may feel that way about us. We have -- among our 180,000 members -- 2700 state and local chambers of commerce and 1300 trade and professional associations. Those groups, in turn, of course have hundreds and hundreds of thousands of members. So we have very well developed communications methods with them, extensive print and broadcast media; newspapers, magazines, newsletters, a regular chamber of commerce department within the U.S. Chamber as well as a trade and professional associations department within our office to particularly get information into their hands.

In addition, our communications capacities reach beyond the U.S. Chamber's members also in terms of our television programs and some of our publications which are sold for general subscription and direct mail matters.

DR. LILLY: I'm wondering how you're taking advantage of the fact that some of your member organizations, for example, in San Francisco and in New York, et cetera, faced the issue very early, long before your national leadership got into the act. Eventually that information filtered out to them and now I'm just hoping it's going back to these places where you say they need it and don't have it.

MR. KLEIN: Very definitely. A number of local and state chambers have been real leaders in this area because they have had to deal with, on an immediate basis, the questions that arise, out of the AIDS epidemic. So they have been an enormous help to us.

For example, the Minnesota Chamber of Commerce and Industry has run a number of excellent programs on AIDS in the

workplace that have really been a model that we have been able to point to other local and state chambers that have asked us how they might pattern their efforts and not reinvent the wheel. So our interest now is really in getting to all of those other communities that I spoke about that may not yet be geared up and pointing to other exemplary companies and chambers that have really been leading the effort here.

MR. DeVOS: Thanks, Frank. We're going to go to Kris.

MRS. GEBBIE: I think I'm going to play the role of designated skeptic this morning. Each of you said something about this Commission's report ought to tell every business in America to have a policy. I think that's been told to every business in America by each one of you from your organizations and probably by several members of this Commission in their various roles. So how could our saying it one more time in paragraph 32 of our report be what does it? That is, either what manner of saying it, or what words should we use or what carrot or stick should we use, that makes our message the one that gets through to the small business in every city or county in this country? Because clearly, I think you all agree, they all need to do what you just described.

MR. STILES: I'd like to respond briefly to say that I think what this Commission advises the government and the country will become a document of extraordinary authority. That is, you have been diligent and I expect you'll be careful and I think your message will become something that other people will pay attention to, not the least of whom might be both candidates for the Presidency. And perhaps the incoming A ministration might well turn to your reports and recommendations, if not as a road map or blueprint, certainly as the collective wisdom of an extraordinary number of people. It seems to me, therefore, your recommendations do bring a semblance of diversity and balance and authority and provide credibility and scope. Many of us in the private sector are often thought to represent narrow or single or vested interest in the epidemic. Presumably, you as a Presidential Commission have no vested interest other than bringing to the country the strongest, the most powerful and the most thoughtful recommendations. In that sense I would hope your recommendations will have a lifetime way beyond the report itself.

And secondly, I think that your recommendations, like many of our programs, must say things once more then we all catch one another saying that every business, every workplace needs an education program. What we fail to say is that we need a repetitive and a redundant education program. Doing it once is not sufficient. And I think what you can do in your combined wisdom and in the authority of your Commission can be extraordinarily useful to the rest of the country by saying,

"See, one more group of people has looked carefully, objectively and thoroughly at the question and here's what they have to say."

MR. MORGAN: I would agree with B.J. I think just including the recommendation in the report by and of itself is not what matters as much as in the influence it will have on others' actions and the fact that it's basic the principle of communications a consistent and repetitious message that you have to address this issue -- organizations have to address it. And I think the more we say it, the more different ways we say it, the better off we'll all be in the long run. The inquiries we're getting on a daily basis are from big companies, small companies, non-profit organizations. We get them from government agencies, people looking for more information and more knowledge about the issue as it affects an organization. And I think including it in your report, just saying companies need to address the issue of having a policy, is one of the things that will have an impact.

MR. KLEIN: I would just echo their comments, they put it best.

MR. STILES: I'd just like to make one other response, and that is that the recent release of very comprehensive and balanced recommendations by the Office of Personnel Management is an extraordinary asset in terms of helping government agencies and government administrators have a set of documents that are thoughtful, balanced and has the authority of being an administratively approved document. And it would seem to me that your recommendations could have equal potential in terms of going throughout the system, both public and private, in terms of setting standards.

MR. DeVOS: Thanks, Kris. Theresa?

DR. CRENSHAW: I've read some and I think it's just excellent some of the best that I've seen on workplace issues. There's one area, however, that I find rarely addressed in regard to workplace issues that I'd like to explore a little bit with you. And that's the issue of secondary infections, not AIDS, not the transmission of AIDS. And I think there are to facets to this and I'd like your feedback on whether you've given this some consideration and what conclusions you've drawn.

Two facets. One is that someone who is immunocomprised is suspectable to just about everything and when someone at work is ill and not too sick to be home but sick enough to still be contagious, they are a threat and a risk to someone whose infected with the AIDS virus. And how is that handled? It seems to me we have a catch 22 by virtue of not being able to protect someone ill from one of the infections that could very well kill them at work.

The second is that many of the secondary infections are airborne or contagious in other ways and were easily transmissible than the AIDS virus itself. And I want to make very clear for the record I'm not talking about the AIDS virus being airborne. But there's an article that came out recently in the April 8th issue of The Journal of the American Medical Association that was really interesting and somewhat disturbing. They did a study on respiratory infections in the workplace, in the military. And they found that there was a 45 percent greater incidence of respiratory infections in the workplace in more modern buildings than in older buildings built in the '40s and the '50s because of the more efficient recirculation of air.

So it seems to me that we need not only look at secondary infections and the potential for harm in both directions, but if these studies have merit and the air conditioning systems that are being used have this potential to make a difference that great, it goes on to mention that 75 million doctor visits and $15 billion in direct medical costs each year are the result of respiratory infections and that billions of dollars in the social and the health costs. So I'd appreciate your comments. I'm not very deeply informed on this, but I'd like to know more about it.

MR. KLEIN: From my prospective, you've raised some very good questions the answers to which may not be known or not yet developed. I think some of those questions in terms of the secondary effects was what I was alluding to in my remarks and in answer to Doctor Lilly's question about still being unaware of certain facts, certain scientific matters for which the development of policies need to allow for the fact that new information may become known.

I think that in terms of the Chamber's support for the idea that an individual with AIDS ought to be allowed to continue working as she or he is able to do so, the effect on and the safety and health of that individual in terms of their susceptibility to other opportunistic diseases and infections may become a factor in that determination.

We already seem to know and accept the scientific evidence that the virus itself cannot be communicated through casual contact, normal contact in the workplace. But these kinds of considerations are serious and from the perspective of the health and safety of the person with AIDS we simply need to approach it with caution. But I wish I had a clear cut answer for you.

DR. CRENSHAW: There is a growing concern among the medical community about tuberculosis which, of course, is airborne and I don't -- this article doesn't specifically refer to whether or not that was one of the respiratory infections

involved. But these are things that, it seems to me, would be awfully nice to have answers to. Anyone else have a comment?

MR. MORGAN: With regard to secondary infection, I think it's an issue that's pretty well handled by the workplace. If you have an AIDS policy that says you will accommodate employees with the virus and that you will help accommodate them if the physician and the employee feels that there's a problem with working closely with employees, I think that can be handled as just part of your normal supervisory practice if you have a policy.

With regards to the airborne infection, I think it's something that needs to be addressed. I serve on our ergonomics committee at work and we have just hired a wellness consultant to come in and look at wellness. We also have industrial hygienists. This is one of the areas they're looking at, the recirculation of air and how it effects health. We really don't know. I don't think there's a whole lot of work that's been done yet. So, I don't have much more information than you do. But we're looking at it. It is a concern.

DR. CRENSHAW: So it is something that's on your mind and that you're --

MR. MORGAN: It is a concern, yes.

MR. STILES: Doctor Crenshaw, it's my concern that from the employee's perspective, the secondary infection that is the most lethal is our anxiety and our ignorance about the disease itself. In time after time in the actual workplace setting, when the employee is clear about his or her condition, where the employee's boss and managers are clear about how they're going to deal with it, the rest of the coworkers become part of the human family of people who are ready to be protective of the diagnosed or seropositive employee's welfare -- medically, spiritually, socially and in every other respect. It's really the other setting -- in which the employee's condition scares, frightens, offends other people to the degree that they want to isolate them, when we want to hold them at arm's length and we want to use the anxiety about secondary infection as the excuse to deprive them of their own ongoing right to work and deprive ourselves of the opportunity to be associated with them.

I think it's <u>that</u> secondary infection that really is pervasive and most destructive in the workplace.

In my own office, in my own work before I entered AIDS, in working with persons who were diagnosed and who wished to remain a part of the productive work force, I found out very quickly that coworkers want to become allies and protectors of PWAs who may be vulnerable to any kind of infection or

rejection. And it seems to me that we see policies as an opportunity to be literate and sensible enough to not allow any secondary infection which would deprive any of us the opportunity to make a living, protect our health and be careful of our coworkers.

DR. CRENSHAW: I agree with you that a lot of aspects of the AIDS epidemic can be misused to promote hidden agendas. My concern is that we not go to either extreme and as I've seen in the last six or eight months in the community at large, both professional and general public, there have been an enormous and very encouraging response from mainstream thoughtful scientists and others to take a look openly and objectively at some of these issues. So I'd like to stay away from the extremes on both sides and just face whatever it is that we do need to face here and take a sufficiently clear look that we can make rational and good policies that are in the best interests of both the infected person and others. So I take in your points. I think they're very important. Thank you.

MR. DeVOS: Thank you, Theresa. Penny?

MS. PULLEN: I don't have any questions.

MR. DeVOS: Can the audience hear what these people are saying adequately? I don't want you to get left out. Beny?

DR. PRIMM: Well, I just read something recently in a magazine that said that you can only get AIDS in the workplace if you are doing something that you're not being paid to do. And in that regard one of the things that has bothered me considerably is the lack of attention in the workplace that's paid to drug use, sharing of needles, certainly drug trafficking and we see this continuously all over the country. And all of these things could make one more suspectable, unquestionably, to transmission of the virus. And my colleague here just wrote something that's really important, the sexual harassment that takes place in the workplace, are all contributory factors as far as I'm concerned.

I've had in my own corporation to get rid of people who have continuously sexually harassed the women employees. Some have been successful in their attempts to seduce persons based on promotions, based on threats and so forth.

What are you doing at the Chamber of Commerce? I know what B.J. is doing. I work with him constantly. And what are you doing, Mr. Morgan and Mr. Klein in that regard?

MR. KLEIN: Well, the U.S. Chamber of Commerce long before it became involved in the question of AIDS, has been involved in the question of preventing, stopping drug abuse in the workplace and drug abuse generally. A colleague of mine on

our staff, sort of our in-house expert on it, has published a book on it, the Chamber has run a number of seminars and otherwise has disseminated a lot of information on prevention efforts, again throughout the normal Chamber of Commerce and membership activities that I described earlier.

This can have, therefore, an incidental effect in terms of helping our efforts now to slow the spread of AIDS. With respect to sexual harassment, we also have a very strong policy on that in terms of the unacceptability of any kind of sexual harassment activities. Certainly from the U.S. Chamber of Commerce itself as well as in terms of advising our membership. I know that right within our own workplace we run regular seminars on this and it has the highest priority of the U.S. Chamber's board and our staff.

MR. MORGAN: With regard to the drug issue, probably the best thing we have done on that issue, and a lot of other similar issues that effect employees individually, has been the implementation of an employee assistance program about five or six years ago. And, training supervisory employees to recognize potential problems with employees and encourage them to use the employee assistance program. This is an outside agency that deals with the problem, whether it's a marital problem or financial problem or drug problem, or alcohol problems. The only report we get back from the employee assistance individual who handles the program are reports of usage. And drugs are a bigger problem than you'd tend to think about, but we don't get any information except that the assistance service is being used.

We have done other things in the drug area, like health fairs. We just had a health fair again last week where we had different types of community based organizations in and employees were encouraged over a couple of days period to go in and talk to different organizations; whether it was the heart association or other types of health agencies, or for drug abuse or alcohol abuse.

We train our supervisors in our supervisory training courses to look for those types of behavior that might indicate a problem and encourage employees to seek assistance. And, of course, we communicate. We spend a lot -- Allstate has spent a lot of time and money through the years on the most widespread source of drug abuse, which is alcoholism and alcohol abuse. And we are doing now more and more on drug abuse as it effects the workplace. As for the sexual harassment issue, we have a very strict policy. We've trained all of our supervisory people. They all received a presentation during their supervisory training and it's a stated policy, a very affirmative policy, of what is acceptable behavior and what is not acceptable.

DR. PRIMM: Do your companies do yearly physical examinations and included in that physical examination is a urine analysis for a drug screen? Is that commonplace? You don't do yearly physicals?

MR. MORGAN: We do not, no.

DR. PRIMM: How then can you recognize the symptomatology just -- do you recognize just by symptoms or behavioral symptoms in individuals?

MR. MORGAN: Behavioral symptoms. Yes.

DR. PRIMM: Absences --

MR. MORGAN: And performance.

DR. PRIMM: -- performance, et cetera. But you do no drug screens on your --

MR. MORGAN: No, we do no drug testing either pre-employment or with existing employees.

DR. PRIMM: What about your member companies, Mr. Klein?

MR. KLEIN: Well, I imagine their practices are all across the board and are in accordance with whatever the local law may be and state law where they operate.

DR. PRIMM: I'm under the impression that many of the Fortune 500 companies now do urine screens for drugs for pre-employment physical and yearly physical examinations.

MR. CREEDON: That would not be my impression -- excuse me. I think that increasingly, although I would doubt that it would be a majority among the Fortune 500. They are beginning to give tests as a pre-employment matter. But my impression is that relatively few test existing employees except in specific types of jobs where they might be a particular hazard. I don't know, for example, whether they're testing pilots now, but they're limited. I think there are a few companies that are testing employees, but I would not think it's --

MR. DeVOS: Thank you, Beny. We're going to go on to Colleen.

DR. CONWAY-WELCH: Thank you. Mr. Klein, I'd like to ask you to expand on your recommendation that the Commission should encourage an environment in which AIDS is handled like other catastrophic illnesses. For example, efforts to amend the law to require employee benefit plans to handle to AIDS

differently than other illnesses should be resisted. This is an issue that has come in front of the Commission a number of times, lifting AIDS out of the usual processes by which we deal with the issues of illness in this country and highlighting it or doing some special things that are specifically focused as opposed to attempting to address system issues, if you will. And I wondered if you could expand on that for us?

MR. KLEIN: Sure. It may even be of questionable legality in some instances to amend an employee health plan, for example, for a special limitation on coverage for AIDS vis-a-vis some other kind of illness. And even if it does not step over the lines of what's permissable, it would seem to us inadvisable to treat AIDS, as I mentioned earlier, to either a greater or lesser standard than other catastrophic illnesses if the whole effort that we're trying to impress upon employers and employees is that AIDS is a catastrophic illness and should be handled as such.

I mentioned in my written statement, for example, the federal legislation now that would expand upon the continuation of health care coverage provisions of what's called COBRA, the Consolidated Omnibus Budget Reconciliation Act. Again, based upon what our members are telling me, the compliance with the law as it currently stands has been an incredible burden for employers and insurance companies and others who administer health care plans. Now we look with some concern on this proposed federal legislation that would expand COBRA and, although it arguably would apply to all types of disabilities, the clear intent of the law is aimed at providing special provisions for those persons with AIDS.

We would certainly encourage the sponsors of that kind of legislation to consider the enormous ramifications that COBRA as it now reads on the book has had in terms of discouraging small and medium size companies from offering health care coverage at all and to the degree to which any changes in that law would become an inordinately greater burden, it might have the, certainly, unintended effect of discouraging employers from providing valuable health and other insurance protection for their employees and their families.

DR. CONWAY-WELCH: Thank you.

MR. DeVOS: John?

MR. CREEDON: I have a question for Mr. Morgan. I would like to reiterate what the chairman said about Allstate having done such a, good thing here in undertaking this work and I don't give competitors, credit very lightly. I read a statement or a speech that Commissioner Pullen sent to me the other day by Secretary of Education Bennett. The general thrust

of his remarks, was that AIDS is primarily a public health problem and should be approached from that standpoint. And one of the things that he encouraged is fairly widespread routine testing for the virus. I think his feeling being that we really don't have enough hard data yet as to how many people have the virus. We have a lot of implications drawn from certain data, but we don't know how many people have the virus and he seemed to feel it was important to try to find out. First because it would be beneficial to the person who has the virus to know that he or she has it and be able to take whatever steps can be taken in light of that. And secondly, that it might be good to know from a public health standpoint.

I noticed the number of points that were made in the study that was undertaken, that one of the points made, and I think you may have reiterated it, was that employers be discouraged from testing employees for the virus. And I'm curious as to what the rational for that was in the conference?

MR. MORGAN: That came as a result of a number of companies that have had experience with AIDS. And basically the main reason is the invasion of privacy, and do you want to get in to start testing employees for individual illnesses or sickness, or do you want to treat AIDS like any other serious illness or sickness in the workplace. And you don't test people for cancer, you don't test them for heart disease, you don't test them for other things, so why should we test them for AIDS? That's basically our philosophy and, we don't test them for venereal disease. You know, there's no precedent to do that any differently.

MR. CREEDON: Yes. Well, I guess, you know, coming back a little bit to your point that Commissioner Primm raised, I don't know what percentage of employers, at least large employers, do provide physical examinations now. And my guess is that fewer maybe than did 20 years ago. But at least in certain circumstances physicals are provided and I think urine analysis would be a part of the physical and maybe blood samples would be part of the physical. So it would be possible where a physical is being given anyway to expand it if the employee was willing. I mean I would certainly not do it on a mandatory basis, but on a voluntary -- here you're affirmatively saying well discourage people from encouraging employees to have a test taken. And --

MR. MORGAN: The Fortune survey that we did of businesses showed about two percent of the companies do any type of testing.

MR. CREEDON: Any type of testing?

MR. MORGAN: And only eight percent would ever want to test in the future if they were allowed to do testing.

MR. CREEDON: Thank you.

CHAIRMAN WATKINS: The other question really might be a suggestion. I know one of your recommendations is that the report be made available to another 25,000 people at the cost $100,000. I don't know where you think the $100,000 should come from, but I was wondering whether (a) Fortune magazine, who was obviously interested, might somehow participate in making such a distribution and also the Chamber. I would think this would be an ideal thing for the Chamber to distribute to 180,000 members instead of just an additional 25,000 and maybe by Fortune and Allstate and the Chamber, maybe a few other people getting together, it could be done. Because I agree with you, I think it's a shame not to give it widespread distribution. I think it's a really good report and we ought to do it. I'm not sure we have to look to the federal government for that.

You know, I'm taking Chairman DeVos' speech here and he usually says something about --

MR. CREEDON: Metropolitan will join you in that.

MR. MORGAN: We're not looking for the federal government to do it. We just think the information needs to get out and it is a serious national problem. We think the information needs to get out so more companies, both large and small, those who belong to the Chamber, those who don't, know it's available.

MR. CREEDON: Right. I agree. I think the cost is not huge. It seems to me it is something the business community should be able to get behind and do.

MR. MORGAN: I don't think it's the cost as much as it is the availability, people knowing where to go to get the information and having it available. The cost is minimal, but it's a small business person not knowing where to go when they have a problem. They may not even belong to the Chamber and who do they go to? Just having it available, public information, so that they can get it readily from someone locally. I think the cost is not an issue.

MR. CREEDON: Well, I suggest Mr. Klein take this under advisement. Mr. Klein?

MR. KLEIN: Well, in fact, it was along those very same lines that we decided to develop yet an additional publication because clearly the one that Allstate has put out is an excellent one and we refer to it often when we've had inquires. But we also felt the need for a separate kind of publication that would be particularly well targeted to small companies. You know, small employers have enough trouble just running their

businesses and manufacturing widgets or providing whatever service they're engaged in. And big businesses, too. And so we felt one thing that would distinguish our publication from some of the others is that it would have in it ready-made materials that these companies might use as well as chambers of commerce and trade associations and B.J. Stiles was a tremendous assistance to us in terms of advising us how this ought to be structured, in terms of newsletter articles that a company might just photocopy right from our publication and put into their own newsletter and they can go ahead and plagiarize it.

That type of material as well as a very ample appendix that would list where they might go in their state for further information on running an education program or simply dealing with the issue.

MR. CREEDON: Thank you.

MR. DeVOS: Penny?

MS. PULLEN: I apologize that I missed the presentation part of the panel. Doing business elsewhere. But I would like to ask Mr. Klein a couple of questions that maybe were not covered.

Does the Chamber have a recommended or model employee education brochure on AIDS?

MR. KLEIN: It is in development as a substantial chapter in our overall forthcoming publication called Aids: An Employer's Guidebook giving employers advice on how they might go about running such a program.

MS. PULLEN: But you don't have a pamphlet that can be handed to the employees as a recommended tool for the employer?

MR. KLEIN: One of the appendixes in this publication is sample information, for example, from the American Red Cross or others that will be something that the employer can photocopy and distribute to their employees.

MS. PULLEN: What would be your opinion of an employee educational brochure from a corporation which has the message to its employees if you use drugs, don't share needles?

MR. KLEIN: Well, we try very hard to understand our appropriate role in terms of encouraging employers to do what they feel is appropriate. So to be honest with you, we've not made a judgment on that and I think those employers who would determine that to be appropriate or inappropriate, we wouldn't try to second guess them.

MS. PULLEN: I would encourage you to be a little braver about that.

MR. DeVOS: Doctor Lee?

DR. LEE: Mr. Chairman, with your indulgence I would like to ask these young people in the back of the room here who have been watching for two days and they are attentive, they are not yawning, they are not talking among each other, they're listening to us. It's very unusual. Who are you and --

CHAIRMAN WATKINS: Wait a minute. Let me say who they are. Doctor Lee's the last one to get the word. This is the very special group from the Hamilton Southeastern High School who are honor students and are here from the human genetic science class. They were here yesterday, they'll be here today and tomorrow. And I think it's a great credit to the leadership of that school to allow these students to come, different groups each day, to listen to these sets of hearings.

We've been talking about AIDS in the workplace, but AIDS in the workplace is also AIDS in the high school. And so when we're talking education, there's a continuum, there's a bridge between the workplace and the school without any question. Hopefully the parents are in the workplace. Hopefully the children are in the schools. The education process that's needed in the country, desperately needed, is going to come to fruition in those two areas primarily and with very special intervention strategies to go not in the workplace and not in the school. That's a whole different set of issues. But you can also influence that. And so to have the young people of America be part of the solution, which is what we must strive for in this nation, instead of the butt of all criticism, is what this class is all about here today. I think it's unusual for a high school to allow their students to participate in something as sophisticated as this and I think it's a credit to them as individuals to be here and to be so attentive as Doctor Lee as said.

So I'd like to ask the students to stand up and let's give them a round of applause for being here today.

DR. LEE: Thank you, Admiral Watkins. I really am very pleased to see students here. You're watching a small very disparate group of citizens try to make a dent in an enormous problem. You're watching the system try to work. We're all on both sides of the table working at this as hard as we can and we appreciate your interest, we really do it. We need it.

Mr. Klein, your background is very interesting as a lawyer specializing in bioethics. That shakes me to my foundations.

The workplace is so vital to the management of AIDS because one of our major problems and one of the ones which I've sort of taken a pet interest in is the people who have lost their jobs, lost their benefits, have become basic and can't get an apartment and relatively have become charges, societal charges.

Your philosophy that this is just another big medical problem and should be treated as such. I'd like you to address the possibility that there are special features to this one, one of which is this codery of young men who have lost their jobs and their homes and the problem is discrimination. And, of course, the other is that we're dealing with a group of people who have no franchise whatsoever, the drug addicts and the society that whirls around them. And we're trying to deal with that and the system to date isn't dealing with that.

This Commission can't turn away from it and we're looking to the workplace to solve at least a small part of it. In Japan you go to work for a company and you give your life for them and the company pretty much takes care of the person. In America it's very different. It's the bottom line and so frequently it's the bottom line every month which destroys this bond between the employee and the employer. And with a background in ethics, how is a chamber of commerce staffer going to face this problem and what would you have us do?

MR. KLEIN: Well, you've hit on a number of very important questions and assessment of the challenges. I think the key to what you said, in my view, is that the workplace can present -- can provide an opportunity to deal with some of those particular challenges. Clearly it would be easy for employers, for businesses, to step away and say, "Well, all the evidence before us suggests that AIDS cannot be transmitted in the workplace and is it really our responsibility to get involved at all?" Fortunately, I don't think most employers who have thought about this issue have responded that way. They realize that it has very serious employer and employee ramifications.

Clearly there's a limit to what the business community can do in terms of reaching out to those with whom they have little or no contact. And that may include a significant portion of effected populations.

I think that what the Commission can do is outlined in our statement in terms of encouraging employers to recognize not only the importance, the value that they can provide in terms of disseminating information to their employees and to their families, but also in terms of preparing themselves to understand all the dimensions of the epidemic so that they don't make blunders and mistakes that would lead to illegal dismissals, for example, or just errors.

For example, an employer might believe that it is being particularly compassionate in terms of notifying coworkers that a particular individual is infected with the AIDS virus in order to encourage them to treat this individual well; when, in fact, they may be violating that person's confidentiality. So our effort really is to try to provide warnings to companies as to the types of issues that they need to think about. And I would just encourage this Commission to use its structure to continue and increase its efforts to encourage private and public sector leaders to get more engaged in the effort.

As I think B.J. mentioned earlier, no one thing that the Commission say will necessarily make the difference. But in conjunction with a lot of other efforts, the repetition will have, hopefully, the desired effect.

I also wanted to, if I may just use the opportunity to amplify a little bit on Commissioner Conway-Welch's question about modifications to employee benefits plans because I can substantiate some of what I was talking about, the COBRA modifications, with some hard data, which I'd like to just read very briefly so it would be officially in the record.

We did a survey of over 6200 companies on their responses to the increased cost and administrative burden of COBRA and asked them, among a number of other questions, what their reaction has been to the requirements under COBRA for the continued health care coverage.

Fourteen percent said that they have increased employee cost-sharing. Twelve percent said they've modified current eligibility requirements. Four percent said they modified post-retirement medical benefits for retirees not eligible for Medicare. Twenty-four percent said they've decided against improving benefits. Thirteen percent said they have reduced or eliminated certain types of benefits. Seven percent said they've reduced present benefits. Two percent said they've discontinued the health plan completely. Eight percent said they will curtail future wage increases and six percent said they would curtail dependent coverage. I think those are very telling statistics in terms of how companies are having a difficult time coping with the current problems and that any ill thought-out expansions of COBRA might have precisely the reverse effect of what is desired.

DR. CONWAY-WELCH: Thank you.

MR. CREEDON: May I comment a little bit on that? Thank you. One of the difficulties, I think, with the COBRA type legislation is that it puts the employer in a position of being responsible for people who are no longer employees. When it's an employee you can deal with that responsibility through

payroll deduction and so forth. But once someone is no longer on the payroll, it's a real burden. So you're saying that the employer for some period of time and some people would make it forever, I guess, is responsible for the health care costs of former employees. So it's a really serious problem administratively. I think this is what Mr. Klein is saying. Just the burden of keeping track of people. You take a large company where there are a lot of layoffs or whatever, and you have tremendous problems.

MR. DeVOS: Admiral Watkins next.

CHAIRMAN WATKINS: First I'd like to echo the remarks of my colleagues, Mr. Morgan, on what Allstate has done. You were kind enough to invite me to speak to your Allstate Forum earlier this year where you brought in so many executives. It was a very impressive group and that was at a time when this Commission didn't have a great deal of credibility.

And to you, B.J., for your willingness early on even while we were still on the rocks and shoals from outside perceptions, to invite us to come in and begin to work with you early on in the National Leadership Coalition on AIDS and to help open the doors and access to many individuals. And the continuing relationship we've had with you has been superb and you've been very helpful. We want to thank you for that.

Now, Mr. Klein, what I'd like to know is do you have a representative on the National Leadership Coalition on AIDS and if you do not, would it not be wise to consider that when you go back and have your people take a look? It seems to me the Chamber should be on that Coalition if it is not because I see in that Coalition a changing set of missions. At one point, perhaps, its mission was to raise awareness in the United States I think that this Commission has demonstrated its credibility in that regard and will help. Then the leaderhip Coaliton's mission is going to be carried out. So I see a changing set of roles where the private public partnership vested in such organizations, in this, not to in any way denigrate the individual organizations, but a cooperative coalition it seems to me to be the way to go. I don't know if you are a member or not, but I would certainly hope that you would be in the future because of the linkage with the small business and large business as represented by the Coalition.

MR. KLEIN: Thank you. We are not a member of the Leadership Coalition, although B.J. has been an invaluable asset to the U.S. Chamber in terms of the advice and information that he has given us. The U.S. Chamber's Board of Directors has essentially adopted a policy of the U.S. Chamber not joining other coalitions and organizations only because our scope and our mandate is so tremendously broad we get asked to join literally

hundred and hundreds of them a year. We are, however, on an informal basis trying to work collaboratively.

B.J. has been, as I mentioned, not only a great help to us but for example, at these Institutes for Organization Management, a continuing education program that the U.S. Chamber sponsors, we'll be providing a seminar on AIDS in the workplace, and we hope to make available the National Leadership Coalition on AIDS publication so that we can advise these companies and chambers of commerce of the existence of the coalition because we think they're doing such excellent work.

CHAIRMAN WATKINS: Mr. Morgan, you talked about confidentiality and I think we would, without any question, endorse all that. I didn't hear the next step, though, what happens in the business leadership when confidentiality is breached. That is, what is the corporate responsibility to the worker in the workplace? And let's don't necessarily focus on breach of confidentiality within your workplace. Say it takes place outside. The person loses their home and perhaps it's a small business and they lose their individual health insurance because there's no group insurance. Is there a court of resort for those individuals within the company? Is there a policy in your pamphlet that goes the next step that says there is a responsibility and there is concern because of the compassionate approach taken by the planning and the readiness for receiving a person in the workplace. Is that something that you have addressed and talked about in some depth to see if there isn't some help to be provided for the person who then is discriminated against in other ways?

MR. MORGAN: That's a broad question. I think we tend to look at benefits, first or benefit policies, and we normally go by our benefit policies. We veer away from those policies all the time, make exceptions for individuals, individual cases.

We try our very best to look at the circumstances and accommodate the employee because the employee is important as well as his or her family, and it tells other employees something about the company. We don't have a policy that says we will do certain things for different people. I think we look at each individual. The confidentiality outside the workplace, it's tough. I think knowing our work force, it would be pretty much handled by the other employees. And that's where I think the education and awareness of AIDS is developing with employees and management. An understanding of the virus, how it affects people, how it can be transmitted, will yield much more compassion.

The Fortune survey clearly showed that. The more senior management involvement, the more experience with AIDS, the more open and compassionate a corporation becomes. The more the

policies change as they get more familiar with it and as their senior management is more aware of it. So I can't give you an answer that says here is how we would react. I think it a very broad topic.

CHAIRMAN WATKINS: No, I think that would be difficult. I'm talking about do you recognize discrimination in the development of a plan within a corporation for dealing with the AIDS issue to take it beyond the confidentiality assurance. What is the corporate discussion that's gone on, how involved will they get in the attempts to assist that worker to the extent that's reasonable?

MR. MORGAN: I don't think it was really discussed as part of the task force. Not in any of the notes I saw. It's one of those areas that you are aware of but I don't think it was even discussed. Breach of confidentiality -- obviously, there are a couple of factors. One is the legal factor. The company does have an obligation if confidentiality is breached. There is some legal recourse the employee has about confidentiality.

And secondly, I think there is a moral obligation that if something the company does or someone in the company does something to injure or hurt another employee, that the company has some obligation. I think it's more of a moral obligation and I think it would be handled on an individual case. I don't see companies setting up a policy to handle each one of those things that could occur.

CHAIRMAN WATKINS: Well, the reason I raised it is we have to face the issue. We've had compelling evidence on the issue of discrimination and whether that breach of confidentiality has taken place within a medical context, which generally is not the case. It's usually some other way it comes out. But the individual is hurt by it and the fear of exposure is probably the major obstacle to getting on with -- data and all the other kinds of things that we talked about.

So we have to come to grips with it and it seems to me that corporate leadership which the political influence in this nation can bring to bear on state legislature a sensible approach to this kind of a set of issues. Unless you are sensitive in the workplace and work this same kind of issue, I don't see how the business round tables or their equivalent in the various states can come to grips with this issue and put the necessary pressure in the right way on the system to be responsive. There has been a hands off policy at the national level, really. People are afraid to get into it too far. And it seems to me that here is another opportunity in the workplace for corporate leadership to come together and find the sensible policies and influence public policy accordingly.

I think it's a very important issue and I didn't see it in your report and it just seems to me that that's a very tough and next step to take, but it seems to me it's time to at least debate it and see where it might end up among those same 150 entities that came together earlier in the year.

MR. DeVOS: Thank you, Admiral. Everybody is avoiding -- not avoiding, but walking on eggs about the real issue involved here which is cost. We have a long history of moving from an individual one time lived in a company town and was totally cared for to where government became more benevolent to where now they're trying to shift it back to business. Does anybody here have any idea what the corporate cost is going to be in education, health planning, increased costs in their health benefit programs? Did the Chamber do a study? Do they have a number?

MR. KLEIN: We haven't, although our research affiliate, the National Chamber Foundation, is planning now and developing a survey, again particularly directed for small and medium sized companies to get a better handle on their responses as well as their best estimates of the costs. In terms of insurance costs and others, we've certainly relied upon the expert information that has been issued, for example, by the Society of Actuaries and others in terms of the life insurance costs and others in terms of health insurance costs.

MR. DeVOS: In other words, you don't really have an answer either?

MR. KLEIN: We don't have our own specific numbers, no. But implicit in your question is a very critical point and that is the costs will be enormous. We don't have a fix yet on what they're going to be.

MR. DeVOS: Well, that's why I find everybody walking on eggs because nobody knows where that leads to and what the ultimate cost is. And for a little guy and a small business he'll go busted. All he needs is one or two cases that cost him $100,000, $200,000 and his whole benefit program is ruined. Whatever it is, because he doesn't have enough people to amortize it over. The bigger companies may be able to roll with it, but we're all trying to figure out who is going to pay the bill around here. And that's what this Commission is trying to help fathom out, too. Where is the balance and who has duty and responsibility. Any commentary you have along that line, long term, would be appreciated for the benefit of the Commission and our report.

MR. KLEIN: I would like to add to that point that although we certainly don't know what the exact costs are going to be in dollars and probably nobody does, we have tried to

advise our members to consider those costs when they're planning their benefit plans, for example, that they need to balance both their own ability to bear the costs with their desire and need to provide to their employees and their families certain protection. That's the whole purpose for those benefit plans.

Likewise, in terms of what types of benefits should be covered under a plan, what types of exclusions if any should be included, the relative merits of self-insuring, which can help them avoid certain costly state mandates versus the risk that would be upon them if they go that direction of self-insuring and understanding the implicit dangers of doing that.

I also just felt I would be remiss if I did not more completely respond to the question or the comment, rather, that was made by Commission Pullen in terms of the Chamber should show more courage in terms of what we might want to tell our member companies vis-a-vis the use of clean needles if the employee is a drug user.

Obviously, we don't look at that at all as a question of courage but rather as a matter of understanding that we exist to serve our members and not the other way around.

MR. DeVOS: Well, this is a beginning of a whole day session and, there are going to be a lot of people talking about various aspects of it and so we're just going to move on. Gebbie has one quick one she said and then we're going to terminate this panel.

MRS. GEBBIE: Well, it's really a follow-up to the questions that the Admiral was asking you in that whole area of discrimination. We have heard mixed testimony on the subject of whether existing statutes dealing with handicapping conditions are adequate to provide protection to persons with HIV infection. It's been interpreted various ways. Some states have laws. I would be interested in knowing the extent to which you have considered that issue and whether a new statute or revision to that statute could more clearly assure that this condition is covered would be viewed favorably by your membership or would be viewed carrying things too far. Have you looked at it and think the present statute is adequate?

MR. KLEIN: Well, very briefly, this is, frankly, the next step for the U.S. Chamber of Commerce in as much as our main mission really is legislatively and policy oriented, this is the -- those are the kinds of questions to which our health care council is next turning its attention. So I don't have a definite answer one way or the other.

I will say that there were some modifications made to the Vocational Rehabilitation Act of 1973 just within the last

couple of months as a part of the Civil Rights Restoration Act that passed the Congress. But the comments of both proponents and opponents of that legislation and the particular amendment dealing with modification to the Vocational Rehabilitation Act as well as other legal analysis seems to leave more questions than answers in terms of whether those changes modify, narrow or reverse the Supreme Court's decision in the Arline case. So I think regardless of how we come out, the courts and the legislatures are going to be dealing with the issue to try to clarify the question.

MR. DeVOS: Mr. Stiles, Mr. Morgan, Mr. Klein, thank you for coming this morning and sharing with us your insights in this great problem. And we wish you well in the work you carry on. And with that, we're going to dismiss this panel and move on to our next panel. Thank you very much.

MR. CREEDON: Mr. Chairman?

MR. DeVOS: Yes, sir.

MR. CREEDON: Could I make a comment just for the record, you know, supplementing in part what you were saying about costs.

MR. DeVOS: John, go for it.

MR. CREEDON: Because it seems to me that one of the greatest concerns of the business community generally right now, and this is aside from the question of AIDS, is the cost of health care for their employees. It's been skyrocketing, for a number of years. It's twice, at least twice the general CPI and it's an issue that, has to be dealt with somehow. So I think your comment is very, very appropriate and especially if there's an expectation that a significant part of the cost is going to be borne by the business community.

We need to understand that. Many of the sessions that I go to, that is one of the major issues, the skyrocketing costs of employee benefits and health care costs generally. I'm sure, Bert, you can echo that?

MR. DeVOS: John, and for the sake of everybody else here, we're going to be on -- in panel four we're going to be working on costs more today, John. And then we can pursue that whole subject with all of its unknown elements.

Workplace Polices: Development and Implementation

Our next panel this morning consists of Peter Bertschmann, Vice President, Human Resources, New England Telephone from Boston, Mass.; we have Anthony Herrmann, Vice

President, Employee Health, Safety and Environmental Affairs, Johnson & Johnson and a sailboat fame. Is that right? Okay. It doesn't have anything to do with your testimony, does it?

MR. HERRMANN: No, only the suntan.

MR. DeVOS: Only the suntan, all right. Sigrid Deeds. Good morning, Sigrid.

DR. DEEDS: Good morning.

MR. DeVOS: Doctor, senior advisor, AIDS Programs, American Red Cross in Washington and Henry C. Ryder of Barnes and Thornburg all the way from Indianapolis. I presume he's now the one who's late? Whenever it's in your town you arrive late. If you're from out of town, you really get here on time.

In any case, this panel is going to work on development and implementation. What you heard this morning in the first group dealt primarily with an overview from organizations that represent broad spectrums of business. In this group we're going to get down to very specific programs for very specific companies.

And, of course, we also have in this group a man I choose to save until last, that's Dwight Sawyer who is Vice President Human Resources of a company up in Ada, Michigan called the Amway Corporation. So we'll get a time in here this morning. And with that, Mr. Bertschmann, we'll begin with you.

MR. BERTSCHMANN: Thank you. Admiral Watkins, Mr. DeVos, members of the Committee, I do appreciate the invitation although I must say that I got a little nervous when you talked about terminating the last panel.

I'm the Vice President of Human Resources for New England Telephone and we're an operating company under the NYNEX holding company, one of the seven regional companies formed out of Bell System divestiture. We serve five New England states, Maine, New Hampshire, Vermont, Massachusetts and Rhode Island and we have 27,000 employees.

New England Telephone had a rather public learning experience about AIDS in the workplace beginning in the spring of 1985 and we did some things right and we made some mistakes. We're a lot smarter now and we should have been a lot smarter then.

One of our installation and repair technicians, Paul Cronan, an employee with over ten year's service, identified himself as having AIDS-Related Complex. One month later this employee went out on illness disability.

Our company at that time was just beginning to explore the issue of creating an AIDS policy. Senior managers from Human Resources, Legal, Labor Relations, Medical and Public Relations had met to discuss a number of issues about AIDS, among them the medical facts, the legal implications, the union issues and the history of our company culture. Within a month, that group had a policy recommendation that was accepted by the officers of the company, and that policy was and is:

"AIDS is treated like any other illness contracted by an employee. Accordingly, if an employee is diagnosed as having AIDS, but is not disabled from working, the employee can return to work. If an employee has work limitations, the company will make reasonable accommodations."

A couple of months later and in September of 1985, after an inquiry from Paul Cronan, the company notified him that he could return to work when his physician felt he was able. However, very shortly afterward his diagnoses was changed from ARC to AIDS, and the employee did not request to return to work at that time.

Paul chose to go public with his situation and with his unhappiness with our company, and in December of 1985 he sued the New England Telephone Company for beach of privacy, employment discrimination, and violation of his civil rights. He sought recovery for, among other things, emotional distress.

After an out-of-court settlement in October of 1986. Cronan returned to work. And by terms of the settlement, he did not return to his original work location. Rather, he went back to a location where he had worked for a number of years in the past. And based on medical recommendations, he returned to work on a half-day basis. Not untypical, by the way, for someone returning from a disabling injury in our company.

The employee's job as an installation technician required him, on occasion, to enter people's homes to do work. And I might add in going public, Cronan had been very visible on major Boston television stations. And although he wanted to work half days, he wanted and we wanted him to assume his normal duties as much as possible. And upon his return the company gave Paul Cronan the full range of assignments it gave to other installation and repair technicians.

Up to that point the company had dealt with the AIDS on the policy level, without really fully understanding the workplace implementation issues. And we had not yet learned the value of company-sponsored education efforts.

Because of the public nature of the case, we asked for and received permission from Paul to "condition" the work force,

that is those employees he'd be working with, before his return to work. Local union leaders, management and his coworkers were briefed on the situation and provided with facts on the disease. And while this was a good first step, it was not enough. Not nearly enough.

On Paul's second day back at work 29 of his coworkers walked off the job. Although not totally unanticipated, we had a labor relations and a media relations crisis on our hands. We needed a strategy to make our policy a reality, and we recognized we had to demonstrate understanding and compassion for all of the employees affected.

Our objectives were to get our employees back to work, to get out the media limelight and, to the extent possible, make sure that such an incident did not happen again. And we initiated a four-phase education program for about 1,000 employees in and around the area where Cronan worked. Local management team was involved at every step of the process, as were our union representatives.

The first day, we showed a videotape on AIDS in the workplace, produced by the San Francisco AIDS Foundation. The next day, two doctors, one selected by the union and one Cronan's own personal physician, visited the local workplace to answer questions employees had about AIDS and its transmission. Anxiety levels began to drop after that session. But our employees were still on the street.

As a next step, employees and their families were invited to an evening session at a local hotel. Again, doctors presented the facts about AIDS transmission and were available to answer questions. A number of spouses and a number of teenage children attended.

After that session, we felt somewhat comfortable that employees had had an ample opportunity to learn and understand the facts about AIDS and how it is and is not transmitted. And 25 of the 29 employees returned to work. For any employees who were still afraid, and there were a few, we offered voluntary individual or group counseling sessions through our employees assistance program and with professionals. They accepted the counseling and shortly afterwards the last few returned to work.

We made a decision not to withhold pay from the employees who had walked off the job, and that is not commonly our practice in those cases. By doing so we acknowledged our concern, I think, for all employees and attempted to avoid punitive or confrontational actions. We learned a lot of things during these events and they may seen obvious now, but I can assure you that they were not then. The first is not to assume that employees are getting the message from other sources.

And secondly, that one opportunity to hear the facts is not nearly enough. Repetition is key.

Third, employees' fears and concerns must be taken very, very seriously.

And fourth, employees need to have a chance to have their questions answered.

And finally, and most importantly, we learned that education, we think, takes care of 95 percent of the problem associated with AIDS in the workplace.

And although we made it through our first episode of workplace AIDS, we realized we needed to put in place a long-term effort to educate employees. An educated employee, we learned, is our best defense against another kind of incident.

As a first step, we sent a brochure on AIDS and its transmission to our 27,000 employees at their homes with a letter from our corporate medical director that explained the company policy on AIDS. The letter included a phone number employees could call in our medical department for more information. And it was a letter and a brochure that we wanted everyone in the family to read.

Medical department doctors have made themselves, and outside experts, available to talk to employee groups about the issue of AIDS in the workplace.

And our major educational effort began nine months ago when we asked area business leaders in Boston to join us in sharing their experiences about how the disease has affected their workplace. And last fall, that group became the New England Corporate Consortium for AIDS Education.

In addition to New England Telephone, the members include: the Bank of Boston, Bank of New England, Cabot Corporation, Daka Food Service, Digital Equipment, Lotus, Polaroid and TEXTRON.

That group agreed to fund production of a localized videotape about AIDS in the workplace and provide ancillary written materials, including a program planning guide and a manual for managers and supervisors.

Golden Green Productions, which won an Emmy for its NOVA special "AIDS: Chapter One," is producing the tape, and George Moseley, on the staff of the Harvard University School of Public Health is writing the material. And Doctor Timothy Johnson, medical director for ABC News, is our on-camera host.

Throughout our efforts we've also worked closely with Boston Aids Action Committee, the American Red Cross and the Massachusetts Department of Public Health.

When nine major corporations band together on an issue, you can leverage some action pretty quickly. And we wanted to deliver a strong message to our employees, other businesses and to the community at large. That message clearly is that businesses need to take responsibility for educating their employees about AIDS.

And if there's any other lesson to be learned here, it is that no business, and I mean no business, 27,000 employees or 27, has now a legitimate excuse for not having a clearly defined policy and educational program posed for the tragic identification of an employee with AIDS. Thank you again for the invitation.

MR. DeVOS: Thank you, Mr. Bertschmann and thank you for the willingness to admit errors made and corrective action taken. We find that very encouraging.

MR. DeVOS: We're going to move next to Doctor Herrmann, Anthony Herrmann, who is Vice President Employee Health, Safety and Environmental Affairs for Johnson and Johnson from New Brunswick, New Jersey. Doctor Herrmann?

DR. HERRMANN: Mr. DeVos and members of the Commission, we appreciate very much --

MR. DeVOS: Would you get onto that microphone, please.

DR. HERRMANN: Let's do this. How's that?

MR. DeVOS: That's better.

DR. HERRMANN: Mr. DeVos, members of the Commission, we at Johnson & Johnson very much appreciate the opportunity to review with you our programs and involvement in the issue of AIDS.

Johnson & Johnson is committed to the health and safety of its employees and family members. That commitment is written into our credo and is highly visible all around us in the facilities and programs of Live for Life. Live for Life is an active partnership of health related services within Johnson & Johnson that include assistance, benefits, medical, safety and wellness. This is a coordinated way of providing opportunities for our employees to become the healthiest in the world, which is the charter of that program, and to maximize the health and well being of our employees and their families on a voluntary basis.

This commitment cannot be met in the 1980s unless we are willing to join the effort against AIDS, and for that matter, alcohol and drug abuse as well. AIDS cuts across all segments of our society. It can be disruptive to our families, communities, schools and workplaces. Johnson & Johnson offices and plants are not isolated from it. It has caused everyone to rethink, at a very fundamental level, our attitudes with regard to life style and behavior and the appropriateness of the workplace as a site of educational intervention.

To meet this challenge, Johnson & Johnson has undertaken a comprehensive AIDS workplace program with five major components:

1: A corporate AIDS policy position statement.

2: A special Live for Life AIDS Education Program.

3: Benefit plan coverage-expansion.

4: Biohazards guidelines because we do deal with live virus in some of our research laboratories.

5: Public/community support, where appropriate.

Maintenance and protection of employee health is a policy of our corporation. Our AIDS policy position statement, however, complements this policy and addresses the rights to employment and benefits, confidentiality, testing, biohazards guidelines and educational initiatives. AIDS testing is performed only on a voluntary basis.

The Live for Life AIDS education program began with a special training session for all personnel managers, physicians, nurses, employee assistance and wellness administrators at each of our 72 operating facilities to educate and sensitize them to the AIDS issue. Awareness and education programs are also available for all employees. Many of these programs are available for family members as well.

Our employee assistance and medical departments provide opportunities for counseling. A variety of videotapes and brochures have been distributed. The HBO/Surgeon General's tape titled "AIDS: Everything You and Your Family Need To Know But Were Afraid To Ask" and the CDC brochure, "What You Should Know About AIDS" have been highlighted.

Last fall the National AIDS Awareness Test sponsored by Metropolitan Life was promoted through desk drops to every employee in the top 25 viewing markets in the country where this program was offered.

"News for Life," which is an in-house communication tool, the Life for Life newsletter, is distributed quarterly to each employee's home and has included articles on AIDS.

In terms of our health care benefit, the coverage was expanded to include voluntary AIDS testing and liquid autologous blood for transfusions for employees and family members.

In terms of community, Ortho Diagnostic Systems, one of our companies, received a special recognition letter from the Surgeon General Koop for supporting the printing and distribution of the Surgeon General's original brochure on AIDS. We participate as a member in the National Leadership Coalition on AIDS, which is a Washington based group that we heard from earlier this morning. In addition, we support the AIDS Research Foundation and were cosignatories of the AIDS ten principles proposed by the Citizens Commission on AIDS.

Active AIDS research is underway in several of our companies pursuing possible approaches to testing, vaccines and pharmaceuticals. Johnson & Johnson recently awarded a grant of $500,000 over five years to Johns Hopkins Medical School in support of constructing special research laboratories for that institution's AIDS research program.

As you know, the Robert Wood Johnson Foundation, although only indirectly associated with Johnson & Johnson, has spent $20 million on AIDS programs making it the leading supporter of AIDS programs among all philanthropies and corporate donors.

In summary, Johnson & Johnson's commitment in the area of AIDS in the workplace specifically and on a very broad scale generally has been comprehensive, sustained and complemented by appropriate policies and guidelines.

Johnson & Johnson's Live for Life program has provided a marvelous vehicle to communicate with employees and their family members regarding AIDS. And just a note about that program, it really was designed to focus on the health end of the spectrum as opposed to the disease end of the spectrum. Therein lies the philosophic base for our approach to prevention. We have been in a position to speak to our employees and families on lifestyle and behavior issues in many other areas. The ease with which we were able to approach the issues of drug and alcohol abuse and AIDS education was, as a result, a very simple task because the machinery was in place and our employees and families expected to hear from us on these lifestyle issues. This has been a very worthwhile experience within J&J.

Even with regard tothe issue of blood supply in the community and, to a greater extent, in our New York region (John

Creedon who headed up that until recently as chairperson), we have used the vehicle of our Live for Life program to promote the notion of a very broad based expanded participation in doing our best to help improve the communities' blood supply. In fact, we expect to triple the blood donor contribution of our employees and family members to the public community. The public blood supply has been impacted to some considerable extent by the issue of AIDS and the availability of blood.

We'd be pleased to answer any questions and consider requests for more information. Thank you very much.

MR. DeVOS: Doctor Herrmann, you along with New England and Johnson & Johnson have been leading the way. We salute you for that.

MR. DeVOS: Now we'll go to Dwight Sawyer from Amway Corporation.

MR. SAWYER: I have some slides to show. If I could have the first slide, please? I'm sure all of the Commission know everything about Amway from having Rich DeVos on that panel. And I appreciate the opportunity as a medium sized employer to come before this panel.

MR. DeVOS: They know more than they want to know.

MR. SAWYER: First of all, we designed our policy around life threatening illness rather than specifically AIDS. That's primarily because of the advent of AIDS growing impact on the population in general and the work force in particular. We did not want to single out this particular illness but to combine it with all life threatening illnesses. We felt that employees with any type of life threatening illness should be treated in a similar manner as it pertains to corporate policies and procedures. If I could have the next slide, please?

One of the main things we're interested in, of course, is fairness and that is how we design a policy. We reviewed available material from other corporations and w reviewed general publications on the subject and designed our policy around what we felt would be fair to all of our employees and consistent with Amway's philosophy. Next slide, please?

We recognized there had to be certain purposes as we dealt with life threatening illnesses. And one of the key points, of course, was recognition that there were various types and some of those you've already heard from from earlier panelists. Heart disease, cancer and AIDS, of course. We've also included in there hepatitis B because of the infectious nature of that.

We also recognize that there were certain needs of employees and the wants of employees and we had to design our policy around a framework where they would accept it -- all employees could accept it. This, of course, includes ill employees engaging in normal pursuit including work.

From a work treatment point of view, it was felt the policy needed to be -- an equitable work treatment for employees based on all categories of employees. Therefore we assured the policy contain guidelines on employees meeting acceptable work standards along with action for those who feel threatened. From a precautionary point of view, we furthermore felt the policy had to reserve the right to have employees examined if there was any question of safety or health problems existing that could impact employees, other employees, company products or its customers.

Next slide, please?

As stated, anytime there is a disease of life threatening nature that is relatively new, such as AIDS, there are a lot of myths, misinformation and misunderstanding as it pertains to the population in general and, of course, employees in the work force in more specific manner. Therefore, one of Amway's first approaches in this policy was developing a sound communication program.

Amway is somewhat unique in this category since we have a 700 seat auditorium and we hold monthly employee meetings. Beginning in late 1986 we started covering in some of these meetings points concerning AIDS. Rich, being a member of this panel, of course, has participated in covering some of these aspects of AIDS with our employees.

We have continued in these employee meetings by having films on AIDS that we feel are very frank and to the point. One of them happened to be a "AIDS Alert" which was done somewhat in the cartoon format rather than individual format and it was extremely well done but very frank and, as I said, to the point. The whole idea is a continuing education concept.

From our management point of view after we developed the policy, we held a very long meeting on this subject, went through the policy with them in detail and in that meeting had Doctor Richard Tooker, who is currently the Chief Medical Officer of Kalamazoo County and is recognized as knowledgeable on the subject of AIDS in western Michigan, make a presentation and answer questions that came up from the management group.

After that meeting we held a special employees meetings for all of our employees and we divide those up so that we have them on each of the three shifts where we have employees.

In that meeting we, again, went through the AIDS policy with our employees and then we followed that up with a presentation by Doctor Tooker much along the same lines that he covered with management with questions and answers in that meeting being given by the doctor.

We have developed a small library of information in our corporate library, information on AIDS including videotapes, pamphlets, publications, articles about the subject that employees can check out. We have a pretty sizeable corporate library with a video library included as part of that. The whole purpose behind that is to give them the opportunity to find out more about the subject so that they can understand it better.

We also have given out to the managers a publication entitled "What A Manager Should Know About AIDS In The Workplace" to further give them data that we feel would be important for them to help answer basic questions on the part of their employees.

Next slide, please?

Now, another point we felt to be very important was reasonable accommodation. This was a part of the policy we felt employees had to know what they would have in the way of opportunity for the corporation to make reasonable work accommodations within the confines of availability of business need.

We specifically included in the policy provisions for employees with a life threatening illness the opportunity to transfer into other positions if, and I emphasize the word "if," they requested. It would not be requested by the corporation.

For other employees we took into consideration that they may feel threatened and therefore have established an opportunity for them to seek transfers, however those transfers are based on the normal transfer procedures of signing for open vacancies.

We also recognized as one of the previous speakers noted that there can be points where employees feel threatened and therefore refuse to work with a fellow employee who has a life threatening illness and they walk off the job. Contrary to the approach that the previous speaker took, we would deny them pay for that period and if it became a major issue for us, we would look at it from a point of view of corrective action if that became necessary.

The policy up to this point contains information on how things are going to be conducted. We next felt we had to cover more specific information.

If I could have the next slide, please?

One of those points was information on who to contact. We felt employees had to know specifically who they could contact for specific information. This would include our medical department and our HR administrators who are being trained to answer basic questions on the subject of AIDS and other life threatening illnesses and also they could go into the library and get some of this other information that would be made available.

The reference to what is available, of course, the library is there and, again, we emphasize the medical department. We have listed the number where people can call anonymously if they wish to do so to find out more information concerning this subject.

It became very important to us to recognize that psychologically many employees need help in any life threatening illness situation which, at times, can be better provided through outside agencies. One of our major referrals is an employee assistance program wherein the employees can be referred without the corporation having any direct contact or feedback, thus maintaining the confidentiality of the employee.

Of course, anytime somebody had a condition of this nature we feel it's necessary for them to have access to knowledge as to what benefits they're going to have available to them from short term and long term disability as well as medical coverage. Therefore we publicize that type of information to them.

The next slide, please.

We also recognize that sensitivity is a very critical thing in a situation like this. Sometimes if an employee is in a life threatening situation the job can be a very strong motivating factor for them to feel they're productive people to the community and to themselves. We feel that is critically important for us to keep that in mind anytime somebody encounters something of this nature.

Next slide, please?

Confidentiality is something that is critically important and you've heard others talk about that already this morning. As a result of this, we have set up a procedure wherein we have what we term a "Need To Know" committee. That Need To Know committee consists of representatives, one representative from medical, one from legal and one from human resources. This committee is very confidential. They will not allow information to be passed on. They will guarantee the information being kept confidential unless the employee has already disseminated such

information. The committee can also act as a reference source on referrals dealing with such things as reasonable work accommodations, benefit coverage, et cetera that we've already covered. The committee also has responsibility from a safety aspect to make a determination as to whether any other member of management need to know the information concerning the illness of the employee because of the products and the safety of the employee and other employees or the products and our customers.

Next slide, please?

We have made some recommendations recognizing that we have had this policy for a relatively short period of time based on the information that we have developed thus far. We feel that the policy should be general dealing with life threatening illness i.e. some other broad base illness rather than just a specific one.

We feel communication is extremely important, as already noted. Communication should be in the form of meetings, should be in the form of publications to the employees at work and also to the home for their families and also access to information such as a corporate library.

We also recognize that anytime there is a new disease identified such as AIDS, we will have to change our policy as time passes as more information is developed on this and therefore the flexibility of a corporate policy must always be there to recognize these changes as and when they come.

Again, we appreciate the opportunity to make this presentation before this panel. Thank you.

MR. DeVOS: Thank you, Dwight.

MR. DeVOS: Doctor Deeds? Doctor Deeds is with the American Red Cross from Washington.

DR. DEEDS: Mr. DeVos, Commissioners, I appreciate the opportunity to present the American Cross AIDS prevention program this morning. My background is in public health and behavioral sciences and I specialize in large scale educational change programs and their evaluation. And as such, I serve as a full time advisor to the Red Cross AIDS program. This is another side of the Red Cross, the non-blood side of the Red Cross in education and training. And you may not be aware of the fact that we provide the largest adult education training system in the country. In 1987 we gave over 7 million certificates in health and safety training. And these are delivered by about 500,000 volunteers and staff in the American Red Cross. So the AIDS program stems from that kind of background and experience.

The Red Cross moved into our blood donor education in 1983 and from there into a broad public information and AIDS program in 1985. We're now -- because the rate of awareness is higher, we're now honing that broad information program into much more intensive educational effort and we're aiming at three priority groups: youth, minorities and workers in their places of work.

We have a long list of materials printed, audiovisuals and so forth which we would be happy to provide maybe if you're interested in them. And, incidentally, some of them are aimed at our young people in high schools and several excellent audiovisuals in that area.

Our work place educational program is called "Working Beyond Fear," and it's now available from Red Cross chapters in all regions, which means that someone from Houston can get the same information as someone from Lancaster County, Pennsylvania or in Indianapolis.

The purpose of the program is to provide factual information to employees about the high risk behaviors related to AIDS so that they can take appropriate action to avoid exposure to the virus. It is also intended to allay fear about working with persons who are HIV positive.

The chapter contact person works with the employer's representative to customize the presentation to the specific business. This is important because there's great variability in workplace settings; organizational cultures you've already heard about this morning, the education and interest, the levels of experience with AIDS. We're now talking about the whole country and you know that the levels of prevalence are much different and the experience that people have already had with AIDS varies a good deal. So we're trying to maximize the flexibility of this program while still retaining a standardized core of accurate information so that we can insure the quality of the program.

The recommended format is a two-hour workshop, minimum of two hours, conducted by a trained Red Cross facilitator. This includes a 30 minute video version of "Beyond Fear" and several video case studies. These are designed to trigger discussion by the employees around all of these kinds of issues, relationships, contacts with coworkers infected with HIV, confidentiality concerns, management responses.

We also encourage access to all community resources so that they can get additional help and follow-up after the program. We provide these programs at various levels throughout organizations. Certainly starting out with the management with the benefits and resource people and so forth and then working down to the employee level is important. And it's in the process

of designing these that we often discuss policies and give employers resources in terms of helping to shape their policies. And we've used a good many of the materials that have already been mentioned this morning.

The fees that are set by the chapters recover the costs that are incurred in providing material and the manpower. There's variability across the county, but an average charge is $150.00 for a workshop for 30 participants.

Examples of the scope of chapter workplace AIDS activity are the programs that were conducted by the Atlanta chapter staff and 202 volunteers. In one year half of their 333 programs that were delivered were to businesses and industries in Atlanta, Georgia, and this included corporations, utilities, a motel chain and federal workers.

The West Chester, New York chapter found that there was more demand in their area for middle size companies such as manufacturers, nursing homes and so forth. They noted that the large scale corporations used their own medical departments and training capacities to provide AIDS training internally, so that we were really providing more education for companies of 500 and less employees.

Some of the barriers that we have discovered in this chapter experience is that AIDS is not given high priority by many companies and this point was well made in the Allstate survey. Providing company time for education is costly and the returns may look at the time as very indirect to the employer. So the companies with hourly wage employees are particularly reluctent to release those employees for these programs. And we find that utilizing the employee time, such as lunchtime and breaks and so forth which is kind of a social occasion often, is not sufficient time nor the proper place to provide an effective intervention.

The size of the company is not necessarily a factor. One of the Red Cross AIDS managers on the west coast has served work places that range from ten to 27,000 employees and she notes that the attitude of the senior management is really the critical factor in terms of the success of the program. and I think this has been demonstrated this morning, too. The potential benefits of a quality AIDS education program range from an immediate general sense of improved morale to an increased knowledge and attitude shifts. We hope they predispose persons toward the behaviors that reduce risk and therefore could reduce the spread of HIV infection. And we do have some preliminary data on our program.

The education about the characteristics of the HIV virus, its transmission routes, patterns, can also lead to the

acceptance of the notion of the non-contagious aspects of this virus. This brings about a compassionate concern for those who are HIV positive and we feel this is the basis for avoiding work site crises and panic.

As also has been noted this morning, employees are not only workers but they're family members and members of the community. They volunteer for churches, school boards, members of service organizations and social groups and they give blood. And thus, the AIDS education program has a ripple effect throughout the -- way beyond the employee's workplace. And just as the employees represent other relationships, educated employers in their roles as community leaders, opinion makers, influences of legislation and resource allocators and philanthropers is a very important aspect of this. Education has an environmental aspect and the whole community's acceptance is a very important part of reenforcing education.

We have made a series of recommendation to you that are pointedly about the quality of educational programs. And I must say that I think the actual content and method of education needs to be addressed very strongly in these kinds of hearings because most of our attention has been focused, I think, on other things.

The cost of initiating workplace education includes both the cost of providing the service, which we previously mentioned, and the cost of the time of the employees along with the cost of the employee time and the planning and the follow-up that was assumed in our previous presentations. And this various from company to company. But this cost must be balanced against the incalculable cost of the loss of productivity, work stoppages, adversarial relationships between management and employees and the possibility of litigation which can occur if the employees are left on their own to do their unsystematic ways of gathering information and opinions about this unprecedented epidemic. Thank you.

MR. DeVOS: Thank you, Doctor Deeds and to the Red Cross for continuing to lead in this field.

MR. DeVOS: Mr. Ryder, all the way from Indianapolis.

MR. RYDER: All the way.

MR. DeVOS: Legal counsel, I believe.

MR. RYDER: Correct. As Hoosiers we welcome this Presidential AIDS Commission to Indianapolis. The Mayor, who will be on your panel later, will give you a more proper welcome and introduction and he does it very well. But it's a pleasure to be before you.

I shall try not in these remarks to be repetitive of what I have included in my pre-submitted written testimony, except to call attention, as a way of summary, to the five guidelines for employers found at Tab 10 of our written testimony. They are, in a way, a condensation of some of the ten principles you've heard before.

One, that employers should deal with employees who are AIDS victims the same as they would with employees with other serious or life-threatening illnesses.

Two, employers should adopt a written policy on dealing with AIDS in the workplace. They should exhibit a strong commitment to that policy and train management and supervisors regarding the policy.

Three, that employers should embark upon an educational program not only to employees about risk reduction in their personal lives, but also particularly in areas where there are special occupational settings where employers may be exposed to blood or blood products, to provide on-going education and training as well as the necessary equipment to reenforce appropriate infection control procedures and insure that they're implemented.

Four, to protect the confidentiality of all medical records of employees who are AIDS victims.

And five, except in unusual circumstances where the occupational setting requires the employee to handle blood or body fluids, not to screen current employees or job applicants for AIDS.

These five guidelines or variations thereof are what we as lawyers in employment law are advising employers, both directly in the lawyer/client relationship, and in seminars which are proliferating throughout the country. For AIDS in the workplace is the hottest of the hot issues in employment law today.

A bibliography this week in books, pamphlets, videos and educational materials is incomplete next week.

Policies, samples of which I have included in our pre-submitted material and which you have seen demonstrated here today by the other panelists, are being urged upon employers with the direction "Adopt one." "Commit to it." "Educate your work force." That is what we are preaching.

What I am going to recommend now to this Commission is not what we are telling employers. The recommendation will be controversial for it would mean a change in the law as it has

been interpreted to date. Nevertheless, I think this recommendation needs to be made, for it needs to be debated, and the underlying problem needs to be addressed by this Presidential Commission.

My recommendation is this: That the Presidential Commission recommend the adoption of legislation to permit pre-employment testing for the AIDS virus and to exempt an employer from liability if the employer refuses to hire because of a positive AIDS test.

Now let me explain this recommendation and justify it before I get hit with allegations of being unfair, discriminatory against the AIDS victim and lacking in compassion.

First, it is not a recommendation that would alter any legislation that protects an existing employee who either is or becomes an AIDS victim. And I use that term AIDS victim in the broadest sense, including a person who has tested positively for having HIV. The recommendation applies only to applicants for employment.

Secondly, if the employer is to be saddled with the cost of insuring existing employees who have or contract the disease, a cost for which estimates range from $75,000 to $150,000 per AIDS victim, not including lost production time from AIDS victims who contract and miss work because of opportunistic illnesses, is it fair to require that employer to hire persons as employees because they are infected with the AIDS virus? Doesn't the fulcrum of fairness tip the scales the other way when it comes to the employer's obligation to hire applicants for employment?

The issue as pointed out earlier this morning by you, Mr. DeVos, is one of cost. Should the employer bear the cost of paying increasing insurance premiums and lost days of production for non-employees who are AIDS victims and who seek employment? For many marginally profitable employers and small businesses, the answer to that question, if "Yes," will spell bankruptcy or closing. And who benefits from that result?

I am suggesting by this recommendation that the Presidential Commission on the HIV epidemic come up with some alternative recommendation for the unemployed AIDS victim rather than tell the employer, as the law has been interpreted to date: "It is your responsibility not to discriminate against the handicapped AIDS victim who applies for employment." All of us, not just the employers and not just the AIDS victims should bear the cost of this epidemic until the cure or adequate defense to AIDS is discovered. I rest my case.

MR. DeVOS: Thank you, Mr. Ryder. **MR. DeVOS:** And with that we're going to go to Doctor Primm down in that corner and --

DR. PRIMM: I'd like you to come back to me.

MR. DeVOS: Okay. Let's go right back to Colleen.

DR. CONWAY-WELCH: I'd like to ask a question of any of the panelists regarding the educational programs that they have in place. What kinds of attempts have been made to evaluate the effectiveness of those programs in terms of the cost benefit ratio? How do you know that what you're doing is working?

MR. BERTSCHMANN: Well, I'd have to -- first of all, we don't consider the progress we've made so far in our education program adequate. And the major effort, as I indicated, is on going as part of the consortium. I'm not sure this is an adequate answer to your question, but --

DR. CONWAY-WELCH: There may not be one.

MR. BERTSCHMANN: We have -- I would give you an example of what I think has helped. We have knowledge of two other AIDS cases and in one case employees are aware of it. It follows a rather basic educational program and there has been no problem whatsoever. That's a very limited instance but it does suggest that even basic education can neutralize a situation.

DR. DEEDS: I'd like to respond to that in terms of our program. We've measured pre-test/post-test knowledge gains. We've measured changes in attitudes and also stated behavioral intention, which is about as far as you can go in the immediate -- in the immediate time zone of providing the program. What we would like to do is to follow-up over a three to five year period and look at many of the kinds of indirect benefits that we assume would come from an educational program and so some quasi experimental design. Unfortunately, those kinds of research programs have not been funded to any extent in the AIDS field. We can cite programs that have been funded in many other places in health promotion programs, cardiovascular disease, smoking programs, et cetera and so forth. And Johnson & Johnson have been leaders in longitudinal data collection for cost benefit effect. That's very expensive, it's long term and it needs to be done. And that's one of the recommendations that we had included in our group and I hope you take -- I hope the Commission takes that up.

MR. DeVOS: John Creedon? We'll come back around if we can. We going to kind of go fast once.

MR. CREEDON: I would like to supplement what has been said, especially about Johnson & Johnson and the fine work you

all have done under Jim Burke's leadership. I think it's exemplary. I'd like to pursue a little bit the recommendation that Mr. Ryder has made and I understand the reason for it. But it seems to me one of the problems is that someone who gets the virus might be asymptomatic for 12 years, so what does society do? I mean, do we not employ somebody for 12 years?

I wonder just whether you might think of an alternative that just occurred to me as you were talking. This is clearly a societal problem and the question is how do you deal with it as a societal problem. One alternative would be to somehow find a way of supporting the employer financially if they are obligated to take somebody that has the virus rather than say you're not going to employ this person. Because there are a million and a half people out there with the virus and, as you know, some of the estimates are even higher than that. And the average period of being asymptomatic may be five, seven or more years, just a societal matter to say well you don't have to employ them, who is going to employ them and what do they do?

MR. RYDER: An excellent point. I intentionally put the recommendation in its starkest form to really draw your attention to it because at the moment it is the employer that bears that responsibility. I suppose it could have been even more stark had I said just eliminate discrimination laws entirely as it relates to employees as well. But I don't think that's right. I don't think that's fair.

I think there is a loyalty obligation that you owe to your employees that the handicapped discrimination laws and the ERSA laws apply and properly should.

I think that when you're talking about applicants for employment, we now, as the law is interpreted, direct the employer not to discriminate against that applicant if the applicant has the AIDS virus. Now I have a feeling that many employers are probably skirting that issue by saying, "Will you consent to an AIDS test? And if the employee -- or applicant refuses to take the AIDS test, as they very well may refuse, then that gives the employer the out.

On the other hand, if the employee consents to take the AIDS test and then if that is used as a reason for not hiring, then the employer stands subject to litigation and has the obligation, at least as the law is interpreted to date under handicapped discrimination laws, to hire that employee and to bear the consequences under its health insurance plans for any future risks that arise.

I agree with you. I think there must be some method. If you're going to tell the employer, you must hire an employee who has the virus, then there should be some sharing of the

costs, whether that's some form of indemnity, whether that's some form of catastrophic insurance until a cure or an adequate defense to AIDS is discovered. It's something that I hope will generate the kind of debate that is necessary. But it is unfair, I think, at this point in time to require employers to treat applicants for employment the same as they treat employees.

MR. CREEDON: Well, I wish you would give this matter further consideration because I think your proposed solution is not a feasible solution. On the other hand, I think there's a problem here and I think, how do you deal with the problem in a way that is feasible and acceptable politically and otherwise? I think it would be helpful if you or anyone that you happen to be working with in this area would give it further thought because, the problem could be much more severe as we go down the road.

MR. DeVOS: Thank you.

DR. LEE: I was going to yield my time to one of my business colleagues until I heard Mr. Ryder. And thank God Mr. Creedon came in before I did, because he cooled me off a little. There's no way that that proposition of yours will ever be proposed by this Commission.

John Creedon pointed out some of the problems. First of all, people can be positive for this virus for a decade and not be sick. What are you going to do with them?

I work in a cancer hospital. I take care of people with cancer and this is one of the -- really one of the most tragic things that I have to deal with is that if people tell the truth, even though they may have been cured of cancer, generally they will not be employed. It is probably in the course of their illness the most devastating thing that happens to them because like AIDS, they go down the tubes financially, insurance-wise, family-wise whenever you put this kind of pressure on people who are also sick, they deteriorate. Husbands and wives go to pieces, the kids go to pieces and it's a tough show.

If you were sick with the HIV virus, the doctor for the company is going to pick that up. If a company wants to say we're not going to hire you if you're HIV positive, that's their business. But for us to put through a thing saying that across the board this should be legislated? Holy mackerel.

I'm left without any words, really, and I'm going to tell you that it isn't going to happen. We're going to have to do something else. I hope we'll edge into it. I hope that these people at this end of the table will help us do it because Mr. Bertschmann, that story was a tremendous story. You treated a guy who really did a number on you like Jesus Christ would want us to treat someone.

So I have to commend you tremendously and I hope that these people at the other end of the table will solve this problem. And we are willing to work with you to do that.

MR. DeVOS: I'm just going to go on down this end and we'll pick up Frank down there.

DR. LILLY: I wanted to ask Mr. Sawyer just briefly. I was interested in your concept of a need to know committee. And I didn't grasp entirely what it was about, how does it fit into the overall context. And also, if you could give us a couple of examples of cases that it has dealt with.

MR. SAWYER: Well, need to know committee is a committee to protect confidentiality of the issue with the employee. And that committee is designed -- frankly, it's just been designed as part of the policy and it has not been called on as of yet because we have not had any cases that have come before it. But it is primarily a confidentiality committee. Try to maintain the confidentiality of a life threatening illness of the employee.

DR. LILLY: How does the committee come to possess the knowledge then?

MR. SAWYER: Because the committee is designed and publicized as being a contact point for anybody who wants to have some further information and kept confidential.

DR. LILLY: I see. So in a sense this is an advisory committee for the individual who is HIV positive?

MR. SAWYER: Yes. Yes.

DR. LILLY: And who wants to --

MR. SAWYER: Or any other life threatening illness that they feel like they want to keep confidential.

DR. LILLY: Okay. I would just pick up on what has been said in response to Mr. Ryder that I took it for a while that you were a very strong advocate of the welfare state since you're putting an awful lot of people on the dole for many, many years at a time. And I was thinking that maybe given that propensity of yours to think in that way, you might want to propose, instead, socialized medicine.

MR. RYDER: No. The issue that -- let me put this is perspective. I made this recommendation, and I thought I made this clear in my remarks, to address your attention to a cost problem. It is a cost issue. And at the moment, even though Doctor Lee made the statement that if someone tests an applicant

for employment and they test positive with the HIV virus, he felt that it was within their right not to hire that person, that isn't the way the law is interpreted today. It is the obligation of the employer to hire that person. Or to say it a different way, it is the obligation of the employer not to refuse to hire that person because the employee tests positive for AIDS, and then subjects the employer to liability and all of the sequential problems and cost problems that are involved.

The only point I'm trying to raise to you today is that it is unfair to attach that cost obligation, which can be tremendous, to the would-be employer that the applicant picks out and says, I want to work there.

Now, I think that it is entirely possible and probable that some solution to help indemnify or to insure the costs so that that person can be employed by that employer that he or she wants to work for. But the present state of the law is, that employer bears the entire cost of that applicant who seeks employment from that particular employer.

If it's a small employer and if that employer should be unlucky, you're going to have the employer go out of business. And what good is that for anyone? So there needs to be a solution to this problem and it doesn't have to be the solution at the other end of the table, even though they represent large corporations. There are many small corporations in this country that are affected by the cost issues and will continue to be affected by the cost issues involved in AIDS in the future. And it's to those that I think that this recommendation is made. To attract your attention to a problem is what I have attempted to alert you to today.

MR. DeVOS: Thank you.

Ms. Gebbie?

MRS. GEBBIE: Just a quick comment to that. You certainly succeeded in getting the attention of the panel. I think it's less than helpful to give us a cost problem with a legal solution that goes a different direction. I would at least have been more helped with some cost proposals that might have spread the burden differently, which I think you've just stated is really your underlying concern. And so if you have some further thoughts on the cost issue that would be helpful, I would appreciate receiving them, perhaps at a later date.

My broader question to the whole panel, but particularly the three gentlemen at this end, the Commission has found for the society as a whole that this epidemic has surfaced many problems and provides, as several people say from time-to-time, a window of opportunity to correct problems that have been

around a long time, problems of confidentiality, problems of a confused illness treatment system. Has that been true in the business setting as well? That is, has the process of looking at what you found about this infection led to critiques of other issues as it affects your businesses or your personnel management policies and move us in a broader sense toward something improved? And if so, could you share comments in that regard?

MR. SAWYER: I think personally that it has made us more aware of the whole subject of life threatening illnesses of every nature and therefore we have designed a policy that we did not have before as a result that has tried to be a treatment -- a fair treatment program for all employees. So it did make us aware of an issue that we had not really paid as much attention to as we should have in the past.

DR. HERRMANN: I know that within Johnson & Johnson and the Live for Life program that we certainly paid a great deal more attention to the sensitivities surrounding the AIDS issue. At the front end of that program all of the management team that would be likely to interface with this problem likely to deal with it were specially trained.

So it did move us in that direction.

MR. BERTSCHMANN: We had set up some interesting discussions, around the issue of privacy, between legal and our medical people. They're still thrashing around with those. We need some help still with that. But let me give you a real example that involved this case that demonstrates how the whole issue of privacy -- how the issue has been escalated in our minds.

If you can picture a foreman in a large organization who is used to having employees return from medical with a statement that says "return to work" or "unable to return to work" of with "return limitations", and that's all, for some historical and continuing privacy reasons, think of the foreman who now has somebody return to work with AIDS who has been diagnosed with AIDS. And who in 99.9 percent of past cases finds the employee, obviously, very willing to discuss why he or she is going to be out. And I can tell you that the issue of privacy better be addressed or we will be placing more people like foremen who are used to having employees voluntarily tell them the nature of their illness and having, by the way, local supervision probe without much fear or concern. Not out of a lack of sensitivity as to what the nature of the illness is.

And in our case I can tell you we placed our local supervision in a difficult position in the absence of a very clear educational program and information on privacy and what it means.

MRS. GEBBIE: When you say address privacy, do you mean by education, by policy or by statute in some way?

MR. BERTSCHMANN: By education. By making it very clear to our supervision that --

MRS. GEBBIE: That's what I thought you meant.

MR. DeVOS: Cory?

COMMISSIONER SerVAAS: I apologize for missing part of the meeting. I had an emergency.

But I want to tell our panel members about Henry Ryder. He's a brilliant labor lawyer -- attorney in one of the largest and most prestigious law firms, maybe the largest, in Indianapolis and has an implicable reputation in his field. And I just want all you panel members to know this because he's known for compassion and his civic mindedness in the city and he gives unselfishly of his time and he does take care of the sick and the poor through the Presbyterian church and he's an outstanding member of our community. And so I don't want you to all think that he isn't right on target when he throws out a suggestion.

I'm sure he didn't do this without a lot of foresight and he knew that it was going to be controversial, I'm sure. But he wants us to think about it. And I wouldn't -- I don't know. about labor laws, but I know about small businesses. And I heard what Henry said about it could be bankruptcy for small business who had the misfortune of getting one AIDS applicant. And if they had two or three, you large corporation people wouldn't understand that because you can absorb. So I think Henry has represented some small businesses and he knows very well how devastating from a cost standpoint.

Now, maybe those who know they're AIDS positive should not go to small businesses. They should go to you large corporations. I don't know how to answer this. If it's a matter of costs.

But I have a question to Henry Ryder and that is, it recently came to my attention that a man couldn't fly a commercial plane for a small company where they charter because he had gone -- he had become insulin dependent in his diabetes. And it matters if you take insulin, you cannot fly a plane. If you don't take insulin, you can. You can have diabetes and fly, but not if you are on insulin.

Now, those are personal things and the employee would keep it to himself and his doctor, but he'd need to not be flying. My question is, are there very many instances like this where if we're making this exception on AIDS that we would make

on diabetes or other illnesses that you labor lawyers see where for the protection of the public the -- it's necessary for the employee to divulge that he's gone on insulin or that when he applies for a job, to say that he is. How does that effect what we can do or can't do in AIDS?

MR. RYDER: Well, that's a different situation because the person on insulin would probably not be regarded under the Arline decision as handicapped. And what puts the AIDS person in the handicapped category is the determination that it is like the tuberculosis problem that arose in the Supreme Court's Arline decision and the determination that that was a handicap and a protected handicap, thus the discrimination question.

But there is also -- there is also a provision in the ERISA laws that provides that you can not make an employment decision if the purpose of your decision is to deprive an employee or an applicant for employment from enjoying the benefits of your either your health plan or your pension plan. So we do have those two laws that apply.

The thing that I think that makes AIDS a distinction even from other life threatening illnesses is the fact that it is of epidemic proportions. No cure or even no adequate defense so far has been found. And the recent statistics that I have seen are that those who are infected with the virus will either develop AIDS or the AIDS related complex, 75 percent of them at least, within six years. So you're talking about a problem for many small businesses who have health insurance programs or even who don't, and this may be an indication to many of them that they should not have health insurance programs if they are under this obligation, that could mean survival of the business. And with other employees out of work, then that presents a problem.

An answer needs to be found, but the answer needs to be directed at the cost allocation. And at the present time the cost allocation is placed not only upon the employer for existing employees for AIDS victims, but also for applicants for employment. And I think that a solution needs to be addressed and a recommendation needs to be made by this Presidential panel on who should bear those costs until a cure or an adequate defense for AIDS is found.

COMMISSIONER SerVAAS: Henry, if you --

MR. DeVOS: Sorry. We got to move on. I'm not going to get into a debate. We're going to move and we're going to go to Theresa. Thank you.

DR. CRENSHAW: The Red Cross is a really widely distributed source of tremendous amount of information on AIDS in recent years and in particular, before then on the blood supply

in general for our community at large, particularly for the general public and physicians. And now you're moving in with some really superb programs it sounds like in the workplace as well. What I am curious to know is to what extent in these programs do you include information about autologous blood?

DR. DEEDS: I heard your comment yesterday and I was a little surprised because our focus is really on contagion and on high risk behavior. One of the reasons that we urge an education program rather than an information program, and by that I mean an interaction so that there's time for questions and answers and responses, is that it's in that follow-up period that employees ask the kinds of questions that they are most interested in. And quite often they will be about the blood supply and about autologous donation and so forth. And so it's at that point in that educational program that we're able to deal with that kind of information.

We do have materials on safety in the workplace, your job and AIDS, the safety of the blood supply and autologous donations and so forth. So it does come out, but it's not the major focus of that particular two hour program. Hopefully, we'd like to have time to follow those up if we had more time in the workplace.

I think that your concern about autologous blood donation is reflected by our concern and that it is beginning to be more and more used by the blood regions. There are variations in the blood regions in terms of how they have worked with autologous blood.

DR. CRENSHAW: I have seen some changes emerging that I think are very promising. And yet one of the catch 22s that I think needs to be highlighted is that when you talk about autologous donations, that refers primarily to predonation of blood and the catch 22 is that since most of the general public has never heard of interoperative autologous transfusion, they don't even know to ask the question. So if it isn't raised, it won't come to their attention. And one of the concerns that I have in terms of the opportunity to get this information across is that, obviously, it does compete with selling hemologous blood and we don't want to put you out of business. Nobody does. On the other hand, the information is part of the overall spectrum of blood issues. In your opening statements you were talking about the universality and the neutrality of the Red Cross and so forth. Does this put you in any difficult position or has the Red Cross figured out how best to negotiate this territory?

DR. DEEDS: Not to my point of view it does not, no. We have the blood and the non-blood side of the house and you might get different responses from other people in the

organization. But as far as we know, we think this is an important issue.

I think the whole issue of donating blood requires a very massive educational campaign. In our analysis of public opinion polls 94 percent of the people are aware of AIDS now, but the misinformation is enormous and particularly in blood donation it's growing. So I think that all of the issues that you raised are a part of another needed kind of public education campaign on blood donation.

MR. DeVOS: Thank you, Theresa. Doctor Watkins?

DR. PRIMM: You were to come back to me, Rich.

MR. DeVOS: Okay.

DR. PRIMM: Mr. Ryder, there are a number of disease entities that require intermittent hospitalization and certainly increased health costs, not the least of which is multiple sclerosis. You did mention the ERISA act today, and you talked about it relative to an applicant and an employee. I thought it only -- that act only applied to employees, not applicants.

MR. RYDER: You're correct in that. You're correct.

DR. PRIMM: Well, you mentioned it in relationship to an applicant. The other thing is, if that's the case and you are representing smaller companies, that is the first part of what I just said in terms of many chronic disease entities including cancer and Bert talked about that, multiple sclerosis, hypertensive cardiovascular disease, unquestionably other kinds of cardiac problems where people can work but the disease is chronic and is really never really cured. Do you recommend that examinations for applicants for employment include tests for heart disease and cancer and those people also be excluded for employment because of the cost that is going to either raise the insurance cost for the group plan for that particular corporation or whatever it might be in terms of problems created for the employer?

MR. RYDER: No, I am not.

DR. PRIMM: Well, then, you know, it bothers me because all these disease entities, any of them eventually lead to death. You predict maybe ten years from time of infection to death for people with HIV infection. How do we know how soon a person is going to die from leukemia or cancer or multiple sclerosis or one of the other chronic disease entities that we know that we don't have cures for?

MR. RYDER: I have no answer for that. The only answer I have for you is that this is of epidemic proportion. Those are not. And that's why I think something special needs to be done in this situation because of the epidemic.

DR. PRIMM: We talked yesterday about other viruses of the same nature as the HIV virus, the HTLV-1 virus that might soon be a problem for epidemic nature also. So then we're beginning to think, you know, from your thinking that maybe all these things ought to be included.

I want to compliment you, Mr. Ryder, and your company and Bob Bellamy who is a partner in this company, I know Bob, for this other document. I think it's excellent. I'm going to use it as a resource document because it has in it all the things that we need and I really appreciate your preparing that.

MR. RYDER: Thank you. Mr. Bellamy was of great help in preparing that. And you'll find -- you won't find in that document the recommendation that I'm making to you today because that's not what we're telling employers. We can't tell employers that.

DR. PRIMM: I understand.

MR. RYDER: That's why I'm thinking it has to come -- a solution has to come from recommendations of this panel.

MR. DeVOS: I think maybe the key on this group is we're seeking input and we have asked you to come here and tell us the things you're doing. And we're looking for a diversity of views on those challenges and the things that we're going to face. And we thank all of you. Admiral Watkins is going to wrap it up.

CHAIRMAN WATKINS: Just a quick one for the three of you over here. The question is are you getting adequate information flowing down to business to give you the ammunition you need to build the kinds of educational programs that you need? Are you satisfied or is there a need for some kind of an AIDS clearinghouse for businesses from which they would draw information? Are you current, do you consider the information either flowing out of the Center for Disease Control, are the other sources into your health groups able to handle this thing or do you feel like you're under the gun here? You have to really fight for the information? And if you do think there should be a business clearinghouse that would provide this information with a better flow, a more continuing flow, would you tell us how we would recommend a design of such a clearinghouse?

MR. BERTSCHMANN: Well, I obviously have some concern for what you or probably no one else can do anything about, and

that's the wildcat kind of stories and headlines, the scare things that appear all over the place. I believe at the moment we feel we're getting adequate information and good information and a lot of it.

CHAIRMAN WATKINS: Doctor Herrmann?

DR. HERRMANN: In terms of our Live for Life program ordinarily and historically we develop our own information brochures and written materials because of the paucity of appropriate precentive information out there. On AIDS we've just done the reverse. There has been so much good information that has come to our attention, we literally have produced nothing unique with a Live for Life label on. We use American Red Cross, and the Allstate materials. Literally, I as a corporate medical director seem to have AIDS information coming over the transom. However, I think that there is some problem of communication of information to society as a whole and into our communities. And we're concerned about that because we think we've been fairly successful in our program internally because we've had a lot of cultural, if you will, readiness and preparedness to have people think about AIDS and behavioral/lifestyle issues.

And I think there needs to be a continual, not one time only, flow of information into the home and into our communities. This really is going to be necessary to support the kinds of things we're doing in the workplace to have it continue to be effective.

CHAIRMAN WATKINS: Do you think the exchange of information on workplace policy has been very successful? Is there a way to share successful workplace policies that we receive in our office? Who else sees these models within the business community, leadership community?

DR. HERRMANN: Well, I think it's one thing for larger corporations. People are addressing the issue. When you get down to the small business unit who may not be members of the Chamber, who might not be members of the National Manufacturers Association, I think that there is some special need for communication that you would be --

CHAIRMAN WATKINS: Is there a potential for some kind of a better partnership between larger business leadership in the local area and small business to at least offer some of the benefits of your own AIDS in the workplace policies and open a forum of that kind?

DR. HERRMANN: We indeed do do that and participate in those kinds of activity.

CHAIRMAN WATKINS: Is that well participated in by small business from your experience?

DR. HERRMANN: From my experience, I think when you get down to the really small business unit you don't find that there is as a great and broad base of participation as you'd like.

CHAIRMAN WATKINS: Do you share those general views you've just heard, Mr. Sawyer?

MR. SAWYER: Basically, yes. We get adequate information as it stands right now at least. And we feel that the easiest way of sharing that with smaller businesses is a lot of communities will put in seminars and ask for panels to be set up like this. And you can disseminate your particular policies that they can use as guidelines or not use, whatever their choice is. But there is not enough participation by smaller corporations.

CHAIRMAN WATKINS: Mr. Bertschmann, do you have a final comment?

MR. BERTSCHMANN: Just a quick comment. The consortium I spoke of is comprised of a number of large businesses who have contributed quite a bit of money to provide the educational materials which are still needed, including a videotape, as a result of a number of people feeling that the printed material is not enough. But one of the principle objectives of this is not to provide large businesses, while that may be one, but it is to having developed this material to then provide it at basic material cost to small businesses all over New England at minimal cost because we too here, in addition to the larger costs of the disease, that the cost of materials and education is high. So we think we're involved in a situation that will provide small businesses at very small cost the ability to educate.

CHAIRMAN WATKINS: I just want to close out by sharing some of the feelings up here on Mr. Ryder's proposal. I think that clearly you got our attention, but by the same token we've had our attention snapped on a number of occasions on this same issue. And we're looking for other solutions right now. And we have not given up that there are other solutions to help out.

Where do you draw the line on your proposal? Heart disease, both parents died at age 40. Is that a risk for business? What about based on smoking. You have a history of smoking. It may be that your longevity is within the time frame of the seven year latency period for the asymptomatic HIV recently affected. So I think those kinds of things concern us a great deal more than the problems that we recognize a small business might have in taking someone on board that's HIV positive. We're getting into now very discriminatory practices when we begin to select out on the basis of some sort of a health

projection and its problems. So we understand the problem, we're going to be addressing that in our report to the extent we can. We can't solve all the problems from this Commission, but I think we can send a better direction than that one. We're going to be looking at the other side, the flip side of discrimination, which is the major bar today of getting on with -- finding out where we stand in the nation on this thing and helping the individuals helping the public health. And that seems to us to be much greater concern than the concern for the potential loss in small business at this point in the epidemic, recognizing it's a issue. We're not trying to sweep it under the table, but I think your proposal is far more extreme than we would consider from all the compelling evidence of over 600 witnesses that have come before this Commission to date.

MR. DeVOS: All of that tells us that there's a lot of unsolved problems here and a whole lot of questions that are yet to be raised. There's a big contrast in the workplace between large and small, but there's also big contrast between regions as to what companies are doing in respective areas as this matter becomes more visible to them and they have to deal with it.

As Dwight is telling you, in our case we've been trying to fashion a policy but we don't know that we have the problem. We're trying to get ahead of it and to get corporate America, small or large, in every region of this country, to start taking preventive action. Even if they don't see it at their doorstep, AIDS is going to be a challenge, as it always is to get people to want education when they don't see the reason to get educated. And so we'll have to work harder at that and maybe this panel could highlight that and bring that to the attention of more people. And the problems Mr. Ryder talks about are going to be real problems that somebody's also going to have to deal with. I think we're fortunate to have large corporations in this country who are ready, willing and able to step over the line and to spend time and energy in education to train their management and staff. But for a lot of the others, it's going to be a tough thing for them just to find the time to say nothing of the resources with which to deal with it. Even more important to get the people ready, willing and able to listen and then to work toward a solution. So it only highlights the challenge that we face. We thank you for helping us focus our minds. Each of you brings a different perspective to our task. And with that, I won't terminate this group, we'll dismiss you and we're going to take a break for lunch and I think we'll be back at 12:30. Thank you.

(Whereupon, the hearing was adjourned at 12:07 p.m., to reconvene this same day at 12:30 p.m.)

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

12:35 p.m.

MR. DeVOS: Good afternoon.

Health Issues and Workplace Environment Concerns

Our first speaker this afternoon is Yvonne Ellison-Sandler. She is the manager of Employee Assistance Program for Levi Strauss & Company. Her responsibilities include: supervision of all professional psychological counseling, management training and consultation, and health promotion services for the Employee Assistance Program, Levi Strauss & Company nationwide.

Yvonne directs all Levi Strauss & Company AIDS education, counseling, training and consultation services. She is chairperson of the Levis Strauss AIDS Task Force and production coordinator of AIDS education materials and company spokesperson on AIDS.

Yvonne began her career with Levi Strauss in 1982. Previously, she had her own private practice in Minneapolis, Minnesota, where she was a psychotherapist and consultant to business on health.

She has held clinical appointments at the University of Minnesota Medical School and Graduate School of Social Work. Currently she is on the clinical faculty of the Graduate School of Social Work, University of California, Berkeley. Yvonne?

MS. ELLISON-SANDLER: Thank you. Good afternoon. It is my pleasure to be with you today to talk about the San Francisco Bay Area Corporate response to AIDS. This kind of exchange of ideas and information is fundamental to any successful educational endeavor, but it is particularly important with regard to AIDS because of its epidemic proportions and many misconceptions that surround this disease.

I'd like to share with you a quote from The Plague by Albert Camus. "Everybody knows that pestilences have a way of recurring in the world: yet somehow we find it hard to believe in ones that crash down on our heads from a blue sky."

AIDS has crashed down on our heads from a blue sky. Epidemics of life-threatening diseases provoke fear, concern and enormous anxiety in people.

At Levi Strauss & Company, we believe it's our responsibility to not only defuse the fear and anxiety our employees have about AIDS, but to do what we can to prevent them

altogether. Ignorance of the causes and transmission of AIDS fuels these fears and contributes to myths about the risks and dangers of contracting AIDS.

At Levi Strauss & Company, we have made a commitment to educate and inform employees about AIDS based on the best available medical knowledge to understand the disease. We want employees to know that a person carrying the AIDS virus is not a threat to co-workers, since AIDS is not spread by common everyday contact.

Our objective has been to curb fears, provide psychological support, and provide financial support. In San Francisco, it has been a true spirit of cooperation between the medical, government and business communities which have driven the development of guidelines to managing AIDS in the workplace.

This afternoon, I would like to discuss our AIDS awareness program at Levi's. I will discuss: one, our company philosophy on AIDS; two, support and education provided through our Employee Assistance Program; three, financial support through employee benefits; and four, what we have discovered are the critical elements to successful AIDS education.

Addressing AIDS in the workplace was not an unusual responsibility for Levi Strauss & Company to assume. We already had in place an employee education program in the Employee Assistance Program that promotes wellness and provides information on various health issues.

As AIDS became an increasingly serious national health program, we felt an even greater commitment to take action, to do what we could to curb fears in the workplace and to stop the spread of AIDS.

We do not have a policy specific to AIDS at Levi's. We have, however, a company philosophy. This philosophy states that all employees be treated equally, with dignity and respect, including employees with AIDS. Employees with AIDS are treated the same as other employees with life-threatening illnesses. It was this philosophy that guided our response to AIDS

We embarked on an education program before we had our first case of diagnosed AIDS at Levi's. It was not an unusual responsibility for Levi Strauss & Company to take on. We had in place an employee education program in the Employee Assistance PRogram that provided information on various health issues and promoted wellness.

In 1983, we responded to a call from a manager who was terrified that she could get AIDS from a gay employee she supervised. EPA responded quickly to her concerns by offering

education about how AIDS is transmitted. We assured her that her work environment would not be putting her at risk. The employee, as it turns out, did not have AIDS, but that call served to alert us to the need our employees had for accurate, up-to-date information on AIDS.

Shortly thereafter, when Bob Haas, now the President of Levi Strauss, stood in the lobby of our home office with representatives of a local AIDS organization, handing out pamphlets to employees, the message was clear, that support for AIDS education was coming from the top.

It was not long after that a workplace package was developed in coordination with the Bay Leadership Task Force and the SF AIDS Foundation. These materials were previewed at a day-long conference hosted by the Bay Leadership Task Force and Levi Strauss & Company on March 21, 1986. Two hundred Bay Area businesses had the opportunity to view the videotape and the associated materials and hear from San Francisco experts on AIDS.

At Levi Strauss & Company, we utilize these materials in the following ways:

The Employee Assistance Program offers AIDS education to company departments. By this time, most home office employees have attended a session. In addition to showing the video, "Talk About AIDS," and providing further information, a medical expert is present to discuss any questions. We also talk about the company philosophy and employee benefits.

A psychologist or social worker from the EPA leads a discussion of the psychological aspects of catastrophic illness. The primary objectives of these training programs are to inform employees of the medical facts, to make sure they understand the company philosophy on AIDS, and to let them know of resources available for further information.

Since we know that distributing written material alone does not guarantee that it will be read, we maintain an extensive health education library with audio and video tapes as well as brochures and books. Employees are free to check these materials out to take home. We have a company health and fitness newsletter that has a regular AIDS column to continually inform employees on the latest information regarding AIDS.

We offer confidential individual counseling and referral services to employees with AIDS, or ARC, as well as their families and co-workers.

We provide management consultation and department counseling when a person has or is rumored to have AIDS.

And we have a company task force which provides direction and guidance to the company on all AIDS direction.

In 1987, we focused our attention on delivering AIDS to our field locations, which was a real challenge because they're scattered across the South. In three months, we held mandatory AIDS education for 14,000 employees that cost us about $60,000.00 in down time and it was extremely well received.

In '88, we're planning to focus our AIDS education on the sales force as well as continuing our efforts in the field and corporate headquarters. Our philosophy of treating all employees equally and with dignity and respect is echoed in our benefits philosophy. Employee benefits are the same for anyone who is ill and it is to go under the short or long-term disability. Medical and life insurance remains in force and utilize a case management approach. We offer both home health and hospice care as alternative to more expensive hospital care. We encourage persons with AIDS to work as long as they are medically able and interested in doing so.

Since 1982, Levi Strauss Foundation and Corporation have made a commitment of financial contributions to various AIDS organizations. We know from employee feedback that our AIDS education is being well received and successful. We're also aware that AIDS is an ongoing process.

I'd like to share with you briefly now the elements that we believe are critical to a successful AIDS education endeavor.

First of all, it's important to target as specifically as possible the employee population that you are trying to reach. This became clear to us as we attempted to go out into our field locations and do AIDS education. The materials that had been developed for San Francisco did not fly in the South in our smaller facilities. Because it was too geared to the while collar population, it was seen as a big city effort. There were really not models on the tape that our hourly employees could relate to. So, for this reason, we developed a new set of materials that we have taken out to the field and tailored to a blue color and a family focus and that's in Spanish and Chinese as well as English.

We've learned that the speaker must be credible and confident when delivering AIDS education. For this reason, we always have a local medical expert on hand. We've also learned it's important to give the audience regional statistics because we've learned that people were more interested in learning about AIDS when they knew what the figures were in their hometown or in their state.

Many companies already have in place employee information programs that provide information on health issues. We would recommend tapping into that existing program. Employees and co-workers should treat all medical information obtained from employees with the strictest confidentiality. If confidentiality of medical records should be in accordance with existing legal, medical, ethical and management practices.

We have learned that management is vital to AIDS education effort. Not only does this lend credibility to the program, but promotes visibility to employees as well as other companies in addressing AIDS. Employees with any life-threatening illnesses, including AIDS or ARC, should be encouraged to work as long as they are able to. Employees who are infected with AIDS or any life-threatening illness should be treated with the utmost compassion and understanding and work accommodation should be in place wherever possible.

Finally, we have found it's important to address the psychological aspect of the disease as well as the medical facts. Frequently we tend to overlook the grief and loss issues that confront a department when someone has a terminal illness. Many employees feel uncomfortable, not because of the fear of contagion, but rather because they don't know how to respond to a co-worker who has a life-threatening illness.

In order to launch a successful education effort about AIDS, employee fears must be identified, acknowledged, and talked about. Once these fears are identified, they must be dignified, understood and respected by managers as well as co-workers. Creating a climate of mutual respect, understanding and clear communication will increase the likelihood of success in AIDS education in the workplace.

We've learned that the employees must have enough information in order to perceive themselves at risk before they will be receptive to learning about prevention. Once they're convinced that this is a problem that does indeed infect them, employees are able to learn more. We find the most effective way that we have found to avoid unnecessary disruption in the workplace is to prepare and education both management and employees about AIDS before the first case arises.

MR. DeVOS: I want to thank you very much and the work you people have done. It's apparent Levi Strauss really dug down in their jeans to deal with this problem.

MS. SANDLER: That's right.

MR. DeVOS: Okay.

MR. DeVOS: Our next participant here is Justin C. McArthur, Assistant Professor of Neurology, Johns Hopkins Medical Institution from Baltimore. Mr. or Doctor?

DR. McARTHUR: Doctor.

MR. DeVOS: Doctor. We screwed up over there and we apologize for that.

DR. McARTHUR: English training.

MR. DeVOS: English trained. Well, I see all the stuff if your listing of achievements. I figured you had to be a doctor to have done all those things.

DR. McARTHUR: Boy scout too.

MR. DeVOS: We thank you.

DR. McARTHUR: Well, Mr. Chairman and Commissioners, I'm delighted to be invited to participate today. As a neurologist, I obviously have a particular interest in neurological impairment and the types of impairment that have been associated with HIV.

As all of us are aware, there's been a burgeoning interest in the neurological problems that have been associated with HIV infection. Perhaps the most terrifying of all of these is the dementia, the progressive loss of cognitive and behavioral function that sometimes is associated with the infection. Perhaps the one point that I'd like to make today is that this terrifying dementia is not an inevitable outcome of HIV infection.

In some patients with AIDS and ARC, we are well aware, a proportion of them will go on particularly in the later stages of the disease to develop this dementia and other neurological problems. But, clearly the dementia is far and away the most important from a number of personal and work related issues. In patients with AIDS and ARC, our own clinical experience suggests that perhaps 20 percent will end up with a clinically significant dementia. That means that 80 percent do not develop a clearly significant dementia.

Now, in patients in the earlier stages of infection, patients who are otherwise healthy, who are asymptomatic, patients who are simply HIV sero-positive but otherwise well, it's completely unknown or far less certain how frequently the nervous system is involved from a clinical standpoint. There is evidence that the virus can gain entry into the nervous system early, but what it does there and how frequently it does it is still uncertain at this stage.

Recently, in fact less than two months ago, the World Health Organization convened a consultation specifically to look at the issues of neurological impairment in otherwise asymptomatic HIV-infected people, healthy HIV-infected people. I participated in that conference, and the idea was basically to pool all of the existing information from a number on on-going prospective neurological studies and come up with what was felt to be a consensus.

I've included in my testimony some of the minutes from the consultation. In essence, when the evidence was weighed, the conclusion was that in asymptomatic HIV-infected individuals there is no increase in the frequency of neurological impairment compared to uninfected comparisons.

Now, what that means -- it doesn't mean that HIV-infected individuals cannot develop neurological impairment, because clearly just as in somebody who is uninfected with HIV, neurological impairment can be a result of drug use, alcohol use, diabetes, a long list of things which can affect the nervous system. What it means is that in healthy HIV-infected individuals, it's uncommon, very uncommon for neurological impairment to result solely from HIV infection. I think that's an important point. If I can make any point today, that's it.

Where do we stand and where do we need to go in terms of --

DR. LEE: Could I have you clarify that? It is an important point. Are you talking about at the beginning of the disease, or are you talking throughout the course of the disease?

DR. McARTHUR: I'm talking specifically, as far as the knowledge that we have up to now, from the studies that have been done which have now looked at over 1,500 HIV-infected individuals in the earlier stages of disease -- let me be more precise. These are individuals in CDC groups II and III, basically healthy asymptomatic individuals with or without lymphadenopathy. So, these are patients who do not have constitutional symptoms, who do not have ARC and who certainly do not have AIDS.

DR. CONWAY-WELCH: Would you repeat your statement again, then, in reference to that?

MRS. GEBBIE: May I ask for one other clarification before you repeat the statement? They could be at any number of months post-infection, as long as they did not have those constitutional symptoms?

DR. McARTHUR: They could be one, two, four, five, six years. The only variable is the presence or absence of constitutional symptoms. You would like me to repeat my statement?

DR. CONWAY-WELCH: Yes, that precipitated Doctor Lee's question.

DR. McARTHUR: I believe the statement was, or I believe the statement that precipitated -- I know what the statement was. The weight of the evidence, at least gauged from pooling a number of on-going neurological studies, was that asymptomatic healthy HIV-infected individuals do not have an increased frequency of neurological impairment. That's compared to uninfected controls.

DR. CONWAY-WELCH: Thank you.

DR. McARTHUR: Where do we go from here, and what do we need to know? What are the obstacles to moving forward in terms of understanding neurological impairment?

The first obstacle is the issue of serological screening. Again, the World Health Organization, the consultation came out with a clear statement in this regard. The statement basically was that serological screening for HIV is not an effective strategy for detecting functional impairment related to HIV.

The second point relates to our lack at the present time of a clear definition of HIV dementia. Different research groups, different clinical groups may call the same patient demented or not demented depending on the criteria that are used. Clearly, this has more than just medical implications. We need a clear set of definitional criteria for making the diagnosis and understanding the diagnosis of HIV dementia. This will probably only come by convening together different professional groups: the American Neurological Association, the American Psychiatric Association, et cetera, together to come up with some form of working group that can attack this problem.

The third point, or the third area that we need to explore that is being explored at least in one risk behavior group, is understanding the epidemiological and the clinical features of the neurological disorders. Most of the studies that are on-going at the moment are in one risk behavior group, that is gay or bisexual men. We need to push out into other risk behavior groups to determine whether the clinical features, the epidemiological features are the same or different. What other variables are important in determining whether an individual does or does not develop neurological disease? Some of those variables may be amenable to intervention.

The fourth point relates to our desperate need for a sensitive yet specific screening test for detecting neurological impairment at an early stage. Most of the studies that have been done up to now and reported up to now have used standard neuropsychological test batteries. They are not directly applicable to some populations.

For example, some of the test procedures are extremely culture-specific or extremely education-specific, so they are not applicable, for example, to somebody who can not read or write. They also may not be applicable to certain risk behavior groups. We don't have well established norms. For example, for performing and assessing neuropsychological tests in intravenous drug users. We need a sensitive and specific screening instrument.

The fourth, and the final point really relates to an overall understanding of some of the neurological disorders. Although we expect that the dementia that's been linked to HIV infection is probably from the virus acting within the brain, we really have very little information about the pathogenetic mechanisms that underlie the viral infection within the brain. What precisely is going on in the brain to cause the signs and symptoms that we see? At the moment, there are a number of funded studies mainly funded through NIH that hopefully will address some of these issues.

Thank you.

MR. DeVOS: Doctor McArthur, we thank you, and I wonder if you could do a 30 second explanation of dementia. We have a whole lot of young people here and you guys in the profession tend to use your jargon. Why don't you try it for them and see if you can do it real quick for them?

DR. McARTHUR: Well, dementia really comes together from a progressive -- and I think progressive needs to be underlined -- this is something that we understand as changing over time. So, it gets worse over time. A progressive loss of a number of mental faculties: memory is the most obvious one, alertness, attention, the ability to concentrate, all of the things that we rely on day to day to perform our work or to learn or to function in everyday activities. Dementia results when the brain has been damaged either by HIV or by other conditions, and causes a loss of those faculties.

MR. DeVOS: Thank you. That helped me a lot. I don't know about the kids, but --

MR. DeVOS: We're going to go next to Doctor Rhame here, who is a medical doctor also, Assistant Professor, Infectious Diseases Section, Department of Medicine, and

Director, HIV Clinic, University of Minnesota Hospital, Minneapolis. Doctor Rhame, thank you for coming.

DR. RHAME: Thank you. I understand my charge here to begin a discussion of the implications for the work place of the potential for transmission of the secondary infections, the infections of which there are potentially about 30. Those are actually outlined on the second page of my testimony here. I've set them out in some kind of table just to get some idea of what the magnitude of the task before me is.

I've divided up this issue into basically three subsets, the three bullets there in the definition or the statement of the problem on page one.

The first is the extent to which the presence of these infections in HIV-infected people causes a hazard to the associates of the HIV-infected people. We're not just talking now about the hazard. We're talking about the excess hazard over random people, and we're not just talking about the hazard to healthy people. There might be some special subgroups like immuno-suppressed patients or persons or pregnant women or newborns that might require some special management.

The other side of it is the risk to the HIV-infected person. I've divided that up into the second and third bullet there: the risk to the HIV-infected person that other people pose; and the risk to the HIV-infected person that features of the environment, animal exposures, environmental exposures, problems which might be occupation related like requirement of overseas travel and the requisite immunizations and so forth.

Now, if I can turn your attention to that table again, it's a classification of these pathogens, germs, by transmission mechanism. You see first off that most of the transmission mechanisms involved there are from the environment, so they really are quite irrelevant. Person to person transmission of most of the pathogens in that first group doesn't occur.

I have salmonella down there as a pathogen which mostly comes from food, although it does come from animals to person and person to person as well by fecal-oral transmission.

I've got some down there which come animal to person, and then I've got four categories which basically transmit person to person.

The first group is a group of pathogens where spread occurs readily, but almost all of us are repeatedly exposed and become colonized early in life. The problem really arises when your colonizing organisms get out of control as your immune system weakens.

The second group is a group of fecal-oral transmissions, basically oral consumption of stool.

The third group of person to person transmissions is where person transmission does occur, but requires prolonged intimate exposures. Therefore, basically adult transmission of these doesn't occur except in people who are having intimate contact.

And the last group down at the bottom, person to person spread of airborne disease, namely mycobacterium tuberculosis, the organism which causes TB; varicella-zoster virus, the organism which causes chicken pox and shingles and measles, is probably a little worse in AIDS patients as well, but we don't have much of it in the country.

Now, with that background, I'm going to read my conclusion and recommendations so I get it right.

Workplace transmission of most of the HIV-associated secondary pathogens is not a problem because:

1) they do not spread from person to person, or do so only during intimate contact;

2) they colonize all humans from early in life; and/or

3) they do not cause illness in healthy persons.

The most important exception is mycobacterium tuberculosis, the organism which causes TB. TB is a problem in this context because;

1) dormant focal infection commonly becomes active in HIV-infected persons;

2) infectious tuberculosis can be present without characteristic symptoms; and

3) tuberculosis can be transmitted by the airborne route to unsuspecting healthy persons.

However, the severity of the problem is diminished because:

1) most U.S. HIV-infected persons do not harbor dormant TB foci;

2) the type of tuberculosis which develops in HIV-infected persons is less infectious than that which develops in other persons who get TB;

3) M. TB transmission is less common in the workplace than in the home;

4) astute physicians should detect and treat tuberculosis before it becomes very infectious;

5) TB is uncommon in exposed contacts who receive the proper post-exposure prophylactic management; and

6) active TB, should it develop in a contact, can almost always be successfully treated.

The other conclusion: special precautions for HIV-infected persons in all other circumstances are either not necessary or, in certain unusual circumstances, can be accomplished with minimal disruption and without significant increases in infection hazard to HIV-infected persons or their associates.

Three recommendations:

1) HIV-infected persons should receive attentive medical care by physicians who recognize their increased tuberculosis risk and are knowledgeable about diagnosing tuberculosis in this context. When active TB is recognized in any person, careful evaluation of contacts in cooperation with local health authorities is necessary.

2) It is probably desirable to exclude HIV-infected, varicella-zoster virus susceptible persons, those are persons who have never had chicken pox before and that only is about two percent of adults in this country, from situations of intense chicken pox exposure. A hallmark might be a person working in a school, a teacher in a school during a school outbreak of chicken pox.

3) There are unusual, occupation-related hazards which pose risks to HIV-infected persons which are sufficiently greater than the risk to healthy persons that special counseling with optional self-exclusion is appropriate.

These special situations include:

- overseas travel to areas of poor sanitation or increased transmission of certain exotic pathogens;

- environmental exposure to soil in areas of coccidioidomycosis endemicity;

- exposure to cryptosporidium, which might occur during large animal veterinary work;

- exposure to toxoplasma, which might occur in work with cats or exposure to animal flesh.

Known HIV-infected persons should not receive oral polio vaccine or BCG vaccine.

And finally, the magnitude of the increase in the risk to asymptomatic HIV-infected persons in these situations is insufficient to constitute a basis for anti-HIV screening.

Now, the balance of the written testimony basically deals with a half a dozen of these things, some of them as prototypes of larger issues.

Thank you.

MR. DeVOS: Doctor Rhame, your ability to pronounce some of those words is amazing.

DR. RHAME: I earn my salary that way.

MR. DeVOS: I do those -- I just slide through them. You pronounce them. I thank you.

MR. DeVOS: Our next presenter is Martin Schneiderman, partner of Steptoe and Johnson, from Washington. As we said earlier, don't step on any toes.

MR. SCHNEIDERMAN: Can't promise on that. I am a partner at Steptoe and Johnson in Washington, D.C. My specialty is personnel consulting with employers, and I also do government contract work. I am an adjunct professor at Georgetown University, teaching EEO litigation.

I point out that I'm here representing my own personal views and not in behalf of any particular client or interest group.

I did want to mention a brief story about, perhaps, the impact of this Commission. Some time ago, I was on a trip to New York to speak at a commission -- not a commission, at a seminar. And I was traveling by train and happened to be preparing my materials and looking at some AIDS-related materials, particularly regarding safe sex.

I don't know if you've all recognized this phenomenon, but I'm sure it's true. There are three events that happen on common carriers.

First, there is some interchange of communication in some fashion.

Second, there is an inherent drive of all people who are not necessarily nosey to necessarily look at what the other person is looking at. I find this to be nearly universal.

The third is that hidden negotiation about that armrest. You have the arm, the front, and this happens all the time.

Well, on this particular trip I had my AIDS-related material. This gentleman looked at what it was. Meanwhile, I had a cold that day, and I will tell you there was no communication. I will tell you that he did read what I was reading. And I will tell you that I had that whole armrest the entire trip. When I coughed, he was way over in the other end.

I tell that story because it is typical of some of the hysteria that we confront. We may have different views about what is happening in this epidemic, but one thing is clear. There is no room for discompassionate and hysterical reaction to events.

I will say that on this trip today, what brought that story to mind is, I had my papers open and a young attractive lady sat next to me, looked over, and I said, "Here I go again."

She said, "You're going to the President's Commission meeting in Indianapolis, aren't you?"

And I said, "Well, there's the impact of the Commission right there."

So, you're doing a good job as far as I'm concerned.

This epidemic obviously is fraught with challenges in a number of disciplines; in medicine, ethics, law, public policy. And your job is formidable indeed. I'm here just to focus on my specialty, namely employment law questions.

When you deal with employment law questions, the preeminent law, as has been discussed, is the handicapped law. Very interestingly, unlike the laws on sex, race, national origin, and age, which applies generally to the population with very limited exceptions through federal legislation, there is federal law here, but it only applies to very limited, but nevertheless large sectors of the population, federal employees, government contractors and subcontractors and those receiving federal assistance.

In addition to that, you have an array of 49 of the 50 states have their own laws on handicap. In addition, you have a whole group of local ordinances. So really, it's a very difficult and messy situation. I will say, most of these laws

follow the federal motto, but that's not entirely true. So, you have a real problem, I think, with some possible inconsistencies in terms of coverage.

I have already submitted to you a detailed discussion of the implications of the line decision in the handicap laws.

I should add, and I've written on these other laws, there are other federal laws of import. The NLRA deals with concerted activity. ERISA, which has been referred to, relates to prohibiting termination of employees to avoid incursion of health and medical costs. Then you have OSHA, of course, which provides a general duty of employers to provide a workplace free of known defects.

Because my time is so limited, I have been asked to focus in on three perhaps different views that you've seen, and one I was asked to specifically deal with secondary infection and I will do so. But I will talk about three general policies, one I think that's working well, one I think that is just wrong and a third which seems to be in need of development of further exploration in terms of medical and possible legal implications.

First, the policy that seems to be working right. The federal government took on, I think, a very early objective allaying concerns about transmission of AIDS. We wanted to calm hysteria in the workplace or everywhere, in society generally. I will tell you that in my consulting with many employers, the reaction was not, "How do we fire persons with AIDS." The primary concern of employers is, "How do we deal with hysterical reaction of co-employees, of supervisors and of customers?" I think much has been done.

Earlier testimony has highlighted the importance of not only the federal contribution, but the company contribution. In every one of my speeches in this area, highlight, number one, the importance of the company's taking its own responsibility in terms of dealing with educating the workforce. Honestly, in this area, I don't think I vary much from what has been the preeminent view of medical and legal scholars and public policy experts.

The second one, I will say that I find myself in the minority in terms of expressing a view in this regard, and that would deal with a particular employment setting in the health care industry. When patients come into hospitals and they're about to be treated with invasive techniques, it is common to have a broad panoply of blood tests taken. This is one area that it doesn't seem to me as if we're following a public health dictate. The policy of the government has been to follow universal precautions. Such precautions are appropriate but it seems to me that health care providers ought to be able to

function on real rather than assumed risk. And given the quality of the tests that are currently available, I don't see why they should not. I would say there's a flip side to this. I would also think that a health care provider organization would have a right to know the status of its employees who will be performing invasive techniques. Not that they should be terminated, but perhaps they ought to be transferred to positions where they are not going to participate in invasive techniques.

I had been asked by a company whether -- they were providing health care providers employment and they asked me, "Is it reasonable for us to test those persons?" Quite honestly, every instinct in me says this is entirely reasonable and I'm considering the legal implications where a federal agency is discouraging that very testing. I find that difficult. So, I think that's a policy that you all ought to consider very carefully.

The third policy that I would talk about now is one that has been alluded to. It is one that I do not regard as having any definitive evidence at this stage. I want to highlight that right off from the beginning. But it deals with this question of secondary infection and secondary effects.

There has been, as we said in the beginning, a very appropriate focus on common hysteria in the workforce by showing that AIDS is not transmitted in the casual setting of the workplace. That's a very appropriate, very important public policy.

It seems to me at some point in time there needs to be a close look at whether persons with AIDS, because their immune system is compromised, are vulnerable not only to the types of diseases that do not pose risks, but other types of disease. TB is one. I think there are parasitic and bacterial causes of diarrhea, for example, that one might want to at least closely monitor in some industries like the food industry.

I have seen in some hospitals that they preclude nurses from working with AIDS patients because of concern about CMV. I ask whether this is concern in the workplace and some doctors privately give me very different views on this issue.

I see a related issue in the dementia issue. I'm very well impressed by the information to date as developed. If it's conclusive, it's conclusive. I will tell you that my concerns stem from a New York Times article in which the military was relying upon some information which seemed to suggest as it was reported, now I have not read the base data, that there is some concern that dementia may be one of the early symptoms. Now, I think a demented lawyer may be a help to most clients, but I think there are some other types of positions, airline pilots,

train locomotive engineers, that we really ought to look at this a little bit more carefully.

I think after we've developed a calming influence in the population generally and we've been able to make some progress, there may be some time necessary to focus in on these secondary important -- not as important as the transmission of AIDS, but nevertheless real issues that we are to deal with.

Thank you.

MR. DeVOS: Good. Thank you very much, Mr. Schneiderman.

MR. DeVOS: With that we're going to go over here to Doctor Lilly. You okay, Frank?

DR. LILLY:: Well, I'm a little stunned, but I'll recover.

Let's see. Ms. Ellison-Sandler, I'd just like to get a little clarification about one sentence that you said and which is also in your write-up, which is, "We provide consultation and department counseling when a person has or is rumored to have AIDS." Could you expand on that, tell me just what that means, what happens precisely?

MS. ELLISON-SANDLER: Sure, I'd be glad to. If there is concerned rumors about someone having AIDS, that may come to our attention by a co-worker, an employee of that work group or by a manager or a supervisor. What we have felt strongly about is that if we did AIDS education on a routine basis, hopefully all of our employees would have a basis of education and then when a rumor came up we could move in again and talk about what their concerns are and go through the process of reeducating them, addressing talking about what their concerns are and kind of bringing it out into the open and really demistïfying what usually is kind of a hysterical response around whether someone has AIDS or ARC in the workforce.

DR. LILLY:: Okay. So, this is a general educational response that you're talking about?

MS. ELLISON-SANDLER: That's right.

DR. LILLY:: I just wanted to make sure it wasn't that you're calling in the person or finding out to what extent that might be --

MS. ELLISON-SANDLER: You mean calling in the person whose rumored or actually has AIDS?

DR. LILLY:: Yes. Right.

MS. ELLISON-SANDLER: No. If they choose to come to us and talk about their medical condition, then we follow through. But that is clearly a matter of choice and one of confidentiality. If they don't want to be involved in anyway, we don't get involved.

DR. LILLY:: Okay.

A question just about a detail for Doctor McArthur. I wonder if you can just list a little bit some of the other neurological problems that I don't think fit under the category of dementia, such as the blindness and hearing loss, for example.

DR. McARTHUR: Well, there's a whole host of very diverse, and some of them quite novel, neurological disorders affecting not just the central nervous system, the brain and the spinal cord, but also the peripheral nerves as well. One of the intriguing features of the neurological disorders is that some of them occur at specific stages of HIV disease. That is, some of them, some of the more unusual ones particularly, the peripheral nerve disorders, can occur at a very early stage of infection. The other ones and the more important ones, the ones that effect cognition and memory, like the dementias --

DR. LILLY:: Are these peripheral neuropathies or are they actually based on central nervous system problems?

DR. McARTHUR: No, these are clear-cut peripheral neuropathies which respond to treatment and act just like some types of peripheral neuropathy that occur in individuals not infected with HIV.

MR. DeVOS: Thank you, Frank.

DR. LILLY:: I'll leave Mr. Schneiderman to --

MR. DeVOS: Gebbie?

MRS. GEBBIE: I'm going to address the question actually to all four of you. Although you each presented somewhat different views, I didn't hear clearly really from any of you what it is you think would be the most perfectly brilliant thing this Commission could say that would help you pursue what you need to do in the work side in academic medicine or wherever in the legal profession. So, I'd like to hear each of you give us what you think is, from your perspective, the most critical recommendation we could make.

As you do that, I'd also appreciate if Doctor McArthur and Doctor Rhame could give us some sense of whether if we had

5,000 doctors in here they would generally tend to agree with you or whether you think you're presenting a somewhat peripheral view in the general medical spectrum.

MS. ELLISON-SANDLER: I would like to see a recommendation made to all businesses, small and large, in all regions across the country that they be strongly encouraged to do AIDS education from a preventive kind of focus.

DR. McARTHUR: Let me just comment as to my eclecticism. The opinions that I have are my opinions, but I think they are mirrored by many other clinicians and researchers in the neurological, psychiatric field. One of the Commissioners -- I think it was not a commissioner -- had mentioned the military's decision at the end of 1987 to ground HIV positive pilots.

That was, in large part, based on a study generated from San Diego by a very well respected researcher there, a psychiatrist called Igor Grant, who I know and who I've discussed the results of his study with. The important point from that study which looked at neuropsychological tests in individuals infected with HIV, some with AIDS, some with ARC and some basically asymptomatic, was that one could find, if one looked hard enough, neuropsychological test abnormalities.

But Doctor Grant also says, both publicly and in the paper, that none of the individuals were demented. I think one important point that the Commission can make is that neuropsychological test abnormalities by themselves do not mean that somebody is demented or incompetent or incapable of working or incapable of making up a will.

The second point, I think, that the Commission should and can stress hopefully is that serological testing, specifically for HIV, should not become a surrogate for functional assessment. Can a person do their job? Sorry to use up time, but the third point relates to other causes of neurological impairment. Drug use, alcohol use, anxiety are all very potent causes, some transient, of neurological impairment. We can't ignore those in dealing with this population.

MR. DeVOS: Good. Doctor Rhame?

DR. RHAME: My conclusion or my recommendation is almost that you don't take any action in this area. Really, TB, in my opinion, is the only significant problem in this area and there is a finite increased risk of your being exposed to TB if you work with an AIDS patient or an HIV infected person. But that risk, for all the reasons I go into in some great lengths, is not large and is manageable should it occur.

So, my recommendation to you basically is that there doesn't need to be any particular action resulting out of the secondary infections. Maybe you should state that, I don't know. You're probably a better judge than I am about how big an issue it is.

I think that, in general, when you think about this, this issue, and that's what I've tried to do the way I put that table out, each and every pathogen has to be considered independently. One of the great jobs of infectious diseases is that each of these bugs seems to have developed its own way about getting around the world. When you just say, "There's a problem which is meningitis," you can't think about the problem of meningitis. In fact, the meningitis problem that AIDS patients get is cryptococcul meningitis and that has never been shown to spread person-to-person, ever, once.

So, you have to think about it very much pathogen oriented. Whether or not there's a societal need for a statement that outside of TB there is no problem and TB is manageable, that's really not -- I don't know if I can make that recommendation to you.

MRS. GEBBIE: You didn't comment on the centrality of your views in the medical community. I think that's important to have on the record, one way or the other.

DR. RHAME: Yes. I presume that it's fairly central. I've shared my written testimony with a couple of people I respect most nearby and most of them think I'm even making too big a deal out of some of the issues, like the coccidioidomycosis in the dirty grader in Arizona. I think I've really split a lot of hairs even to the extent to which I've done it.

MR. DeVOS: Thank you, Doctor Rhame.

MR. SCHNEIDERMAN: I will say that my recommendation is only that there needs to be further medical exploration of these issues. We've heard differing analyses and conclusions taken by the military establishment. I will tell you that hospitals have different views about CMV. I have had doctors differ in seminars that I have chaired on the issue of CMV as to whether it's a good idea to have pregnant nurses and pregnant employees working closely with AIDS patients.

I will tell you that I can't question these doctors on the medical issues, but I will tell you that I have talked personally with a number of doctors who have different gray areas, not major differences. This is not a major issue of the same ilk, of transmission of AIDS, but it is an issue that we should not close our eyes to. I think we need further

exploration of it. TB, in particular, is one because it is growing dramatically in New York and some other locations. We ought not wait until all the cases are there before we say, "Aha, we have a problem." I think we ought to be exploring it more.

MRS. GEBBIE: Thank you very much.

CHAIRMAN WATKINS: Let me just clear up one issue on the military. When the report that Doctor McArthur mentioned here earlier came out in the paper, we happened to have hearings that day from some of the best minds in the world on neurological damage and early symptoms who gave us rather strong evidence that supports Doctor McArthur's position.

In addition, the knee-jerk response out of some in the military moved rapidly to do what you suggested. The decision by the Secretary of Defense wisely turned it off, said, "Now, wait a minute. We don't have the data. The best in the country is not giving us that information." I don't know the extent that that was exposed to peer review and had a good solid review by all the proper people in the medical profession, but I can assure you that it's the kind of knee-jerk response on the basis of spurious reports that come out without the kind of licensing that goes on in peer review that get this thing confused.

We had a pretty clear indication that in fact there were many other debilitating things that would down a pilot long before we go to HIV positive asymptomatic considerations, such as, "When did you have your last drink? How old are you?" and other important questions.

I want to put it in context because the military has not made a move on that. There have been lots of pushes by the services to stop people flying expensive aircraft if, in fact, early neurological damage is in fact the case. But that has not been the case. The military has not made a decision. So, I want to clear that for the record.

MR. SCHNEIDERMAN: And I just wanted to mention that the evidence that is most tenuous indeed, and I agree with you, is the issue of dementia of people who are asymptomatic. I think there's very weak evidence on that. As to people who have full-blown AIDS, I think the numbers are fairly dramatic that this is a concern. How we apply --

CHAIRMAN WATKINS: But, Mr. Schneiderman, let me tell you this. We have extensive annual physicals that test the motor responses and all the other responses of our aviators in all services. They are far better able to decide performance on the basis of neurological damage. Those kinds of things are in being and working all the time. So, it isn't as though we're ignoring the issue, but we're looking for more clear symptoms

that there has been some performance damage which to me is a more sensible criteria along the lines that Doctor McArthur mentioned.

MR. SCHNEIDERMAN: I haven't in my recommendation said that the private sector should adopt the military standard. I am just pointing out as to the question of is there a central uniform view that there appears to be on this issue. Unlike transmission of AIDS, there seems to be more uncertainty and disagreement. The scope of that is something for you all to decide.

MR. DeVOS: All I can say is it was spoken like an admiral. Okay, Cory?

DR. SerVAAS: Like the Admiral, I'm confused on -- well, not confused. I need some clarification from Doctor McArthur and Doctor Rhame about an interview we had with Doctor Richard Price of New York City. I understood when we researched this that he's very well respected by the CDC in his work. My question to you is, when he reported that 25 percent of patients first present -- HIV patients he sees, HIV infected patients first present with neurological or psychiatric symptoms. Could either of you or both of you comment on his work? Is he controversial or is he not mainstream, Doctor Richard Price, in this testing and research?

DR. McARTHUR: I know Richard Price very well and we collaborate together on a number of projects. In fact, his brother works at our institution. Doctor Price was really the first neurologist to recognize that patients with AIDS developed or could develop dementia. He really opened up the whole field. There's no question but that he's very respected and is the expert in the field. I'm surprised he's not here today.

But one of the points that he makes when he talks is that his experience is from a very selected group. He's working, as you know, at Memorial Sloan-Kettering and sees basically patients who are referred in for neurological assessment. They have a relatively small group, a selected group there of patients. It's not a large in-patient service and it's just confined to basically one risk behavior group and not many.

As I indicated in my written testimony, there is a range to our current understanding of how frequent this dementia is. Doctor Price's estimates are at the top end of the range. That's not to say that his estimates are wrong. I believe that they're correct for the population that he's dealing with and for the criteria that he's using to diagnose dementia. Other groups see a different spectrum of disease in a different spectrum of patients and maybe using different criteria. This is one of the obstacles.

If we're going to understand this, not just the clinical manifestations but the epidemiology, we all have to be talking the same language. So, no, he's not wrong in the advice that he gives you.

DR. SerVAAS: Doctor Rhame?

DR. RHAME: Doctor Price is the preeminent person in this area. We're vigorously courting him to be the Chairman of our Department of Neurology at the University of Minnesota, in fact.

DR. SerVAAS: Okay.

DR. RHAME: Let me add something to it because I think it's been perfectly well stated. The issues for the future are a little more complex. It is plausible that after 50 years of infection, 50 percent of the people will be immunologically intact, but 80 percent of the people will be neurologically damaged. We may find that the neurological damage occurs in a higher fraction of people, but takes longer. It may as well be that therapies are going to a better job of protecting the immune system than protecting the CNS. So, although I think it's perfectly stated in the current situation, we have a few hurdles yet to go before we know how it's going to play out.

DR. SerVAAS: Thank you, Doctor Rhame. Thank you.

MR. DeVOS: Thank you, Cory. You're going to be next, but I want to see if anybody has anything for Ms. Ellison-Sandler, because she has to leave promptly and catch an airplane. Does anybody have anything special for her? If not, you're going to get caught up in the regular flow here. Okay? And if you feel you have to leave, then go, and we thank you for being here. Theresa?

DR. CRENSHAW: Doctor Rhame, is that correct?

DR. RHAME: Rhame, like tame.

MR. DeVOS: He's the fame of Rhame.

DR. CRENSHAW: Okay. In hearing you discuss the secondary infections, if I understand you correctly, in the health care and workplace setting the other infections play a trivial role in terms of cause for major concern. Tuberculosis has some, but is manageable. And that AIDS patients get a different form of tuberculosis than most health care workers or others would be susceptible to.

On the other hand, there's an article on an Urbana epidemic where 12 Urbana nurses caring for patients suffering

from both AIDS and tuberculosis have tested positive for TB. Is there any follow-up on that situation, or are you familiar with it?

DR. RHAME: I'm not aware of that situation. Tuberculosis --

DR. CRENSHAW: I mean, that doesn't seem like something that other people don't catch.

DR. RHAME: TB transmission in a hospital does occur from patients that are not properly isolated and who have not been started on therapy. The infectiousness of TB diminishes rapidly as soon as therapy is started.

I don't mean to say it's an ignorable problem. There is a real, albeit small, increased risk to being associated with AIDS patients or other HIV-infected persons. The magnitude of that risk is really not great enough to require special restrictions on the behavior of HIV-infected people, in my opinion, for the reasons I outlined.

But, that problem is not one that you can just dismiss. You've got to spend a lot of time thinking about it to get to the place where I am on that. I didn't have time to really expand on exactly why, other than that very brief summary, I think the problem is not of sufficient magnitude to require special restrictions. But, all those things do play into it.

It is, for instance, the case that people under medical attention do generally get therapy pretty quickly before they become very infectious. It is generally the case that the types of TB which develop in HIV-infected people are the disseminated TB throughout the whole body, or TB in some other place than the lungs, neither of which are very infectious. It's the focal infection of the lung that occurs most of the time in non-AIDS patients that is the most infectious form of TB.

So, it requires a lot of thought to get to the point -- a fairly rigorous analysis to get to the point where I am on that. And it's certainly not one I want to dismiss, and there certainly will be more transmissions in this country from the average HIV-infected person than from the average non-HIV-infected person in the next decade.

DR. CRENSHAW: It seems to me that there are two issues on this point. One is that it gets so incestuously linked up with what are we going to do about it, that it makes it very difficult for people to look at just what is really happening. And if we look at 12 nurses in one small hospital in a small city getting TB, that isn't minimal issue for health care workers certainly.

DR. RHAME: No, no. I don't mean to dismiss it. About two percent of AIDS patients will get TB, and that's going to be a big issue.

MR. DeVOS: Okay. Thank you, Theresa. John?

MR. CREEDON: Mr. Schneiderman recommends that the present policies which discouraged testing in advance of invasive medical procedures be reconsidered. I mentioned this morning that I recently read a paper by Secretary Bennett, the Secretary of Education. He recommends, among other things, in that paper that testing generally be encouraged on a more widespread basis and specifically in the hospital setting. I forget now whether he would mandate it in connection with hospital admissions.

I wonder if Doctor Rhame and Doctor McArthur have a view on that specific subject either with respect to surgery or with respect to admissions to the hospital generally.

DR. RHAME: In my former life, I was an infection control person. Let me start on that. I don't think the issue here is voluntary testing. In our hospital -- and this is the way it is in most parts of the country, outside of the coasts. If a surgeon wants to test his patients, he can test his patients. I don't think there's anything wrong with that as long as he observes --

MR. CREEDON: Without asking them?

DR. RHAME: No. As long as he observes the consent and counseling issue, there's nothing wrong with that. The issues really are, if he wants to take the time and the effort to do that for people who are extremely unlikely to be infected. The people who get surgery by and large are elderly and not HIV-infected. If he wants to take all the trouble for that, if he or she will as well go ahead and operate on the person who refuses testing without testing them, that's fine. I mean, nobody would object to that.

The real question is whether or not it's worthwhile in terms of the number of people you're going to turn up, and in terms of those rare circumstances, if any, where you can't do for everybody that which you should do for the HIV-infected person. As long as he observes that willingness to counsel and consent and go ahead and take care of the person who refuses the serology, that's where the only issue lies.

MR. CREEDON: Well, I interpret what you said that you would not require testing for people admitted to the hospital, nor for people who were having surgery. You would not require it as a matter of course?

DR. RHAME: In my opinion, the issue boils down to, if a surgeon could make a case for me that there's something he needs to do for the HIV-infected person that he can't practically do for everybody -- and I haven't really had that case made to me persuasively --

MR. CREEDON: But, what about the risk of his own -- his own personal risk as a result of the operation?

DR. RHAME: Well, are you saying that if a person's positive he shouldn't do the surgery, or are you saying --

MR. CREEDON: Well, I'm not saying he shouldn't do it. I mean, if I were a surgeon and I were about to operate on someone, I think I would rather know whether or not the person had the virus. I might be a little more careful, I'm not sure, just with respect to the possibility of infection or whatever.

DR. RHAME: And there's nothing wrong with that, in my opinion, as long as you do the counseling -- and this is the way it is in most hospitals. As long as you do the counseling and consent, and as long as you're willing to go ahead and operate on a person who's --

MR. CREEDON: But, you would leave it up to the particular surgeon and not require it as a matter of course?

DR. RHAME: I would not require it. I would not want my hospital to get behind this effort and to take on, for instance, the burden of doing the counseling and consent, unless that surgeon had made a case for me.

Let's say there's some kind of surgery, the prototype usually mentions cardiovascular surgery because that's probably the most bloody, where he really could make a case that there were some things he was going to do for the HIV-infected person that he shouldn't be doing for everybody. If he really made that case for me, then I would feel, as the hospital epidemiologist, that I would want to get behind his program and make sure of the counseling and consent, take the responsibility for doing it and take the responsibility for doing the testing. I haven't had that case made to me well enough yet by any surgeon.

MR. CREEDON: Doctor McArthur?

DR. McARTHUR: Well, we're in a different part of the country, and our population at Hopkins is a bit different. But, I would echo your sentiments exactly. We do not support mandatory universal screening for all hospital patients.

MR. CREEDON: How about for surgical patients?

DR. McARTHUR: We do not support universal mandatory testing for surgical patients either, simply because half of the patients that we operate on are women who are quite likely to have false positive test results. Our counseling system would be totally swamped dealing with false positives even before we got to the true positive infections. So, we do not support universal mandatory testing.

We are fairly liberal in allowing serological testing for patients who are having surgery, either elective or on an emergency basis if the surgeon wants to know or if the patient has a risk factor for HIV-infection. There is a practical reason to know, because the surgeons do different things in the operating room for HIV-infected patients in terms of procedural things, how they prepare the operating room, the number of personnel who are assisting, the type of personnel who are assisting.

MR. CREEDON: You want to respond, Mr. Schneiderman, at all?

MR. SCHNEIDERMAN: Well, I prefer -- the policy I was referring to had a CDC policy which generally contemplated the concept of universal precautions, and that was it. If I understand, the substance here is they would prefer not to have universal mandatory testing. I would prefer to see a procedure that encourages testing, but is not necessarily mandatory, and informs patients in advance.

I think evidence has also indicated here that it is very worthwhile information to know by doctors and health care providers. Again, I think given the overall reliability of the tests, and I'm talking about the sequential tests, ELISA twice and Western Blot, I think it is a reliable test that we ought not close our eyes to.

MR. DeVOS: Thank you, John.

DR. RHAME: There's a wrinkle, I might just say here. The question in part -- at the University of Minnesota Hospital, about 300 anti-HIV serologies are done a month in this context. It's been that way for a long while because we've never restricted people from doing it.

MR. CREEDON: How many a month?

DR. RHAME: Three hundred a month on patients.

MR. CREEDON: Out of how many operations?

DR. RHAME: I think they do around 16,000 operations a year, or something like that. It's a pretty good sized facility.

MR. CREEDON: So, out of 1,500, 300 are done?

DR. RHAME: Not one has turned up an HIV infection in a person who was unexpected or had no known risk factors or no conceded risk factors. So, it's really very inefficient in many parts of the world in terms of getting to it.

What is interesting, and the wrinkle I want to put forth to you is to what extent is the hospital obliged to make sure that the individual surgeon is, in fact, doing the counseling and consent correctly. There is evidence which has been produced in St. Paul Ramsey Hospital in the Twin Cities area to suggest, and I think it's my experience as well, that the hospitals are -- that oftentimes there is no evidence in the chart that there has been adequate counseling and consent.

So, to my mind the issues are, what do you do with the person who refuses the serology, and what are you going to do as a hospital? To what extent are you obliged to make sure that the individual doctors in your hospital are observing the things that I feel should be done ethically in approaching the patients?

MR. SCHNEIDERMAN: Can I just say that I'm not against refusing service at all. That's not at all what I have in mind. I will say that one day, given even the infrequency of this event, if a person goes into a hospital for a hip operation and comes out with AIDS because of blood transmission through the surgeon, there is going to be one major law case. I'm not sure we ought to wait for that. But, I think these are concerns. We have to deal with frequency over balance against the tragic results.

DR. RHAME: There will be an HIV infection transmission to a surgeon for sure. If you're lucky, it will happen while your Commission is no longer in existence.

MR. DeVOS: Penny?

MS. PULLEN: Mr. Schneiderman, you said, "I am not against refusing service." Did you mean, I'm not for refusing service?

MR. SCHNEIDERMAN: Yes. I'm sorry. Thank you very much for that correction, if we're on video tape in particular.

MS. PULLEN: I didn't think you wanted a misstatement on the record on something like that.

MR. SCHNEIDERMAN: I appreciate that.

MS. PULLEN: Doctor Rhame, in your paper you indicate that people whose immune systems have been compromised can render

a false negative on the tuberculin skin test. How difficult is it to diagnose someone's tuberculosis if they are HIV-infected or otherwise immune compromised, and are there diagnoses missed on this?

DR. RHAME: It can be very easy to miss. There are a couple elements which go into the hazard side of this thing. One is that TB is sometimes the very first manifestation of illness in an HIV-infected person, so you may not even know they're HIV-infected at that point. They can be skin test negative by virtue of their abnormal immune system, because it takes a normal immune system to produce the red lump that develops in those of us who have a positive skin test.

So, it can be very difficult to diagnose, particularly if it's disseminated and doesn't produce an abnormal chest x-ray. You might not get it for a while. It is, however, those cases which are the most difficult to diagnose which are the least likely to be infectious. Because, that person without any abnormality in the chest x-ray is probably hardly infectious at all.

TB infectiousness is extraordinarily variable, so you will find that case where you get one extremely infectious person who can infect a whole bunch of people around them. The majority, probably 80 or 90 percent of TB patients are hardly infectious at all. But, that's absent AIDS. It's probably even higher in the AIDS context. So, it can be very difficult to diagnose for sure.

MS. PULLEN: Do you see any implications relating to the TB connection concerning the placement of people who are HIV-infected -- whether they are AIDS patients or sick for some other reason and are HIV-infected and may be carrying tuberculosis and may not have been diagnosed -- putting those people into nursing homes?

DR. RHAME: I think that --

MS. PULLEN: I mean, in terms of with elderly infirm people, not in terms of a nursing home that is there for AIDS patients.

DR. RHAME: Or even worse, around children. Because, I think TB is a bigger hazard to those under six than it is to the elderly.

MS. PULLEN: Well, in your paper you do indicate that old age can be one of the aspects of the difficulty of fighting off a TB infection if one picks it up.

DR. RHAME: For sure. I think there is an increased risk of exposure on the part of people in the workplace around HIV-infected people. It's not large, but there is definitely an increased risk.

I'm just basically arguing that I don't think the magnitude of the increased risk is high enough. It's counter-balanced by the relative infectiousness, and if the HIV-infected person gets adequate medical care the diagnosis will be made and the treatment started before the infectiousness gets to a point where it's substantial.

We will have to do contact evaluations of the people around those HIV-infected people who get TB to make sure no transmissions have occurred. So, --

MS. PULLEN: One of the policy considerations that's going on right now in terms of the care and treatment of people with AIDS is whether they should be placed in nursing homes, whether nursing homes that already have an elderly population should be encouraged or given incentives to take and treat AIDS patients.

It has been presented to me that one of the problems with that is that nursing homes typically do not take people who have infectious conditions and consequently don't have the training and the equipment and the policies and procedures for infectious conditions.

But, beyond that, what I want to ask you is, in such policy considerations about placement of AIDS patients in nursing homes, should the risk of tuberculosis transmission to the other patients in that nursing home or to the care providers and then to the other patients be a consideration in that policy?

DR. RHAME: It should certainly be considered, but I don't think it's substantial enough to keep those patients out of nursing homes. Nursing homes are probably a little better off than other work places actually, because by and large they've got baseline skin tests on all of the employees and clients in the nursing home. So, they're actually probably in a little better shape for managing those exposure episodes which occur. Those episodes will occur and they will require management.

MS. PULLEN: Does that mean at least we'd be able to find out whether it was because of that because we already know the person used to be negative?

DR. RHAME: Right, exactly.

MS. PULLEN: I'd rather prevent the infection.

DR. RHAME: We do have -- in this country today, one out of every 10,000 Americans gets TB every year. So, even independent of the HIV infection we all have some risk of being exposed to TB.

MR. DeVOS: Thank you, Penny. We're going to move on. Burt?

DR. LEE: A note for Doctor McArthur. We did have Dick Price here. Our opening gun in New York, he was a featured speaker in last September and a lot of his reprints were submitted for the record. He was unable to be here today, actually. We invited him again, which was unusual.

I am fascinated by this problem, though. I was there for that whole neurologic/psychiatric meeting at Rockefeller and Memorial last October. I don't know if you attended it. But, the statistics there were so striking, because it was 80 to 90 percent of the people who die of AIDS are going to end up with some kind of neuropsychiatric manifestation, and 20 percent of them are going to present with that feature according to some of the observers at that conference.

And then, we hear from the military -- and they were strong about it -- a month or two ago. They didn't buy it, and you don't buy it. It's a very key point. Obviously, what you're looking at are the really higher integrated functions, the judgement, the memory, maybe affect, et cetera, the first things that you start to notice. I know the tests can't be that good. How firm to you feel about your position on this point?

DR. McARTHUR: I feel a lot firmer having discussed this within the last two weeks with Richard Price. I wish he had been here, because I think he could clarify some of his more recent thinking on this.

Let's just take two groups of patients, the asymptomatic HIV-infected persons first. Basically, what we're saying, or what I'm saying representing at least on on-going study -- what the U.S. Air Force is saying, and I've referenced them in my written testimony, and in fact what Richard Price's group is saying, is that asymptomatic HIV-infected individuals don't have clinically significant dementia, on the basis of HIV.

DR. LEE: Until other things happen.

DR. McARTHUR: Yes. But, of course --

DR. LEE: In other words, it's never the first thing that happens.

DR. McARTHUR: "Never" is not a word one uses much.

DR. LEE: Yes.

MR. DeVOS: For a guy that young-looking, Burt, he knows a lot.

DR. McARTHUR: "Never" is, you know, a relative term. But, in terms of policy statements, in terms of health policy, in terms of implications for the population, my belief is that asymptomatic HIV-infected individuals do not have clinically significant impairment.

That doesn't mean that if you run four hours of neuropsychological testing, one out of those 30 tests might not pop up as abnormal. That has no relevance in my view for their day to day function.

DR. LEE: How many of ARC cases have it?

DR. McARTHUR: Well, that's the one group. I said I wanted to talk about two groups, because the information is better for the groups at the most extreme ends of the spectrum, the asymptomatic healthy infected individuals and for the patients with full-blown AIDS.

There's been less work done in patients with ARC, partly because people disagree as to exactly what ARC constitutes, exactly what the symptoms are that make ARC. We have to bear in mind that all of these definitions are somewhat arbitrary. They are just words. Maybe what we should be looking at is a more systemic evaluation, they're degree of immune compromise, their level of T-helper lymphocytes, rather than these arbitrary words.

But, anyway, the second group is the group with AIDS. Doctor Price and the Memorial Sloan-Kettering group and our group, if we do full neuropsychological testing, if we apply all of the tests in our books to patients who are in the hospital with, say, pneumocystis carinii pneumonia, we'll find abnormalities in 80 to 90 percent of them. But, as I said before, that doesn't mean, in my book, that they are significantly demented, necessarily. It's very hard sometimes to explain exactly what is causing those test abnormalities. Could it be a result of what's going on in the rest of their body? It doesn't necessarily mean that they're demented.

Just one last sentence. I think there is less disparity in the observations that are being made by Price, by Grant, by us, by the Air Force, than would appear at first sight. I think we're basically coming towards a consensus. The numbers may be a little different. Some groups may say five percent, some groups 15 percent, but I think the overall message is relatively clear.

DR. LEE: Could I ask, Doctor Rhame, just one thing? You omitted amebiasis and hepatitis from your schedule there. It was a beautiful article you wrote. How about food handlers? Did you omit it for reasons?

DR. RHAME: My answer there is that in my mind the answer there is that ordinary hygiene on the part of the HIV-infected person should prevent the issue. Food-borne amebiasis transmission is not very common, but salmonella could. There certainly are chronic salmonella excretors probably a little more commonly among the HIV-infected people and other persons.

But, it really takes a gross breach of ordinary hygiene on the part of the food handler for that to be a problem. I think that's the protection we have. One percent of Americans have salmonella in their stool, so we're not -- it's a big background in which there might be a slight increase in salmonella excretion.

DR. LEE: Thanks.

MR. DeVOS: Thanks, Doctor Lee. We're going to go to the Admiral a moment.

CHAIRMAN WATKINS: Doctor Rhame, we've been seeking some source of advice to those that are HIV-positive that would give them both hope on the one hand, and also better advice as to what to do with themselves on the other in terms of exposing themselves to operantistic infection opportunities.

Now, you've given us a menu of things here. It's the first time I've seen this, but then I don't read the Journal of the American Medical Association and the New England Journal of Medicine and all those sorts of things. Is the list that you give all inclusive? Has it been well accepted, at least at this point in time, as the kind of advice that HIV-positive individuals should be advised of?

It seems to me that if you could take that and convert it to English, such as coccidioidomycosis endemicity. Is that some kind of a little parasitic mealy bug or something? And can't we say it that way so people would really understand, and where is it?

I mean, in other words, is there a way to convert this into a menu of recommended health practices that a person that's HIV-infected could follow and enhance his deterrence to getting opportunistic infections of the type you listed here? And is there something being worked on within the medical profession to come out with something that's accepted across the nation, at least at this point in time to the extent we know it?

DR. RHAME: I don't know that any such set of recommendations has been prepared for HIV-infected people. The list is my own. The AIDS-defining pathogens are out of the CDC's AIDS definition, but the right-hand column is my own.

CHAIRMAN WATKINS: Is it worthy of us recommending that we should -- that the proper authorities should come together and produce such a thing? It seems to me it's another point of sensitivity to those infected, that we're trying to do the best we can. We're somewhat short-changed, I think, on our ability to deal with can you build a set of their own health practices that enhance their lifespan. That hasn't been that clear from anybody that's come before us.

On the other hand, you're telling them, "These are opportunities you should not expose yourself to."

DR. RHAME: That's an extraordinarily good idea. The most common question that I get as a physician caring for HIV-infected people is, "What can I do to maximize my health opportunity." And the bottom line, basically, that I wind up saying, unhappily, is, "Basically, do whatever everyone should do. You know, get enough sleep and exercise and don't smoke and don't drink too much and, you know, think peaceful thoughts, and have a good diet." I mean, that's basically what you say.

But, I think you could produce, in fact, some concrete statements out of it. I think this list isn't all-inclusive, because it really trails off to pathogens which have only a slight, very slight increased hazard to HIV-infected people. So, you could draw the boundaries. Some people would want to throw nocardia off this list, because the number of extra infections which occur in HIV-infected people is not great. But, it's probably a little bit, so I put it on.

All those common things, like influenza and colds and so forth look like they probably aren't any worse in HIV-infected people than they are in anybody else, or aren't any more problem. So, I think that as far as just going out into society, there's really no reason the HIV-infected person shouldn't have a totally normal existence in that kind of thing.

These weird things I have in recommendation 3 there probably apply to 1000 of the 1,000,000 HIV-infected people in this country.

CHAIRMAN WATKINS: I see.

DR. RHAME: I mean, there really are very specialized kinds of things. Although you could prepare a list which says, "Don't change your cat box if you're toxoplasma sero-negative," that is, if you've never had it before, and "Don't handle raw

steak without washing your hands." I mean, you could make a few things like that.

CHAIRMAN WATKINS: Well, you're making a recommendation to us in your written document. That's what I'm trying to get at. Are you telling us, then, that it's not a significant recommendation?

DR. RHAME: No. I think you could produce, and it would be desirable to produce a set of recommendations which would not be applicable to a large part of anyone's life, unless you happen to be an earth-grader in Arizona where there is that particular fungus, coccidioidomyces, growing in the soil.

So, for most people it would be a fairly minor change in their lives, but it would be a good idea to have such a list of things, official recommendations for maximizing your health if you're HIV-infected, and I don't think it's been prepared.

CHAIRMAN WATKINS: What about it, Doctor McArthur?

DR. McARTHUR: I think it's very important for the Commission that we don't make the mistake that collectively the medical profession did two or three years ago when we realized the routes of transmission for HIV to health care workers. Many of us became rather cavalier in terms of our approach to patients, "Oh the risk is so low we don't need to worry about it." Then, along came the splash cases where health care workers became infected through non-needle stick exposures, through splashes on mucosal membranes.

I think both for the HIV-infected person and for the non-infected health care worker treating them, the more we can do to maximize health -- I realize the risks may be small and I applaud Doctor Rhame for drawing up the list -- I think we need to take it from here and I think it needs to be expanded into a definite set of recommendations. Even though the risk may be very small, I think it's definitely worth spelling it out in black and white on paper.

CHAIRMAN WATKINS: Who should be brought together to do that, what leadership specifically?

DR. McARTHUR: Doctor Rhame should take total responsibility --

CHAIRMAN WATKINS: Okay, I've got the picture. Thank you.

I just have one other quick question. I'd like to get just a specific answer if you have it. If you don't, it would be useful for me to get it.

When we were at San Francisco General, I asked a specific question. How many times have surgeons going into operations with patients indicated that this is in the best interests of the patient to know the HIV-positive in a confidential patient to doctor relationship. That has been presented, and in no case that they could give me was that turned down by the patient.

That is, specter of the patient refusing is always there and thrown out on the table. I want to know how many times you have had this situation arise where it's in the best interests of the individual to know, irrespective of the health care provider or the surgeon doing the operation, and that patient has turned it down. "I refuse to be tested, even though you have advised me it's in my own best interests because of the operating procedures and the kinds of things that I may be exposed to." How many?

DR. RHAME: There certainly have been -- we've had two refusals that I know about in our hospital.

CHAIRMAN WATKINS: Out of how many?

DR. RHAME: Probably 2,000, something like that. Both of them, I think, were refusals without -- in people who had had no risk activities actually. They heard the counseling shtick and they just said, "I don't want to do it."

CHAIRMAN WATKINS: Doctor McArthur, how about in your case?

DR. McARTHUR: We've had several refusals, partly because we're so close to D.C., where people are extremely concerned about having on their medical records the results, even if they're negative, of an HIV blood test.

CHAIRMAN WATKINS: Out of about how many, would you say?

DR. McARTHUR: Well, we've cared at Hopkins for about 800 patients with HIV infection.

CHAIRMAN WATKINS: And you've had several?

DR. McARTHUR: But, these by and large are probably not infected patients. I mean --

DR. RHAME: I'm saying only -- now, the asymptomatic screening context, to my mind the issues are very different in the person who has symptoms --

CHAIRMAN WATKINS: But, I'm getting back to this point of mandatory. Even under certain conditions, is it not -- within the patient to doctor relationship that we have now -- isn't it doing most of the job, when it's necessary from a medical point of view?

DR. McARTHUR: I think voluntary testing and counseling works 99 percent of the time. If you explain to a patient why you think it may be important to do the blood test, I would agree with you, it's very, very uncommon for them to refuse.

CHAIRMAN WATKINS: Thank you.

MR. DeVOS: We would like to thank all of you, Doctor McArthur, Doctor Rhame, and Mr. Schneiderman, for joining us today, and for your insightful views on this matter. We appreciate it very much. Thank you very much.

We will immediately go to our next panel, and we're going to deal on the economic impact of all of this. We started out this morning with an overview of AIDS in the workplace. We moved on to specific examples of what various companies were doing. We went from there to this panel on some of the possible methods of further transmission of secondary diseases that are affecting all of this. And finally, there's a price tag for all of that, and that moves us on over to the economic impact of some of these things in the work place primarily.

We have one more panel later this afternoon, and that panel will deal with public sector issues outside of the Washington scene or the federal government, which we will be taking testimony on next week in Washington. So, we will deal with it as it relates to local communities and other state, county, and municipal employees. So, we will be talking about that at our next panel.

Economic Impact

This panel deals with economic impact. We have with us the Honorable Frank S. Swain, Chief Counsel for Advocacy, U.S. Small Business Administration, from Washington. Doctor David E. Bloom, Professor of Economics, Columbia University, New York. And Ms. Patricia A. Wiley, Managing Consultant, A. Foster Higgins and Co., Inc., from New York.

So, we have three distinguished people who will deal with the economics of all this, and we'll begin with the Honorable Frank S. Swain, Chief Counsel for Advocacy, U.S. Small Business Administration, from Washington.

MR. SWAIN: Thank you very much, Mr. Chairman, and members of the Panel. I'm indeed pleased to be asked to participate in the Panel's very important deliberations.

I've been able to follow some of the statements here today. I understand this morning there was quite an extensive discussion of the implications of the AIDS situation for the workplace.

I think it's important to point out, and our statement attempts to make, basically three points: first, involving the overall lay of the land, if you will, on where small businesses are and how they operate; secondly, how that leads to some implications on the challenge of informing employers and employees of the various manifestations of the AIDS situation; and third, how that leads, in our opinion, to some implications involving the ability of small employers to cover their employees with health insurance.

I'd like to summarize the high points of my statement. I appreciate, as I mentioned, the Commission even taking a look at the issue of small business. Because, it really is quite a bit different than taking a look at how larger managed operations deal with any given labor or personnel issue, whether it's AIDS or anything else.

Most of -- of course, it goes without saying that most of the businesses in this country are very small. They do have a significant economic impact. The President issued a report yesterday, his annual report on the state of small business, which documents that through this most recent decade two out of three of the new jobs in our economy, the net new jobs, came from small firms.

Small firms in this country are defined as firms with under 500 employees, although I might add that if you changed the definition to under 100 it wouldn't alter the statistics all that much. Small firms employ over half of the non-government work force and contribute about half of the gross national product.

I also might state that there is a strong labor economics series of articles on the issues of labor mobility in small business, which I think is relevant to this Panel to the extent that small businesses do a lot of starting and failing. They do a lot of growing and shrinking. They do a lot of hiring and firing. So, although I don't treat it formally in my statement, to the extent that the issue is whether the employer can, should, or must test or do anything else, bear in mind that for every person that's actually hired by a small firm there is a lot of other hiring decisions going on. So, this is going to have a particular impact on the smaller employer.

Now, small firms, I think, relative to the Panel, have some different ways of operating than large firms.

First of all, you asked that I indicate what the economic impact of the AIDS crisis is on small firms. Well, of course we don't know for sure. We can always take the statistics and extrapolate from some total estimates of loss of productivity and extrapolate in small firms. But, I think that I'd like to focus the Panel, if you will, on the ability of small firms to deal with the financial consequences of the AIDS situation.

First of all, most small firms have a relatively small scale of income and profits. Therefore, the way they deal with external factors, whether it's AIDS or anything else, differs very much from larger firms. The growth of AIDS cases may exacerbate difficulties small employers already confront in establishing employee benefits. It's likely that health and life insurers, as we've seen some evidence of already, will tell you of underwriting restrictions for small firm employers and employees.

Secondly, small firms that are able to provide employee benefits do not enjoy the benefits of a large pool, a large underwriting pool. Because a small firm's risk pool has fewer employees among which to spread costs, one case of AIDS in the work force could raise costs for experienced-rated benefits to the point where the benefit is prohibitive for all employees.

Thirdly, large and small employers differ in their ability to absorb other less measurable AIDS-related expenses, such as costs for complying with legal requirements related to discrimination, testing, and confidentiality. I mention this because in preparation for our statement, and certainly other witnesses have advised the Committee -- most recently, Mr. Schneiderman -- that there is not only one federal law which may or may not apply because the Rehabilitation Act applies only to government contractors at the federal level -- but, there are 49 state laws that may or may not apply to businesses at various sizes and that may have differing definitions of what exactly is regarded as a disability or a handicap. And, in addition, there seems to be some increased trend toward municipal or county level laws.

The potential for all employees within a small firm to learn that a co-worker has AIDS is greater than within a large firm. I think the potential for workplace discussion and apprehension is a great deal larger. In effect, the small firm manager is in a considerably different legal environment and I think management environment than a larger firm.

In particular, we would like to point out the fact that small firms in certain industries may well have greater

difficulties working within a competitive health insurance system in the sense that there is some evidence that a number of insurers are avoiding coverage of certain industries where they make a judgment that those industries may be highly populated by employees that may have a particular sensitivity to AIDS.

We're not making a statement of whether there ought to be employee testing or there ought not to be employee testing and not making a statement on whether carriers ought to do testing or not. What I am saying is that for carriers to write off an entire industry or entire industries that are highly populated by small firms because of some rather summary judgments about the likelihood of losses because of AIDS in certain specific companies, I think is inappropriate and certainly falls against, as we read them, the guidelines of the National Association of State Insurance Commissioners.

To summarize, we make two types of policy recommendations, one involving awareness for small employers and the other involving issues relating to underwriting. Just as the economics of management are different in small firms, the economics of delivery of information are different. I congratulate those many companies that are preparing some very sophisticated materials. Usually small firms can't afford to buy sophisticated materials and so the very essence of how one delivers information to the small employer is considerably different.

We would suggest that low cost or free education materials providing general legal AIDS related information specific to small firms should be disseminated to small employers. The question naturally arises, who and how and who will pay for it? In trying to think about this issue, I'm aware, of course, that Doctor Koop is about to mail to every household through HHS a flyer of general information on AIDS.

The Social Security Administration and the Internal Revenue Service are the only two sources of the names and addresses of every employer in this country. There's no private sector organization that has it. There are lots of companies that sell lists and Dun and Bradstreet, of course, sell lists, but it seems to me at least worth discussing that if the Commission is interested in getting the word out on the workplace implications of AIDS and AIDS policies, that it may well look into whether IRS or SSA, which after all keeps employer identification numbers -- you can't hire a person in this country without applying to the IRS for an employer identification number -- might be an appropriate way to disseminate a basic brochure on workplace responsibilities.

After all, there are about five million employers. There are about 13,000 companies in this country that have more

than 500 employees and all the rest have fewer than 500. So, if the challenge is getting the word out, then just as HHS seems to feel it appropriate to send to every household, it may well be appropriate to send to every employer through the IRS or through the Social Security Administration. Of course, our agency and several others could assist in writing or producing such a brochure.

Secondly, we suggest, of course, that National Leadership Coalition on AIDS and other representatives that are interested in the AIDS situation pay particular attention to attempting to focus their materials and dissemination of their materials to smaller firms.

In the area of employee benefits, our testimony, our statement points out what I think is a particularly vexing public policy issue, that is to say that there are about eight million people in this country who work who don't have any health insurance at all. About six million of those eight million do work for small firms. So, whether we're talking about AIDS or any other health issue, there are a lot of people that work for small businesses that don't have health insurance coverage.

Now, I say that fairly directly because I think it is due to the fact, and we've taken quite a close look at this issue. It is due to the fact that the people that don't have health insurance coverage tend to be working for firms that are generally start-up firms or the very smallest firms, firms of fewer than ten employees. In fact, 40 percent of the companies that don't have health insurance problems are mom and pop grocery stories with fewer than ten employers, literally the corner store that may well be a family type business.

So, the issue of how to solve the access to health insurance for all employees is not a simple one. As a side bar to this discussion, I personally do not agree with the approach that the government can mandate that that insurance coverage be provided because I think it's just going to end up trying to square the circle. There are a lot of these companies that cannot afford coverage now and a government regulation saying they have to provide it is simply not going to solve the problem.

But, of course, when one is discussing on how the AIDS crisis will impact small firms, one can take a particular look at the issues of non-provision of benefits in small firms and we think that that's why you have to take a look at a variety of options that would seek to encourage coverage by small companies of their workers. That's why we're particularly concerned about whatever trends there may be about insurers pulling out of the market of writing small firm coverage. A very large company does not, generally speaking, have medical underwriting. There's such a large pool that it may well be self insured or, if not insured,

that the carrier will feel that everything actuarially evens itself out and there won't be medical underwriting.

All literature says that most small group plans are medically underwritten. So, if there is a discovery of an AIDS case or a potential AIDS case in a small group plan, the results for underwriting are going to be, I think, immediate and much more significant, either withdrawal of coverage absolutely or significant increase in the premiums.

I think that the issue is whether carriers are carving out entire industries that are largely populated by small firms. One can argue that there's a lot of insurance out there and they can always buy it someplace. But the point is that if you're trying to encourage small employers to cover their employees with insurance, they need to have a variety of competitively priced options. And if there are just one or two companies writing insurance in a particular industry, then I think that discourages the tendency of small firms to cover their employees where they don't already have the insurance.

MR. DeVOS: Mr. Swain, I'm going to ask you to conclude and then we're going to move on here in a minute.

MR. SWAIN: Well, I got just about to the end of the statement, Mr. Chairman, except to note that we think the Commission should urge states to adopt the insurance commissioner's model underwriting guidelines. I think that would solve some of the problems that we've noted and take a closer look at the issue of how small firms are underwritten and certainly also take a look at the results under state risk pools which have been established in ten states.

Thank you, Mr. Chairman.

MR. DeVOS: Thank you. You're going to have more chance to talk. We're just going to try to get everybody in here.

MR. SWAIN: That's quite all right.

MR. DeVOS: Doctor Bloom is Professor of Economics, I believe, at Columbia. We're honored to have you here this afternoon.

DR. BLOOM: Thank you, Mr. Chairman. My name is David Bloom and I'm a professor of Economics at Columbia University and a Research Associate at the National Bureau of Economic Research.

I'm primarily a labor and population economist and I've been working on economic aspects of the problem of AIDS for a little over one year now. I've come to Indianapolis with my

colleague, Sherry Glied, who is sitting just behind me and who is available to help answer any questions you might have.

MR. DeVOS: Why don't you bring her up and let her sit over here so we can see her a little better, okay?

DR. BLOOM: Okay. I think that would be quite appropriate.

MR. DeVOS: That's such a low down seat back there behind you. Why don't you introduce her again, so they can all see her better?

DR. BLOOM: My colleague, Sherry Glied, who is a PhD candidate in the Department of Economics at Harvard University, and a specialist on the economics of legal issues.

MR. DeVOS: Okay. We want to welcome you as well.

DR. BLOOM: We're here to report to the Commission on the preliminary results of an on-going study that we're conducting on the impact of the AIDS epidemic on the American labor market.

The results we have to report today are in many respects quite disturbing. Our analysis of data contained in the Census Bureau's 1980 and 1987 current population surveys reveals some evidence that the AIDS epidemic has led to labor market discrimination against single males over the age of 30 in the City of San Francisco.

Now, let me relate to you right at the outset the principal facts supporting this conclusion. In San Francisco, the unemployment rate of males aged 18 to 65 was identical in March 1980, what we refer to as the "pre-AIDS era," and March 1987, what we think of as the "present AIDS era." In both years, the unemployment rate among males aged 18 to 65 in San Francisco was 6.1 percent.

But, the unemployment rate of males age 30 and over who were not married increased by a factor of five between those years, from 2.3 percent to nearly 12 percent, 11.8 percent. This is a remarkable increase in the unemployment rate that occurred between the pre-AIDS era and the present AIDS era. In contrast, the unemployment rate of all other adult males in San Francisco actually declined between those two years by about a third, from 6.8 percent to 4.6 percent.

Now, this finding does not constitute direct evidence of discrimination. Although we don't find evidence of such dramatically different movements in male unemployment rates in other cities in the U.S., this finding does provide some

indication that the labor market is responding to the AIDS epidemic by discriminating against individuals who are either known to be members of high risk groups or are perceived to be likely members of such groups.

There are two main reasons why we think this finding reflects discrimination. First, the most natural alternative interpretation of our result, namely that the unemployment rate for single males in San Francisco increased because many were too sick to work, that alternative interpretation is not supported by another analysis we did of labor force participation data. Moreover, the definition of unemployment itself requires that someone be available for and actively seeking employment.

The second and really the main reason why we think our finding reflects discrimination is that it can be quite costly to a firm to employ an individual who subsequently develops AIDS. These costs can include increased health and life insurance premiums and lost investments in hiring and training, as well as less visible costs that arise from the fears and perceptions of co-workers, customers and employers themselves.

Our rough estimate of the expected, of the perceived cost to an employer of employing an individual who is known to be a homosexual or a bisexual male in San Francisco or New York City is in the range $3,200 to $14,000. This reflects a lower bound estimate of the additional cost over the expected duration of employment that a typical employer is likely to perceive when he or she compares the cost of employing a member of that high risk group to the cost of employing an otherwise comparable individual who is not a member of that high risk group.

Now, before I conclude this statement, I'd like to draw attention to one other prominent feature of labor market discrimination resulting from the AIDS epidemic. That is that the group of individuals suffering this discrimination consists of all individuals with demographic characteristics that make them likely members of high risk groups. The group discriminated against is broader than the group of individuals who are truly at high risk for the development of AIDS. It is even more broad in comparison to the group of individuals who will ever test positive for HIV. And it is considerably more broad than the group of individuals who will ever develop AIDS.

In other words, many, many individuals who will never develop AIDS are being discriminated against as a consequence of the way the labor market is dealing with the epidemic. They're being discriminated against because of two key features of the current legal environment. First, because in most jurisdictions employers cannot legally discriminate against workers who actually have been diagnosed as having AIDS or AIDS related complex. Second, because employers can in most jurisdictions

legally discriminate against individuals who are not otherwise known to be HIV positive.

The American economy operates primarily on the profit principal. Thus, our reasoning in this matter is very simple. The AIDS epidemic gives employers an incentive to discriminate against individuals perceived to have a non-trivial risk of developing AIDS because the epidemic increases the cost to employers of employing such individuals.

Put another way, because employers generally do not know whether an employee will ever develop AIDS and because the law prescribes discrimination against workers who are ill, the law effectively encourages employers to make guesses about who will become ill and to discriminate accordingly.

Now, let me conclude by saying the following. What Ms. Glied and I have produced are some plausible facts about the impact of the AIDS epidemic on the labor market. Our analysis is not an invitation for industry to discriminate. It is just information on what actually is happening. If our basic message is upheld in further analyses, and if American society is sufficiently unhappy about the content of that message, it seems absolutely clear to us that market forces will have to be actively redirected to alter this situation. Thank you.

MR. DeVOS: Good. Doctor Bloom and Ms. Glied, we thank you for your contribution and your fine work in this field.

MR. DeVOS: Ms. Wiley is next and she comes from New York City and the firm of A. Foster Higgins. Welcome to you.

MS. WILEY: Thank you, Mr. Chairman. We are a management consulting firm and work primarily with employers, large employers as opposed to Mr. Swain's discussing smaller employers. These are companies who usually have more than 500 employers and anywhere up to probably a quarter of a million or more employees.

I was asked to talk about the practical issues for employers who are facing increased workplace costs due to AIDS. My focus is primarily on the costs of employer sponsored benefit plans, that is their life, disability, and health insurance plans.

My comments are based on the written data I submitted, including a survey Foster Higgins conducted entitled, "Company Practices and Procedures: AIDS and Benefit Plans," and my written testimony and recommendations. The statistics I'll cite today are all from this survey. If there's any myth I've encountered in the non-business world about how business treats AIDS it's this, that employers and insurance companies will go to any

length to avoid paying claims if the cause of the death or disability or medical expense is AIDS. Well, this is simply not true. Most companies are not avoiding the challenge of the cost of AIDS. A solid majority, 81 percent, believe that employers should bear the major cost of treating AIDS for the participants in their own benefit plans. An even greater number, 87 percent, believe that AIDS should be covered by their benefit plans the same way any other life threatening illness is covered.

This evidence points to acceptance by employers of their economic responsibility and their recognition of their own benefit plans as a major funding source for medical treatment.

The real concern for business over the next several years will be finding ways to manage those AIDS related expenses. While I'm pleased to report that for the most part employers have accepted a financial role in the AIDS crisis, we do worry that employers are missing opportunities to manage those anticipated cost increases. And AIDS will inevitably bring cost increases to employers because the cost of AIDS related benefits eventually rests with the employer.

If an employer has to pay them now or later, and as that later gets nearer to each employer as the number of AIDS cases increases, why not have employers seize the opportunities that are available now to manage those costs?

I thought I'd highlight for you a couple of things we see as the opportunities for employers. First is an ability to measure the potential cost to the organization. It is possible to estimate the number of workers and their dependents who might become infected, to estimate the hard dollar expenditures for the life, disability and medical programs, and at least begin to measure some of the soft dollar issues like worker productivity.

Employers can also write and communicate a management policy for catastrophic illness and we've heard a lot about that today. But then also use the management tools that are available to them to help control their costs.

Probably the best example in medical plans is the case management program. Medical case management programs are designed to help patients experiencing catastrophic illnesses by having an assigned case manager work with the patient and their physician to outline the alternatives to acute care, arrange for the care itself and facilitate payment for that care through the employers benefit plan. The patient has an advocate and help getting services and the employer can be sure that they've provided cost effective benefits.

Next, employers can recognize just how effective a communicator they can be. As a very credible source of

information for employees, their families and the public, employers can control short-term costs like employment disruption and long-term costs like medical expenses by educating about the disease. Our surveys show that 82 percent of employers thought they should be involved in AIDS education but only 28 percent were doing so.

Finally, there are still many companies who do not recognize that AIDS is very much the business of business. Their involvement needs to start with top management because AIDS will eventually impact their bottom line.

So, despite the fact that AIDS means talking about something that usually doesn't come up in polite business conversation, like sex and drug use and death, it needs to be addressed in business, preferably before the employer is literally faced with AIDS. If you wait, you lose the advantage of a planned policy and you spend more time and money catching up.

The last point is that employers really do need support to meet their challenges and look toward government in some areas. For example, hospices, home health care and extended care facilities are a cornerstone to an employers management of their health care costs. An employer can hire a case manager to determine the appropriateness of the alternatives to acute care, but what does that employer do if there's no hospice in an area, if a nursing home won't accept an AIDS patient or if there are not enough home health care workers to meet demand. This is an area where employers would like to see some government stimulation or possibly regulation to open up those things.

I've tried to highlight some of the challenges we see employers facing and our recommendations for meeting them. Personally, it's been occasionally frustrating, but for the most part gratifying for me to work with my corporate and non-profit clients to help them meet the dual demands of AIDS, of balancing their financial or economic concerns with fairness for their employees. I want to thank the Commission for having me here to testify.

MR. DeVOS: Good. Thank you, Ms. Wiley. Beny?

DR. PRIMM: No questions.

MR. DeVOS: Okay. Colleen?

DR. CONWAY-WELCH: No questions.

MR. DeVOS: John? Mike please, John. We don't want to miss the voice of Metropolitan.

MR. CREEDON: Doctor Bloom mentioned that his studies suggested, I guess -- the conclusions were not clear -- that in San Francisco there may be some discrimination in employment taking place. I wonder whether you've thought about how we might deal with that if it does in fact exist.

DR. BLOOM: That wasn't the primary concern we had in the project so far. I guess I don't feel that we've thought about it enough to make any in-depth recommendations. We're just interested in establishing that yes, there seems to be some discrimination out there and it makes sense.

MR. CREEDON: Not enough at this point to be concerned? Is that what you're saying?

DR. BLOOM: I think we should be very concerned. The unemployment rate of single males over the age of 30 in San Francisco quadrupled between 1980 and 1987. So, I think we should be very concerned. I think we can expect to see that spread beyond San Francisco in the coming years and I think it's an indication of how the American labor market is responding to the AIDS epidemic. I think it's a very serious issue.

MR. CREEDON: Well, I guess my question is, do you have any suggestions as to how to deal with it?

DR. BLOOM: No, I heard your question the first time. I can give you a menu of options, but as I say, I don't really feel capable of going into the pros and cons of each. There are things like anti-discrimination legislation, government --

MR. CREEDON: Well, there is such legislation now.

DR. BLOOM: There is such legislation now, but as I mentioned, while it prohibits discrimination against people who are actually diagnosed as having AIDS, it doesn't say anything about people who you suspect of being likely to develop AIDS. So there's no legislation that prohibits discrimination in most jurisdictions. There are some exceptions.

As a government health insurance to cover AIDS, for example, covering AIDS under Medicare such as the exception that's made for end state renal disease. That would be another way to limit the costs that employers would have to face if they employed individuals who eventually developed AIDS. By limiting those costs, there would be less incentive for employers to discriminate.

There are a variety of possibilities. It's still an early stage of the research, so I don't have much more to say.

MR. CREEDON: Thank you.

MR. DeVOS: Burt?

DR. LEE: I'll pass. I wasn't here.

MR. DeVOS: Frank?

DR. LILLY:: Well, I was extremely fascinated with your research so far. We've already heard a great deal about AIDS related discrimination in this panel. I'm not sure that we've heard what your message is. I think it's one that we need to hear.

I want to pick up where Mr. Creedon left off in questioning what we might do about this. I wonder if it is adequate -- I personally doubt that it is -- but what do you think would be the impact of stating in legislation or regulations or whatever about AIDS related discrimination that not only can one not discriminate against people with AIDS or with HIV infection, but one cannot discriminate against people perceived to be in those two categories? What would be the effect of such recommendations?

DR. BLOOM: Well, there is actually some legislation along those lines that is already in effect. Going the legislative route to try to outlaw discrimination is quite difficult. Number one, it's very difficult to prove discrimination. Number two, I think the experience of women and blacks in this country indicate that that hasn't been very effective. We all know that there is legislation in Title VII of the Civil Rights Act of 1964 which prohibits employment discrimination against women and blacks, et cetera. I don't think it should be a surprise to any of us that there is still persistent discrimination against those groups.

DR. LILLY:: Yes. I don't think the Ten Commandments eliminated sin either somehow. On the other hand, I'm not sure that I agree with you that the federal anti-racial discrimination statutes have failed to do any good whatsoever. Certainly they have not solved the problem, I agree with you.

DR. BLOOM: Actually, it might be useful if Ms. Glied would just say a word or two about the type of statutes -- I mean there are some examples of the kind of thing that you're mentioning. Maybe she could just say a word or two about that.

MS. GLIED: Actually, San Francisco has a municipal ordinance that does prohibit discrimination against both homosexuals and people who are perceived to be at high risk for AIDS. That doesn't seem to be completely solving the problem.

There's also the problem that if you define the law quite narrowly -- however narrowly --

DR. LILLY:: Is it possible that the problem would be a lot worse in the absence of that?

MS. GLIED: Oh, it's entirely possible that it would be worse. But there is this sort of additional problem that if you define the law to protect a narrow group, employers can always go one step back and just find some other characteristic that's correlated with --

DR. LILLY:: "You smell bad."

MS. GLIED: Right. So, you can only go so far as long as the economic incentives are there for the employer to discriminate. They're going to try and do it if they can.

DR. LILLY:: So, you think the situation is pretty hopeless?

MS. GLIED: No, I think the law can certainly be helpful, but I just don't know whether it can solve the whole problem.

MR. SWAIN: May I make a comment, Doctor Lilly?

DR. LILLY:: Please.

MR. SWAIN: This month's issue of Inc. magazine, which of course is a magazine that's targeted on managers of small firms, I think has a questionnaire, "Fear of AIDS," and it relates that 40 percent of the personnel managers ranked co-workers fear as a major factor, but only 11 percent ranked potential for increased health insurance costs.

So, I think the point is, why do employers discriminate regardless of whether the law says it's right or wrong and whether it can be proven? It seems to me that there are at least two reasons, and maybe in certain industries, food and so on, there are third reasons. But the two primary reasons seem to be co-workers' apprehension and health insurance costs.

The solutions to each of those I think are quite different. The result is the same, discrimination, but the solutions are different. The seems to me the co-workers apprehension solution is a bit more possible. That is increased information, as we've had some discussion on here today and I'm sure you have at your other sessions, on how you get AIDS, how you transmit it to co-workers, customers, clients and so on.

The solution to the health insurance issue is entirely different and much more complicated. So I think that one approach is strengthening laws. For the reasons that have already been cited, that's not a perfect approach. But another

approach is trying to solve some of the basic reasons on why discrimination exists in the first place. Perhaps if there were wider awareness among smaller employers in particular of the consequences, and in many cases the entirely benign consequences of hiring an individual that has AIDS or AIDS related syndromes, then that might eliminate some of the economic reason for the discrimination in the first place.

DR. BLOOM: Perhaps I could just make a footnote to that comment. That is that many small businesses are not very experience rated when it comes to their health insurance. In a sense, they don't end up paying the costs in terms of higher premiums or it's spread over a much, much wider group. I think perhaps that's the reason why a relatively low fraction of companies in this survey indicated that increased health insurance premiums are not a major concern. In that respect, there's a big difference between large firms and small firms because the extent of experience rating is much greater in large firms.

MR. CREEDON: But that could be very temporary because the number of cases that have surfaced so far in relation to what will surface based on projections is quite small.

DR. BLOOM: I don't understand. Why does that make it temporary that small firms are less experience rated?

MR. CREEDON: No, I'm saying that the impact of AIDS on small business health insurance premiums hasn't really been felt yet.

DR. BLOOM: Even if there's an increase in the number of cases --

MR. CREEDON: Ten years from now it's going to be quite different.

DR. BLOOM: -- they will not be paying--

I mean the personal medical care costs of treating AIDS have been estimated between $40,000 and $80,000. Now, if you're not experience rated, you don't end up paying that. You pay a portion of it--

MR. CREEDON: Yes.

DR. BLOOM: -- but a much smaller portion. I think that's a big difference between small firms and large firms.

MR. CREEDON: Yes, but if there are a couple of million people out there that have it and come down with it, that's significant.

MR. DeVOS: Okay. Kris?

MRS. GEBBIE: This is going to be a somewhat muddled question, I think.

What I've heard this afternoon is a little bit different than what we've heard a couple of other times and places. Particularly, this morning we had a witness who affirmed that the direct economic consequences of HIV-infected employees were so dire for small businesses, were so overwhelming to so many small businesses, that some fairly large-scale effort needed to be mounted to protect them from going under. The particular suggestion made didn't make a lot of sense to at least several of us on the Commission, but the point was clearly made.

Yet, as I listened to what's been said here, I hear a need for education, which is consistent with what we've heard at other times and places and not particularly unique to small business although we have to find a new mechanism to give it to them.

And then, the point that the illness insurance costs for their employees need to be dealt with, but that that's not an AIDS-specific issue. That's a small business cost of doing business related issue, and I haven't heard anything that says AIDS adds a particularly unique burden to that process as opposed to the employee with coronary artery disease or the employee who got run over by a runaway van in the parking lot.

So, help me out with whether I'm missing something you were telling us about the unique burden of AIDS on small businesses, or whether that is somewhat of a false alarm to us and we should be focusing on some more generic things with small businesses, if we focus on them at all.

I don't mean to exclude you from that, Ms. Wiley, if you have comments on it. But, these folks were the ones who more particularly talked about small businesses.

MR. SWAIN: Well, I wasn't here for your witness this morning. I think there is no evidence that I'm aware of, any demographic or statistical evidence, that more AIDS cases have occurred among small employers than large employers. The only even allusion to that was my statement that in certain industries, carriers have said, for whatever reason, "We're going to decide not to cover any business in that particular industry." And in many cases those industries tend to be industries that are made up of lots of small firms.

I'm not sure that I'm ready to say that right now AIDS is a tremendous crisis today for small employers. But, I think that as we observe the expansion of this virus and its effects,

that if we were to have this meeting five years from now my answer might be entirely different.

But, I think that the reason that it's a problem has more to do with the fact that the one unique situation is that small employers do tend to hire more young people and more people without a previous job, more people coming off unemployment, and more minorities. Frankly, larger firms tend to have more white males of prime working age, and small firms tend to hire everybody else in the work force, proportionately.

So, to the extent that there are risk groups that are made up primarily of those employees, those types of workers, then it's to some degree potentially a large or small business problem. But, it's primarily a small business problem, because most of these small employers don't have a lot of cash flow, profitability, flexibility to handle the AIDS issue when it comes up.

MRS. GEBBIE: But is that unique to AIDS or is that the issue of the small employer with any kind of a sick employee?

MR. SWAIN: No, I don't think that's unique to AIDS. As you suggested, it's not unique to AIDS anymore than coronary artery disease. I think the sort of workplace management personnel issues are unique to AIDS and I think they are handled somewhat differently in a small firm perhaps than in a larger firm.

DR. BLOOM: I think it's a good question that you've asked. In many respects, a lot of the analyses you've heard are applicable to coronary heart disease as well as to AIDS. But there are two distinct features of AIDS that are important. Number one, AIDS is quite expensive to treat. It does tend to be more expensive than most other serious illnesses, or certainly at the high end of the range. In addition, it happens relatively early in a worker's life cycle, which means that you -- how do I put this? For an economist, you care more about things that happen right away than that happen in the future because money has different value if you look at it at different points in time. So, something is going to happen if someone has a risk of coming down with heart disease 35 years into the future. The cost to you today, the present value of that cost is reduced substantially as opposed to if you know they're going to have some problem like that in the next year or two. A $1,000 cost 35 years from now is much less meaningful than a $1,000 cost one year from now.

MRS. GEBBIE: As I said, my question was fuzzy. I want to try and pin it down. I didn't hear anything in the last little while that makes me think we need to pose an economic AIDS specific solution for small businesses. We might need to be

proposing a health insurance or illness cost insurance proposal that's relatively specific to small business. Is that a fair statement? Again, am I missing something?

MS. WILEY: Can I just add? There are two ways that small businesses who have health benefits for their employees get those benefits. One is to buy insurance and the other would be to self insure. If you buy insurance from someone, as Mr. Creedon said, over the long-term, and it might not be this year or next year, but over the long-term, those costs are going to go up because of AIDS, because insurance carriers are reacting and increasing their premiums. So, that is AIDS specific, I think. The other is that --

MRS. GEBBIE: But not unique to small businesses.

MS. WILEY: Yes, more than large business. Large business does not have the same problem because large business pays their cost anyway.

MR. CREEDON: Well, I think there are a lot of small businesses that do not carry insurance for their employees. So, I don't know to what extent the answers to some of the questions you got reflected that. I think you said that there were eight million people employed who do not have insurance of any kind.

MR. SWAIN: That's right.

MR. CREEDON: There are 36 million people in the United States, that's an estimate, who have no health insurance of any kind. So, I think Mr. Ryder this morning, his emphasis on small business going bankrupt, I think it would be more likely that they'd just drop the health insurance rather than go bankrupt if that became a problem.

I agree. I don't think that the health insurance alone right now for small business is a huge problem because of AIDS. But I think if you look down the road to five, ten, 15 years, whatever, then it could be very significant.

MRS. GEBBIE: Yes, but the solution might not be AIDS specific. It's the illness insurance coverage piece, I think.

MR. CREEDON: Well, health insurance generally has problems right now, but AIDS will exacerbate it.

MRS. GEBBIE: Yes.

MR. DeVOS: We're going to listen to Doctor Bloom.

DR. BLOOM: Thank you. I think it's important to recognize that there are differences between small firms and

large firms when it comes to the impact of the AIDS epidemic. They're not all in the direction of increasing the costs that small firms face. So I think your conclusion that we don't need separate policies is probably correct.

In favor of small firms is the fact that, number one, they are less experience rated in their health and life insurance benefits.

In addition, and please, Mr. Swain, correct me if I'm wrong on this, but I believe that small firms are less likely to offer benefits and less likely to offer as much benefits.

Now, against the case of small firms -- I mean what makes things more difficult for small firms is, as Mr. Swain mentioned before, that the perceptions and fears of co-workers are probably a much more serious problem, and also that the financial cost of an AIDS case developing is potentially more meaningful just in terms of the viability and the continued existence of a small firm.

MS. WILEY: Can I add the one caution for small business which is over the past few years many businesses have self insured their benefits rather than purchasing insurance. I've done some work with employers in New York who have been encouraged over the past few years to self insure. In a place like New York, if you self insure, you could meet financial devastation by having one or two workers out of a population as small as 100 contract AIDS. That's one place I would say that small business should get a recommendation.

MR. SWAIN: I'd just like to make one point. I'm not sure -- and Doctor Bloom and I can carry on this conversation another time. I think I would disagree with one thing that he said. The evidence that we have is that small firms are more likely to be experience rated than large firms and that's a trend that's going to continue. We cite the Office of Technology Assessment study in our report.

Be that as it may, I think that's the trend. Experience rating is an increasing trend. So, whether it does or doesn't happen much now, I don't think that tell us that it's not going to be a problem in the future.

The other factor, of course, that Doctor Bloom suggested was in small firm's favor, that many of them don't provide insurance in the first place, doesn't help us solve the AIDS crisis.

I'll mention one final factor which we outlined in our statement. I think there's been some previous testimony before the panel on that. That is the federal COBRA law, well meaning

in its intention to provide continuous coverage, has indeed resulted in some cases in the phenomena I think Mr. Creedon alluded to, which is that when the costs go up, the response is that firms don't go bankrupt, they simply discontinue their coverage for their hard cost reasons or paperwork reasons or whatever.

MR. DeVOS: Theresa?

DR. CRENSHAW: Forgive me if this was answered in your testimony and just let me know that. Of both large businesses and small businesses, what percentage of the insurance premiums are directly paid by the employee and what percentage are covered by the employer and what are the implications for the future when insurance premiums go up to absorb the additional health costs, whatever they may be, of the AIDS epidemic? Anybody.

MS. GLIED: It's actually not that different for small firms than large firms. It's between 11 and 16 percent of premiums are paid by employees. But you would expect that if premiums go up a lot for employees who are not in high risk groups, they may demand higher wages for working with people who are in high risk groups because they realize that their own payments into the health plan will go up.

MR. DeVOS: Theresa, all premiums are paid by employees -- are all paid by customers. They're all paid by customers who are the final user of that product. In some form or another, it gets to the customer.

MS. GLIED: Just to confirm this thing on experience rating, experience rating is probably increasing for small firms. But since large firms tend to be more self insured, and self insurance is like 100 percent experience rating, the effect of that is that small firms are less experience rated than large firms. If you take --

DR. CRENSHAW: What does experience rated mean?

MS. GLIED: Say a firm has an AIDS case. Their insurance company pays out a certain amount of money. The question is, how much does the firm's premium go up after it has one case. Insurance companies consider the size of the firm in deciding how probable it is that since you've had one case, you'll have more cases.

DR. CRENSHAW: It seems that ultimately then what we're really talking about is as simple as what Mr. DeVos said in that it comes out of the consumer who purchases whatever the product is and the taxpayer for what dimensions we cope with on the taxpayer federal level. We've got to cover it somehow through these two sectors.

MS. GLIED: And the take-home pay of workers.

MS. WILEY: There's definitely a trend toward increasing that sharing with employees of the premium too. It's been going up the past few years.

DR. CRENSHAW: Getting them to pay more?

MS. WILEY: Yes.

MR. DeVOS: Admiral Watkins?

CHAIRMAN WATKINS: Mr. Swain, do you have any documentation to date where specific cases involving AIDS in the workplace for small business has eventuated in the demise of that particular small business? We have not had that brought forth to the Commission. There were allegations this morning that there was a specter hanging over the nation and we were about to go under and we should have some discriminatory laws put into effect right away to take away the small business employer's liability for any individual that might come for new employment with them that might have the HIV and to allow them to do the testing in order to hire.

Are we at that point in the nation where we have that kind of serious problem where we need to have discriminatory laws?

MR. SWAIN: In our office, or I think within the Small Business Administration experience, we do not have in our records any extensive documentation of businesses that have actually failed because of AIDS. I'm not saying that it hasn't happened, but I --

CHAIRMAN WATKINS: Have you seen any articles anywhere in the nation that have come to your attention about it?

MR. SWAIN: The articles that I've seen tend to be along the lines of how employers cope with AIDS and how employers are apprehensive about AIDS. I can't think of any articles I've personally seen about actual AIDS cases and how they've been handled. The issue of testing I think is a different issue. A small employer does want to know what is legally appropriate and not legally appropriate. But I think that that's not necessarily to be connected up with --and I think that's a legitimate issue for the panel to consider. But that's not necessarily to be connected up to the small firm issue.

In fact, if I may analogize this to the drug testing issue, most of our inquiries about drug usage has been, "What do I do once I find out an employee is using it? Not whether I'm allowed to test that employee or not," because in most cases

testing is very experience, it's time consuming and except for certain industries I'm sure, it's not a salient factor for most hiring decisions.

CHAIRMAN WATKINS: Have you had any input from the National Association of Independent Businesses or whatever the association is that says that, "This is such a big issue now that we are proposing the following very significant legislative actions to protect small business in American from the HIV epidemic"?

MR. SWAIN: I'm not aware that the National Federation of Independent Business or any other major small business group is proposing a law that would require testing or -- I think that those laws have pretty much been handled on a state by state basis. I'm not aware of any national consensus on that within the small business community.

CHAIRMAN WATKINS: At this point in time, is Small Business Association in any way recommending to the Commission in any of your documentation to us that there be legislation that we would propose in favor of small business preferentially at this point in time regarding the HIV epidemic?

MR. SWAIN: No, we're not proposing that you recommend any federal legislation whatsoever. We are proposing that you recommend as an option some federal information dissemination and we are proposing that you recommend that states adopt the National Association of Insurance Commissioners Underwriting Guidelines on avoiding discrimination in sales of insurance.

CHAIRMAN WATKINS: Thank you.

MR. DeVOS: I don't know whether it's Doctor Bloom or Mr. Swain relative to this matter of discrimination. The Admiral is zeroing in on whether cost is the real bug-a-boo in small business hiring such people or whether there's other fears that are far greater than that. We've talked about feelings of other employees. But in the kinds of businesses you're talking about, right down on Main Street where they interact with the customer everyday, I think there's a very big fear on the part of those people as to who they hire as to the reaction to the customer. That's not going to be resolved until you get down to talking about general education to get rid of the fear in a very broad spectrum. This little guy who's got a ma and pa and two or three employees, he doesn't have hiring policies. He doesn't have practices. He doesn't have anything. He just hires somebody he thinks will do the job that will be favorable and meet the customer and do well. The last thing he needs is somebody that would turn the customer off. I don't think he understands costs or any of the rest of it. He's just trying to survive.

So, I'm not being critical of where you are. I'm just saying, you run your numbers out and then beyond the numbers there are other things that are so great you can't put your hands around them. So, the greatest thing this Commission can probably do is raise this level of awareness right down to that customer. Then I think you're going to do it.

You're all shaking your head. I'm not trying to make a speech. You're confirming what I'm saying, that there's those other factors that you can't put your hands around and you can't legislate it. Not that I know of. When ma and pa decide they want a guy or don't want a guy, if they don't like him, they'll get their son, they'll get some other relative. That's just the way those things react. Do you want to say something to that?

DR. BLOOM: Just that I completely agree. But I don't think it's something we can get our hands around and we are in the process of trying to look at changing composition of the labor force in firms of different sizes, including all the way down to the ma and pa shops on the corner.

MR. DeVOS: Fine. I have 7,000 employees around the world and you have all these departments, you have policy and procedure, but that isn't the way I started. You hired somebody that looked warm. He's all right. You put him in there. If he didn't work, he left because you didn't get along. He knew it and you knew it. It wasn't discriminatory, it's just you didn't hit it off.

It's a difficult thing when you get down to small businesses where the owner is also the manager operator and try to cope with it. He doesn't have lawyers. He doesn't have a staff of people to know whether he's discriminating or not discriminating. He just doesn't feel good, so he didn't do it.

But I'm not disinterested in that. I'm just saying that's the huge problem of education at the lowest levels because of the impact customer to that employee. That's the kind of shops you're talking about. I run a big hotel as well and when you start staffing restaurants and all those things that interface directly with that customer, you begin to ask yourself all those other questions.

But I want to get over with you, Ms. Wylie, just for a moment and then we'll conclude. That has to do with cost. You're talking to us about cost savings and how we can do that.

As we've looked at some of these programs, and number one is education, and I don't know whether you can put cost savings dollars to that or not, but we had to work on fear within the organization first of all, just so they didn't panic as a general human being. I don't know what the impact is on that,

how many conversations you save, how much efficiency you gain in a company because the people aren't worried about what's going to happen next or is this person contaminated or isn't he. The decrease in efficiency has got to be fantastic as to coffee shop time and all the rest of it.

The next thing is the discriminatory issue. Are you willing to work with somebody and how are you going to get along together and how are we going to make that mesh so that fear disappears? But the last part of that thing is what we've been trying to work on, that is prevention. There are, I think, some major cost savings if you can alert your employees to methodology and their behavioral conduct to really reduce the epidemic in general. I haven't heard a lot about that when we talk about corporate education, but it is a major portion of the educational job. I think the cost savings to that company will be fantastic, if they will all tend to that with their employees. It shows love, it shows care. First of all, you have a policy that will care for them. Then you begin to talk about how you can conduct yourself to avoid this.

MS. WILEY: For the most part, when we talk to employers, we talk about predicting their costs from now until 1991. When employers ask about costs beyond 1991, the word is education. Really what's going to happen in the workforce and with your employees dependents is set by their behavior of the past years. To get into the future, beyond the next four or five years, it depends on behavior and behavior is education. So, that's phase two of cost savings.

MR. DeVOS: I just hope that in whatever you're training your people to do and talking to them about it, you're really working on that prevention thing and behavior modification so that we prevent the spread. But I'm always intrigued with cost discussions and how somehow the company is going to pay, the employee is going to pay. I tell you, the customer pays every time, no matter what the equation is or the employee has to give up. If an employee is going to pay more taxes, he has to give up something personal and you all know that. So, it finally gets down to the bottom line. It means the average American citizen pays or the worker just has less to have. So, these are big issues. We want to thank you for being here today. We appreciate your concern and your input and the knowledge you bring to bear on the problem. The Commission is grateful to you. Thank you very much.

Public Sector Issues

CHAIRMAN WATKINS: We have in the next panel today a little different focus. The focus of the last panel is going to be on the public sector. We'll be looking at issues in concern to the state, the county and municipal employers and employees.

The Commission will cover issues concerning the federal sector at our upcoming meeting next week, May 16th. Today's witnesses will include the Honorable Mayor of the City of Indianapolis. He has indicated that he will be a little late arriving. I'd like to ask the indulgence of the other witnesses and we'll proceed with the hearings, continue with whoever is speaking at the time the Mayor arrives, if in fact we have not completed all your testimony, and then allow the Mayor to pick up and, knowing he probably has time constraints on him, to allow him to have some flexibility. Is that satisfactory with the witnesses?

So, we'd like to have Mr. Jordan A. Barab, Occupational Safety and Health Coordinator, American Federation of State, County and Municipal Employees, AFL-CIO, Washington; Mr. Richard M. Duffy, Director, Department of Occupational Health and Safety, International Association of Fire Fighters, Washington, D.C.; Mr. Dewey R. Stokes, President Fraternal Order of Police, Columbus, Ohio; and Mr. Don Novey, State President, California Correctional and Peace Officers Association, Sacramento, California, if he is here. It looks like he may not be here yet.

If you'd take your places at the panel and we'll proceed with the statements starting with Mr. Barab.

MR. BARAB: Thank you. My name is Jordan Barab. I'm the Occupational Health and Safety Coordinator for the American Federation of State, County and Municipal Employees. AFSCME has over 1.1 million members across the country, many of these including hospital workers, mental health, emergency care, corrections, law enforcement, custodial and waste water treatment, who commonly have on-the-job contact with blood and body fluids.

The purpose of my remarks today is to address the concerns of public employees. As you will see, the concerns of public employees are very often no different from private sector employees, except for two areas. First, there are more public employees in such occupations as health care, corrections and other jobs which may have significant direct contact with persons with AIDS.

Second, to the extent OSHA is stepping in to protect the health of care givers, it should be remembered that except for in 24 states which have federally approved OSHA plans, public employees in this country are not covered by OSHA and therefore do not fall under the OSHA's targeted inspection program.

AFSCME has been dealing with AIDS since early 1983 when we received an urgent request from members of a local representing mental health workers. They had just received their

first resident who was known to have AIDS. Management was trying to keep it secret and no training or education had been done. We were asked to come in and do training for the workers at the institutions.

Since that time, information on AIDS has been AFSCME's most requested item. As we began to write fact sheets and do workshops for health care workers, mental health, corrections and others, we found a shocking pattern of disregard for basic blood-borne infectious disease precautions. Workers had not been trained, equipment had not been provided and work procedures had not been adjusted.

For this reason, AFSCME petitioned the Occupational Safety and Health Administration in September of 1986 for three items: an emergency temporary standard covering blood-borne diseases such as AIDS and hepatitis B; inclusion of infectious diseases into the OSHA hazard communication standard; and a generic OSHA standard covering all infectious diseases.

As you may be aware, OSHA rejected all three of our requests in favor of a targeted inspection program covering blood-borne infectious diseases in health care workers. As health care workers are not the subject of the hearing today, I will not concentrate to any great extent on the problems of these employees. I'll address the remainder of my remarks to those public employees who are not hospital workers.

Corrections and mental health. Corrections officers and mental health workers across this country have expressed an enormous amount of concern about AIDS. As the population of most prison systems contains large numbers of HIV drug users, there were a large number of prisoners with AIDS and with the HIV infection. Furthermore, Corrections personnel frequently experience violence where there is exposure to blood as well as unsanitary conditions where urine and feces is thrown at them.

Mental Health personnel also face these conditions, in addition a number of person who cannot be responsible for their actions. Furthermore, as cases of AIDS related dementia increase, more and more persons with AIDS will find their way into mental health institutions.

Institutional employees are in dire need of training. Traditionally, management's first response is to say as little as possible, tell everyone not to worry and go on about their business. This approach only increases whatever panic was already forming among the employees. We are frequently called in on an emergency basis to educate workers about AIDS.

The second problem is that management often does not make protective equipment available, even where obviously needed.

This includes rubber gloves for cleaning up blood spills and resuscitation masks for artificial respiration. Unfortunately, as correctional personnel are not classified as health care workers, they do not fall under the OSHA directives. Similarly, CDC has no guidelines for correctional institutions.

Custodial employees. AFSCME represents a large number of school and other custodial employees. While it is not immediately obvious that these persons should be concerned about AIDS, in fact whenever a child is injured or ill, it is the school custodian who must clean up. While this does not have to be a high risk venture, it is important, nevertheless, that these workers at least be provided with gloves and training on how to clean and disinfect. Custodial personnel as well as groundskeepers in other buildings report finding used needles in the trash or on the grounds. Again, they need training on how to deal with such occurrences.

We feel that blood, where it is found, should be treated like a toxic substance and that workers need to be trained to deal with it safely. Like corrections personnel, school and building custodians do not fall under OSHA guidelines.

Sanitation. As Bill Borwegen from the Service Employees International Union will make clear tomorrow, the infectious waste management procedures at many hospitals have completely broken down. This leads to infectious waste being tossed out with the regular trash. We receive frequent reports from our members who are sanitation workers about finding red bags full of bloody materials, needles and sometimes even body parts.

Giving workers the right to know about chemicals they are exposed to in the workplace has been one of the major health and safety items of this decade. Dozens of state and local laws and a major OSHA standard give workers the right to know about chemicals they are exposed to. AFSCME feels that employees also need to be trained about the infectious diseases they may be exposed to. While it is obvious from my previous remarks that this is true for AIDS as well as hepatitis B, it is also true for other diseases which should peripherally be the concern of this Committee.

For example, many persons with AIDS are developing active cases of tuberculosis. TB is an airborne disease and the precautions used around persons with TB are therefore very different from those to be used around persons with AIDS or any other blood-borne disease. Workers who work around persons with AIDS therefore also need to be trained about TB.

I should also mention cytomegalo virus here which is known to cause birth defects in pregnant women. That's also a

disease that occurs with many persons with AIDS and it's something that workers who are pregnant or are planning to be pregnant at least need to be educated about.

Universal precautions. The bottom line is that it's impossible to determine solely by a person's job title whether or not he or she will be exposed to body fluids. It is therefore essential for all employers to analyze an employee's potential for exposure according to the actual work he or she does in order for them to be able to take the universal precautions that the CDC recommends. This approach is endorsed by the joint advisory notice issued by the Departments of Labor and Health and Human Services.

Testing. AFSCME opposes any mandatory testing of any employees in any occupation. Aside from the obvious civil rights problems such testing could cause, there is no evidence that infected employees are a threat to anyone else. There has been considerable controversy within our union, however, about testing prison inmates and mental health patients. Some feel that given the level of violence and unsanitary conditions in these institutions, such testing may be warranted in certain situations. Others feel it is unnecessary or, at most, it should only be done if there has been direct contact.

Civil rights. One area I have not covered in my oral remarks is workplace discrimination against persons with AIDS. I believe that's been covered in other hearings before this Commission. AFSCME believes that AIDS or infection with HIV should fall under the provisions of the Rehabilitation Act of 1973 and a reasonable accommodation should be made for all who need them. I've not gone into great detail in this area of testimony because the concerns of public employees are not unique in this area.

In conclusion, public employees do much of the most important and dangerous work that this country needs to make life safe and enjoyable. In the case of AIDS, we will increasingly provide the bulk of the care givers in hospitals, prisons, mental health institutions and schools. For the service, we need to receive proper education, training and protection which will enable us to do our jobs with the energy and caring that the public and persons with this terrible disease have come to expect. Thank you.

CHAIRMAN WATKINS: Thank you, Mr. Barab.

CHAIRMAN WATKINS: Mr. Duffy?

MR. DUFFY: Mr. Chairman, Members of the Commission, my name is Richard Duffy. I'm the Director of Occupational Health and Safety for the International Association of Fire Fighters.

On behalf of our organization, which represents 175,000 paid professional fire fighters throughout North America, I appreciate the opportunity to address the President's Commission on AIDS. Fire fighters as a group are at risk of contracting HIV and other communicable disease transmitted through their contact with blood and body fluids. In fact, there are very few fire fighters in our country who do not come in contact with injured and bleeding victims of fires and other accidents, often in a dangerous, uncontrolled environment where changes for exposure to these diseases are greater.

Unfortunately, much of the attention within the medical and scientific community has focused on protecting hospital workers from infectious diseases, particularly AIDS. Insufficient attention has been paid to protecting emergency response personnel who work in unsterile environments that are less easily controlled than a hospital or a clinical environment.

According to a survey of occupational deaths and injuries that our organization has been conducting for well over 30 years, about two percent of all fire fighter injuries received during emergency operations were contraction of a contagious disease. Contracting a contagious disease was more prevalent than cardiac abnormalities, cold injuries, heat exhaustion and heat stroke among injuries received at an emergency scene by fire fighters.

The above documentation indicates that this Commission and the Reagan Administration can no longer ignore the needs of emergency personnel as it develops its policies and standards on occupational exposure to HIV and other communicable diseases.

At the IAFF, we're extremely proud of a recent publication that we developed on guidelines to prevent transmission of communicable diseases during emergency care for fire fighters, paramedics, and emergency medical technicians. This was the first set of guidelines specifically adopted for emergency response personnel. It has been well received, with more than 30,000 copies already distributed around the country.

Additionally, the National Fire Protection Association, a voluntary consensus standard-making organization for the nations fire service has recently taken action to publish a document almost identical in context. We believe these guidelines represent a rational and a practical approach to the prevention of communicable diseases during emergency care and victim rescue. In an emergency care setting, the infectious disease status of patients is frequently unknown by both providers -- the fire fighters -- and patients themselves.

For example, in Phoenix, Arizona, fire fighters and paramedics responding to a call, found a man lying in a parking

lot near a bar. The man had been beaten, injured, was unconscious and was probably drunk. What the responders, the fire fighters, did not know as they eased him onto a backboard was that he was also a carrier of hepatitis B. As the victim was being strapped to the backboard, he was revived and became violent. While thrashing, his nose began to bleed. He also spat at the fire fighters and paramedics. During the struggle, several fire fighters suffered cuts and abrasions.

I give you this example even though it involves hepatitis B. It forced the Phoenix Fire Department to initiate a complete contagious disease program, including the full inoculation of all personnel with hepatitis B vaccine as well as putting in a full-time contagious disease officer. It was their position that if one of these paramedics or fire fighters contracted hepatitis B, the cost for that one injury alone would have been offset by having a full contagious disease program which they have implemented. It's one of the first fire departments throughout the country to do so.

Since in an emergency care setting, the infectious disease status of patients is frequently unknown by both providers and patients themselves, the IAFF believes that this Commission and the Reagan Administration should insure, through its policies and regulations, that all patients be considered infectious.

Prior to any contact with patients, emergency response personnel must be required to cover all areas of lacerated, chapped, irritated or other damaged skin with adhesive dressings and emergency response personnel with extensive skin lesions or severe dermatitis must be required to refrain from any direct patient contact and from contacting, using or handling patient care equipment until that condition is healed.

We also believe that it is imperative that all needlestick/cut/slash injuries be recorded by emergency response personnel and other health care workers in the OSHA log or a system developed by the fire department. Proper documentation of such exposures needs to be maintained.

Workers who suffer needlestick injuries, other penetrating wounds or are somehow exposed to blood or body fluids should be offered medical attention immediately. Such medical attention must include post exposure counseling, voluntary testing, prophylaxis, medical screening to determine a worker's status and this should be provided at no cost by the employer to the employee.

The worker should also be offered a follow-up test at an appropriate interval to see if a conversion has occurred. Exposed employees and their families should be offered medical

counseling in order for them to deal with the situation. Medical records should remain confidential between the employee and the medical personnel conducting the screening, counseling, et cetera.

In the area of protective clothing for emergency response personnel, our union believes that structural protective equipment must be worn, especially in a situation where rough or sharp surfaces are likely to be encountered, such as removing victims from automobile accidents. We also believe that the use of disposable latex or vinyl gloves must be used and required for all personnel prior to initiating any emergency patient care. Mechanical resuscitation devices, such as bag-valve masks and oxygen-demand resuscitators, must be available to all fire department vehicles that respond or potentially response to medical emergencies or victim rescues and they should be used. Mouth-to-mouth resuscitation should not be used, whatever the case may be. These mechanical devices must be available and utilized by these personnel.

We also believe that masks, goggles and gowns must be present at all times and all fire department vehicles that respond to or potentially respond to medical emergencies or victim rescue. The employer must make sure that not only this clothing is provided, but that they are donned and used in situations where blood or blood splashes may occur.

We also strongly believe that puncture resistent, shatterproof, disposable containers be required on all fire department vehicles for placement of all sharp objects.

In the area of cleaning and disinfecting, a concerted effort must be made to ensure that bleach is never used on any fire fighter protective gear, coats, trousers, fire fighter gloves and fire fighter station and work uniforms, contrary to the policies that have been put out on the street now, especially those by the Centers for Disease Control. Bleach does compromise structural integrity and/or fire retardancy of the fabrics that are used in fire fighter's equipment. When contaminated clothing cannot be cleaned with a mild detergent in a hot wash cycle in a front-load washing machine, then the clothing must be disposed of in a proper fashion.

We also recognize and acknowledge that the training of emergency response personnel across this nation is haphazard and not uniform. I give you this example. Two fire fighters in Barre, Vermont are currently under investigation for possible serious disciplinary action because they put on gowns and gloves prior to treating a prisoner who attempted suicide and had admitted in open court that he had AIDS. No formal training was ever provided to these Barre, Vermonth fire fighters who now face disciplinary action and have had their emergency medical

certification removed--at least temporarily--because they decided to utilize gowns.

A written bulletin from the Vermont Department of Health to emergency responders advised using individual discretion when treating potentially infectious patients. However, a nurse transmitting on a radio to fire fighters at the scene informed them--not knowing the condition involved, that gowns were not necessary when treating any patients that have AIDS.

It is evident that a uniform training program for emergency response personnel must be an important policy consideration. Incidents such as the one that recently occurred in Prince George's County in Maryland where fire fighters were denied knowledge of a patient's HIV status by the hospital after responding to a situation where a massive amount of blood was present and fire fighters were exposed to should be prohibited. Fire fighters learned that the patient was HIV-positive through indirect, informal sources. The individuals that transport infectious patients should not be denied information available to others who treat that same patient in the hospital.

Most hospitals have systems in place, either formally or informally, to notify their own personnel who have had a significant contact with a patient who, in the normal course of their treatment, is disclosed to be infected. Several states have already adopted legislation mandating hospitals to extend this same protection to the field. Emergency response personnel are at equal or perhaps even at a higher risk of exposure.

Ironically, in the state of Maryland, where the P.G. County case had happened, the state promulgated a notification law. However, because of political considerations, the bill was doomed if they included HIV in it. Thus, HIV was exempted from the notification law. Many other states have adopted hospital notification provisions for emergency response personnel.

Although out union believes that confidentiality provisions should be incorporated, we do not believe that an issue of privacy should deny workers the right to know about a patient's health status. National notification procedures should be a priority of this Commission's recommendations.

As we have mentioned, many in the medical community have minimized the risk of exposure for emergency response personnel to disease such as AIDS. However, these risks exist with consequences not always strictly medical.

For example, in Southern California, a fire fighter responded to an auto accident which required emergency medical care. The auto and the patient were located at the bottom of a

cliff and fire fighters at the scene had to repel with ropes down the side of the cliff to reach the emergency scene. THe victim was found to have stopped breathing. Instead of waiting for mechanical resuscitation to be lowered down the side of the cliff, CPR, which included mouth-to-mouth resuscitation, commenced. Despite this effort, the victim died. It was later determined that it was a suicide and the victim did have AIDS.

When the fire fighter explained the situation to his wife, she immediately became hysterical. Separation did and still continues to this day with that family and friends, including fellow fire fighters avoiding any contact with this individual. Even though the blood testing for this individual performed thus far has shown no signs of the AIDS virus, this man had very real fears and very real concerns.

The impact of AIDS in the fire service has another dimension as well. That is fire fighters who contract the disease, whether due to occupational exposure or personal lifestyle. While we are in agreement that casual contact at most work sites posses not threat of transmitting the AIDs virus, we believe that the workplace environment confronted by fire fighters does pose a potential treat of transmitting the AIDS virus to fellow workers and the general public.

The emergency environment faced by fire fighters is often uncontrollable with many, many hazards. According to our data through our death and injury survey, 20 percent of all injuries of fire fighters at the emergency scene are lacerations and contusions. Furthermore, almost ten percent of all fire fighters throughout this country can be expected to suffer a laceration or contusion at least once during the year. This high probability of attaining a cut during emergency procedures must preclude the employment of individuals with AIDS to do active, emergency fire fighting duties and, of source, emergency medical duties.

That is not to say that our union or the fire service lacks any compassion. In fact, one of our locals in Warrenville Heights, Ohio recently negotiated a contract with the provision that provides that any fire fighter with AID shall be insured of his entire salary and benefits until his death or normal retirement age. It is a policy that recognizes the risk of emergency operations and exposing fellow fire fighters and the public to blood contaminated with the HIV virus. It also recognizes the responsibility to reach out and assist those victims of AIDS.

Before closing my remarks, our union hopes that this Commission will utilize its influence to support the enactment of H.R. 3418 which is currently in the U.S. House of Representatives. In summary, this measure would require

hospitals to transmit notification to the employers of emergency response personnel who transport a victim to a hospital and is found to be infected with AIDS, hepatitis B, hepatitis non-A/non-B, pulmonary tuberculosis and meningococcal meningitis.

It also provides funding for the development of training curriculum by the Centers for Disease Control for educating emergency response personnel with respect to the prevention of exposure to infectious diseases. It establishes three grant programs totaling $25 million for states to implement the CDC training curriculum, to conduct demonstration projects to provide vaccines and to make voluntary AIDS testing and counseling available to emergency response employees notified of an exposure to an AIDS patient. It also insures emergency response personnel maintain confidentiality and non-discrimination protects for AIDS patients.

Once again, we appreciate the opportunity to address this Commission. It's our hope that this Commission and the Reagan Administration will ensure that emergency response personnel, including fire fighters, paramedics and emergency medical technicians are adequately trained, provided protective equipment, vaccinated if there is availability, and notified after any of their exposures.

CHAIRMAN WATKINS: Thank you, Mr. Duffy.

MR. STOKES: Mr. Chairman, Members of the Committee, I am pleased and privileged to have this opportunity appear before you and to speak on behalf of 190,000 full-time law enforcement officers in the Fraternal Order of Police.

The spectre of AIDS has obviously been a matter of great interest in both the public and private employment sector. With the possible exception of the health care community, I can think of no profession that is more critically concerned with the issue than the members of the law enforcement community.

If is my intention today to be very brief and identify the principal concerns of the members of the Fraternal Order of Police and in understanding the context in which the law enforcement officers deal with the AIDS syndrome.

It is not my purpose, and I hope there is no need for me to list to you the various ways which law enforcement personnel most often become exposed to the AIDS virus. It should enough be to say that our members are asked to confront, control and often confine members of the public generally and members of the highest risk groups specifically under the circumstances that are extremely dangerous in all senses of the word. Whether administering first aid to a bloody roadside accident victim of collecting evidence at a bloody crime scene, there are, or at

least we have reason to believe that there are, great dangers in our job because of this deadly virus.

We're an extremely dedicated group of professionals who have voluntarily assumed the responsibility and the risk of fighting crime. We used to know what we were up against. We knew what would happen if we were careless. Our collective experience helped us to confront these risks. We are training to accept the facts of life.

AIDS and the fear of AIDS, however, is something totally different. Wee read the newspapers, we listen to the TVs and we hear the horror stories and we believe that we have reason to be concerned. It's hard for us to do our job when in addition to other concerns that we have learned to deal with, we must deal with the uncertainty of AIDS.

We want to perform our duties fully and without reservation. However, it is not easy to do so without some degree of assurance and protection against the real, and in many cases, the imagined threat of AIDS.

In addition to the fear of contracting AIDS, there are also the practical and human consequences of exposure to the contraction of AIDS. These are some of the most common question that we are asked as an organization. "Can I really get AID? How? Is there anything I can do prevent it? Is there equipment to protect me? Who will pay for the equipment? What is an employer doesn't have the money? What happens if I'm exposed? What happens if I get AIDS? Will I lose my job, will I die? What do I tell my family? Who will pay the bills and who pays the doctor and the hospital? And if worse happens, will my family be taken care?"

Much general information is being distributed to the public. Many police departments have AIDS policies, almost all of which are similar and tell us to be careful, to wear gloves when able, to handle evidence carefully. Yet these policies rarely tell us what will happen if. We don't ask for the impossible. We simply want the truth about AIDS, getting it, preventing it and dealing with it. Three general areas of concern exist, contraction, prevention and assistance.

Contraction: How do you really get AIDS? Can you get AIDS from a crime scene, a bite or a fight? If any, how many law enforcement officers have contracted AIDS in the line of duty? How reliable are the statistics we're reading about? Who has or hasn't contracted AIDS? Should education or informational efforts be directed the police officers, their spouses and their families? It's a growing concern that officers may become exposed to the virus, bring it home and infect his or her family.

Prevention: What are the most effective means of prevention? If there is equipment to minimize the risk of exposure, will governmental employers have the funds available to buy the necessary equipment? Are present policy policies adequate? Are they the product of last year's medical studies? What steps should be taken to identify carriers of virus who may be exposed to police officers during a confrontation? Are our female officers who may be pregnant at a greater risk?

Assistance: What are the legal and factual consequences if a police officer is exposed to or contracts AIDS. Will he or she be suspended? Will they lose their job? Will I be considered injured on duty? Will I be considered disabled? How long will the sick or injury leave last? Then what after it's concluded? Will my health insurance cover everything? Will there be deductibles? Will health insurance be available? Is getting AIDS covered by workers compensation laws? What assistance will be available to me and my family after I learn that I have been exposed to the virus? Who will help us deal with the fear and the stress? Will counseling be available to me and my family? Who will help us through the testing period? And if I contract AIDS, will there be a family counseling available to help me keep my family together?

I've just listed a few of our most pressing concerns. I noted just this past week that the New York Appellate Court threw out a lower court's ruling that a woman who bit a deputy sheriff could not be tested for AIDS. How do you deal with the fact that often the courts will do noting to assist in those circumstances where a real possibility of AIDS contraction exists?

One common denominator exists for all of us, education and information. We're bombarded with news about AIDS, yet we are confused. Through a comprehensive focused educational program which is supplemented routinely and focused specifically for law enforcement personnel, many of these issues I have raised could be addressed. Through the collection and analysis and distribution of real and factual data, I believe many of the fears pervading law enforcement can be quieted. An educational program based on current data will allay fears, improve the precenton of AIDS exposure and contraction and assist officers and their families to cope with the fears and the facts about AIDS.

Accordingly, we have a number of recommendations I would like to briefly list here. Data should be collected through mandatory reporting requirements of all law enforcement related AIDS incidents. This would include job related exposures and contractions of the virus as well as underlying data concerning the circumstances of each case. While this data need not identify specific officers, the data can identify the most

frequently occurring incidents and thereby assist in focusing our attention on the highest risk activities and their prevention.

A specifically focused enforcement educational program using the data collected on incidents and most current medical data available concerning the contraction and prevention of the virus.

Third, subsidy or assistance should be offered to public employers to insure that effective protection equipment is available, despite the perpetual financial problems public employers operate under.

Fourth, a national policy should be established to standardize the response of public employers to public employees who have been exposed or have contracted viruses. Specifically, this should include guidelines, recommendations and requirements concerning the issue of relating to health, disability insurance, workers compensation, disability pension and aftercare. Should law enforcement personnel who contract AIDS in the line of duty have to pay for their own tests and treatments or be subject to deductibles? We hope not.

On behalf of the 190,000 members of the Fraternal Order of Police, I want to thank the Commission for its interest and this opportunity to present our views on this most troubling subject.

CHAIRMAN WATKINS: Thank you, Mr. Stokes.

CHAIRMAN WATKINS: We're very honored at the arrival of the Honorable William Hudnut, III, Mayor of the City of Indianapolis. We thank you for taking time to come today, Mr. Mayor.

We also appreciate the warm and friendly relationship that your people have extended to us here during our stay. It's been a great visit and these facilities are probably the best we've seen. We very much appreciate the attention of the local media and the interest shown by your high school students and others who have attended the hearings. So, thank you. We'd like to take your statement now. I know you are pressed for time.

I will ask the Commissioners to frame their questions in their minds for the Mayor. We will focus our questions to him and then he will be leaving right after we complete. We'll start over here with Mr. Creedon after the Mayor has a chance to make his opening statement. Mr. Mayor?

MAYOR HUDNUT: Thank you very much, Mr. Chairman and Members of the Commission. First of all, on behalf of the City of Indianapolis, it is indeed a privilege and a pleasure to

welcome you to our city. We're grateful for the opportunity we have to extend to you our hospitality and we're also grateful for the work that you're doing.

I am particularly please to have an opportunity to share just a few brief thoughts with you. Coming form the vantage point of being mayor of this city, being a generalist and not a specialist, I was interested in and find myself supporting the testimony you've just heard from Mr. Stokes. I'm sure that the other members of the panel that are dealing with the public sector issues have some very thoughtful presentations to make. But I thank you for giving me the opportunity now to make mine.

I'd like to introduce to the panel Ms. Kristie Hill, who is our city attorney, who is with me, who assisted me in the drafting of the policy I'm going to tell you about, and Mr. Don McPherson. They're both sitting right in back of me. Mr. McPherson is the Director of our Department of Administration, where most of the responsibility for implementing our policies will be lodged. It is conceivable that I might not be able to answer the questions that you ask me. If not, with your indulgence --

CHAIRMAN WATKINS: We'd be pleased to have them join you. Maybe we could just shift over. We'll get some chairs and ask your colleagues to come up with you, Mr. Mayor, and then they can be free to answer questions. We'll put the names that you gave us on the record and include them as part of the witnesses.

MAYOR HUDNUT: We are very grateful for the opportunity that your Commission has allowed us to share out thoughts as a public employer about the AIDS epidemic in America and , more particularly, in Indianapolis.

To date, there have been 120 cases of AIDS reported in Marion County, which is the county in which Indianapolis is lodged, with 59 deaths. It is estimated that 50 to 100 times that number of reported cases exist, but have not been identified.

The State of Indiana ranks 13th in the nation in the number of reported AIDS cases. By the end of 1989, statistics predict that there will be 270,000 AIDS cases in American 179,00 deaths. All of our lives will be touched in some way by the AIDS virus, whether it be as an employer or co-worker, relative or friend. I think we must marshall a compassionate and professional approach to this subject. The City of Indianapolis is the 9th largest employer in Marion County with 4763 employees. As the mayor of this city, it is my responsibility to protect the rights of all of our citizens and all of our city and country employees.

The AIDS epidemic represents a challenge, in respecting individual rights on the one hand while at the same time safeguarding public health. The federal and state governments have worked hard toward developing policies and program on AIDS. The recently announced federal government guidelines for employees and recently passed state legislation by the Indiana General Assembly, with leadership of Senator Patricia Miller from Indianapolis, places an emphasis on creating an awareness and understanding of AIDS related issues and employee conduct towards HIV-infected co-workers.

I also applaud this decision and the efforts of HHS Secretary, Doctor Otis R. Bowen, whose name I had to work in since he used to be the government of the great state of Indiana, and Surgeon General C. Everett Koop in their recently announced campaign to mail an AIDS informational brochure to every household in the nation.

It is our responsibility as employers and as elected representatives of the people in this country to educate the public about AIDS, how it is transmitted and how transmission can be prevented. We take this responsibility seriously in our city. This afternoon, shortly before I came over here, I signed an executive order stating the city's policy on AIDS and our employees. I would like to take just a couple of minutes to share this policy on AIDS and our employees. I would like to take just a couple of minutes to share this policy with you and announce it publicly in the hopes that it might serve as a guide for other municipalities across the state and nation. I don't know how many other cities and states have these policies, but knowing that you were coming, three weeks ago I asked these individuals and some others in City Hall to help us work up this policy statement.

The executive order that I signed this afternoon states the following. There are ten paragraphs in it.

1) The City of Indianapolis shall not discriminate against any employee or applicant for employment with respect hire, tenure, terms, conditions or privileges of employment or any matter directly or indirectly related to employment because the employee or applicant is or is suspected of being infected with the AIDS virus.

2) The City shall allow employees who are infected with the AIDS virus the same leave allowances and considerations as are available to an employee with any other type of physical or mental disability.

3) The Department of Administration, which Mr. McPherson heads, shall develop an education program about AIDS and make it available to all levels of City employees.

4) The Director of the Department of Administration shall appoint an AIDS coordinator who shall be responsible for establishing an education program on AIDS; who shall keep current on the latest AIDS information and therefore act as an AIDS clearing house for the City; who shall generally coordinate all of the CIty's efforts in dealing with the effect of AIDS on the City's work force; who shall be the City's liaison with other agencies dealing with the AIDS question; and who shall perform any other duties as assigned by the Director of the Department of Administration.

5) The City shall further make available to employees and the general community ongoing educational opportunities about AIDS through its program capabilities on Channel 16, our government access channel.

6) The Department of Administration shall explore the availability of counseling through its employee assistance program and wellness programs for City employees who may be infected with the AIDS virus.

7) The City shall make available to all City employees free AIDS testing should any City employee desire to be tested.

8) The City shall maintain the confidentiality of any information received regarding whether an employee is infected with the AIDS virus unless the employee explicitly gives written approval to disseminate such information.

9) All City agencies whose employees come into contact with blood or bodily fluids on a regular basis shall provide training and develop safety procedures to be used by their employees in dealing with such bodily fluids.

10) The City shall comply with all state and federal laws and regulations regarding AIDS.

On behalf of the policymakers and health officials here in Indianapolis, I urge the citizens of our community to learn about AIDS and to take the necessary precautions to prevent contracting AIDS. I thank you for the opportunity to appear before this distinguished Presidential Commission.

CHAIRMAN WATKINS: Thank you, Mr. Mayor. We appreciate very much the effort that you've put into the development of that policy. We'll receive that executive order the Commission records.

MAYOR HUDNUT: I believe that's been given to your staff.

CHAIRMAN WATKINS: And we'll start the questioning with Mr. Creedon for the Mayor.

MR. CREEDON: Well, it sounds like an excellent statement, Mr. Mayor. One of the things I wondered whether it covers recommendations that several of our other panelists have made, and that is to give notification to either the police officer or the other work if there is an incident involving a person with AIDS and blood and so forth?

MAYOR HUDNUT: Well, Mr. Creedon, I'm sorry that I didn't hear all the testimony that preceded me, but I think that in a general response to your question, the paragraph in here on procedures would cover what you are --

MR. CREEDON: Does cover? Fine.

MAYOR HUDNUT: including, although its not explicit. But it is implicit in the directive that I want to give to your Director of Public Safety, for example, to develop procedures that will protect the safety of our public safety employees as they are working with people who are in some sort of distress. It seems to me that the notification should be there and that would be part of the procedures that will implement as a result of this executive order. I might just add that if there are others with similar kinds of recommendations, we'd be glad to hear from you.

MR. CREEDON: The other question -- do I have two Mr. Chairman, or one?

CHAIRMAN WATKINS: Yes, please.

MR. CREEDON: You indicated that there have been 120 AIDS cases in Marion County and 59 deaths, not an insignificant number certainly. I wonder, in dealing with these cases, and I address the question not only to you, Mr. Mayor, but to your associates, what have been the most difficult issues that you've had to deal with and are there any recommendations that you would make to us as a Commission in relation to those?

MAYOR HUDNUT: We have a Marion County Health Department which you may or may not have had a chance to be introduced to. They could answer the question much more helpfully than I could.

Let me just say in a general way that I think as we got into this over the last two or three years, one of the main things we had to overcome was attitudes and attitudinal change, not just here but throughout America with regard to the presence of this virus and its epidemic proportions. That involved a learning experience for all of us.

You say what was the most difficult thing that we had to deal with? I suppose just the necessity for people coming to understand -- if you can put it this way, I guess that you don['t treat these people like lepers and put them off somewhere.

You all know about Ryan White and the problems he's had. He's not from Indianapolis, he's from the road a little ways. We're a suburb of Kokomo and he's from up that way! But I think the way in which he described his experience to you and to the American public illustrates the kind of problems that you have to deal with with regard to understanding what AIDS is all about, with an acceptance of it, with non-discrimination and with a professional and compassionate approach to it. Maybe there's something more that either of you could add.

CHAIRMAN WATKINS: Thank you. Doctor Lee?

DR. LEE: Along with Mr. Creedon's questions, I'm interested in the demographics of the Indianapolis problem. How many drug abusers do you have, how many women do you have, how many kids do you have?

MAYOR HUDNUT: I'm sorry, I can't answer that. We could get that information for you and make it available to the record probably before you leave town, but I don't have that available to me. Well, may I do after all. Beverly Guidara, I should have introduced you. My press secretary and executive assistant. Pediatric cases increased from 11 cases in 1981 to 750 cases i 1987. That's the national figure, isn't it? Aren't you giving me national figures here?

MS. GUIDARA: Yes.

DR. LEE: Well, we don't want to push you. I thought that your administrative aide might have had that. We've been terrifically concerned particularly by the pediatric problems because they're going to impact like the dickens on your local hospital system. I was interested to know what the character of the problem was here.

MAYOR HUDNUT: I'm sorry I can't answer that, but I tell you what, I'll get you the answer.

CHAIRMAN WATKINS: I think it might be useful for us to have the demographic breakdown because we're often accused of being New York biased, for example, that we're not that interested in others. So, I think it would be useful to know just how it is broken down and perhaps that 200 minus cases that you've already had some of your projections, how they're demographically broken out and how you would estimate some of the projected problems in the city here under your purview.

MAYOR HUDNUT: It's just been whispered to me that we do have somebody here from the Marion County Health Department. Can they answer?

CHAIRMAN WATKINS: Yes. Please come forward and state our name.

MAYOR HUDNUT: Please come forward quickly.

CHAIRMAN WATKINS: Just grab the microphone there and don't hesitate.

MAYOR HUDNUT: Mary McKeever from the Indianapolis Public Health Department.

MS. McKEEVER: Right. Marion County Health Department. The question originally about the cases and the breakdown, we have about 83 percent of the cases that involve homosexual/bisexual males. Lumped in there are the IV drug using homosexual/bisexual males. We have about seven percent intravenous drug users listed as the risk. We have two percent parent at risk, two percent partner at risk, two percent transfusion hemophiliac, and the rest is sort of insignificant.

But 90 percent of our cases involve some sort of sexual activity. Then seven percent is the IV drug using. We guesstimate that in the state there about 7,000 IV drug users.

We've just started a program to have a community health outreach worker go out into the streets to find the people that are using drugs that we can't reach through treatment programs and to gather some information from those people as well as educate them.

CHAIRMAN WATKINS: Do you have the general demographic mix between white, Hispanic, black or other minorities just generally in the city?

MS. McKEEVER: Yes.

MAYOR HUDNUT: You mean in the population or in the --

CHAIRMAN WATKINS: Yes, just the population in the city.

MAYOR HUDNUT: Well, we have about 750,000 people in Indianapolis, may 6,000 Hispanics. Maybe one to two percent Hispanic. Probably in the whole of Marion County, 20 to 22 percent black and the rest are caucasian.

CHAIRMAN WATKINS: Thank you.

DR. LEE: How about the babies? How many babies do you have in Indianapolis now with AIDS?

MS. McKEEVER: Three, 0 to 13 pediatric.

DR. LEE: Three, 0 what?

MS. McKEEVER: Age group 0 to 13, three cases.

DR. LEE: Three cases.

MAYOR HUDNUT: How about from straight blood transfusions, I thin we have four.

CHAIRMAN WATKINS: Thank you. Doctor Lilly?

DR. LILLY:: Well, I want to congratulate you on your policy that you've promulgated and insist that these gentlemen have told us how much they need education. I hope you carry out the policies with respect to educating your employees that you have told us you're going to in this proclamation.

I would also say, and perhaps I should save this for later on, but I'm wondering why these gentlemen who represent unions aren't taking on some of that responsibility themselves?

MR. BARAB: We are.

CHAIRMAN WATKINS: Ms. Gebbie?

MRS. GEBBIE: This is perhaps a different angle on part of the point that Doctor Lilly was raising. To what extent were line workers in your various departments consulted or involved in development the policy or to what extent is there thinking about their involvement in the methods of carrying it out or was this a management policy that some folks went off and wrote? It's a good policy. I'm just interested in that interaction because that seems to be a critical use in many settings?

MAYOR HUDNUT: We designed this order with the hope that we would establish a well-grounded policy now that is pro-active rather than simply react after the fact if an AIDS situation involving a municipal worker should happen to develop. Kristie, do you have any more of a specific response to her question?

MS. HILL: I think it's important for you to know a significant amount of the policy has to do with the wellness program. Our employees were involved in the development of that program and they will be involved, I think they have to be involved, in the development of the procedures that are directed to be developed under this order.

MRS. GEBBIE: This is a kind of a very hard question to answer, I think. In a lot of settings, the people who work in the public hospital or the public health department have already been looking at this issue and think it's important. Perhaps the public safety personnel is also, but the people who run the road department say something on the order of, "Why are you bothering me with this?"

Do you have a feel for that among your managers and workers whether they've been waiting and are excited about this or whether again you're so far out front of them with thinking it's time for a policy that you're going to have to do some catch-up work?

MAYOR HUDNUT: Well, let me begin by saying that I think there is a very real and legitimate concern among our public safety personnel, the paramedics, the police officers, the fire fighters, some of the people that are represented by the union spokespersons over here on the panel because they're dealing with it on a regular basis, as are many of our public health personnel in the health and hospital corporation here.

Beyond that, I cannot say how much of a concern there is among our city employee population. But we do have a generalized commitment to what we call a wellness program and an employee assistance program. I think that we are sensitive, at least in terms of management policy, to the fact that when there are these concerns, they should be dealt with and we're trying to make available to our personnel the opportunity to receive counseling and to have their problem and their concern dealt with in a constructive manner when it is raised.

MRS. GEBBIE: Thank you.

CHAIRMAN WATKINS: Dr. SerVaas?

DR. SerVAAS: Mayor, the question that Doctor Lee asked you about, the demographics, I just wanted to menton for the rest of the panel something very surprising about Indiana. We have so few cases and no one really understands the teenager prevalence. But we recently had information 17, 18 and 19 year olds who wouldn't have thought they were high risk or they wouldn't have applied.

Do you see anything, as a result of those numbers, that our city should be doing with 17, 18 and 19 year olds? In that instance, we found that they doubled from 17 to 18 and then it was three times as much prevalence in the 19 year olds over the 18 year olds. Is that surprising to us in Marion County in that we think of something we can be doing in the schools with the 17 year olds? How do you see -- we're talking about AIDS in the work place and I guess that this may not be as important.

MAYOR HUDNUT: Well, I think that we recognize that this is a multi-faceted problem and that it requires a multi-jurisdictional approach to solve. For example, here in Marion County we have an independent health hospital corporation which is not under the direct administration of the city or the Mayor's office and the public health officials can speak for themselves and I'll ask Mary to come up an help in answer to the question in just a minute.

It seems to me that one of the things we've said in this executive order with regard to establishing and AIDS policy for city employees rather than the general population is that we're going to comply with the state law that was adopted under Senator Pat Miller's leadership here in the last session of the General Assembly.

That required that each governing body of a school corporation establish a 13 member AIDS advisory counsel. One member must be a representative of the local or state board of health and must be trained in the area of dangerous communicable disease. Two student members, two teacher members, two parent/guardian members, two members representing school administrator and two representatives of health care professions and two citizen members.

This council would be required to identify and study educational materials and resources on AIDS that are available for use in the schools and their school corporation, determine which materials and resources are based on sound medical principals and reflect the attitude of the community, recommend to the school corporation educational materials and resources on AIDS that reflect the attitude of the community and it requires the governing body; the school corporation, to consider the counsel's recommendation.

So, this is trying to get at that teenager problem through school policy, which is hopefully where most of the teenagers will be at some point in their teenage life. Mary, is there anything that you want to add?

MS. McKEEVER: Aside from outreach, with extracurricular sorts of activities that happen in the count, it takes a long time to develop curricula. Something that is good and something that can be comprehensive on different levels from kindergarten through 12. IPS is involved in that process right now, developing a curriculum for K through 12 in family life education.

Another thing is we're thinking about doing some sort of pilot program for peer support groups. We've had lots of students tell us that you don't reach them by adults talking to the students. So if we can train the students to talk with each

other an support themselves in whatever sort of a decision that they make and educate themselves about AIDS transmission and support themselves in maintaining safe behavior, that that might be a way to go. That seems to be something that's happening in some of the more progressive programs across the country. So, we've been involved in all those things.

CHAIRMAN WATKINS: Excellent. Doctor Crenshaw?

DR. CRENSHAW: With regard to the earlier testimony on fire fighters and policemen, have you seen or do you anticipate seeing any drop off in your ranks as a result of concern about this disease?

CHAIRMAN WATKINS: Doctor Crenshaw, I'd like to focus on the Mayor. He's going to have to leave in a few minutes.

DR. CRENSHAW: Oh, I'm sorry.

CHAIRMAN WATKINS: Mr. Mayor, in your good executive order here now, is there a mechanism within say, the National League of Cities, Conference of Mayors or whatever the title is of the national level bodies that meet periodically and coordinates these ideas, a way to share that? is that part of an ongoing program with your colleagues in the other states to share these concepts to move the educational process at the most efficient rate?

MAYOR HUDNUT: I think to be honest with you, sir, I would have to say that this is a concern among the big city majors, of which Ed Koch is the chief spokesperson. The smaller cities and towns, you know there are 33,000 local jurisdictions around the country and you can't say they're all concerned about this problem. But when I talk to my colleague Ed Koch, for example, about the problems that he's facing in New York, AIDS is very, very high on his list. The same would be true in the other big cities.

The answer to your question is yes, we can share this policy and we will send it to both the United States Conference of Mayors and the National League of Cities. The National League of Cities is a broader based organization. But between the two of them -- and the National Association of Counties would be a third. Between those three organizations, I think that we would be representative of well over 90 percent of the local government officials in the country.

We are having a spring leadership conference next week of our Indiana Association of Cities and Towns which represents the 116 cities in State in Indiana. I will take our executive order to them and move it along in that way, not with the attitude, "Look what a good boy am I," or anything like that, but

simply, "This is what we're trying to do. Do you have a problem? Can we share our ideas with you? This is what we've done. How do you react to it?"

CHAIRMAN WATKINS: But it comes across to the Commission as a very concise, clean document that rings well with us in conjunction with over the 500 witnesses that have come before us. I think it's a commendable effort on your part. As your first item, you went right into discrimination which takes some backbone. We know that and it's an important issue as we move into all these other areas.

Many of the questions that Mr. Stokes -- we have to answer a lot of questions. When you pull those strings, you find suspected or anticipated discrimination at the end of the line with loss of jobs, health insurance, you name it. So, I think forthrightly addressing that up front and not disguising it down somewhere in the bottom is a courageous move on your part and I commend you for it.

MAYOR HUDNUT: Thank you.

CHAIRMAN WATKINS: So, I'm encouraging you to move it. We like the words that we heard from you.

MAYOR HUDNUT: Thank you very much.

CHAIRMAN WATKINS: Now, if there's any wish that you would have that we as the Commission could do to make your life as the major of a great city in the country easier in this area of the epidemic, what would you want us to do?

MAYOR HUDNUT: Find a cure or prevention.

CHAIRMAN WATKINS: Okay. How about number two?

MAYOR HUDNUT: Back us up in our non-discriminatory policy and also in the educational effort that must be made and help to develop the national consciousness on this subject. We need to have a war on this just like we've got a war going, and I don't want to offend anybody, on smoking. There's a national mind set that 's being developed with regard to smoking. We need that on drug abuse, which you're not here to discuss. We need a Marshall Plan on drug abuse, but we also need, I think, to develop the kind of mentality in America that filters down here to us at the grassroots, us little old mayors and local officials and to the people that we serve that cautions them about this and educates them on what they can do to prevent it and all the rest of it. "An ounce of prevention is worth a pound of cure," to coin a phrase.

CHAIRMAN WATKINS: Thank you, Mr. Mayor, very much for coming before us today. We'll let you go back to work.

MAYOR HUDNUT: Thank you. We're very pleased to have you here and we wish you well.

CHAIRMAN WATKINS: Thank you very much.

MAYOR HUDNUT: Thanks.

CHAIRMAN WATKINS: I'm going to turn the chair over briefly to Doctor Lee and then let's proceed back to Mr John Creedon with questions for the remainder of the panel.

DR. LEE: Mr. Mayor, by the way, we are here to talk about drug abuse. We're very, very interested in it as a part of this problem and we're going to be heavily concerned with it on our final report. Thanks for your comments.

Mr. Creedon, you want to start the questioning for the rest of the panel?

MR. CREEDON: Yes. I'd like really to follow up a little bit on the brief question that Frank Lilly asked. Throughout, the testimony of all three, it seems to me there are a couple of things that are common. One is that there's a need for special training on the part of either health workers, fire fighters or police officers or anybody who's dealing with blood or exposed to it. Certainly that is one category of training that needs to be given. I assume that the unions involved here are doing some of that currently.

I guess the other part, and it's part triggered by one of the comments that Mr. Stokes made, and that is that to some extent the threat here is a real threat. How do you separate that in people's minds? Again, I guess it's training or education or whatever. I suppose hereto you people can probably do it better than anybody else.

MR. BARAB: Yes. Just to repeat, we've been doing a substantial amount of training. We've been doing it since 1983 through fact sheets, workshops, through other publications. I think the other unions represented here and the unions you'll be hearing from tomorrow are doing the same.

Two aspects of that. One is we found that the kind of training and education that many of our members have been getting, to the extent they've been getting it, especially in the non-health care settings, has been very poor. They've either been getting very little training, or they've been getting inaccurate training, or they've been getting education that has had contradictory statements. In many cases, we've heard from

our members that they don't know who to believe or if to believe anyone anymore.

MR. CREEDON: That's because the municipalities themselves are not doing the job.

MR. BARAB: Well, it's not just municipalities. I'm talking about mental health institution management and that type of thing.

MR. CREEDON: Yes, right.

MR. BARAB: Right. Part of the problem is they're not doing the job. Part of the problem is the way they're doing the job. We've also been finding that in this case we can divide the world into two groups, those that know a lot about AIDS and those that know a lot about what happens in the work place. Unfortunately, we don't always get both types giving the training. We'll get someone that knows a lot about AIDS but knows nothing about what happens in a correctional institution and a mental health institution, or for example, in a sanitation work place. Or we'll get someone who may work in the facility and knows what goes on there, but doesn't necessarily know a lot about AIDS.

We found that the only thing worse than no training is poor training. If you have an expert in front of you that supposedly knows what they're talking about and then you find out they don't, then you don't know who too believe and you don't want to believe anyone.

So, again, we've been called in on more or less an emergency basis in a lot of situations and we've been told not only by our members but by management that our materials are much better in terms of not only the accessibility of the information but the relevance of the information to the specific work places and anything they've been able to get from the government agencies.

Again, just in reference to one other statement you made in terms of the real fear versus the imagined fear, that is a problem. There is a certain contradiction in that if you compare AIDS to hepatitis B, OSHA reports that between 200 and 300 health care workers die every year from hepatitis B that they contract on the job. I don't think they're aware of anyone yet that's actually died of AIDS that they've contracted on the job. There are other cases of people who have been infected on the job and now have come down with AIDS. Most of the fear has to do with AIDS. That has to do with, obviously, various things associated with AIDS.

So, to the extent we're dealing with the actual risk in terms of the actual illnesses, I suppose we're spending an inordinate amount of our time training about AIDS. On the other hand, it has raised our members awareness and concern about infections diseases in general which is very good, especially concerning hepatitis B, AIDS, as well as other diseases and health and safety in general. So, even to the extent that we're quelling people's unreal fears, it certainly has not been wasted time.

MR. CREEDON: Well, there are a lot of fears that are probably exaggerated and yet there are problems too. It seems to me you have a difficult challenge here to do both, to get away so people aren't imaging fears that aren't real, and yet at the same time deal adequately with the real fears.

MR. STOKES: If it's a perceived problem, then it is real to the individual who perceives it.

MR. CREEDON: Oh, yes, absolutely.

MR. STOKES: In our job, and I'm speaking just from a law enforcement perspective, that 's what I know, that's what I do. So I've got to speak from the law enforcement area and to what Doctor Lilly said a while ago. Yes, we try to educate and we have to work with the municipalities. That's why I said the first thing they cry about is there's not enough money to go around.

These are some of the materials that I received from around the country. Baltimore, Maryland seems to be, in my opinion, for a police department, the most advanced in this area. A police officer that arrives on the scene of a family disturbance where there has been someone shot or just a physical confrontation where blood has been spilt doe not have time in an emergency situation to don a mask, put on goggles and put on his boots to wade into that situation to quell it before someone is either permanently maimed or killed in those types of situations. That's what we're dealing with.

Our people have been told, we have read, I've been to several seminars, we send people to seminars to talk about AIDS. Can you contract AIDS through the tear duct, through the nose, through the mouth? Is it only through blood? Is it through body fluid? How long do body fluids live outside the body? How long does my crime scene search unit have to wait if there's an AIDS virus? How long would the virus live in the deceased? How should they handle that body? What should they do to properly put on and take off gloves and outfits? We're now getting to the point where we educate our people to that, how to put it on, how to take it off.

We understand as police officers in this country that we're never going to be in a situation of utopia where we'll have time to don the eye goggles and the mask before you go in. It's just not practical. We accept that as part of a risk. But a doctor or a nurse in a hospital doesn't.

What we're asking for is if we have to take that initial risk, the same as a fire fighters, then we believe that after that person is diagnosed as being positive, the courtesy is to come back for the safety of the officer and his family to tell him or her that they've had that contact. In some cases, two lives may be in danger.

MR. CREEDON: I agree with you. That's why I asked the Mayor that question, so that he would get assurance that at least in Indianapolis they're going to do it.

CHAIRMAN WATKINS: Just a quick follow-up, Mr. Stokes. WOuld you just amplify, how do you keep track of that particular sequence of events that when the HIV determination is positive can be fed back and properly employed? In other words, how do you document when you go into that situation after the fact? you've said, "This is what transpired." Does that get into your own records?

MR. STOKES: Yes, sir.

CHAIRMAN WATKINS: So you have sufficient tracing then and you can go back and find anyone who was cut, hurt, exposed?

MR. STOKES: All the hospital would have to do in our county is call the appropriate agency or contact the police department. We have AIDS in transport arrests slate sheets, all that information is made available. When you take someone to the hospital, you sign that you took that individual. Then the Department could trace back each and every officer that was at the scene of that disturbance or that wreck. Yes, sir.

CHAIRMAN WATKINS: Is that fairly common as far as you know across the country?

MR. STOKES: Oh, yes, sir, very common.

CHAIRMAN WATKINS: That doesn't add any additional burden, is what I'm trying to say. That's already being done and so there's no additional burden to set up a system that would permit you to get to the right people with the right information, assuming that that HIV status could be given to you?

MR. STOKES: Yes , sir.

MR. CREEDON: I know Mr. Duffy, in his comments, recognized that there is a problem here of confidentiality. I assume that in the case of the law enforcement officers there would be the ability to deal with that as well.

MR. STOKES: I guess you get concerned about the statistics. The statistics that I have here on AIDS from around the country and the policies, until we say that we finds a cure or vaccine, then something has to be done. Not too many people are living that contract the AIDS virus. They are dying from it.

MR. CREEDON: Yes, about half --

MR. STOKES: 120 and 59 dies, that 50 percent almost.

MR. CREEDON: Right.

MR. STOKES: That's the true statistics throughout the country. So, confidentiality of the individual becomes a minute problem in the face of death. I think we've got to carry out --

MR. CREEDON: But, Mr. Stokes, one of the issues here is that there may be a million and a half people out there who have it and some of them -- now, they could be part of an incident, for example, involving a law enforcement situation where they have the virus and they might not come down with AIDS for 10 years.

MR. STOKES: True.

MR. CREEDON: So, the one issue that we find going around and hearing people from different walks of life and their concern is this one of discrimination that the mayor referred to. In other words, if it gets out that someone has the virus, then you have a whole raft of discrimination problems that they have to deal with. So, I understand what you're saying, but I think the confidentiality issue is not one that you should overlook at all.

MR. STOKES: I don't think you just throw it aside and overlook it, but I think you have to weigh the confidentiality of an individual in concern with me as a person who's out there working everyday. I don't go to work with the intentions as being shot, stabbed or killed or contracting a disease that I can take home and pass on perhaps to my wife and my children who, in that case, would be innocent victims. I think there has to be some compassion and understanding for the public servant that goes out there and consummates this daily act.

We have contact with three percent of the population on a daily basis. Three percent of the population, of which the majority of the citizens of this country could care less about

and don't want contact with them. So, I think there has to be an overt act to protect us. That's what I'm talking about.

MR. CREEDON: I agree. I think there has to be a balance. But all I'm suggesting is that the confidentiality aspect is a factor that needs to be balances.

MR. STOKES: And I think that you can do that with the hospitals on the contact with the Department and coming back and saying. "You have had a contact with a person that had tested positive," without even telling them who that person is. THey may be able to go back and rationalize and figure it out, but I think if you say to them, "That's immaterial who it was, if it was John or if it was Jim, it doesn't make any difference who it was. You had that positive contact. How are you going to deal with it with you family and how are you going to deal with it as an individual?" That's important.

MR. DUFFY: You've put sa number of complex issues on the table and I'd like to respond to them. First of all, in terms of education, which both of you brought up, our union likewise is trying to educate our members on this subject. I have a full-time staff -- professional and support staff -- of nine people solely devoted to safety and health. The number one priority of our union this last year, because of obvious concern, has been contagious diseases. We have produced two videos on it which have been sent out to every local we have in the country. We did our guidelines, which were sent out to every local and will make any quantity available to anyone else that wants them. We just release posters on contagious diseases that we would hope hang in every firehouse throughout the country.

Even with all that work, we're not touching anybody until the cities, those responsible for their employees -- which fire fighters are -- start implementing education programs. I'm glad to see that Indianapolis -- I guess it's a big coincidence why it was issued today -- but I'm glad to see them beginning a program of training their people. Hopefully they will develop a program first, since there is no standard program for training emergency response personnel.

Additionally, when we educate our membership, we're getting to our member's leaders. Out of 175,00 people, we don't always get to the guy in the street, the rank and file. That's a problem with any education procedure coming from a national level. We can only hope we get there.

The notification issue is much more complex that you're presenting right now. We have the major hospital association groups adamantly against any notification of police and fire and other public employees and they will fight it to the hilt. They're claiming legal problems, anything that they can do to

claim why they won't notify. They're using legal issues as a roadblock for this issue.

In addressing the confidentiality issue, which I certainly strongly believe in, and I don't want you to misinterpret our organization's belief, we are also trying to get information. I presented examples from small cities in my testimony because I think its important. These exposures are not just occurring in New York, San Francisco, Miami, and Washington, D.C. It's indeed a national concern, which I'm sure you're aware of.

However, I have to go back to one of the major cities. In San Francisco, our local there requested about three years ago for locations of the AIDS hospices throughout the city of San Francisco. They did not want that information -- they wanted that information provided to the dispatch officers in the dispatch department and in the fire department.

So if you call 911 in San Francisco and you say you're having a problem at one of the AIDS hospices, that dispatcher will now that and will be able to inform and only inform that responding vehicle that it's an AIDS hospice. The city would not do that. The community was against. Our local brought suit against the state under the Cal OSHA law, under their right-to-know and they've lost that.

The policy that they've come out with now in San Francisco,, which is indeed unfortunate because it hypes up the fears of everybody -- is that everybody they respond to is considered to have AIDS and they're treated appropriately. That's their reaction to not getting information. So, there's a lot more complexities in addressing this issue and there's a lot of groups out there putting up roadblocks to getting that information out.

When we treat a victim on an emergency scene, we do not have the opportunity many physicians have to scrub up or clean up -- which I realize is to protect the patient as well as the provider. WHen you're elbow-deep in blood from an individual who just went through a windshield of a car, that opportunity doesn't avail itself when you're dealing with life. Fire fighters, paramedics, police officers and other public employees have to work under these conditions. To tell those people they can't get any notification if an individual has a contagious disease, whether it be AIDS or hepatitis B or any other contagious disease is criminal. So, it's much more complex.

MR. CREEDON: I appreciate your clarifying for me the importance of the municipality or whatever the local governmental body, the real responsibility for education and so forth has to rest there and you can stimulate it, but it has to

be there. I guess the question you raise about the hospital as being unwilling to give you that information may in part be influenced by the fact that there have not been any cases so far, I suppose, and they may have some liability. So, it could be that it would be necessary to have some legislation authorizing them to release the information to you. I'm sympathetic to what you're saying and certainly if there are any cases showing that the threat is a real threat and not an imagined threat, which I guess we haven't had --

MR. DUFFY: Some of the health care providers such as the police and fire have been taken out of the health care provider link. Other people are notified. The emergency room people find out. In some cases it's informal. In one case, we want to lump fire fighters and police in to the health care provider system, but in terms of notification we want to specifically exclude them.

MR. CREEDON: Well, all I'm suggesting is you may need legislation to do what you want. Thank you.

MR. STOKES: It could be a recommendation. We were hoping, at least I was when we talked about this, hoping that that may be a recommendation of this Commission to the government that we have to consider that. We do have confirmed cases of police officers now who have gotten AIDS in the line of duty, have now tested positive. I think that's going to increase over the next five to ten years.

MR. CREEDON: I think it would be helpful if you submitted data on that to us and would think that the Commission should consider what's being recommend.

CHAIRMAN WATKINS: Well, we did have the presentation from the Governor of Rhode Island who had proposed to the state legislature a change to the law that would allow the information to flow out of the hospital back to the appropriate authority, protecting confidentiality on the individual, carefully passing that information back for blood contact cases. In other words, when the situation occurred, a proper entre into the system would be made saying, "This did occur under these circumstances. We are concerned because of the circumstances. We need to have that information because we have a clear case of blood interchange with our providers." That was a law -- we don't know what its status is, but I'm just telling you there are others that --

MR. DUFFY: I can tell you because I assisted in writing it. It has passed.

CHAIRMAN WATKINS: Yes.

MR. DUFFY: Rhode Island fire fighters and our office worked on the Rhode Island law.

CHAIRMAN WATKINS: Has is now been passed into law?

MR. DUFFY: Yes, it sure has been.

CHAIRMAN WATKINS: We didn't know that. That's good for the record. We'll take a look at that and see if there's something we should do at the federal level to make recommendations to --

MR. DUFFY: If you like, I can provide you with other state laws as well that address similar issues.

CHAIRMAN WATKINS: Where that's already been done? Are they almost comparable in other states?

MR. DUFFY: When it comes out of my office, they're all the same, same computer. We just change the name of the state. But yes, there have been some change in it, but they're typically all the same. I'll send you the ones that we have.

MR. STOKES: Maryland just passed one. It's on the governor's desk. There's also two pieces of legislation in the Congress of the United States on AIDS, one submitted by us and one submitted by the fire fighters dealing with the same subject.

CHAIRMAN WATKINS: There's been no action on this H.R. 3418 as far as I know at this point in time. But all of you support that particular piece of legislation that's sitting up there? Are you all familiar with it?

MR. BARAB: We're not familiar with the details of it.

CHAIRMAN WATKINS: Well, this is the one that was mentioned, I think, by Mr. Duffy.

MR. DUFFY: The Senate AIDS bill does not include it. It looks like right now the House AIDS bill will include it. In the conference committee they're ready or that compromise. It only addresses police, fire, and not all other public employees.

CHAIRMAN WATKINS: Well, we'll get access to the bill. I just wanted to find out whether you supported it. Thank you. Doctor Lee?

DR. LEE: These guys have worked over all my questions so hard that I've got nothing left except to tell you that I strongly support putting you people in the loop. I am very sorry that Mr. Novey isn't here because these poor guys in Corrections take a terrific hit on this as well.

There's one thing I guess none of the bills address as far as I know. We've tried to address it as a Commission. That is, when can we force somebody to have the test done? In the prison system we can't, can we?

MR. STOKES: We represent quite a few prison deputy sheriffs, that watch over prisoners in felony and misdemeanor cases. Right now you're right, prisoners use this as a line of defense when they're incarcerated, as far as feces, spitting or even cutting themselves intentionally to bleed on guards or trying to lead them into confrontation. But those individuals, and I don't believe it would be a violation of the 4th Amendment if those individuals are suspected of having a virus being tested for the protection of the other prisoners and the guards themselves. But it is, it's a serious problem within the prisons.

DR. LEE: But they can't be forced to do it, can they now?

MR. STOKES: No. I think there's going to be some test cases, just like the one that's come up out of -- we just had a state trooper in New Jersey where a prisoner that was under arrest bit his finger off, the end of his finger. Now, I think that person has a right to be tested for the protection of the officer. I'm sure there's going to be some cases go up to the Supreme Court or to the Supreme Court of the state. But right now, I think you should be allowed to test them. I would take it as a test case if it comes up in our jurisdiction for someone whom we represent.

MR. BARAB: We represent about 80,000 corrections officers. In many cases, we have asked to have prisoners tested and it hasn't gone through. They just passed a law in the state of Washington though which originally had a provision where we could have mandatory testing. I'm not sure if that provision survived the final cut. That was a few weeks ago, but I can check that.

DR. LEE: There's no other state, Ms. Gault? Is there a state, Kris?

MRS. GEBBIE: Well, under Oregon Public Health Law, I can ask anyone to be tested if I believe they are exposing others to any communicable disease. The individual involved has the right to refuse that test, and if so I have the right to treat them as if they're infected. That's used most commonly with tuberculosis where the person refuses to be tested and so on. We can then keep them in isolation as if they had TB until we can test and proceed.

In this case, the issue I think would be whether you test them or not, whether they're positive or negative, I'm not quite sure what difference it does in either their management or the policeman's management, but that law in Oregon would apply if there was a determination that the individual had been put at risk of the disease and we didn't have adequate information. That's not unusual state law around communicable diseases. It exists in several jurisdictions.

DR. LEE: Well, how does it apply? We just listened to this woman here yesterday talked about how her husband got a blood transfusion and then she got AIDS. Now, these fellows are in this very sticky environment and sure, they did what they had to do and what use is it because the thing has been done. But they should know because they don't want to infect their wives.

MRS. GEBBIE: And the point is that if you can test, if you have a test result, you can either say, "Yes, you might, or no, you might not, "or you'd have to say, "You're going to have to wait six months to see whether your antibodies turn positive anyway." There's the immediate management of that police officer or fire fighter is exactly the same regardless of the test result. You may increase or decrease the anxiety level slightly by having more information, but it doesn't make the kind of management difference that it makes with something like hepatitis or tuberculosis or many other conditions. That's an important difference that's a part of this perception problem we all have of sorting out how this disease is and isn't different than other conditions.

MR. STOKES: Doctor, I think that's why it's important that we get good information and back to the officers. It's just like you said, if you're tested and you know that he tests positive and he bit me an draw blood and a week later after I.m tested I can test positive or negative and six months I'm going to be tested again.

I think the other thing I tried to address in my statement was, how do we deal with that officer's psychological problems with his family life and his wife in the meantime? That's what I was getting at with the counseling. I understand what you're saying, but there's a lot of officers out there and a lot of the general public that feel that the test is imperative to prove one way or the other and the initial test is not conclusive from the education that I've gotten on the subject.

MRS. GEBBIE: And I believe you're right on that. That's why we have so much education to do about a whole lot of the related issues on this epidemic.

MR. DUFFY: The Reagan Administration has gone gangbusters for urine testing for drug testing. If they were so

adamant about looking at drug use in federal work places, maybe perhaps they can also draw up a policy on testing. It's a problematic area. I certainly appreciate the complexities of it, but I think someone needs to look at it and perhaps the Commission would want to recommend that the Reagan Administration develop a policy on such testing and test it. It's a lot easier putting an individual with TB away under a state law, but I'd love to see you be able to do that with AIDS.

MRS. GEBBIE: Again, in most jurisdictions, the exact same law applies and the same tests of appropriateness would apply and I think those laws will work.

MR. DUFFY: Theoretically.

MRS. GEBBIE: No, I thin k those laws will work with HIV the same as they work with the others.

DR. LEE: I understand what she's saying, but I'm with you guys. I would want to know and I would want to know now and I wouldn't want to have to be hung up by it. If there was the slightest problem, you have to keep a distance from your partner. It's a major, major, major problem. We're going to be hearing policemen's wives and firemen's wives here two or three years from now with the same thing.

MR. DUFFY: But we can't even get the information from people that have been tested and show -- there's two levels of problems here.

DR. LEE: Yes, I understand that and I don't like it.

MR. DUFFY: Both those that the hospitals know and won't give you and then, of course, the problem with testing people.

DR. LEE: Thank you.

CHAIRMAN WATKINS: Doctor Lilly?

DR. LILLY:: How does one establish that a given case of HIV infection or of AIDS in your ranks is work related?

MR. BARAB: How does one establish that?

DR. LILLY:: Yes.

MR. BARAB: CDC has a procedure for establishing things like that. Basically what they do is immediately after a suspected exposure they'll do a test, a base line test to see what your infection status is. If you test negative, they'll do periodic tests thereafter and if you test positive after having

proved you were negative and having proved that you had an actual exposure, you will be determined to have been occupationally exposed.

DR. LILLY:: So, you're telling me that the people that are in your union are automatically tested after each exposure?

MR. BARAB: No, no, no, they aren't generally. But that's the way CDC determines.

DR. LILLY:: No but I'm wondering how you determine.

MR. BARAB: Well, we don't. So far we've had a few cases of people who have called us up and said, "Listen, I just got stuck by a needle from someone that was tested positive to AIDS," and we will recommend that they immediately go and get tested and then get tested periodically thereafter. So far in our union, we haven't had anybody, luckily so ar, that has claimed that they've been exposed, or at least have tested positive due to an occupational exposure.

MR. DUFFY: I appreciate your questions as well. We have no known HIV conversion from job exposure but we are investigating one right now. We've had a number of people HIV-positive sand some with AIDS and we've had a number of fire fighter deaths -- none of the deaths as best we know right now occurred because of job exposure. There were other reasons for it.

However, in our case, it's based on assumption and in some cases presumption if it was an exposure. It's very well documented in the fire department and police departments as well. Any time anything is done in a fire department, and police departments as well, it's documented in log books. Every time a truck is started, every time it pulls in and out, every run it's on, what happened on the run. They fill book after book after book and they end up in big rooms like this somewhere. But that documentation exists.

And an individual -- and we've done it in cancer cases with fire fighters -- is able to go back and to research every response he's made during his full career.

Now, without response, is there any way you can equate that? You can presume it is and you can assume it is, but we don't have any real way to do it except, of course, as Jordan mentioned, some of the CDC guidelines, which haven't been fully implemented anywhere to the best of my knowledge.

MR. STOKES: I think, Doctor, if you can go back and you can show that there was a physical confrontation and there was blood at the scene or other body fluids excreted at the

scene, when you transport someone to the hospital for treatment or when they're incarcerated in the jail where they're already locked up, those are all documented records. When a person is transported, treated by the nurse on duty, treated by the on-duty doctor, all those things are documented. So that's how we go back and show the correlation between an opportunity to be exposed to a disease and then a person testing positive.

DR. LILLY:: Well, an opportunity to be exposed to a disease in a person who has a documented negative status.

MR. STOKES: Right. If you were to show up positive five or six months later after release or confrontation, we would still be able to show that that officer or those officers, either acting as --

DR. LILLY:: That sort of implies to me that that person was, in fact, tested immediately after that exposure to make sure that they weren't already positive.

MR. STOKES: But I think as one of the gentlemen up here pointed out awhile ago, you can test positive and not show up with the illness for five, ten years later, they say.

DR. LILLY:: Sure, but that's not what I'm talking about. I'm talking about was it really that incident that infected the individual as opposed to some other incident or some other behavioral pattern?

MR. STOKES: We've got three departments. One has definitely said in Newark, New Jersey that the officer contracted the AIDS as a direct result of that contact and has now died. We have 15 in one other state that are under suspect of AIDS and three in one other city that have suspect of AIDS and trying to go back and show whether it was directly job related contact. So, those records are going to be maintained. In the future, I think you'll have the basis to respond positively to your question.

DR. LEE: Actually, in the back of my mind, I'm just wondering, should fire fighters and policemen be routinely tested?

MR. STOKES: I think now most of -- at least I'll speak from out department. On an annual basis, we are, with out annual physical.

MR. CREEDON: Are you?

MR. STOKES: Yes. you can request that through our annual physical when you're tested. I did last time.

DR. LILLY:: But it's voluntary?

MR. STOKES: Yes, sir.

MR. DUFFY: Most fire departments in this country don't test, don't even give people physicals. Too much bucks. We have fire fighters that pend their whole career in the fire department and the only physical that they have had is when they entered the job. And even that was just a cursory medical. It's sad. You'd think that from all the injuries and all the deaths of fire fighters, you'd think they'd have implemented a complete physical testing and they have not. It hasn't occurred. I don't know if we'd be against doing that, but we certainly are for a full physical program on an annual basis for fire fighters, for the basis of establishing a baseline to exposures.

I'll tell you though, your question is interesting because we've been very successful of documenting hep-B cases with fire fighters. For example, we had a fire fighter that died a year or so ago in a small town in Ohio. Through a needlestick seven years prior to that, he went through debilitating liver and associated disease with hep-B for seven years and suffered like a dog from it until he died. That was well documented because it was a needlestick. Now, needlestick injuries are, I guess, a lot easier to document than others.

It's going to be very difficult with AIDS because of the latency periods and whether they're going to pick it up or not. A lost of it will be based, as I said before, on assumption and presumption.

CHAIRMAN WATKINS: Mrs. Gebbie?

MRS. GEBBIE: Two or three, I guess, observations before I get to my question.

One to Mr. Duffy. When you mentioned that fact that because of the lack of information right now, many fire fighters are treating everybody whom they encounter as if they were infected, most people involved with this epidemic would applaud that regardless of whether we ever sort out this reporting issue. That application of universal precautions in the first aid setting is exactly consistent with universal precautions in the in-patient care setting. I doubt we're going to see us move very far back from that in anything resembling the new future for a whole bunch of reasons.

A second observation on the issue of notification that nobody's mentioned so far, I believe the Rhode Island law deals with this, and that is the reciprocal notification of the patient who may have been exposed to the blood of the care provider. At least in hospital settings when that tradeoff is pointed out,

people suddenly start looking at it differently. I don't think the principal is any different in either case and I hope your union members, I talk to all of you about this, are thinking of that as we look at who needs to know what about exposures.

Where I really want to go with a question to each of you or a request for some more observation. I think at the heart of all of what you've said is this whole issue of adequate communication in designing policies so that the people involved in both writing and implementing the policies feel that they can trust each other that they know they're dealing with facts and can go forward.

Much of what you've described sounds to me like its been based on some real frustrating experiences in which you've gotten confusing information that feeds misperception rather than feeds accurate perception. The continuing doubt about work place exposures for emergency personnel is a concern, when in fact there have been no documented cases of AIDS that I know of from that kind of work place exposure.

I wish we had here at the table with you some of the sheriffs, police chief, fire chiefs, fire boards, police boards, county commissions for whom your members work or public hospital boards, Mr. Barab, for whom your employees work, so we could hear a little more about what is going on in the dynamic that is making it difficult, apparently, for you to reach a resolution in a sensible, trusting way, and leaves you looking for a national solution to some of these things. There may be a need for some national things, but a lot of this is going to be resolved in each individual worksite. It sounds to me like something is terribly wrong here from your perception. Can you tell us more about that process, what's making it so hard for you?

MR. BARAB: We had a conference a couple of months ago. It wasn't really a conference, it was sort of a large meeting, where we brought out corrections people in and all our mental health people in and some of our hospital people to talk specifically about the testing issue. It was very interesting because what we found was that, first of all, there's a great divergence of opinion about whether all correctional inmates should be tested or mental health residents should be tested, when, if, what conditions and that type of thing.

Generally, we found those members of ours who had the most experience with AIDS and have the most people to care for, in other words those of our members in New York, were the most opposed to any kind of testing or segregation. Those who had the least amount of contact, and correspondingly or coincidentally, the least amount of training and education were the most in favor of testing. It was obvious why that is, I suppose.

Especially when you look at our situation in New York several years ago, they were all very much in favor of testing everyone and segregating everyone that might be HIV-positive. And over the time, they have received very good training and they've grown accustomed to guarding or caring for people with AIDS and that fear has gone down. Some of the other people in other parts of the country had just seen their first AIDS cases, had received either no training, very poor training and in some cases had wild people running around biting them on purpose and that type of thing. They were the ones that were probably most in favor of that kind of testing.

Now, in terms of your statement concerning the universal precautions, we've more or less given up -- well, we haven't given up but in terms of the testing, we realize that you're never going to test everybody. You couldn't test everybody and even if you did it wouldn't be accurate. So, we've got to have universal precautions. You have to assume that everybody you come into contact with is infected. The only time we have a strong consensus in favor of testing is post-exposure when this source person's status is already known. But again, it is an issue that we're all over the board at as far as our members are concerned.

MRS. GEBBIE: Yes. What about this issue of how you bring people together to work this out sensibly at the local level? I get the sense that there's nobody there listening to you when you ask the question or that they're giving you a runaround or that your local health departments are useless in providing you sensible advice, although they say that's one of their jobs. What's the dynamic that makes this such a difficult issue?

MR. BARAB: Some health departments are very good and some are very bad. The day wee had this conference, somebody handed me a newspaper story saying that some nurse had given training to some police officers in Harrisburg saying that AIDS is spread not only through blood and semen but also through saliva and tears. This was in the newspaper. I don't know if they misquoted her or she actually said that or what, but that's an example of the kind of training people get. The kind of fears, when the real fears get to false fears, go to paranoia, seems to me directly related to the type of training.

As I mentioned earlier, that training deals with not only how knowledgeable people are about AIDS, but also how knowledgeable people are about what goes on in the work place. You'll be hearing more about this tomorrow. But in discussions with CDC, the policymakers at CDC and OSHA, you find that a lot of those policymakers tend to be administrative types who may know a lot about AIDS and their institutions in general, but very little about what actually goes on in the work place, on the

floor itself and what kind of exposures people actually have and how frequent those exposures are. That's a problem too. You really need people that are familiar with the work places.

MRS. GEBBIE: Well, could we be helpful to you? I guess I'd like to hear from Mr. Duffy and Mr. Stokes too. But could we be helpful to you by some recommendation that would push policymaking that involves line workers in that process? I'm looking for what we could say that would make a difference.

MR. BARAB: Definitely, and for all training, not just infectious diseases or AIDS. But we strongly encourage the employers to do the training. Also, if they're going to do the training, to have us involved in the planning and in the actual training. If they're not going to do it, we end up going in and doing it ourselves. We don't have enough time, obviously, to train a million members. So we try to get the employers to do it and to do it well and to use the resources that they have available. But we will do everything we can in order to actually help them do it.

MR. DUFFY: The answer is real easy. I can be short. It's money. It's the obvious. I don't know how much the fire chiefs will say, because they're political animals and their comments are a function of the political entity that they work for. However, it costs a lot of money to train people on health issues. You can even look at the comments from the mayor of Indianapolis and all respect for the major, it's not that expensive a program. They're going to develop a training program. They're going to have in a non-discriminating clause, which we would object against because I think in emergency cases there should be discrimination against people. I don't want that out of context. I don't think fire fighters that have AIDS or any other blood-borne contagious disease should be fighting fires and providing emergency medical care until they don't have it anymore or they should be found other fire department jobs such as those in support services. So, I think the discrimination clause has to be looked at.

Their sick leave allowances, you have that now. If you're sick, you can go out and you can use your sick leave up. So, at least for the fire department here and around the country, it's not an expensive program. But when you get into expenses is when you have to put an ambu bag on every truck, when you have to provide a fire fighter with a gown and gloves that he's going to throw away after using once, when you have to provide pocket masks for every fire fighter and resuscitators in every truck and not just on a handful of them. That's where -- and you look at it and it doesn't seem very expensive and to me it doesn't seem very expensive but you're dealing with cities that have finite budget and other priorities instead of putting masks and

disposable gloves on a fire fighter. That unfortunate, but that's the reality of what's out there.

So, it's purely bottom line. It's not that they don't want to do it, it's the cost of doing such a program. We've worked now for two years with a full program on hepatitis-B, spent almost a half a million dollars. We developed videos on hepatitis-B. We've increased the hepatitis-B vaccination of fire fighters rom six percent a year ago up to almost over 25 percent of all fire fighters. A good accomplishment, the most successful occupational program that's ever been done in getting people vaccinated.

Other departments just won't do it. The bottom line is not that they don't want people to get hepatitis-B vaccines it's money. It's $100 to $300 for the series of shots and they don't have that money. When you take that to New York City which has 13,000 fire fighters times $100.00, its a lot of bucks. If you get Mayor Koch, who is the head of the Mayor's program on AIDS, and ask him why he doesn't spend $1.3 million on vaccinating fire fighters for hepatitis-B. he'll just say the money's not there. We just closed fire stations down in New York City. That's our priority, to give fire protection and not inoculate people for that. AIDS is the same way. So, it's a money problem. And education programs are expensive.

MRS. GEBBIE: So, you think that the money for that education should come from outside the employment setting and be poured in or do you think we ought to say something about the money setting priorities within the existing system?

MR. DUFFY: Well, we're dealing with public employees, so it's going to come for a tax base somewhere. So, there has to be tax base money, whether it's local level or federal level.

MRS. GEBBIE: But which -- I'm pushing you. WHich ought it to come from?

MR. DUFFY: I could personally care less.

MRS. GEBBIE: But we're looking for recommendations.

MR. BARAB: I don't think in terms of the training -- that it's that much of an additional expense. The OSHA Hazard Communication Standard requires all employers to train their employees anyway about what chemicals they're exposed to. So I don't think it would necessarily be that much additional expense to train them concerning the infectious diseases they are exposed to. Now, when you get into the cost of protective materials and equipment, that may be a different story. But in terms of training, it shouldn't be that much of an additional expense.

MR. DUFFY: H.R. 3418 provides $25 million of federal funding to begin to develop a curriculum. It would be nice to have, a federal curriculum developed so we don't have every city developing their own, number one. Number two, the pilot programs that will be initiated on that, there is $25 million. Obviously not enough money, but if there is some recommendation the Committee could make would be to support those efforts to get a national curriculum and to have the federal tax base support training these people. That's the only way it will be done effectively beaus then you don't have to go through the individual tax bases.

MR. STOKES: Let me respond to your question with a request that the Mayor did awhile ago. Let me bring the president of the local lodge of the FOP up and let him address your question as to how well that's functioned here in Indianapolis.

CHAIRMAN WATKINS: Just announce your name here so we can record it.

MR. BLACKWELL: My name is Leo Blackwell. I'm the President of FOP in Indianapolis. I wish that the mayor or some of his entourage were still here because I would like to respond to his well-intended press release that he had today and his proclamation.

Approximately 18 months ago, when I first took office, I went to the Chief of Police here in Indianapolis with a case of hypodermic stick of a police woman who was searching the purse of an arrested subject and inadvertently stuck her finger with a hypodermic needle. The arrested subject said she was, in fact, a positive AIDS carrier. The police officer followed procedure, documented the case, sent the hypodermic needle in for testing and for results. She waited three to four days with no guidelines, no contacts. She determined then that inadvertently that needle had been destroyed with other narcotics paraphernalia. There was no way to go back and double check other than to go find the arrested subject who had since been released from jail and have that person tested.

I documented that case, sent it to the Chief of Police, asked for some guidelines, sent along with it information on Fraternal Order of Police seminars and other seminars around the country on the problem with IDS and suggested that we develop policies within our department that would address the needs of law enforcement officers. To this day,, I have not heard any response of a positive nature until the Mayor comes here today and makes a very eloquent.

However, the people who are charged by him with developing those policies are not in this room listening to what

they should bee listening to. They need to get to the line officers, to the fire fighters, to the police officers, to the ambulance drivers, medical technicians and say, "What do you need? How can we help you?" They aren't here. They made a nice show and they're gone. And I wish that Doctor SerVaas was here because I know that would get back to Mayor Hudnut because I know they're very close. I'm sure it will anyway.

These people need it and we've been trying to get it done. And to answer your question, ma'am we can't get it done on a local level. We need some prodding by the federal government, whether that be proclamations, whether it be help at the legislative level or whether it be funding. Something needs to be done and all of the rhetoric and all of the proclamations throughout the country are not going to help to get the situation resolved.

We have police officers, police women, fire fighters out there who are exposed to situations and weeks go by before they have nay response from the hospital.

I have another incident. AA hospital that is a stone's throw from here, from this building, an arrested subject was sent in after a bad fight and a gunshot. The police officers administered first aid, as did the fire fighters. The subject was sent in. On the way to the hospital he says, "Oh, I have AIDS," and it was a boyfriend situation, homosexual situation. They send the guy in and it took six days for the hospital to get a response back to those persons involved at the scene who were exposed to the blood, six days to finally determine that this man was not a positive AIDS carrier. In the meantime, these people were pulling their hair out. "Do I go home? Do I talk to my children? Should I be with my wife? Should we drink from the same glasses? How should we cleanse?"

There are no answers. We don't have those answers. And apparently, my prompting at the local level is not getting the job done. It took this Commission coming to Indianapolis to get the Mayor to make a proclamation. To me, that's not enough.

CHAIRMAN WATKINS: Well, may I just follow up? What avenue do you have there? This is a very important accusation you're making. We're not an arbiter in that in any way, but you've made it now publicly. What is your normal avenue of appeal here? It seems to me that with this proclamation there is a new opportunity to do something better perhaps than in the past. Your colleagues who are municipal employees, if they found the same response to their appeals for similar kinds of situations from the mayor would be able to band together and say, "We've gotten the proclamation. Here are the issues we have facing us. Here are the ones that have not been responded to." You certainly have avenues, if the normal system can't stand it,

to use other means of getting the information through. It's a very important issue.

So, I'm not sure what this Commission does with that. That's a local issue, but if we can help at the Commission level, and we probably will make some statements along these lines, then we can do that. But we're not going to be able to solve a local governmental problem at this session. And yet you're raising it. So, I feel compelled to follow up on it to a certain extent, to the extent we have any authority.

Is this something that is shared by other agencies, municipal employee agencies here in this county?

MR. BLACKWELL: I would suspect that it is, but I can't speak for them. All I know is it's my particular problem with law enforcement. To answer your question, what are the channels, what are the ways of --

CHAIRMAN WATKINS: What's the normal way that you would make this approach now to --

MR. BLACKWELL: Being an Admiral in the Navy, I'm sure you're familiar with the chain of command.

CHAIRMAN WATKINS: It's easy in the military. I've found it's very difficult in the private sector. I used to give the right full rudder order and everybody went to the right. I now give the right full rudder order and everyone says, "Who the hell's this guy?" I understand the problem, but there must be a mechanism to move up the line here by some technique in Indianapolis like the television is not here now and would normally have picked this up and been on the evening show.

MR. BLACKWELL: I think that with the Mayor's proclamation, and I'm sure that it's made in all sincerity, there will be a mechanism put in place. But I just know for the past 18 months I've been looking for just such a vehicle.

CHAIRMAN WATKINS: But the whole country is in this situation. I really recommend that you move aggressively now with the Mayor's proclamation. Assume that it was given in good faith. It sounded to me as those though it was given in good faith and I think all the nation needs to pick itself up and move much more aggressively now. So, this is not a unique experience that you're facing here. I'm sympathetic with it. I would just encourage you to press on and through our contacts here, we will make it known that some people think there's not much teeth in the rhetoric in the past and I hope this is a new opportunity for them to be heard.

MR. BLACKWELL: I asked to be recognized so that I could respond to Mrs. Gebbie's suggestion that we have some front line people involved. This is the same message that I delivered to Kristie Hill, the Mayor's legal advisor, as they left. I said, "Kristie, this is great. Let's get together on it." She said, "Yes, we must." I've made a note to that effect and I will see that she does.

My point is that there are front line people who have things to offer who can tell these administrators throughout the nation of the problem first-hand and then they can look for a solution.

MRS. GEBBIE: Well, you've helped lay out what I was trying to push for. There's been a lot of rhetoric about every employer, and in my mind I include public employers in that rhetoric, ought to be doing something. You speak for some folks who feel that, A, very little has happened, as near as I can tell, and B, when it's happened, appropriate front line people haven't been involved.

It's still not entirely clear to me what we as a Commission can do. I doubt we're going to recommend passing a law that orders every public employer to create a forum to design an AIDS policy because by the time you passed a law, we've wasted another year.

Somehow I think we need to be helpful in saying, "It's past time to get on with it. Sit down and do the dang thing." The facts are there. You know the work site, the scientific people know the issues. How we say that in a way that's positive and helpful is what I'm still grappling or. Your comments have been helpful in seeing a little more light in that fog of how we could do it. I appreciate your coming forward.

MR. STOKES: What I said in the initial statement was a coordination of all this information where it's funneled down and it's factual and there's some way to update it. I went to a seminar in Philadelphia, spent three days there, only to have people from Atlanta and local doctors and some people stand up and ultimately wind up in a dispute in front of 125 police officers about what we should or should not be doing and how or how we cannot prevent the spread of AIDS. It became very evident that we were in a very turbulent time for information, factual information.

I guess what I'm saying to you now as a Commission, try and get us the factual information that fed back to us that we're not feeding outdated information or information that is not a fact. Can you contract AIDS by shaking hands? No. That's pretty evident. Now they're saying, can you contract AIDS through body fluid, blood, in the mouth, eyes, tear duct, nose?

Can you or can't you? Yes or no? And on what percentage? If it occurs, does it occur every time?

MRS. GEBBIE: See, from the point --

MR. STOKES: The front line people that we represent -- I'm a police officer. I'm not a chief of police. You get to the chief of police position and you're far removed from what a street officer is doing down here. That's what I'm saying to this Commission. That's why I cam to you today with questions, not answers, because I don't have the answers.

MRS. GEBBIE: Let me just point out to you before I finish up, because I have taken too long here. At least some people listening to your presentations, others from folks like you, would say that union representatives are, in fact, making more of the confusion that need be, are emphasizing the lacks and gaps in the system, not for what it will do about this particular infection, but because of what other gains or moves or maneuvers you can make as a bargaining unit.

I'm not saying what truth there is in that or to what extent anybody really buys into it. I've heard that said. Certainly when you reemphasize those confusions, when in fact the vast preponderance of people speaking speak on a very common basis of how you can and can't transmit the disease, it can lead credence to those who want to discredit your role as opposed to helping you further what I think is a legitimate mission in protecting your employees.

I just shared that with you as something that is sometimes heard by folks outside wondering what you're yammering about when you're raising this issue.

MR. STOKES: Our mission as the Fraternal Order of Police is to represent professional full-time law enforcement officers and our first line is to offer them that protection, whether it be on AIDS, guns, bulletproof vests, security in the jail, whatever it is. The other people out there can say what they want. I'm not a high paid union official. I belong to a professional organization. I make $27,000 a year, that's it. So, my endeavor here is as a representative. Most of the people in mu organization are volunteers.

Getting back to what Doctor Lilly said awhile ago, give us the grants and the aids that are passed out to other people and I'll put together a staff of people, as Duffy said a minute ago, of nine, ten people and come up with a front line police officer's solution to your problem.

Whether you get it implemented or not throughout the country, I don't know. I don't know whether Mayor Hudnut or

Mayor Reinhart from my city, or Mayor Koch or the mayors from all the other major cities would implement the program, but we do have a vehicle available to us to do that through a National Law Enforcement Steering Committee and we'd be interested in doing that.

I don't care what the other people, I guess, are saying. I know what out interests are and what our concerns are and AIDS is a major issue right now. When we put on an AIDS seminar, it's a packed house. But I'm just saying to you, to pack the house, I want to make sure we're giving them current factual information. That's what I'm really reaching out to you for. Tell them to get us current factual information and a point of dissemination.

MRS. GEBBIE: Thank you.

CHAIRMAN WATKINS: Doctor Crenshaw?

DR. CRENSHAW: I completely support your concern about some notification of emergency workers in the police and fire department to exposure to an infected person. I would like to also point out that it isn't correct that even though you may go through the same motions, regardless of whether you know or not, you don't go through the same emotions at all.

In the number of police officer families that I treated in therapy, I would say easily I had to do 50 percent less therapy with the policy officers whose subjects voluntarily were willing to let them know that they were antibody positive or were willing to subject themselves to a test. And the ones who weren't, 50 percent of that therapy went toward dealing with their anger toward the system and it was much, much more difficult for them to cope with the whole experience. They went through cruel and unusual punishment. So, I think that's something important and something that's very rarely brought to light.

Secondly, I have some concern about a double standard that we tend to set as we put two guys on the spot over a concern about your health issues related to AIDS. That is, you're charged with protecting the public safety, our safety. What I hear over and over again is that when society doesn't do everything reasonable within their power to protect your safety, morale problems develop. That's why I asked the question originally. Are you experiencing or do you anticipate a loss of personnel based on any of the problems that you are seeing within your communities?

MR. STOKES: I think, Doctor, as the virus situation becomes more prevalent and I think as candidates for police and fire sense that this is a real danger to them, that may impede us

from recruiting those qualified individuals that are out there. As I said earlier, we don't have that opportunity to take those precautions that are provided inside the hospital emergency room or even in some cases with fire fighters. You're involved in situation before you know that it's a negative situation, that it's an HIV situation. I don't know whether that answers your question.

MR. DUFFY: I don't know why anybody in this world would ever want to be a fire fighter. I'm a fire fighter union's health professional, but I don't know if I have answer if it's lessening the amount of people because we're dealing in an economic sense. Because of the unions out there, it's a well paying job perhaps.

But on the other hand, we're dealing with a population that has a mortality ratio far above the general population and we're dealing with healthy workers because it's a medically selective job to begin with because you have to go through medical training and agility testing, et cetera, before you can get on the job. And then you see the same set of people with a mean age of death at 59, 60 years old compared to the general population. That's more than significant. All the mortality work that's been done so far has shown mortality in almost all cases either identical or greatly above the general population. So, even if you're identical to the population, you're still far exceeding it because your dealing with a healthy population group.

Do people consider that in a job when they can leave high school at 18 years old and start up at $24,000 $25,000 a year? I doubt it. But it sure comes to play four years, five years later. We are though seeing the fire fighters wearing protective equipment. In the fire environment, they're wearing their breathing apparatus and their clothing more. And now in the health care providing environment, if there's such a word, we are seeing fire fighters demanding to wear gloves and demanding to fully implement a protocol which I agree everybody should abide by.

DR. CRENSHAW: Thank you. I think you're just making my point stronger. That is that all of you are not asking for a risk-free environment and enter knowing that. And the morale impact, feeling abandoned by policies and frustrated by not being able to take all the limited precautions available could have significant impact in the long terms. Thanks.

MR. DUFFY: But I think the employer has the responsibility still of making that unsafe job as safe as they possibly can make it.

MR. STOKES: Doctor, that what I was saying in the opening statement. When we take the job, I understand there's a risk involved. But I would be negligent if I didn't have my vest when I went to work or if I went into raid a crack house today and didn't take and place the SWAT unit in the most cautious manner to insure the safety of myself and the other officers to do that search warrant.

It's taking that precaution, going the extra step. That's what we're saying here. If it's the rubber gloves, if its the wearing of the mask, if it's a psychological follow-up that necessary after an HIV-positive, then that's the precaution and the training that our departments should be doing with the police officer.

I understand those risks and I know tomorrow I may catch it and there's not anything I can do about it. But what I am saying is, train me so I can prevent it if it's preventable. Train me or give the department the initiative to train, to give the psychological training to my wife and to my children. I don't want to go home and spread it to my children or to my grandchildren in some cases.

DR. CRENSHAW: Thank you. I think you've made your points really clearly. I hope everybody listens.

CHAIRMAN WATKINS: Let me close out with just one question for you, Mr. Barab. We've had people come before the Commission that have looked in from outside into the OSHA responsibility, mission statements and so forth, and feel that somehow the ball is being dribbled around between a variety of agencies on responsibilities for other than health care workers.

As you look into the OSHA mission statement and responsibilities, does it need to be expanded and clarified as to who is in charge of safety in the work place for federal, state, local, county employees?

MR. BARAB: Well, I think it's clear that OSHA's really the only agency we have now that's responsible for work place health and safety.

CHAIRMAN WATKINS: But I mean for AIDS now. I'm talking for HIV-infected individuals, for AIDS.

MR. BARAB: I don't think it matters. Their mandate is work place safety, whether that be chemicals, ladders, scaffolding or infectious diseases. I think to a certain extent mainly due to our pressure and the pressure of the unions and workers, they've picked up the ball: not adequately but to a certain extent, with health care workers. But they still have a long way to go with other --

CHAIRMAN WATKINS: But is that a matter of mission statement change? Should the Commission be recommending -- after all, that's something we can impact on heavily.

MR. BARAB: I think definitely the COmmission should do that in terms of health care workers, in terms of other employees who are exposed to blood and body fluids and most importantly in terms of education and training. OSHA has a mandate to require that all employee be trained about chemicals, so they certainly could do the same time for infectious diseases.

CHAIRMAN WATKINS: But informal connections say that that's a fuzzy mission responsibility as some of them view it. Now, we haven't pulled that string and that's why I'm asking you as kind of a user looking into the system and you've obviously answered yes, more can be done there.

MR. BARAB: Yes.

CHAIRMAN WATKINS: More aggressive leadership there and taking charge of that situation. Do you agree with that?

MR. BARAB: Yes, definitely. In terms of their right to know, there are already two states that are dong that, that are requiring training for infectious diseases.

CHAIRMAN WATKINS: Well, I want to thank all of you. It's refreshing on the one hand to have your candor and it's sobering on the other to know what you people face is the real world everyday. We've seen it in our travel around and we respect what you're doing.

Why would anyone want to be a fire fighter? If you'll read the latest edition of The Saturday Evening Post, Mr. Duffy, you'll see a picture in there of me at eight years old wearing my fire department uniform. For many, many years before I thought I would do into the Navy because we were fighting WOrld War II, I was going to be a fire department person because I think it's a great draw still in this country. There are a lot of people that want to serve. It's up to us to make that environment safe. It's up to us to build the incentives when people want to go into that profession and stay in it. It's important to the nation as is the police department. We know that.

So, I would never sell the American people short. They'll be there to volunteer. We've got to be fair with the fire fighters of the nation and give them a chance, the same with the police department, to do their jobs. We have hamstrung them over the years. There does tend to be a migration because of our constitutional setup to be more interested in the accused and we always have to be fighting to find the right balance in there.

So, we appreciate what you've done and your candid testimony before us. It's useful to hear from you all and I think it's been a valuable presentation. Thank you very much.

We'll adjourn until tomorrow morning at 9:00.

(Whereupon, at 5:30 p.m., the above-entitled matter was adjourned to reconvene tomorrow morning at 9:00a.m.)