TRANSCRIPT OF PROCEEDINGS

NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

PERSONNEL AND WORK FORCE HEARING

Pages 1 thru 271

Washington, D.C.
July 18, 1990

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NATIONAL COMMISSION ON ACQUIRED IMMUNE DEFICIENCY SYNDROME

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PERSONNEL AND WORK FORCE HEARING

Wednesday, July 18, 1990

Interstate Commerce Commission
Hearing Room B
12th & Constitution Ave., N.W.
Washington, D.C.

The Commission convened at 9:10 a.m.

COMMISSIONERS PRESENT:

June Osborn, Chairman
David E. Rogers, Vice Chairman
Enrique Mendez
Eunice Diaz
Charles Konigsberg, Jr.
Harlon L. Dalton
Belinda Mason
Diane Ahrens
Scott Allen
Larry Kessler
Donald S. Goldman
Don Des Jarlais

ALSO PRESENT:

Dr. James O. Mason
Dr. James R. Allen
Mr. Irwin Pernick
Maureen Byrnes, Executive Director

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C O N T E N T S

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P R O C E E D I N G S

MS. BYRNES: Good morning.

As the duly designated official for the National Commission on AIDS, I would like to convene this hearing in Washington, D.C., and turn it over to the Chair, Dr. June Osborn.

CHAIRMAN OSBORN: Good morning, and let me apologize to our witnesses and friends in attendance for our lateness. As some of you heard me say, we ran into a totally unaccustomed problem of being unable to get taxicabs from the hotel where we usually stay. They usually are just crawling all over the place, and it took us quite a long while this morning, so I am very sorry to have you waiting for us.

We are focusing in this meeting on the issues which I think may turn out to sound quite urgent to a lot of us of both present and future health care manpower, and we are going to be looking at the various facets of that, in terms of the need to be educating and the need to be caring at the present.

So, we have a very distinguished group of people who will be speaking to us, and I hope -- I won't take the time to introduce all of the Commissioners to you. I think

you can see who we are and we will be interacting extensively with you.

I do, however, want to say a special word of welcome to Dr. Mendez, who is joining us as the Department of Defense Assistant Secretary for Health and is I think the permanent designee from Secretary Cheney, so we are very pleased that you can be our steady companion at this interesting time.

COMMISSIONER MENDEZ: Thank you.

CHAIRMAN OSBORN: Dr. Rogers, would you like to say anything before we get started?

COMMISSIONER ROGERS: Only that I am looking forward today. We are dealing with an issue that seems to me one that restricts a great deal of what we ought to be doing for people with HIV infection. We have got just the people we need to tell us how to correct that sitting in front of us, and I would just like to welcome them and thank them for being here.

CHAIRMAN OSBORN: And one other logistical comment. If I look like I disappear, I'm still here, it is just that this chair so low and I am so low, you just have to act on faith that I am still here.

[Laughter.]

With that, let me thank the first panel, and would you introduce yourselves as you speak, so that everyone will know.

Dr. Ginzberg, would you begin, please.

DR. GINZBERG: Okay.

I have submitted a summary of my points to you. I don't know whether they were distributed or not, but if they are, I think the best thing you can do with me for the few minutes that I am around is I will make a few major points, which may or may not be part of your thinking, and then you ought to ask me questions, I think. That will be the better way to proceed. I have been in the classroom for 55 years and I know you shouldn't lecture at the students.

CHAIRMAN OSBORN: You and Dr. Rogers have infected each other, because he says the same thing.

DR. GINZBERG: The points I want to make are the following: Number one, it's impossible to say that the U.S. health care system hasn't been attracting lots of people. We grew by 50 percent in the last decade. In the 1980's, we went from about 6 million people in health care to 9 million. That's a rate of increase that indicates that the sector has

surely been able to get lots of personnel.

That doesn't mean that every last nook and corner is covered, and by colleague Dr. Curran will point that there are problems on the nurse side. But by and large, the health sector has done very well.

The second point is that it has done very well, because we have been spending very large amounts of money in health. We were at about $250 billion as the annual expenditure in 1980. We are at $600 billion in 1989. With those kinds of dollars flowing, there is no great mystery as to why you were able to attract all the people you wanted, by and large.

The next point is that we have basically a very heavily hospital-based system in this country, maybe not as bad as the British and the Swedes, but it's very heavily hospital-based. As I read the AIDS story -- I don't know anything about AIDS, except that I'm a friend of Dave Rogers, and so I learn something by association, but otherwise I don't know anything about AIDS.

The point the strikes me is that, basically, you want to treat AIDS patients to the maximum possible degree outside of the hospital. You have to put them into a

hospital occasionally, but you sure don't want them in a hospital very much.

I did a quick calculation, and I told Dave this morning, that for a patient day in new York hospitals, about $800, plus or minus a few dollars, and you ought to be able to get pretty good home care for $80 a day, not for full-time, but for home visits, for an AIDS patient, so that is a 10-to-1 shift. That means you want to do everything possible, if you want to improve service for the dollars that are around and the few dollars that you're going to get additional, of making sure that the system of treatment is as much as possible out of hospitals.

The next thing I think is, if you read this morning's paper, the Washington paper, you will see that two of the projects, Project Safe and Project Clean, about which I know nothing, are going to be closing down because of money, so as an economist, I want to emphasize to you that it is not a human resource problem, it is, in the first instance, a money problem. If you have the money, you will get most of the people you need. It may take a little time of adjustments and nurses get themselves all mixed up via the hospital administrators, so that you get rid of all the nurse assis-

tants, then obviously you are going to be in trouble. But if you are have the money, in this kind of a society like ours, you will get the people.

The next point is that home care, we spend $1 billion in New York City on home care a year for 50,000 Medicaid patients. They are very low wage-earners. If we were to increase the salaries of home care workers by $1 an hour, that would increase the Medicaid bill by $100 million a year in New York City.

I will repeat that slowly, because these are the realities of the figures that you are dealing with. We spend $1 billion a year for 50,000 patients on Medicaid home care in New York City, and if you increased by $1 -- and they are entitled to it, as far as I am concerned, it is a lousy job and no place to go and so on -- that would cost you $100 million.

So, the problem of how one squares the needs of AIDS patients with the dollars in this big system and the earnings of the people who are involved in providing care is the central issue.

The fact that AIDS is moving from the gay community increasingly towards the drug community means that the human

resource problems are worse, because you don't have the support of the volunteer community to anything like the same extent, and whole outreach problem and the whole support problem with the drug community is three times worse. So, from that point of view, it is just awful, in terms of that dimension.

I think I will stop. I have told you enough bad things, that money is the key, that you have to move towards ambulatory and home care -- no, one more point I have.

The public hospitals that carry a disproportionate share of caring for poor people and for AIDS patients and everything else, they are, of course, at the bottom of the heap, because we really don't believe in the poor of this country. So, if you don't believe in the poor, you let the public hospitals run at the worst possible level. Therefore, if you dump all the new AIDS patients into them, you've got one hell of a mess, and as far as I'm concerned, those are the dimensions of the problem.

I feel awful, because now, as I look at AIDS, you're getting a few drugs that will prolong the life of the AIDS patients, and I'm not so sure, if I was an AIDS patient, given this circumstance that I am talking to, that I would

want my life prolonged.

CHAIRMAN OSBORN: Thank you very much.

I think we will proceed with all three witnesses, and then we will have the opportunity for interaction.

DR. CURRAN: I am Connie Curran.

I have prepared testimony and I hope you have a copy of it. I would like to start by giving attribution to the three places where I got the statistics that I am sharing with you this morning.

Initially, I was Vice President, of the American Hospital Association, and while at AHA, I got involved with this manpower issue. After that, I was on two large research projects, one with Dr. Ginzberg at the Commonwealth Fund, provided the financing for it, and we basically described the current nursing population, and I will talk to you about that.

The second project I was principal investigator of was funded by the Pew Foundation, and we looked at issues of health, health manpower, actually nursing recruitment and retention.

Yesterday, as I was leaving my house in Chicago, I got a copy of a newspaper that I get every week called "Health Week," and it had some interesting statistics about

predictions for the needs for other groups of health care workers by the year 2000. These statistics are not in my testimony, and I just wanted to share them with you.

They are suggesting that, by the year 2000, we will need 70 percent more medical assistants than we have today, 66 percent more radiology technicians, home health care workers will need 63 percent more home-makers, we are going to need 60 percent more medical records technicians, and so on and so on and so on. I will be happy to furnish these to Maureen, if she wants to share them with you.

When I looked at those numbers, I thought to myself, perhaps the best thing I can help the Commission with is some lessons that we think we have learned from the nursing shortage and, hopefully, we won't repeat the manpower shortages of these other groups.

A couple of things that I would like to tell you about is, when we looked at the nurse supply -- and Dr. Ginzberg was one of my co-investigators on this project -- we found some interesting things out.

We found that the new supply of nurses, the new people coming into nursing, first of all, is skimpy. Less than 4 percent of college freshmen indicate they want to be

nurses. It was 40 percent 20 years ago of women who went on after high school, and now it is down to 4. It's skimpy.

It's not as bright as it used to be. Ten, 50, 20 years ago, three-fourths of all the nursing students in the country were in the top quarter of their high school class. Last year, three-fourths of them were not in the top quarter of their high school class.

The new supply is old. The average new graduate nurse last year was 28 when she graduated. She's not nearly as old as the existing supply, which we will talk about in a minute. The new supply continues to be incredibly white. As an occupational group, we are 90 percent white and we are 97 percent female. We simply do not look like the people we serve, and that's a major issue for this profession.

I am not sure exactly why. I think a big part of it is money. Like my friend Dr. Ginzberg, nursing education 20 years ago, the best diploma school in the State of Wisconsin -- and I was growing up then in the State of Wisconsin -- one could go for 3 years for $325 -- 3 years of education, uniforms, room, board, housing and books were $325. So, even a poor girl, even a farm girl, all sorts of people could raise $300.

Today, even with community college, which we all brag about how low tuition is at community colleges, we are not addressing the cost of housing, we are not addressing the cost of -- many of these people are single parents, trying to support children. Young people can't afford nursing education today. It doesn't provide the cheap vehicle out that are provided in the sixties, fifties and seventies.

When we look at existing supply -- so the new supply is skimpy and not as bright -- when we look at the existing supply, we can best describe it in one word -- old. The average staff nurse in the country turned 40 in 1989.

Now, 40 isn't so old for those of us who have been there, but 40 is old to do the work of a staff nurse; 40 is old to run the 100-yard dash from the nursing station to the patient's bedside; 40 is old to run to the pharmacy, the kitchen and all of the places that we send nurses; 40 is old to work 12-hour shifts, to be expected to work double-shifts, because the shift behind you didn't show up for work; and 40 is much too old to rotate shifts -- all of which we ask the current nursing supply to do every week, every day, in every hospital and every nursing home in this country, and now even in home care.

When we ran home care in New York City, one of the big advantages was it was Monday through Friday, 9 to 5. Home care is now 24 hours a day, 7 days a week, just like hospitals and nursing homes, and that current supply, contrary to popular opinion, is working.

When Eli and first started the research, we all sort of believed that somewhere out there were a bunch of dusky nurses, and if we could only find them, we could find some incentives, that economists always tell us there's incentives, to bring them back into the labor force. Well, they are simply not out there.

Only 4 percent of the nurses in the United States who are licensed are not working in nursing, they are working in other disciplines, and those 4 percent, which is a pretty skimpy percent, made 50 percent more money last year than the nurses who stayed in nursing, so they are not coming back, either. There is not a recyclable supply out there that we can find to bring in.

That sort of describes the supply. The demand situation is a grim one. Demand has increased four-fold since the early seventies. Demand is being driven by principally two factors. One is the aging of the American

population. This elderly American group is going to need more and more nursing care, with their chronic illnesses in their homes, in their nursing homes, even in physicians' offices, and certainly in hospitals, and it's being driven by technology.

In our Commonwealth Study, we discovered that 10 percent of the beds in our country's hospitals are classified as high-tech special care beds, and they consume 40 percent of the nurses. So, certainly, as you look at your own institutions, where we are adding new beds as high-tech -- I just did some work at Stanford University, and they added a procedure called ECHMO. Now, I don't really know what ECHMO is. It deals with babies. But I will tell you, ECHMO takes two nurses per baby per shift, or six nurses in a 24-hour period. ECHMO is a black hole for nurses.

I would tell you that the one thing that we would recommend is we have to look at how we utilize this precious resource of human capital in health care. We simply have not used technology in the health care industry to extend the life and the productivity of our workers. We still use nurses -- Eli and I like to say that we're in the 1970's mindset that says computers are rare and expensive and nurses

are cheap and plentiful, and actually, in 1990, it is the opposite. Computers are cheap and plentiful and nurses are rare and expensive.

In hospitals, the average nurse spend 38 percent of her time documenting, writing, that's 3 hours on an 8-hour shift, and yet only 12 percent of the hospitals in the country report they have computerized patient documentation systems. So, we're using these old wrists to spend 3 hours a day writing, rather than using computers to do that documentation and using nurses to be at the bedside. We simply are going to have to look at substituting capital for labor, because the shortages in nursing are reflected in shortages in licensed practical nurses who staff the nursing homes in this country, shortages in home health care technicians, all of those groups are going to have to be, I believe, extended by the use of technology.

I would end by saying that I think money is part of the answer, certainly, money to nurses, who earn about 25 percent of what their physician colleagues earn, but money for education, money to help young people come into health care, and, more importantly, money to help minorities and men come into nursing and move into the ranks, so they can help

meet the manpower needs that the Department of Health and Human Services and the Department of Labor are predicting will increase by 60 percent for registered nurses in the next 10 years.

I, too, will be happy to take questions. Thank you.

CHAIRMAN OSBORN: Thank you. That is superbly helpful.

Dr. Cooke?

DR. COOKE: Thank you.

I am Molly Cooke, and I am going to be addressing now primarily the issues of AIDS and physicians. I, too, in part of my prepared testimony, emphasize four major points that have to do with the preference and reluctance among physicians to work HIV infected people, how that reluctance affects physicians, career physicians, what the sources of the reluctance are, and, finally, some issues that have to do with physician burnout.

My first point is that many physicians are reluctant to take care of people who are HIV infected through the system, but the prevalence of this reluctance is clearly reflected in internal medicine residents who, given the way care is set up in this country, should we expect to provide

the vast majority of the basic services that HIV infected patients will require.

I believe that only 10 percent are really actively interested in working with AIDS patients, and at least 30 percent are actively disinterested in working with AIDS patients, and the remaining 60 percent is neutral at this point, while probably a significant component of that 60 percent are relatively disinclined, they are just not as overtly hostile as the 30 percent that I referred to.

The basis for most of my comments, particularly the numbers that I just gave you, is that a study that is in progress now, medicine residents nationwide, done by the California Statewide Task Force on AIDS, of which I am the principal investigator.

Whether the number of internal medicine residents willing to work with AIDS or HIV infected people will be sufficient to meet the needs of the patients is really beyond the scope of my study, though let me say that I am a proponent of the model of care information and solutions that incorporate HIV infected patients in an internal medicine practice.

And if internists and other primary care clinicians were spending 20 percent of their time taking care of HIV

type patients, I would estimate there would be somewhere between 8,000 and up to 18,000 physicians providing 20 percent AIDS care, depending upon the assumptions you make about frequency of visits to AIDS patients. So, you need a lot of people willing to do a relatively small amount of AIDS care, if you can successfully deliver in this kind of diffused or disseminated model.

If 10 percent of residents are interested in providing AIDS care after completion of training, that can introduce maybe 400 new willing internists per year. It takes a whole long time to get to the number of providers that I anticipate that we will need. So, that's my first point.

My second point concerns the career decisions that people who are reluctant to work with HIV infected patients make. What you see most attention in the press are instances of which states refuse AIDS treatment. The physician is confronted with a patient who seeks treatment and the physician says I can't as a matter of ethics. That is actually relatively rare. Physicians, when they are confronted with patients feel fairly compelled to treat, particularly when the need is high, and will often will treat

even if they don't want to. So, what reluctant physicians do is avoid situations in which they are likely to encounter that.

Clearly, this is already happening in our setting of over 1,000 residents. A quarter of them leave the training programs to be start in the areas in which they literally have the intention of avoiding contact with HIV infected people. When we ask about what you intend to do, another quarter says I intend to practice in a location which will not put me in contact with HIV infected people, and close to 20 percent intend to choose a low-AIDS presence practice specialty, so basic cardiology care to chest medicine, infectious disease or general internal medicine.

People were also indicating an intention to choose practice specialty groups which can hide a myriad of discretions over the patients that they will and won't see. Remember, we are not talking about search and seizure internists, where the least professional ethic is where we take all comers and do our best, but clearly these residents are looking for ways to get more control over the kind of care that they are going to be doing.

My third point concerns the sources of reluctance,

why are these residents unwilling to work with HIV infected patients. Again, I think that some things are different from the reality. Clearly, the issue that has received the most attention is the question of occupational risk, concern about occupational infection, a totally legitimate concern for physicians who work with HIV-type patients.

I don't want anything I say to be construed as a dismissal of that theory of legitimate concern, but that's not why people are choosing not to work with HIV infected patients. In fact, not surprisingly, the people who do work with HIV infected patients have a lot of concern about occupational transmission of their people who are really likely to have to deal with this in their day-to-day professional lives, and one hopes not, but may have to deal with it in their personal lives, as well.

What distinguishes people who intend to treat from people who do not intend to treat are four factors, two of which relate to the kinds of people who could be getting AIDS, some negative attitudes about gay patients and negative attitudes that IV drug users are both strong predictors of unwillingness to work with AIDS patients, residents who are uncomfortable with some of the apparent medical aspects of

AIDS medicine as we now know it are unwilling to work with AIDS patients.

By this, I mean residents who hare troubled by clinical situation is in which the cure rate is low or non-existent, situations which raise feelings of therapeutic impotence and clinical situations in which non-technical skills are required. So, residents talk about social service needs of AIDS patients and the burdensomeness that those needs are associated with the resident's point of view.

Finally, residents who are having a relative weak sense of professional responsibility, residents who have a more libertarian formulation of physician responsibility are much less likely to treat AIDS patients, people who have a higher sense of service commitment with the medical profession. But to reemphasize my initial points, fear of containment does not distinguish the treaters from the non-treaters.

The fourth point that I want to make -- the three preceding points really pertain to the decision to treat or not treat. Clearly, some people are deciding to treat. The fourth point concerns those people. It is obviously critically important that we keep those people, having said what I implied about the paucity of reinforcements for them, we have

got to keep them at work.

Now, I am going to come back and speak from the physician's point of view, to a point that Dr. Ginzberg has already raised. One level on which this question of burnout has been addressed as a psychological one has to do with issues of grief saturation and psychological support. I think those are important, but, frankly, I don't think they are as important as help for people who are providing care.

This is increasingly an issue as to demographics of the HIV change, and people who are working with lots of AIDS patients can be increasing found at under-funded, overtaxes, public institutions, working all by themselves, with an expanding population of very needy patients. The people who are working at those institutions -- and this comment is not restricted to physicians, by any means -- has to do with everybody working at those institutions, are of high IQ, very service oriented people who get their gratification by feeling that they are doing good work.

If we put them in a situation where they cannot do good work, because they can't get their sick patients admitted and they can't get their less sick patients discharged to appropriate situations, they don't have drugs and

they don't have nurses and the other medical assistants and the radiation technologists and all the people they need to help give the care, they are deprived of the gratification, the thing that is keeping them working.

So, I would think this is a much more compelling issue than the important issues that we assess in AIDS work. Really, there are two things, from the physicians' point of view, that we need to be concerned about. One has to do with the increasing numbers of HIV infected patients and their geographic dispersion. I think we are going to have more primary care clinicians who are willing to and are technically prepared to discuss HIV risk, to HIV tests, to appropriate counseling, to interpret test results, to assess people who are fond to be HIV infected, and to begin treatment.

Really, all people going into primary care kinds of activities need to be prepared to do that in 1990, and I am concerned at the low number of residents in my study that say they are willing to do it.

The second problem is a really different problem, and that has to do with keeping the people who are prepared to want to do AIDS work, and I think that is not an attitudinal kind of a problem, but is a resource problem.

So, I will stop there and, of course, take questions, as well. Thank you.

CHAIRMAN OSBORN: Thank you all for exceptionally helpful testimony to the point.

Questions from the Commission? Dr. Konigsberg?

COMMISSIONER KONIGSBERG: I have a question for Dr. Curran regarding the nursing situation. I certainly noted the difficulties in recruiting nurses and all the things that you mentioned. Could you comment a little bit on how this relates to community or public health nursing? Because there the salaries are lower, there is an additional set of difficulties, and as we move more and more to out-of-hospital models of care, at least in my experience, we are going to be depending more and more on local health departments, on BNA's, hospice, et cetera, et cetera.

DR. CURRAN: There are two pieces of information that might be helpful there. Two years ago, we did ask the question of hospitals who had a home health care branch or a home health care service related to them, about did they believe they had a serious shortage: 25 percent of the hospitals that had home health care types of nursing reported serious shortages of home health care.

Again, that would not have happened 10 year ago, when home health care was a very different kind of work than it is today. I'm sure it is higher than that today, but there is no more recent statistics, so they are having a hard time recruiting there.

I will tell you, I was the chief nurse at Montefure Medical Center in New York City, in the Bronx, and we did a great deal of home care, those of you who are familiar with Montefure. And while I was there in the earlier eighties, we went to the people that we were serving, not just AIDS patients, but the poor in the Borough of the Bronx, the neighborhoods become so unsafe that we actually -- and these nurses were very committed to being there -- that we actually went to having to get escorts in many of the housing projects and many of the areas, to send the nurse out with an escort.

Of course, then you get into that whole thing that Dr. Ginzberg talks about, cost, and you are almost doubling the cost, because you getting another human resource person, et cetera, et cetera.

In nursing homes, which certainly we see more AIDS patients being placed in long-term care facilities, they are reporting a 19 percent shortage of their budgeted positions in

nursing, but nursing homes had traditionally been staffed by licensed practical nurses, which, those of you who are familiar with hospitals, know that many hospitals laid off and decreased their numbers of licensed practical nurses in the seventies, they went to nursing homes.

Well, now that we have this terrible nursing shortage, hospitals are recruiting back those LPN's. They can pay better, you know, they are more attractive, I think perhaps more exciting, better benefits, and so the long-term care industry, both in home care and in institutionalized long-term are, I am very worried about manpower there. I think it is going to get much worse in acute care. They simply can't compete. They can't compete in terms of money.

COMMISSIONER KONIGSBERG: Just a follow-up comment, Dr. Osborn.

At least in my experience, the difficulty with public health nursing, which is an extension, really, of what you described for nursing in general, is that much more was asked of the public health nurses in the past, it's no longer a hand-holding kind of thing. In the home, we asked them to be advanced registered nurse practitioners, we ask them to be managers and administrators.

The pressures in large cities, in the clinics, the burn-out factor, the safety factor which you mentioned, with crack cocaine, in particular, is becoming a problem, at least in urban areas. Compounding that is what I think is a lingering poor image of public health, even though we asked more then, at least public health nursing and community health nursing, and the salaries are -- if there is a salary difficulty in acute care institutions, public health is always several notches below, and it just makes it very difficult. I bring this up, because I think the Commission needs to take note of this and how much we in public health depend on nursing far more than we depend on physicians. That is a good point.

CHAIRMAN OSBORN: Thanks, Charlie.

Don Goldman and then Harlon Dalton.

COMMISSIONER GOLDMAN: Thank you. This is really a question directed at all three of you, if any of you want to reply.

One of the things which I have noted at some of our sites across the country has been the disparity in the way that wards and areas of the hospital are specifically devoted to patients with AIDS and HIV infection are affected.

Just by way of example, we visited Los Angeles, two of the hospitals we visited, one of them the Los Angeles County and one of them the VA Hospital in West L.A.. Both of them, at least, reported on average approximately the same percentage of nurses who were what they described as agency or floating nurses, as opposed to permanent staff.

Yet, within the AIDS specific wards of the hospital at L.A. County, I think they said 99 percent of the nurses there were agency nurses, whereas, in the West L.A. VA Hospital, it was indicated that the AIDS portion of that hospital was considered a preferred assignment and virtually every nurse on that area was, in fact, a permanent staff nurse, and none of them were floating nurses.

How does that deal with any of the items that you have been talking about, and are there any lessons to be learned from that that you think are useful, and does that reflect what's going on elsewhere?

DR. CURRAN: The first thought that came to my mind is wondered if that VA Hospital had any agency nurses at all, because in many VA institutions, they simply have not had access to that labor supply. I mean that is not --

COMMISSIONER GOLDMAN: Both hospitals reported that,

overall, 30 -- I don't know if all 30, 25 to 30 percent agency nurses overall. But I have seen that elsewhere in other hospitals. Some hospitals seem to have in their AIDS treatment areas, you know, all agency nurses, and others of them seem to have almost none.

DR. CURRAN: I don't have any definitive data on that. I will tell you that yesterday I addressed an operating nurses meeting, and I started out with talking about the fact that we have a terrible shortage of operating nurses in this country, and I said why do you suppose that is. These were operating room nurses, and the first response was AIDS, which just astounded me, because that is not really part of our objective data.

Part of it is because they are very old and schools are not training OR nurses and all this sort of thing. But it was the first word out of their mouth, and I said do we really know that's a fact, and they said absolutely, that nurses' husband and families have said they don't want them working in the operating room any more, if those hospitals do surgery on AIDS patients.

So, I'm sorry I don't have any data related to the use of agency nurses, except that hospitals are using them in

large, large proportions and they are incredibly expensive. They are two to three times as expensive as an average ROE nurse, but I don't know the relationship of those kinds of temporary workers to AIDS patients.

CHAIRMAN OSBORN: Harlon Dalton, Jim Mason, and -- oh, excuse me.

DR. COOKE: I could make one comment on that preceding question. I suspect that it is quite dependent on the politics of nursing within a particular hospital, and you may not be able to find the consistent for that reasoning, consistent, if that is hospital to hospital.

At San Francisco General, the nurses on the AIDS unit look much more like the nurses in the ICU. It is a preferred assignment, nurses are all self-selected to work there, and they are much more -- one thing that comes right to mind is they are much more white than the ward nurses and they are also much more gay, and that is the mechanism for their self-selection. There is very strong leadership on that unit, and I think for that reason they accept that assignment.

COMMISSIONER DALTON: I have one question for Dr. Curran and one for Dr. Cooke.

Dr. Curran, you mentioned briefly in your testimony and also briefly in your written statement that it's important to recruit more people of color into the nursing profession. As I recall, you said 90 percent of nurses are white. And you mentioned in your testimony that one way of doing that would be to increase funding for nursing education for minorities.

I guess I would like to ask you to reflect a little more for us why those numbers are as they are, and then, given that why, what else can be done besides additional funding to correct that imbalance.

DR. CURRAN: Again, my opinion, not my data on wy it is. For many ethnic groups in the United States, the first woman that went beyond high school went to become a nurse. That was certainly true for the Irish, it was true in large part for the Italian and the Germany communities. And now as we look at Hispanics and blacks, that has not been the pattern.

So, when I first started to worry about this, I went into New York City to talk to the President of the Black Nurses Association, who at the time was a woman named Alicia Georges, and I said, "Alicia, why aren't black young people

coming into nursing?" She said, to me, "Connie, if a black person has the wherewithal to go on to school, the money, the time, the access, why would they choose to join another oppressed group?"

Of course, my first reaction was we're not opposed, but my brain overruled my mouth and I thought a minute on that, and I said to her, do you think we really appear to be an oppressed group. She said absolutely. You know, we have -- and she is a black nurse, of course, and she said we have no independence, we have no autonomy, and she went on and on about that.

I think that also the lack of black role models, I mean you certainly will hear from Clair Andrews later. She has been incredible. I mean the black nurses we've had and the Hispanic nurses we've had that have moved into leadership positions I think have worked very hard at that. But it is pretty hard for a blue-eyed blond -- I mean I worked in the Bronx -- to out -- and I did go to high schools in the South Bronx -- and to tell people to be a nurse. They didn't identify with me, they didn't relate to me, and, quite frankly, we didn't have the money to support them.

I will tell you, in New York City, unlike any other

city I know of, the hospitals, 1199, which is the Health Care Workers Union, and the City University, Lehman, which was our college in the Bronx, went together and creates a program that enabled people who worked in health care, non-skilled workers, to go 4 years to Lehman, if they chose a health career, and not only were they paid their tuition, they were paid three-fourths of their monthly salary, so they obviously could pay the rent.

I think we have to be more innovative, as we look at our relationships between employers, educators and unions, to support that, but I also think the Federal Government has to take a much more active role in recruiting.

I think the issue with men, men have simply never selected nursing, and now women are becoming more like men, as we make our career choices. I mean we are looking at money, security and autonomy, and nursing has never offered those, so we are certainly not going to increase our numbers of men until we change some of those issues.

DR. GINZBERG: I think there is another dimension or two here that ought to be put on the table. Leaving the discrimination factor aside -- and I don't think you can, because I think the fact that the nurse leadership, you will

forgive me, is solidly anti-anybody except for whites, so it was a big factor, because nursing is a very decent and kind of an educational experience, so if you're not wanted, you don't go there.

But the important point today is not that. The important point is that the nurses also send very confusing signals out to the oncoming generation, because, for 40 years, they kept saying you had to get a bachelor's degree. Now, Connie's statement was absolutely correct, if you're going to go get a bachelor's degree and you come from a minority group, it made no sense necessarily to go into nursing. We have quite a few women physicians among the blacks, you are getting more of that.

The real point of the issue is what about the 2-year community college prepared nurse, and that reflects back on the weakness of our secondary school systems in the major metropolitan centers, where the major black populations are. Unfortunately, in the absence of rich programs, because the youngsters come through the end of high school unable to handle the simple mathematics and the simple science that the nursing license requires, that unless you build 6-month programs to bridge that -- and that's all you need -- you can

now, at $30,000 a year, I would bet my last nickel, as an economist, you will get plenty of minority nurses, once you offer them the educational opportunities in a two and a half year program to go into a $30,000 a year job.

The whole question of the pst can be liquidated, I think, in terms of the future if you can get that school bridge, but in the absence of the school bridge, it still isn't going to work.

DR. CURRAN: We looked at L.A. two years ago, Eli and I -- and I always think of Los Angeles as not having a minority, it really being a mix of whites, blacks, Asians and Hispanics -- and in L.A., in the graduating classes in the nursing schools in 1987, I guess three years ago now, there were only 18 percent of the students in Los Angeles were non-white that came out of nursing school. The majority of all new graduates last year, three-fourths of all graduates in nursing last year did come out of community cclleges, so Eli is -- I wouldn't say he's correct in his characterization of nursing leadership, but I will say that certainly the movement has been to the community college program. But even there, we are not attracting our share of minorities, even in cities like Los Angeles.

COMMISSIONER DALTON: Thank you, both.

My question for Dr. Cooke, you indicated in your testimony that you preferred a model where a broad number of internists would spend a relatively small proportion of their time seeing AIDS patients. In your written testimony, though, you indicate that there's essentially "no information available" on the capacity of people who were non-Aid specialists to handle different kinds of HIV infection or complications. So, I guess I'm a little curious about what supports your preference, and I also wonder whether there are in the pipeline any attempts to study the quality of health care that can be delivered by folks who do this. Casually may be a pejorative way to put it, but certainly a small part of the time.

DR. COOKE: Well, I chose the word "preferred" in my oral testimony, because it is at this point a personal preference, without substantiating data. The reason that the model appeals to me at this point is, first, I think it is going to be a necessity. I think two things are happening with the epidemic. It's a paradox. One is it's becoming concentrated in, ghetto-ized in very depressed areas in the inner-city, but at the same time it is extending out in lower

numbers, but extending into the general population in such a way that I don't think that physicians can really expect, no matter where they choose to practice in the United States, to be guaranteed that they won't see HIV infected people.

So, I think, in fact, that it is just a reality, unless we are going to require that the AIDS patients in Iowa and Louisiana and here, there and everywhere come to the cities that have been most identified with AIDS during the first decade of the epidemic, it's just a manifest reality that more physicians are going to have to be prepared to do a little bit of AIDS care.

The second reason that I favor the model is that I think that it is good for the care providers, in the sense that it is less exhausting and, speaking from my own experience, I am a general internist and I take care of -- I spend more than 20 percent of my time taking care of HIV infected people.

But my non-AIDS patients in several important sense almost subsidize my AIDS, in terms of my time. I can spend 5 minutes on a patient who has uncomplicated hypertension and simply wants her medications refilled, and that gives me 35 minutes to spend with the AIDS patient who is having a lot of

trouble with dealing with the family about the diagnosis and has very complicated technical decisions to be made about their care. So, both in terms of my energy and my time, I think the model has some appeal.

Now, one could argue that, as a general internist in San Francisco, am I not really, by virtue of where I practice, an AIDS specialist, and I won't defend myself against that charge. I think we need to look at how much AIDS care primary care physicians can do as part of a general practice. I know of no funded efforts to do that. I'm actually interested with some collaborators in looking at exactly that question, because I think it's a very important policy question.

CHAIRMAN OSBORN: Dr. Mason?

DR. MASON: Madam Chair, I know that our time is about gone, but I --

CHAIRMAN OSBORN: I think we should go a little longer, since we started late and this is an important topic.

DR. MASON: I did want to commend all three members of the panel for their excellent testimony. I wish there were a lot of additional time, because I think, in defining the problem, they have certainly raised questions that the

Commission needs to focus on. With time being limited, maybe I could simply ask each one of them, if there is time, they could try to respond, and if not, for the record.

Having painted a very lucid picture of the problem in the economic area and in the nursing and physician responders, what would be your number one recommendation that you would like to give to the Commission to solve the problem or the problems that you have so well described to us this morning?

DR. GINZBERG: Well, I'm on the spot first, because I started first. I suppose, really, following the last discussion, you cannot continue, I think, to isolate the AIDS patient from mainstream American medicine and expect anything very good to happen, either to American medicine or to the AIDS patient.

That is, the size of the epidemic is now on a scale that makes it, I believe, essential that every piece of the total medical system we have play a part in the proper treatment and support and care of these people. That's another way of saying that, whatever weaknesses we have in the system -- and I started by saying I thought we were an over-hospitalized system, in terms of emphasis -- if we do

sensible things for the AIDS patient, it will pay off for the total system, so that will be the encouragement, I would hope, for the rest of the society, to really become a little bit more interested in AIDS. As long as they don't think it is their problem, they are not going to do very much.

Now, as I see it, one has to go both ways, one has to really try to get the local communities to understand that the bulk of the American population is vulnerable, if the AIDS patients do not get "treated, prevented, assisted," and so on. You can't really live in a society if you're neglected.

In the process of trying to get a community understanding that that's the problem, then I think you have the beginnings of a chance that it will no longer be possible for young students coming into medical school or residency to think that they can walk away from that. That is just ridiculous.

Now, the only idea that came to mind while this last discussion was going on, we have had sexually transmitted diseases as a problem in this country for a long time, and it struck me as to what extent did the American medical fraternity deal with sexually transmitted diseases, and I'm afraid we have inherited the notion that we didn't deal with that

properly, so we will do the same things with AIDS. It won't work with AIDS, I don't believe.

That's the distinction, and I think we are just coming up to that point, and the only way I can answer Dr. Mason is to simply try to educate the American people to believe that it's their problem, not the AIDS patient's problem, because there will be no proper medical care, sooner or later for the bulk of the middle class. We see this already in New York. You can't get into a hospital, because the AIDS patients have got it so crowded.

My wife was in Hawkwish, which is the private part of Presbyteria, and the whole floor was full of AIDS patients, and it was very hard for her to get any kind of floor nursing, because they were commanding the essential resources.

That's the way I would go. Not an easy story, but I would think with long-term payoff for all of us, because we will build up the home care program, we will build up more ambulatory stuff, we will learn maybe even to use nurse practitioners effectively, because I would assume they could be used very effectively in ambulatory community clinics and so on, and that's the way we have got to push it.

DR. CURRAN: Again, like Eli, I think the issues

are systemic to the whole health care delivery system of our manpower, and I really think there has to be some policy decisions around supporting more than medical education in this country. I mean I think there have to be some policy decisions to support young people to choose health care, not for young people to choose health care as well, and I think we have to start incentive systems to use their manpower wisely, to really be using health care professionals to do clinical care and administrative care, and not to do manual labor, to start using technology, using -- I mean you would be surprised how many hospitals don't use Fax machines, you know, a simple Fax machine you can pay for with one trip to the agency nursing. When you put in a Fax machine, you can save a lot of 40-year-old legs running down lots of hallways, and that kind of technology I think we have to incent the industry to recruit, to utilize and to award people in health care in ways to help what is happening right now. Because if we have these labor shortages, not only will the AIDS patients be impacted, the elderly will be impacted, and as Eli points out, in New York City, one in four positions is vacant right now for professionals, so the whole system is being impacted all the way down.

Thank you.

DR. COOKE: I'm sure I am not saying anything different than the two preceding witnesses. We agree totally. I may articulate it a little bit differently. I think the first step is there needs to be a clear national commitment to take care of AIDS patient.

As Dr. Curran just said, one would hope would have a possible effect or failure to do may be reflective of what I now see as an inadequate national commitment to take care of ill people, in general, part of a larger discussion that I am sure is familiar to all of you. But I don't think that we have at this point a clear national commitment to take care of AIDS patients.

As I said in my written testimony, we have done as well as we have done so far, I think in large part, because the gay community has advocated very effectively for themselves, and really at least in San Francisco, not let us get away with not taking are of them.

As the disease moves into different populations, I am very concerned that, with relaxed pressure on the system, our lack of commitment may become grossly apparent. So, I think first we need the commitment and, secondly, we need a

commitment to do it right, and doing it right will take innovations both in terms of the way we delivery care -- Dr. Ginzberg has spoken about increased outpatient services -- clearly, we need different ways to articulate the parts of the health care system, so that acute care hospitalization is not so utterly detached from ambulatory care and from various kind of extended care settings. It would much more efficient, if you can get a system of care that accommodates the needs of patients along a disease that obviously has a real clinical spectrum, and it is going to take money.

CHAIRMAN OSBORN: Linda, why don't you go next, and then Dave Rogers, and then I think we will probably need to move on.

COMMISSIONER MASON: Like Harlon said, we are down here in the cheap seats, with no marker.

[Laughter.]

Thank you all for your testimony. I have just a couple of quick questions, one for Dr. Curran. I didn't really get to read all of your written testimony, but did you address the issue of possible nursing avoidance related to AIDS and HIV infection, in the way that Dr. Cooke said that young doctors are reluctant to take care of people with AIDS?

So, are people avoiding nursing, besides economic factors? I mean are there other pressures that are related to HIV infection that have been documented and that are more than just anecdotal, or do you know?

DR. CURRAN: I know of no documentary data along those lines. In fact, most of what I heard about is care in hospitals, which, of course, was San Francisco first and New York City, is that nurses have often preferred to work on those units, largely, again, by gay nurses moving in to help take care of a gay patient population. But I know of no documented data of nurses refusing to give care or deciding not to choose nursing because of the possible risks.

COMMISSIONER MASON: So, you don't really see that as -- even in spite of the fact that you see some sensitivity about operating room nurses and --

DR. CURRAN: No, the OR nurses did tell me that yesterday, that they think that's why people are not choosing in the operating room. We simply haven't done that kind of a study. I think we ought to. I think it would be well worth looking at, in terms of, you know, how big of a factor is that. Again, that is one of those things that is hard to capture, how do you find people who didn't choose.

COMMISSIONER MASON: Okay.

For Dr. Cooke, is there any hope that the numbers of doctors willing to treat people with HIV infection will increase, or are we looking at a pretty static population? Are there any incentives that we can give people besides supporting people who are already willing, and just sort of an observation?

Dave Rogers and I were talking last night, and if this whole question is about attitude, what kind of hope do we really have on impacting it? Dave Rogers and I decided that you could probably teach somebody to put the lid back on the toothpaste, but you can't teach them to be a better human being or have a bigger heart, you know.

COMMISSIONER ROGERS: At least Linda thought she could teach them how to put the cap back on the toothpaste.

[Laughter.]

DR. COOKE: It is my feeling that there is no real evidence for that.

Let me say a couple of things. First, medicine is undergoing a lot of changes, some of which may be beneficial in this respect. It is clear from my data and from similar work done by other people, for example, that women are

substantially more likely to tend to are for HIV infected patients than men. So, as medicine feminizes, that may be very good with respect to the HIV epidemic.

Second, people who choose primary care tracks within internal medicine, in contrast to the conventional or categorical training, are much more likely to tend to work with HIV infected patients, tend to be more service oriented, people who look around and say where is there a need.

So, as one hopes, at least I hope, that primary care continues to grow and develop as a model for training and the desire to increase the availability of physicians to HIV infected patients may be just another reason to support that innovation in medical training.

Of the four things that we found to be major factors in distinguishing the treaters from then on-treaters, I think two are more potentially intervenable than the other two. It seems that we ought to be able to do something within medical training to help people cope with their feelings, as physicians, in situations where they can't cure people.

Physicians want to cure people, and that's fine, but many times, we can't. I think, frankly, that AIDS has

flushed out a problem that has existed for a long time. We get frustrated with people that we can't make better, and many of us tend to avoid that. But there ought to be various kinds of coping skills which can be taught in the course of medical training and which should be taught to the benefit of AIDS patients and other people in whom cure is not a realistic therapeutic intention.

The second factor that I think is relatively intervenable has to do with sense of professional responsibility, and that's a little more complicated, since, in contrast to nursing, the ethic of medicine is much more heterogeneous. I think, though, nurses may share some of the attitudes of physicians with respect to gay patients and IV drug users. They have a much clearer sense of what nurses ought to do, when presented with a sick person or with an epidemic.

There is real debate within medicine about what the obligation of physicians really is, and I think we need to keep talking about that. It may be especially important to have the right people talking about it. And I think we need to deal with the real attitudinal stuff, attitudes towards IV drug users and attitudes towards gay patients in the course

of medical training.

All patients are the same to me. I put on my physician persona and I get out there and treat, and I don't care if its patient A or patient B or if they are a drug user or not a drug user. Of course, we do care, but that's all ignored in the course of medical training. I think ignoring it is not a helpful approach. We need to put it out on the table and talk about it, and I would hope that. In fact, we may be able to do more positive things with attitudes, but I'm not confident that we can.

CHAIRMAN OSBORN: Thank you.

COMMISSIONER ROGERS: I know we have got to quit. I know what Dr. Mason said, what a privilege to listen to these three. Your recommendations are so sensible, it is going to take us a long time to address them all.

I have read your eloquent papers on what we might do about nursing and I have had a sneak preview of Molly's distressing attitudes that physicians have and I hope we can work on.

I might just ask Dr. Ginzberg one question, while we have got you here, as I can't bear to let you all go so fast. You mentioned this striking dichotomy between $800 a

day in an acute care hospital and $80 a day if we could get them into less intensive home care, nursing care, or what have you.

You and I know both vividly know that the so-called NIMBY syndrome, the "not in my back yard," has simply prevented us from doing this in New York, and I'm sure it has been a problem in San Francisco, too. Any words of wisdom on how we might get those units out there, so that we can get patients out of the hospital and into other care settings?

DR. GINZBERG: That really relates to Dr. Mason's question also, as to what would you really like to do. I really think that the question of the attitudes between the community, its governmental structure and its human responsibilities are out of whack. I mean the fact that the City of New York doesn't have "the governmental powers" in the reality of the politics to insist that each of the boroughs, let's say, on some equi-basis, to establish three or four more nursing homes.

There's really a distinction, as far as I am concerned, when I think about Western Europe, which I know pretty well. It's inconceivable, by any other so-called advanced economy, that the government doesn't have the

capacity to put essential public facilities in some kind of a reasonable way in the territories over which it has jurisdiction. That simply means that we are about 40 to 50 years behind other civilized countries, that's all. I wish I had a simpler way to put it, but that's the way I see it.

We were 40 years behind in starting social security in this country, and we really don't have a government that operates effectively and appropriately at each of the levels. And until we can get the government to discharge its minimum responsibilities, like establishing health facilities that communities need, I don't know how to get around that.

COMMISSIONER ROGERS: I think I bowled the ball right down your alley.

[Laughter.]

CHAIRMAN OSBORN: Let me also express my thanks for the wonderful testimony, and we very much appreciate you taking the trouble to be with us.

We will go on now to the panel discussing recruit and retention. If you could come up and testify in order and, for the sake of everybody in the rows behind you, introduce yourselves as you speak. And as we did with the previous round, if you can make your comments quite brief, so

that we have a good chance for interaction. Where there is written material, Commissioners are always very conscientious about that, so that will give us more opportunity for interaction.

DR. KELLY: Hi. I am Joyce Kelly, and I am from the Association of American Medical Colleges, and I am very pleased to be here today to share some results of empirical work with you.

Maureen, Vern and I attended a conference about three weeks ago, at which I presented some of these empirical results, and she thought it might be useful to the Commission members to be briefly acquainted with some of the work that we are conducting at the AAMC.

I have a set of slides here, a hard copy of the slides, and what I would like to do is just walk through those. I believe they are in your Commission book, and this is what the first page looks like, and also there are extra copies for the audience, so if you would turn to that.

What I would like to do is shift gears rather substantially from what we have just spent our time on. We have obviously been taking a very macro view, an overview towards the AIDS epidemic, and we think considering a variety

of options that might be possible, in terms of treating patients and serving these patients.

What I would like to do now is focus on hospitals, specifically high AIDS hospitals in New York City, and using data about the behavior of graduating medical students, I would like to acquaint you with what my colleagues at the AAMC and I have learned about choices that those U.S. graduating seniors from medical schools are making, in terms of changes regarding selecting New York City as a place for their clinical training site, and then within New York City, either seeking out or avoiding the high AIDS hospitals.

So, on what I have labeled Slide No. 2, selection by residents of GME training programs, there is really three relevant aspects of this research. The first has to do with attitudes about AIDS, and these data have been collected through interviews and literature, some of which are published in the current issue of the AAMC Journal "Academic Medicine," results of the surveys, some of which we have just heard about previously, in which investigators asked graduating medical students, would you be willing to train in an area where there is a large number of AIDS patients, would you be willing to serve these patients.

The second component of this type of research is really looking at behavior, so it doesn't ask residents what would your attitude be, but it looks at the selection that seniors make, and the question we are asking, with the small piece of research I am going to present today, is are seniors graduating from all of the medical schools, the 127 medical schools in the U.S., are they continuing to be attracted to New York City at the same rate as before the AIDS epidemic, and then within New York City, are they redistributing themselves among hospitals. We also asked the related question, are they beginning to avoid some of the specialties that may be more associated with AIDS.

Now, there is a third component of this research, and that has to do with hospital policies, and I will just sort of preview that quickly. It relates to the question that Dr. Mason posed earlier, and that is, once we look at our research findings and we consider what we have learned, the next question is what about an action plan.

What we are doing right now at the AANC with the Council of Teaching Hospitals, which are the 400 major teaching hospitals in the country, about a year and a half ago we set up a blue ribbon committee that developed a set of

policies and procedures that those hospitals should put into place that have to do with the rights of the patients and also the rights of the health care workers who are serving those patients.

We have just completed within the past couple of weeks a survey of our 400 member hospitals, which are the major teaching hospitals in the country, and we have asked them the extent to which they actually have implemented those policies and procedures, and we are also offering them some services, one of which would be trying to set up a joint disability program, so that health care workers who were exposed to AIDS would have a more comprehensive disability program than currently exists.

So, the answer is yes, there are things we can do, and that is put more effective policies and procedures into place at the hospital, which is the major employer of most health care workers who are exposed to AIDS.

Turning to Slide No. 3, this is a very simple overview of our research plan. We look at low versus high AIDS areas, we sort of arbitrarily define the Nation as a low AIDS area, New York City is a high AIDS area, and then within New York City, we distinguish municipal hospitals, and

virtually all of the teaching public hospitals of New York City have a high AIDS caseload, and for our research, we define high AIDS caseload as a concentration of at least 5 percent of AIDS patients within the patient population.

Now, some of these hospitals have a considerably higher caseload than that. So, virtually all of the municipal teaching hospitals are high AIDS hospitals, and then we distinguished the private nonprofit or the voluntary hospitals in the high and low AIDS groups.

We then look at the positions that are offered by hospitals, and these are clinical training positions, whereby graduating medical students actually get their clinical training so that they can qualify to take the board exams to be certified in whatever training program they have gone through, and then we compared general internal medicine, where residents are likely to have a lot of contact with AIDS patients with all other programs, and we have annual data 1983 to 1990.

The next slide just gives you a quick overview of what we can do with these kinds of data. These have been color slides, so I apologize that they are not better labeled. The top line on this slide is all positions offered

throughout the country. This is the sum of all clinical training programs for all first-year residents who have graduated from medical schools.

The dotted line centered about that, around 13,000, is the U.S. medical graduates who are matching into these programs. The difference between the positions and the U.S. medical graduates -- and you see the positions is up around 19,000, U.S. medical graduates is around 13,000 -- that difference is filled by foreign medical graduates, osteopaths, and other types of positions, or some of those positions remain unfilled. So, we hear a lot about fill rates being an issue.

The two lower lines present these same data for new York City, so we see the number of positions offered in New York City, and then the number of U.S. medical graduates matching into those positions. So, this gives you a sense of the magnitude of these numbers.

Turning to Slide 5 and the following slides, what we have done here is we look at 1983 data and then we compare changes from 1983, and what you see, we compare New York City versus the Nation, and what you can see, on balance, New York City over time is attracting a lower proportion of residents

among the national total over time.

Now, you see for 1989 a big peak, and that peak is represented by Code 405, which was the New York State regulation regarding hours and supervision, where they really jacked up the number of positions, they jacked up the recruitment efforts, and they were able for that one year only to attract a large number of residents, many of whom thought that life would be better under Code 405, with hopefully better supervision and reduced working hours.

The lower two lines show trends in medicine, and the most significant thing here is the substantial decline of interest in general internal medicine. We can talk a lot about primary care and we can hope that more and more people are attracted to primary care, but what the behavioral data are showing us is that primary care is headed right down the tubes, as clinicians are increasingly interested in subspecialties.

So, simply put, what this slide shows us is that, over time, New York City is attracting a reduced proportion of first-year residents. Now, we cannot attribute that to AIDS, because of all of the other changes that have happened in New York City over time, the regulations regarding hours and

supervision being one, overcrowding at the hospitals, financial distress, et cetera. So, put altogether, what we can say is that fewer physicians in training are going to New York City. The proportion has declined over time, but we cannot attribute that solely to AIDS.

Looking at the next slide, what we have done here is distinguish the three types of hospitals that I mentioned previously, the public hospitals and the private hospitals, the privates distinguished between high and low AIDS. I think the absolutely startling thing here is that U.S. medical graduates are avoiding the public sector.

Now, we know this from other types of research, this is something different, but complementary. The municipal hospitals are becoming less and less competitive over time, less and less attractive to the U.S. medical graduates, and these data very clearly distinguish that. The fact is that the nonprofits, whether they have a large number of AIDS patients or a lower number, are still doing relatively well. The folks that aren't doing well are the municipals.

Turning to the next slide, which is Slide No. 7, this is looking just in medicine, it is not look at all residents, and here again we see that the municipal hospitals

are doing somewhat less well than other residents or that the nonprofit hospitals. But the most startling thing on this slide is the very precipitous decline between 1989 and 1990 in the high AIDS private nonprofit hospitals. This is the match that only occurred 3 months ago, and so I have been on the phone pretty much non-stop with program directors in New York City, discussing some of these results.

Each program director knows about the results of their own program, but they didn't quite understand that other programs were doing similarly poorly. What happened is, last year, with hours and supervision, everybody did great, and everybody thought, gee, maybe we are going to start doing better, and now things essentially have fallen through the floor again.

Turning to Slide No. 8, what we have done here is combine the sense of demand, which is the number of positions that are funded and offered, with supply, which is the number or the proportion of residents filling those positions. The most interesting thing that we see on this slide is the top line, and the top line shows the proportion of positions that are filled by U.S. medical graduates.

What we see is that, in 1983, more than 90 percent

of all positions in the high AIDS private hospitals were filled with U.S. medical graduates. That proportion has declined just in the past 7 years to well under 50 percent. So, it means that the hospitals are offering the positions, they are funding the positions, they are not filling them with U.S. medical grads. They are either going unfilled or they are filling them with FMG, with osteopaths or with others.

I would like to conclude with what these slides have shown us. They have shown us that, over time, the U.S. medical graduates are somewhat less attracted to New York City, they are considerably less attracted to the municipal hospitals in New York City, and they are filling a substantially lower proportion of positions.

My final conclusions is, with my co-investigators, Dr. Roberta Ness and Dr. Charles Killian at the AANC, we currently are studying Los Angeles, San Francisco, and Chicago, and we have also selected five low AIDS cities, and in those cities we are trying to disentangle this municipal effect from a voluntary effect. So, we are trying to understand how much of this is the national decline of municipal hospitals and how much it has to do with AIDS

patients.

Thank you.

CHAIRMAN OSBORN: Thank you very much.

Dr. Burnett?

DR. BURNETT: Good morning. My name is Caroline Burnett, and I am Senior Consultant for the Commission on the National Nursing Shortage. I am very pleased to be here.

I was very interested in listening to Dr. Curran's comments this morning, as she really painted a very accurate and very thought-provoking picture of the nursing shortage.

What I would like to do this morning is talk a little bit about what the Commission is charged with doing and how nicely what I think we see as our direction fits into many of the issues and concerns that Dr. Curran identified in her testimony.

As many of you might know, Secretary Bowan had a 1988 Secretary's Commission on Nursing, and that Commission was charged with the responsibility of identifying what the characteristics of the nursing shortage exactly were. That Commission also put forth many recommendations which have actually led into the formation of the current Commission on the National Nursing Shortage, which Secretary Sullivan

chartered as of February this year.

We are chartered for a full year, beginning with June of this year, which coincided with our first Commission meeting. Our Commission is charged with the responsibility of looking at five major focus areas. We are charged with the responsibility of looking at recruitment and the educational pathway, retention and career mobility, restructuring of nursing services, and better and more effective utilization of nursing personnel, information systems and nursing technologies, as well as data collection and analysis. It sounds kind of familiar to some of the issues that Dr. Curran raised as major concerns for us.

I feel that I can most benefit all of you by sharing with you some of the initiatives that are currently under way that do address those issues, and then also give you a flavor of what the Commission members are currently thinking of in relationship to the development of projects for this particular Commission.

What I would like to do is break it down into each one of these areas and talk specifically about recruitment and the educational pathway. As Dr. Curran indicated, one of the major problems is that many ethnic groups have not been

targeted, many other minority groups, as well as men in nursing have not been targeted for entering into nursing practice.

Recently, the Association of Community and Junior Colleges, funded by the Metropolitan Life Foundation, put forth an initiative funded by institutions to address one of these issues, and the major specific objectives of this project were to increase the ethnic minority and male individuals entering nursing, and to encourage more nurses to complete the ADN program, so that there is a focus to target ADN education.

One of the problems with a lot of the initiatives that I will lay out for you is that we don't have any data yet. A lot of these are very new initiatives, so we don't know what impact these things are going to have at this point.

A second area, a very important manpower issue, is being funded by the Robert Wood Johnson Foundation, and they just funded a number of new programs in late spring. I would like to just review a couple of them for you. The one that I think is really quite interesting is called "I'm Ready," and it means increasing minority representation through educating and developing youth, and one of the major thrusts of this

program is to attack that, address the needs of high school students, starting as early as the 7th grade, and giving them the kind of educational support, mentoring and financial support that they need in order to start thinking about a career in health, and particularly a career in nursing, and the support continues through the completion of a bachelor's degree in nursing. It is a very innovative, new type of program.

Another program that is similar is one that will involve public schools, that will allow high school seniors to begin their nursing career as high school seniors, and this is occurring at the Methodist Hospital in Gary, Indiana, so that they will get some education towards nursing as they complete their final year in high school, and then go on to complete a bachelor's degree in nursing.

The TEAGLE Foundation, because they felt that they needed to address the need for getting more LPN's educated in the bachelor's degree level, put forth an initiative this spring, and they also have funded a number of programs that will allow better flexibility for the LPN to move to the RN level.

One of the issues that Dr. Curran raised also is

that we don't provide enough support for these individuals while they are going through the program, in other words, how do we help these individuals carry on their lives while they are pursing education. A number of these initiatives, particularly the TEAGLE Foundation initiative, will allow that. They provide some monies for the day-to-day types of things. They allow the individual some counseling support that helps them be a single parent, that helps them be a student, which is probably something they are not used to being, and they get some counseling and some mentoring along with the fact that they are having to go back to school and maintain at least a 2.5 academic average.

The Division of Nursing, under its authorization of the special project and grants, also is addressing this particular issue and they are trying to look at programs that will achieve baccalaureate degree level nurses, and provide for upward mobility of para-professional individuals.

I think that there are a lot of initiatives out there that are ongoing, both from the Federal and the State, as well as private foundational perspectives, but they are new. A lot of them are very new, so we have not seen how that will translate into realized increases in our manpower.

I think it is also important for us to think of some initiatives that maybe haven't been addressed in these areas, and I think one of the major things is the preparation of faculty in schools of nursing. What with the shortage, what with the oppressed wage structures, many faculty have left and gone into acute care or other practice settings, where they can get more money, and that has put a drain on having adequately prepared faculty members in schools of nursing, so we need to design ways to increase faculty salaries, as well as the salaries that is a great issue relative to the nursing practice community at large.

I think that some of the other issues also need to coordinate some curriculum planning with various agencies that are specialty organizations. For example, the American Association of Critical Care Nurses is working to develop some curriculum for programs that would then try to mesh the acute care institution needs and the curriculum needs, and that would again help to make things more real to the students.

Moving on to recruitment and retention, a think a program you might be familiar with in New York is the Project LINC Program, and that means Ladders in Nursing Careers, and

this again is another program that allows individuals -- it is not just nurses, but individuals that are aides or are interested in becoming nurses, to have that career mobility, and it is supported by the Robert Wood Johnson Foundation and a number of foundational funds within the State of New York, and this allows, again, career mobility, so that you don't lose nurses to other fields, and it also allows individuals who perhaps do not have the money initially to go into a nursing career to have that opportunity now.

One of the other issues that was brought up earlier is our utilization of nurses, and a number of hospitals have taken this on themselves. They have developed creative differentiated practice models that I think will enable nurses to be utilized better, that they can, in fact, find out exactly what level of nurse is needed to cover what level of care, and a lot of hospitals have taken the initiative to do this.

In the area of restructuring and better utilization of nursing care personnel, the Robert Wood Johnson Foundation and the Pew Foundation are leaders in this area, and they have funded a number of projects that will address restructuring and they are in the process now of awarding final

projects to 20 hospitals around the country, and one of the good things about that and one of the limitations is that it really focuses on acute care, and the major has been to date, but as we all know, a lot of the care needs are shifting to the non-acute setting, long-term care nursing home, home health care settings. They have recently put out another initiative that will address some of the needs of the ambulatory care and long-term care areas.

Information systems is another area that needs an incredible amount of work, and I think that is one of the areas that this particular Commission thinks is very, very important, and it is integral to the restructuring process, because it is one way to design more effective ways to utilize nursing personnel, to get rid of some of the need for the paperwork, to enable to do the kind of care planning that they can do through the use of an interactive system. This again will make the time of the patient increase and will also decrease the burden on nursing.

As I mentioned earlier, the Commission met first on June 11th and 12th, here in Washington, and out of that meeting they looked at a lot of these initiatives that have been going on and they decided that, of the five major areas

that they were charged with developing projects in, they would condense those into three major focus areas.

So, we have combined the recruitment and retention, since those conceptually transverse into the acute care setting, as well as into the educational area. They have brought the structuring of the information systems project as one, and then they will have the data collection and analysis as one work group.

The three major areas that I think they are feeling need to be addressed is the long-term care area, how impacts will impact on future care needs, how can we design projects to address those kinds of areas, what kinds of information systems do we need, and they also are looking at what kinds of projects and programs can we develop that will bring the younger individual into nursing, realizing that it is a very critical problem and we do have an older population of nurses that will opt out, if you will, for retirement or disability or whatever. So, we are really looking at how we can answer some of the issues that Dr. Curran brought up earlier.

I think I will stop now and take questions. Thank you.

CHAINMAN OSBORN: Thank you very much.

General Adams-Ender?

GEN. ADAMS-ENDER: Madam Chairman, distinguished Commissioners, ladies and gentlemen, I am Brig. Gen. Clara Adams-Ender, Chief of the Army Nurse Corps, and I thank you for your invitation to appear before you today and to present some information about the recruitment of minorities into the nursing profession.

I believe that, at the end of my testimony, you will conclude that I was not here to tell a story about how easy and simple it is to recruit minorities, but to tell you about how it can be done with a program borne out of commitment, dedication and devotion to a cause considered to be worthwhile. That cause for the Army is really providing the nursing strength that is necessary to care about soldiers and their families during peace and war.

I believe that I am eminently qualified to provide an accurate account, because I have spent almost 20 of my 31 years in the Army actively being involved in recruitment of professional nurses.

Recruitment and retention of professional nurses has always been a priority for the Army Nurse Corps. It becomes more crucial and challenging during periods of

overall shortages of nurses, as we are experiencing in the United States today. Since minorities are a part of the potential workforce needing employment, we consider it important to pursue them as nurse employees for the Army Nurse Corps.

The objectives of my testimony are to list the priorities in the recruitment of minorities and to discuss a successful minority recruitment program in the Army Nurse Corps. There are two priorities which must be embraced in the establishment of a minority recruitment program in nursing. They are commitment and action.

The demonstration of commitment begins, with us, with the Army leadership, and its stated philosophy as an equal opportunity employer. That commitment has been pervasive throughout all of the subordinate units and agencies. In Army nursing, we have targeted minorities, which includes men, in recruitment programs since the early seventies. Research into work patterns for minorities clearly showed that they are much more likely to seek full-time employment and to make career decisions sooner.

Because of a commitment to minority nurse recruitment for active duty, over 14 percent of Army nurses in the

Army Nurse Corps today active duty are African-American, and 25 percent are male, in comparison to 3 to 4 percent representation for both of these groups in the general civilian nurse population. The statistics are similar for nurses in the National Guard and the United States Army Reserve.

There must also be a commitment to targeting students early, preferably in high school, so that they will be able to take natural and behavior science courses, which are prerequisites to a nursing curriculum. We work closely with high school counselors to insure that students are informed of this need.

The need for action cannot be overemphasized as a priority. Nurse recruitment, in general, and minority nurse recruitment, in particular, must be viewed as programs involving marketing and sales of a product. Consequently, the strategies employed must be the same as those which yield success in marketing and selling any product.

The marketing and sales of Army nursing really involves two projects, the Army and nursing. Therefore, ion the establishment of a marketing strategy, we focus on those two products in our sales and advertising plans. For example, you may have heard, read or seen the Army slogan of

"Be all you can be, go Army" in the media.

That slogan has been quite popular in recruitment for the Army, because it implies that the person who joins the Army can reach new heights and gain new opportunities in the Army, irrespective of color gender. In Army nursing, we have adopted the slogan that "Army nurses are proud to care," because we feel it best portrays our commitment to providing quality nursing services to soldiers.

Continuous research and study are performed via surveys, opinion polls and focus groups to determine the best methods of marketing Army nursing. After these methods are determined, we then use that information to recruit in the various nursing markets.

Action must also be clearly evident in maintaining a minority nurse recruitment program. In Army nursing, we are able to draw much information from a rich and proud history of the caring, concern and commitment of Army nurses, as they provided nursing services to soldiers from the battlefields of France in World War I, to prisoner of war camps in World War II, to the rice paddies of Korea, and to the tent hospitals of Vietnam.

We market and sell the Army Nurse Corps as a

professional, proud and powerful organization, which offers challenging choices to nurses. We are professional, because we offer unlimited opportunities for continued growth and development in nursing; we are powerful, because we maintain autonomy and governance over our nursing practice; and we ar proud, because of our status as Army nurses, and our ability to be ready to serve soldiers when the need arises.

The salaries and benefits are also competitive. We maintain a very close association with the civilian nursing community, professionally, socially and politically, so that nurse leaders and other influences are constantly informed about the opportunities in Army nursing.

In addition to being Chief of the Army Nurse Corps, I am an active member of major nursing organizations in the civilian sector. I am also a professor at several universities around the country, and I make numerous academic presentations before nursing audiences at conferences, seminars and workshops, and periodically I sleep.

[Laughter.]

All of these activities assist greatly in nurse recruiting efforts for the Army. A successful nurse recruitment program begins with sound planning and organizing. The

organization for the recruitment of Army nurses is established on the specific commands which have recruiting as their primary mission. The Army nurses assigned to these commands include minorities and men. They are all involved full-time in nurse recruitment.

Minority nurses are targeted in these programs by working closely with colleges and universities, with historical and predominant minority student concentrations, minority group organizations and via presentations at local and national conventions, conference and career days.

In addition, the Army leadership recently approved funding for the establishment of an Army medical department enlisted commissioning program. With this program, we are able to target active-duty enlisted soldiers who have completed two years of general education courses for completion of baccalaureate degrees in nursing. A percentage of these students will be minorities, including men, because of their higher percentages in the enlisted ranks.

These are the major plans and strategies used to recruit for a total force of 15,000 professional nurses, with a need to fill about 1,200 of these vacancies each fiscal year. We believe that it is important to ensure that

minority recruitment is a natural part of our overall nurse recruiting efforts. We also utilize minorities, including men, at every level of recruitment, to enhance role modeling and cultural diversity.

In summary, two priorities which must be embraced in minority nurse recruitment are commitment and action. A successful minority nurse recruitment program must reflect intensive marketing and sales of a product. In this case, the product is nursing services.

Successful recruitment programs must also target the audience for which it is intended. We have demonstrated in the Army Nurse Corps that one can be successful in recruiting minorities by selling Army nursing as a challenging choice and as a service provided by a group of professionals who are proud to care.

Madam Chairman, this concludes my formal statement and I shall look forward to your questions and those of the other distinguished Commissioners.

CHAIRMAN OSBORN: Thank you very much. I must confess, it is very nice to hear a success story every once in a while in the testimony.

We have time, I think we will take time for some

interaction. We really appreciate the rich testimony that you have all given us.

Do you want to start?

COMMISSIONER DIAZ: This is for Dr. Kelly. Based on the findings of data you presented here, do you project that now and in the near future, as your study completes, of the high AIDS incidence areas, we will be seeing an increase of public hospitals that are attending to large patient populations of HIV infected individuals fill essentially their residency spots with FNG's primarily?

That is of some underlying concern to me, because I know that many of the training places where the FNG's come from, particularly around the globe, may not be as sophisticated as we are in our American medical schools integrating AIDS curriculum from day one. Just about all the schools, I believe, part of the AMC Corps really do have some level of AIDS training during the 4 years of the curriculum, and because many of these FNG's are trained in countries where AIDS is just now becoming a situation that causes some concern, they may not have this kind of clinical and academic base in the field, and I am concerned because such large numbers of minority populations are being served primarily

through public hospitals, and the first point of contact with a doctor will be many emergency rooms or these people assigned in residency programs and come basically with no knowledge about HIV. Do you have any explanation?

DR. KELLY: That precise question occurred to me in January, as we were doing this research, and I spent the month of February telephoning program directors in all of the major municipal hospitals in the country, and I have had a structured telephone survey and I found that two factors are associated with success in a municipal hospital.

One is adequate funding, and those municipal hospitals, for whom their local jurisdiction has made a commitment to adequately fund that municipal hospital, on balance are doing relatively well. Those municipal hospitals -- and one that occurs to mind is Charity in New Orleans, I don't mean to pick on that, but there are other municipal hospitals throughout the country that are not being adequately funded and they are having extreme difficulties in many, many areas. Throughout recruitment, they are understaffed, people are overworked, they are harassed, and so we are finding it also for health staff recruitment with young physicians, but it is not unique to that.

It is a pervasive funding problem that is affecting the personnel from the top to the bottom, so one is funding and that is the commitment of the local jurisdiction, and the second is whether or not the municipal hospital has entered into a joint program with another hospital, so that residents may have more diversity, and a very good example of that is Dr. Cooke this morning, her example of San Francisco General.

San Francisco General does not operate their own independent clinical training programs for physicians. They are all completely integrated programs with UCFN. So, when residents are recruited into the program, it's the integrated UCFN program that they are recruited into, and they rotate through a number of hospitals, including private hospitals, the State hospital UCFS, San Francisco General, the VA, et cetera. So, those seem to be the two factors that are associated with success.

COMMISSIONER DIAZ: Thank you.

CHAIRMAN OSBORN: Dr. Mendez?

COMMISSIONER MENDEZ: My question is for Dr. Kelly. I understand your curves to mean basically the results of this last match, is that correct?

DR. KELLY: That's correct, a 1990 match.

COMMISSIONER MENDEZ: I just wonder if the cohort of graduates from New York City schools basically behave the same way as the total, or did it behave differently?

DR. KELLY: I wonder that same thing. I regret to say that we have not completed our analyses. That is a companion analysis and I don't remember precisely what the preliminary findings were, so I would rather not say. But we are distinguishing graduates of the only city and then we are also looking at what Jack Grettinger at the NRMP calls networks, which are the school, with its historical affiliations with the hospitals, to try to understand whether or not graduates are going outside of those networks.

COMMISSIONER MENDEZ: If you are going to do those, I presume that you are also going to, hand-in-hand, be looking at the behavior of those graduates that are coming from high AIDS areas versus low AIDS area. We are trying to define how much of that is remediable, in terms of medical school, you know, type of input to these students.

DR. KELLY: That's right, and obviously that is a concern for us at the AAMC, you know, to the extent that the problem begins with the clerkships in medical schools --

COMMISSIONER MENDEZ: That's right.

DR. KELLY: -- then hopefully that is something that we could help with some policies in place to address.

COMMISSIONER MENDEZ: That's right. Well, that's the idea of both of my questions.

DR. KELLY: We are very concerned, and once we finish those, I will be happy to communicate the results to you.

COMMISSIONER MENDEZ: I would be happy to get them. Thank you very much.

Thank you, Madam Chairman.

CHAIRMAN OSBORN: Harlon Dalton?

COMMISSIONER DALTON: Gen. Adams-Ender, I notice you smiling during the last panel, and I know why. I didn't necessarily want to assume that you are going to address the problem of minority recruitment, but I am certainly delighted that you did.

The word I heard most often in your testimony was commitment, and you obviously talk a lot about technique, which you also indicated that there must be the desire in the first place. My question actually doesn't have to do with minorities. I jut have a small personal question. You talk about marketing. I am curious about whether, during the run

of the television show "China Beach," whether that, in fact, affected recruitment of nurses into the Army.

GEN. ADAMS-ENDER: We can't say specifically if that affected us or not at all, because we really didn't do any research, asking people if, indeed, they came in because of "China Beach." I can add, though, as an aside that we do a lot of work with that TV show, to make sure that the image stays correct.

COMMISSIONER DALTON: It is a superb show. My question has to do with a statement in your testimony. You indicated that "we," meaning Army nurses, "are powerful because we maintain autonomy and governance of our nursing practice." That struck me as very much at odds with the nursing profession generally.

As Dr. Curran pointed out in the last panel, one of the difficulties with being nurses, obviously, is the lack of autonomy and self-governance, and it just struck me as unusual that, in an institution that I think of as particularly hierarchical, that the nurses have managed to carve out autonomy and independence, and I just wanted to hear about how that works.

GEN. ADAMS-ENDER: Well, I think part of carving

out the autonomy and the governance has to do with where one gets placed in the hierarchy, and I think one of the things that I see to be very important in that area is that, about 20 years ago, when the Department did see fit to promote females to the rank of flag officer or general officer, that that did, at the same time that it placed women on a certain kind of status, that it also placed nurses on that kind of status, because one of those persons was the Chief of the Army Nurse Corps, who got promoted to general officer, and as a result of that, they are on the same decision-making level with other decision-makers within the Army, and that does indeed make a difference in terms of dealing with that autonomy.

I, for example, as Chief of the Army Nurse Corps, manage the policy development for nurses, no matter where they are assigned in the world. As the Chief of Staff of the Army says to me often, he says really and truly, you are the nurse expert in the Army Nurse Corps, and as a result of that, when he needs information about that particular group, he then must ask me about that, because I am the resident expert in nursing.

CHAIRMAN OSBORN: Dr. Mendez has a quick follow-up.

COMMISSIONER MENDEZ: Yes, just a quick comment, as a fellow who spent 28 years on active duty in the Army in the medical department, I think, from the standpoint of a physician, which is what I am, and someone who has been a hospital commander and so on, there are other things that I think are important in terms of your question, and one is, very clearly, the participation of the nurse on those things that are both the incumbency of and affect nursing, both what occurs in the hospital, as well as what occurs in administrative terms in the development of any headquarters, I think that is a most important thing.

The second thing is one that has to do about career development and assignment as a relevant responsibility that is professionally guided by nurses, and that occurs not only from the standpoint of the career branch that specifically deals with nurses, but it occurs also within the hospital itself, despite the sub-specialty of the nurse. She is guided within her nursing endeavor through a nursing-type of input, despite the fact that her work may be surgical or preventive medicine or what have you, and those two things I believe, both work assignment as well as that career goal, go hand in hand, and I think that has been an important conse-

quence as the years have gone by.

CHAIRMAN OSBORN: Ms. Ahrens?

COMMISSIONER AHRENS: Thank you. I have a comment and perhaps a question of Dr. Kelly, and then a question of Gen. Adams-Ender.

Dr. Kelly, you use a term that I have some concern with, and that is in defining the local hospital, you use the term "municipal hospital." I am not sure how you define that term, but one of the things I think this Commission is struggling with understanding is who is responsible for doing what, that is, what governmental level is responsible for doing what, and also to try to transfer what we learn to the general public.

I understand the use in New York City, but I heard you use the term referring to these kinds of hospitals across the country, and I am wondering, in your definition and your use of this term, whether it is based on ownership, whether it is based on funding of indigent care, and if that is the term, in terms of those definitions, that you really intend.

DR. KELLY: The term that most folks use is "public hospitals," so you read in Dennis Androulis' work in JAMA and other places, and the term that is used is "public."

I use what I believe to be a more precise term and that is "municipal," which means city or county owned, so it means owned and operated by a local jurisdiction, and the reason I make that distinction is that state-owned hospitals also qualify as public hospitals, the University of Michigan, the University of Iowa, the University of Nebraska, and when you look at their patient population, you look at their costs, you look at many other factors, those major hospitals are more similar to the major private hospitals than they are to the county and city owned hospitals. UCSF looks more like Stanford than it looks like San Francisco General, so I believe that calling all of those hospitals public is quite misleading.

COMMISSIONER AHRENS: I have to confess my interest in this is from the county side, to some extent, and as I understand the national picture, most of the public hospitals in this country providing major services to people with AIDS are owned and/or funded by the counties, and in helping us and others to understand who is responsible, I think that it is helpful to be fairly specific and clear.

I understand that in New York City, when you say municipal, people think of city, but I think when you say

municipal across the rest of the country, they think of city as well, and it kind of avoids who really is responsible in so many areas, and I am just sensitive about this and think we need to be --

DR. KELLY: I hear what you are saying, but I think San Francisco would be a good example. If you talk about the public hospitals in San Francisco, there is UCSF and there is also San Francisco General. They are not similar in many ways, they are very, very different hospitals.

I certainly agree with you, of course, that the majority of AIDS patients are in the local jurisdiction owned and operated hospitals, the municipal hospitals, the city hospitals. They are not in the state owned public hospitals.

COMMISSIONER ROGERS: I think Ms. Ahrens wants credit for county hospitals, and I think you are including those in your municipal hospital group.

DR. KELLY: Yes.

COMMISSIONER AHRENS: But the public doesn't, in general, and that is why I think we have to be very careful about the terms we use in defining who is responsible.

I have a question of Gen. Adams-Ender, and that is we heard about the difficulty of meeting the costs of

education for minorities and interesting them in the nursing field. I wonder if you have a comment, with your successful program, how is it that you deal with this cost factor, educational cost factor, or do you have something in place within your system that handles that?

GEN. ADAMS-ENDER: Well, in relationship to education overall, you must understand that most of our nurses are recruited with their basic education, they already have that when they come in. But because of the shortage that we have now, the program that I mentioned, the Army Medical Department enlisted commissioning program, this is a program that is primarily designed to be able to increase the numbers of folks that I can get into the system from those who are already in the system, in general.

You see, we have nursing assistants, from licensed practical nurses to other kinds of assistants, that help us within the Army Medical Department, and they help us within the nursing services, and, as a result of that, part of that group then was selected, about 90 of those folks were selected this year, this fiscal year, go back and complete their bachelor art degrees, because they have 2 years of general education courses.

So, that is the only program that we have at this point in time that is really one of what you would call a scholarship type of program, but we had to do that because of the fact that these individuals need to remain at their same rank so that they can go off to school and complete their education, without being in utter poverty doing it.

The thing we found out about many of the folks in the Army today is 50 percent of the Army is married and, as a result of that, these folks also have wives or husbands and families and must indeed go back with that, so give them a stipend and send them back with their salaries, and then can go and complete their last 2 years of college and then graduate with baccalaureate degrees and the opportunity to gain a commission and to serve as officers in the Army.

CHAIRMAN OSBORN: Dr. Konigsberg, we will give you the last question before we break.

COMMISSIONER KONIGSBERG: I won't take the risk of trying to engage in a definition setting, after the municipal. I would like to just say a word about community nursing and then direct a question to Dr. Burnett in relation to the National Nursing Shortage Commission.

When I think of community nursing, community nurses

or community health nurses, I think of nurses who work in health departments, in community health centers and migrant centers, and perhaps in home health agencies, as well, although I see that is somewhat different, in a way.

My question to you, in listening to your testimony, Dr. Burnett, and trying to speed-read through the material that you sent, including the roster of membership, is what emphasis or do you plan to place an emphasis on community nursing, or do you see that as a problem.

DR. BURNETT: It clearly has been identified as a problem by the Commission members. I might point to two members that are on the Commission, Francis Baby, who represents home health agencies, and also Paul Willging, who represents nursing homes, bring an other than acute care perspective to the Commission.

COMMISSIONER KONIGSBERG: Is there anyone representing local health departments or community health centers on the Commission?

DR. BURNETT: No.

COMMISSIONER KONIGSBERG: I would just politely express a concern over that. I know that you can't fix that and no one can now, but that does bother me.

CHAIRMAN OSBORN: I think with that, let me thank you again. It has been very helpful testimony.

Maureen, you had an announcement about the break?

MS. BYRNES: I just wanted to ask if you could beg your indulgence and allow the Commissioners to help themselves to some coffee first, so that we can get back on track as quickly as possible, and then you are more than welcome to assist yourselves. Thank you.

[Brief recess.]

CHAIRMAN OSBORN: I think we have airplane schedules to be concerned about, the fact that we are running a little bit late and I appreciate your patience with us, so let me ask you to get started again. And would each of you mention who you are, so that the people behind you can be aware of who you are.

Please go forward, Dr. Smeltzer.

DR. SMELTZER: Thank you.

I am Carlyn Smeltzer, and I am Vice President of the University of Chicago Department of Nursing.

I would like to thank the members of the Commission and the audience for this opportunity to again present a success story in recruitment and retention of staff nurses.

I would like to thank you for having me participate in nursing manpower issues of the National Commission on AIDS.

I would like to reiterate one hospital's personal experience with the issues of recruitment and retention during a time period when the nursing shortage is crucial.

As you are well aware, immune suppressed patients require a large amount of nursing care, intensive care through the progression of their illness, not that unlike oncology patients. Nurses are proud to give both competent, technical care, as well as having time and ability to give caring care to patients in a team environment.

The problem today in giving care to immune suppressed patients is exaggerated by the overall shortage of nursing that you have heard Dr. Curran and others report on. Although the University of Chicago Hospitals has not seen a large HIV adult patient population, although we have it in numerous neonatal patients, we face similar issues, because of our large oncology patient population, of which it is very difficult to recruit and retain staff nurses.

We were in an area, unlike many other institutions, of rapid volume growth, particulary with intensive care patients. The hospital is currently 560 beds, and we need to

expand to 620 by January of 1991, and a majority of these patients are oncology patients.

The hospital currently has a 14 percent vacancy rate, that equaled about 125 staff nurses, with a 22 percent turnover rate. During the last 2 years, we increased our budgeted positions by approximately 100.

The hospitals, although 14 percent vacancy rate seems very achievable and certainly a very positive statement for an academic health care center, continued to out-perform every other medical center in the Chicago area, in terms of recruitment and retention. Annually, we hire approximately 300 nurses, and we interviewed approximately 500.

With the new bed openings of only 60, but yet intensive care beds, it was estimated that we would need to recruit approximately 500 nurses annually to fill approximately 300 positions.

A current analysis of our recruitment activities indicated that we had 500 applicants a year, we were able to interview and recruit approximately 60 percent of those, but during the last 2 years we were not able to increase our applicant pool, as testimony has proven earlier.

A further analysis indicated that, within one year

of hiring a new person, 59 percent of the 250 or 300 staff nurses hired, resigned from the University of Chicago Hospitals. Further analysis indicated an even a more difficult situation, that approximately 2 years ago 1 nurse equaled .8 FTE. Currently, they are only working to a .7 FET, so parttime workers were going more parttime or fulltime workers were going parttime.

The nursing department identified a problem. The institution wanted to participate in a solution, and recognized that it was a large institutional issue. A planning process, which did not only include the nursing department, but included corporate planning and development, because we thought it was a large marketing problem -- and you have heard before that it was an economic problem -- so the finance department was continually involved in meetings. The human resource department, labor and management, because they are unionized hospitals, and the public relations department was convened to attack the problem during a 3-month period.

The first issue that was attacked was do we really know what nurses think about the University of Chicago Hospitals and what they recognize and what they want from it. We had marketing focus research groups, which are not a very

traditional method of finding out what nurses want, and from the five focus groups, composed of 10 nurses each, we found out that nurses wanted respect, professional autonomy, they wanted physician-nurse relationships to be adequate in the institutions, they wanted an adequate orientation, as well as time to provide teaching to the patients.

We further found out that nurses want to be, as we knew, compensated for their value and worth to the institution. We had targeted five different proposals of compensation, to see which the nurses would be more attracted to. These were nurses that had left the University of Chicago Hospitals, nurses that worked within 3 minutes radius of the University of Chicago Hospitals, and nurses that were 2 years out of school and experienced nurses.

It was continually pointed out to us that the nurses wanted flexibility in the benefit package and compensation, they did not want gimmicks nor bonuses, but they wanted to be paid like professionals and shown that they were making life and death decisions.

We gave them five different types of proposals, bonuses, an enhanced benefit project, a benefit package, and we also set out to give them a proposal that, after 24 hours

of work, they would be paid a per diem of 20 percent more an hour to compete with the agency nurses.

Our data further indicated that our fulltime equivalents were decreasing, but yet, from the focus groups and from studying our own nursing personnel, 60 percent of our staff nurses were working for agencies outside the University of Chicago Hospitals, which meant that at any one point in time we could not depend to do their own overtime in our institutions, we were increasing the amount of 12-hour nurses in the institution, so the nurse could work 3 days in our work environment and then go work at a different institution less productive.

Although we had a 14 percent vacancy rate at any one day, 10 percent of that was filled with agency nurses, which are 80 percent less effective. So, at any one point in time, there was only a 3 percent vacancy rate at the University of Chicago Hospitals, but that did not allow growth.

I think we looked at and we looked at compensation very hard, and looked at our orientation program and the other types of benefits that the staff nurses wanted. We came up with what I think is a very innovative compensation package that was coupled with an aggressive marketing and

retention plan.

The compensation package, which was very difficult to get through the union environment also, was to incent the nurses to work more in their own institution, for them to think twice before they decreased their hours to go parttime, and for them to start giving us the agency hours they were giving to other institutions, and also to become more competitive with the agencies.

The compensation plan included a 10 percent pay raise across the board, with an additional 2 percent 6 months later, which again was the time period when 59 percent of the nurses decided to quit. The package included an imaginative series of incentives for nurses, to increase their hours at the University of Chicago Hospitals. After 24 hours of work in a 40-hour pay period, they receive an additional 20 percent. They receive 15 percent for evening differentials, and 20 percent for nights, and $2 pay differential on weekends per hour.

The next thing that happened is this was coupled with an aggressive marketing plan and a retention plan. As a result of the whole package, the nurses were the highest paid in Chicago, yet they think twice about not working their 25th

hour at the University of Chicago Hospitals.

If we had our own staff nurses parttime workers giving --

COMMISSIONER ROGERS: Carolyn, let me interject.

DR. SMELTZER: Yes.

COMMISSIONER ROGERS: We have your eloquent written testimony and you might give the points that you really want to punch home to the Commissioners. We know you have to leave and we want to let them ask you a few questions.

DR. SMELTZER: That would be fine.

The end result of the compensation package and retention package and the end result of having the recruitment office open 7 days a week, was basically 100 phone calls a day.

Now, remember, last year we only had 500 applicants for an entire year, and in one week we generated 700 phone calls, with 60 percent of those individuals wanting to interview at the University of Chicago Hospitals. Within 19 days, we had 127 people state that they would work at the University of Chicago Hospitals. We have 250 interviews scheduled during the next 3 weeks, and we now have a vacancy rate of less than 5 percent, and I have been able to, in 19

working days, open 20 beds.

Thank you.

CHAIRMAN OSBORN: Thank you. In view of your tight schedule, with everybody's concurrence, I think we might give the Commissioners a chance to ask a couple of questions of you and then go on to the rest of the panel, so that you don't miss your plane.

Any questions? Larry Kessler.

COMMISSIONER KESSLER: Can you explain what you mean by if they work more than 40 hours, they collect another 50 percent overtime bonus? Is that time and a half?

DR. SMELTZER: Basically, it's time and half for working over 40 hours in a workweek or working after 8 hours in a day.

COMMISSIONER AHRENS: I guess I'm just curious to know where you think all of these folk are coming from, the ones that are coming into your hospitals now, are they coming out of other hospitals?

DR. SMELTZER: It is just amazing. I spoke to the orientation class on Monday, there were 57 people in the summer, of which they usually would all be orientees, approximately 80 percent of the 127 that we hired so far are

experienced nurses from either agencies that have worked at the University of Chicago Hospitals, or other hospitals within Chicago.

COMMISSIONER KESSLER: Has the impact, in terms of the salary, had any effect on the daily rate that you can tack?

DR. SMELTZER: No. No, because of the revenue that we receive from increasing the open beds.

COMMISSIONER KESSLER: Okay. I think that's a crucial point here, that most municipal hospitals and even private hospitals keep debating the rate, and we are finding resistance of policy-makers to increasing the nursing salaries, because it is going to increase the rate. But your evidence is contrary to that?

DR. SMELTZER: Correct.

CHAIRMAN OSBORN: Thank you very much.

Dr. Rango?

DR. RANGO: Good morning, and thank you for inviting me to testify.

I would like to begin by saying that the National Commission has been a real shot in the arm for all of us working in the area of HIV, particularly for those in front-

line states like New York.

I also want to acknowledge the intensive amount of cooperation and dialogue that has already occurred as a result of Maureen and her staff making several pilgrimages to New York, and it has really been amazing to us, in the state and in the city, to have a Federal Commission spend as much time in a high-prevalence area like New York trying to get at what all the problems are.

The AIDS Institute, as I think many of you know, is in the State Health Department, and we are the lead state agency, doing everything from prevention community services to the AIDS designated hospitals. We are also responsible for policy and planning.

When I spoke with Maureen about the testimony today, she asked me to put the problem of physician recruitment in high prevalence areas like New York City in a little bit of context, and then to develop some recommendations that might be useful for the Commission's deliberations.

I think all of you know that the epidemiological and clinical trends that are we are facing in the city and state are similar to those across the country. We are looking at an expansion at both ends of the disease spectrum.

With increasing numbers of people coming in at the stage of early intervention and a sort of paradox of success phenomenon that we've seen before in geriatrics, that is to say, as we get better and better at treating advanced HIV, we are seeing people living longer and longer with substantial cognitive and physical disabilities, so it really is putting a burden on our health care delivery system at both ends.

We are also witnessing in the city, as elsewhere, an extraordinary link between various kinds of substances use and HIV, not only heroin, but also crack and cocaine and alcohol, and with increasing documentation, we are finding that, particularly with respect to drug users, underlying mental illness, so these are people that are thrice at disadvantage. They have the HIV infection underlying mental illness and then, of course, the substance abuse problem itself. Those people are particularly problematic, because they fall into the bureaucratic cracks, no agency, state, city or local, really wants to deal with this particular population, and yet they are probably at the highest risk, for a variety of bad things, like homelessness, TB, untreated STD's and other medical-psychiatric disorders.

You are all aware that we are facing in the city an

acutely strained hospital system, and it is for a variety of reasons, not only HIV. You are also aware that, as we approach the problem of physician and nurse recruitment, we are dealing with the legacy that we have created in this country over the last 20 years, namely, a very weak infrastructure of community based primary care, and now we have to do something about it with respect to the epidemic.

I want to be very candid with you, and I speak only for myself. I believe that a very serious problem in dealing with this epidemic has been the absence of leadership and support at all levels, and particularly, I will speak to the issues in New York City and New York State.

We have found in the city that there have not been a lot of friends in the corporate sector -- there have been some, but not as many as we would like -- to come forward with some private-public partnerships that would have been very valuable, particularly for community based organizations.

We have found that the foundations have followed, with few exceptions, the pattern of indifference and very inadequate funding, and particularly the foundations that we expected to do more, like RWJ, Ford, Pew and the rest. They have done some, but I don't think it's too unfair to say that

the level of funding has been far too little and too late.

I also want to speak a bit about the academic medical centers and the academic leadership. I do so with a little bit of fear of trepidation, with one of my mentors, Dr. Rogers, sitting here,but I would say that our association of deans in New York City and New York state have ben largely silent over the first decade of the epidemic. On the occasion when they spoke, what they had to say was irrelevant and not particularly focused.

I would say that, with a great deal of sorrow and would hope that one of the things that the National Commission would do would be to put a fire under the academic medical centers, so that they start embracing the epidemic, put a fire under the foundations, so that they start doing more, because we at the Federal, state and local level cannot do it alone.

I want to place these comments in marked distinction to the heroic dedication of the doctors, nurses, social workers, and community based agencies that have worked very, very hard on the front lines. Those remarks are not meant to apply at all to them.

When we look at the issue of physician recruitment

in a place like New York City and New York State, the approach that we have followed has been ad seriatim, to try to build a foundation of reimbursement and support, and then to look to specific personnel initiatives.

I brought along today the Governor's 5-year plan that the AIDS Institute prepared already 2 years ago. We are in the process right now of doing an update, and I have these copies available for the Commission's consideration. It represents a blueprint for action. We did specific cost estimates and we addressed everything from community services to health and social services, as well as expanded bed capacity and personnel projections.

I believe that unless you have that kind of political consensus as the basis for moving forward and have the politicians, frankly, committed to the kinds of planning recommendations that occur in a document like this, it is very, very difficult to mobilize support for the kinds of expenditures that are required.

The second thing that we did, and I think it was a theme that was picked up on by an earlier speaker today, and I refer you to perhaps the handouts that were made available. I am not just going to walk you through them very, very

briefly, but I think that unless you have this as a base, physician recruitment becomes an irrelevancy.

What we tried to do in New York State was to create an enhanced Medicaid reimbursement system across clinical settings. What we began with was a very simple principle: Provide the providers with extra money for providing extra clinical and case management services, and what you see there are the Medicaid differentials, from everything from home care to two levels of nursing home care, hospitals, and now, we are proud to say, we have a schedule of primary care rates that address the questions of counseling and testing, the initial examination, and then, of course, the immunological monitoring. Without this kind of foundation of reimbursement support, you are building on very, very weak foundations, in terms of trying to recruit physicians.

The next handout is just to indicate that, after we addressed the question of Medicaid reimbursement, we then tried to initiate a series of targeted grant programs to really put some money out there to do the job. We combined some of our CDC money with state money, to have some prevention and primary care initiatives in the following sites: free-standing community health centers, local health depart-

ments, drug treatment programs that are community based, particularly in disadvantaged communities, again with the notion that those front-line agencies can do the job.

I think it is fair to say that these grants on top of the rates have provided a reimbursement structure that will allow organizations from hospitals to community health centers' drug treatment programs to enter into the HIV field. Without that financial incentive, again, you are building on sand.

We then proceeded with a series of HIV personnel initiatives. I am not going to go through them, but they are there for you, from everything from state health service corps, to a variety of other para-professional tracks that we are developing with the CUNY university system in the city.

The issue that I would like to address perhaps most specifically today is one that appeared initially in the 5-year plan, and it is essentially the establishment of an AIDS Corps. We are fairly persuaded -- and this is the last handout that I provided -- we are fairly persuaded that we have to turn around the problem that now exists in terms of all the career impediments that stand in the way for doctors and nurses to practice in community based programs and

dealing with disadvantaged, if not stigmatized populations.

Therefore, with the assistance of the Governor and the Legislature, we are given $1 million this year to develop an HIV clinical fellowship program. As someone who is a graduate of the RWJ clinical scholarship program at a time when Dr. Rogers was running things, I can tell you that it is clear to me that we have got to establish a leadership cadre in these community based organizations, in order for us to be able to recruit and retain doctors and nurses committed to those populations. We have got to think in terms of agents of change and we have also got to think about the establishment of local service consortia that are made up of teaching hospitals, as well as community based agencies like drug treatment programs, community health centers, and the like.

Again, I emphasize that those partnerships have to be equal. We are thinking about by directional referrals among those agencies. We are thinking about establishing career trajectories, so that some of the academic goodies that exist in large teaching hospitals will be made available for doctors and nurses who want to spend their intellectual professional life dealing with these populations.

Nothing less than that is going to work, in my

judgment, and I also believe in the multiplier effect. A hundred of these people can change the world in New York City, and Dr. Mason and the rest of you who are at the Federal level, we are looking forward to working with you. We believe that if we were given something like on the order of $10 million, we could expand our statewide program and really do a job in all the boroughs, as well as other state areas that are hit by the epidemic.

That is pretty much what I wanted to say. I want to thank you again for inviting me. If there are any questions relative to the handouts or anything else I said, I would be happy to take them.

CHAIRMAN OSBORN: Thank you. We will get to questions quite shortly, but I also want to thank Dr. Rodriguez for his patience and let's hear from you, please.

DR. RODRIGUEZ: Thank you.

My name is Rene Rodriguez, and I would like to thank you for allowing me to testify before the Commission here today. I will speak on behalf of the Interamerican College of Physicians and Surgeons, of which I am the President.

The ICPS is a national medical organization that

was created with the purpose of promoting greater communication and cooperation among Hispanic physicians practicing in the United States. In doing so, we have established a strong link with most of the local medical societies and Hispanic community based organizations, and we have been delving deeply into their concerns on a vast range of health issues. AIDS is one of those issues.

As of May 25, 1987, 75,477 adults of AIDS cases were reported to the Centers for Disease Control; 5,056 of those cases were Hispanic. However, there is a reason to support that the figure of infected Hispanic is much higher, since AIDS patients, specifically Hispanic, at times are unwilling to seek medical care, for fear of persecution. Approximately 70 percent of the AIDS patients among blacks and Hispanics are in the age range of 20 to 30, indicating that this epidemic is striking hardest at the future of the Hispanic people, the youth.

Furthermore, black and Hispanic women account for 718 of all cases of AIDS, and while 15 percent of all adult AIDS cases are Hispanic, 237 of all pediatric AIDS cases are Hispanic. In comparison, intravenous drug abuse associated with AIDS comprise 6 percent of AIDS cases among white, but 35

percent among Hispanics. Excluding AIDS cases contracted from homosexual and bisexual behavior, black and Hispanics are the highest at-risk group for AIDS, comprising 71 percent of all cases.

It has become clear that the AIDS epidemic is surely the great core of the Hispanic community. Attitudes and beliefs of Hispanic physicians, for some time now we have been collecting data on the attitudes and beliefs of Hispanic physicians regarding HIV infection, diagnosis and treatment, with the purpose of increasing their awareness and fostering their involvement in the battle against AIDS.

In particular, we recently conducted a focus group study on this subject, with the support of the National Institutes of Allergy and Infectious Diseases. Our findings should be significant for any assessment of the impact of AIDS public policy on the Hispanic health care community. Our particular study was confined to physicians in the New York metropolitan area.

We found that, given the high incidence of AIDS among Hispanics in the New York metropolitan area, Hispanic physicians collectively diagnose, treat and test for very few cases of HIV infection.

It is our assessment that most cases of probable HIV infection among Hispanic go undiagnosed. Since 85 percent of the Hispanic population are typically treated by physicians of their own communities, because of language and cultural barriers, Hispanic physicians neither attend to the early detection of HIV infection, nor recommend testing for their patients as a matter of routine. They provide almost no pre-test or post-testing counseling, and normally it is the patient, rather than the physician, who initiates testing procedures. Once again, the result is that most of their patients who are infected with HIV go undiagnosed until they are afflicted with a serious AIDS-related opportunistic infection.

If the physician is going to initiate testing, he must first recognize risk behavior or detect symptoms of infection. Yet, most Hispanic physicians tend to avoid the issue altogether by not asking the questions that might indicate whether a patient is at risk of infection. The possibility of a patient being infected with HIV does not figure prominently in potential prognosis.

Additionally,most of the physicians we interviewed indicated that when they do get a patient who tests positive

for HIV infection, they feel inadequately prepared to extend primary care to that patient, even if he is asymptomatic. Hispanic physicians seldom have a clear understanding of the benefits of early detection in treatment. Nor do they sufficiently comprehend the basics of patient management for persons with AIDS.

Few seem to be aware of AIDS clinical trials -- infrequently, if ever, recommending them to their patients. Therefore, it is not unusual that the prevailing data should indicate that most Hispanic physicians -- not unlike the majority of physicians working among the general English-speaking population -- are reluctant to become more involved in the diagnosis an treatment of AIDS.

Why is this so? Because, more often than not, physicians feel the disease is overwhelming, both for the patient and for the physician, that there is too much for them to know in order to feel competent, and because they are overwhelmed by many other problems, including an overcrowded waiting room. All these findings clearly point to a dire lack of training and to a lack of incentives and motivation to further training.

If this situation is to change, Hispanic physicians

need to understand the benefits of early diagnosis, and they need to further their training to enable them to feel confident enough to identify individuals as members of a risk group, recognize early symptoms of HIV-related infections, advise patients at risk on desirability of HIV testing, provide qualified post-test counseling, offer early treatment to those patients with CD4 counts less than 500 cells per cubic-millimeter, or make the necessary referrals for treatment, know where to refer patients with problems they are not skilled to handle.

The Hispanic patient: Regarding AIDS education in the HIspanic community, the question is: Are Hispanics getting the message> The answer is no.

Our study also revealed that a patient's past or current sexual practices are not usually included in the information gathered by the physician in the patient's clinical history. Both physicians and patients have barriers to a candid discussion of sexual history or substance abuse. This perception mainly arises from an inadequate understanding of AIDS on the part of the Hispanic patient.

The AIDS information that floods the mainstream English-language media and resource centers does not readily

work its way into the Spanish-language media. There is no systematic or nagging dialogue occurring in the Hispanic media about AIDS. Hispanics are simply not getting the message.

Hispanic physicians state that most of their patients don't know how to protect themselves from HIV infection. They plainly say their patients are not informed, that they ignore the basic facts about AIDS. There are numerous reasons for this. Some are cultural, some arise from the lack of resources going into education of minorities, but mainly because most resources are not granted or channeled to the institutions that do have the necessary cultural understanding to make sure the message is heard. The institutions that have firm grass roots in the community, at least they are not granted on a scale large enough to make the needed impact.

Nevertheless, such obstacles can be overcome through better patient education programming, and the implementation of a routine risk assessment questionnaire that physicians can put to all their patients, and a methodology for its proper use.

We believe that the Hispanic medical community has a major role to play in the education of community members

regarding HIV infection. Hispanic physicians should be provided with the necessary informational tools and rewarded for their efforts. Moreover, they should represent the front line of any AIDS educational campaign in the Hispanic community.

Continuing medical education and recruitment: The changing demographics of the Hispanic population is a factor aggravating the spread of AIDS, and points out the urgency of attacking the problem without further delay.

Since 1980, the Hispanic population has grown 34 percent, while the general population has grown only 9 percent, and if Census Bureau projections are correct, the Hispanic population will double by the year 2000. Including an estimate 3.5 million illegal aliens, close to 25 million Hispanics live in the United States today. Currently, this population is younger, it averages 28.9 years against 32.2 for the general population.

Now, assuming that 80 percent of Hispanics are treated by the 24,000 Hispanic physicians practicing in the Continental United States, mainly because of the language barrier, we conclude that there is one Hispanic physician for every 1,000 Hispanic patients. That is more than double the

patients per physician found in the general population, which you know is one for 400.

It is a heavy burden on physicians already strained by a disadvantaged population characterized by a higher incidence of almost every noticeable disease, unequal access to almost every modality of health care, that for cultural reasons typically has poor compliance with medical treatment and short-range therapy expectation, that has great difficulties in paying for health care and is frequently uninsured.

Such characteristics, however, show that the difficulties in addressing the problems of the diagnosis and treatment of AIDS cannot be attributed solely to a serious lack of professionals, rather, let me say bluntly, to inadequate policy in motivating existing physicians to the task and failing to deliver education that reaches the community. There have been no efforts to develop and implement original training programs that can benefit physicians already heavy burdened.

The lack of professional skills is also critical among nurses and other health care personnel. Recruiting Hispanic health support personnel is certainly necessary, but it is not the main solution to the problem.

To understand the enormous impact that physicians can have in slowing down the spread of infection and detecting infection at an early stage, one must understand the relationship that exists between the Hispanic doctor and patient.

In the Hispanic culture, a doctor is a highly esteemed individual and is seen as a strong figure of authority. The physician is in the best position to educate, address the concerns of their patients regarding AIDS, promote testing in individuals at risk, and counsel them in every aspect related to testing, and make the necessary referrals and recommendations for treatment.

Despite their lack of motivation to treat HIV-infected patients, Hispanic physicians can be challenged to identify patients at risk for HIV infection and encourage testing. But motivating and training Hispanic physicians for this task and involving them in an educational campaign that could effectively limit the spread of infection in this community requires a more elaborate approach than the conventional training courses and seminars.

In my view, Hispanic physicians are the key actors in any effort to stop the spread of the disease in the Hispanic community, particularly those who specialize in

general medicine, in family medicine, internal medicine and obstetrics/gynecology. If we can involve them in this task, we will soon see the results.

Thank you.

CHAIRMAN OSBORN: Thank you very much, Dr. Rango and Dr. Rodriguez.

We are running behind, as everybody knows, and so we will probably need to curtail questions somewhat, but we should take at least a couple.

COMMISSIONER AHRENS: Dr. Rango, let me preface my question by saying I guess my knowledge and understanding of the health care system in New York City is really almost non-existent, but I have the impression that the community based organizations have played a very good role in addressing the AIDS epidemic in that city.

I guess my question is based on the little I do know about how minority populations access health care incentives, when, in fact, the access at all is pretty heavily dependent on a public health care system. My question is, as the faces of this epidemic changes color and sex, do you sense that, in your city, that community based organizations are up to this challenge, or will the minority

populations rely primarily on the public health care system? Could you talk a little bit about that, and its implications for funding?

DR. RANGO: I get your point. What we have tried to do with respect to the epidemic, however, is to adopt a balanced approach. I think your question is directed in the epidemiological trends, indicate a change in the complexity of the epidemic and the risks associated, and yet we also know that there will continue to be substantial numbers of white gay men that will march through the epidemic that will not obviously be a future item.

The community based organizations will be considered a full-track approach to the management of the epidemic. I was asked to speak today on physician recruitment and perhaps didn't spend as much time as I would like on the other, but as we approach the epidemic, we want to provide adequately persons with health and social service agencies, and I addressed that in my testimony, but what I did not mention is that the state and city -- speaking for the state, we fund about 160 community based organizations of all kinds, HIV specific, adolescent, specialty organizations, women's organizations and the like. And I can tell you that, in

terms of the continuing care, pursuing one quarter, without equally addressing the issues of care together will result in a lop-sided system.

I could also tell you that it is not easy to try to make your articulations between community based organizations and the health care. We spend a fair amount of our time bringing people who work in the community together, but by all means, the community based organizations in our state and city play a leadership role in responding to the epidemic. Funding is asexual and we don't have nearly enough at the city level and the state level or at the Federal level to fund community based organizations, as the case stands.

CHAIRMAN OSBORN: Ms. Diaz?

COMMISSIONER DIAZ: Dr. Rodriguez, I wonder if you could tell us, within your focus groups of Hispanic doctors, whether some ideas came forth as to where Hispanic physicians may best be congregated for education on HIV. I know that you are aware that there are Federal funding mechanisms that subsidize the training of minority physicians and others in this epidemic, and I am just wondering if you had any thoughts as to where the best place to gather significant numbers of physicians that can help do the kinds of things

your paper so eloquently describes.

DR. RODRIGUEZ: Definitely, we know that most of these physicians, the Hispanic physicians are concentrated in the main cities where all the Hispanic patients are and, you know, those are very simple. In New York, Los Angeles, Chicago, San Antonio, and in Miami, those are the big cities and those are where the big concentrations of Hispanics are, and those are the places where I think there should be places for training these doctors.

I don't think that we can be so naive in thinking that these doctors are going to come all the way to Atlanta to take courses at the CDC or anything like that, because these people have big practices and, you know, we cannot just depend on the public sector, we have to use the physicians who are practicing and seeing the patients, because those are the physicians that can really refer and make a diagnosis. I don't think we are going to get the Hispanic physicians treating a lot of HIV patients, but unless we can make them to recognize this early enough, I think that will be a great impact, and I think it has to be concentrated in the cities where they are.

CHAIRMAN OSBORN: Scott, Larry Kessler, and David

Rogers all have questions, and I hope we can do them briefly, because you have stimulated a lot of interest, and yet we are getting behind.

COMMISSIONER ALLEN: On the issue of pediatrics, for either one of you, I notice you didn't mention pediatrics in the last litany of physicians we need to deal with, and since it's a different dynamic, to some degree, especially in the social context, where do you see the recruitment of the pediatrics, the pediatrician in this solution?

DR. RANGO: The pediatrician -- I think I have that in the flier -- is one of the specialties that we have targeted with respect to the fellowship program. We have a number of determinants in New York State that are addressed specifically to pediatric AIDS, with recruitment involving pediatricians.

I would simply say that the challenge for us is not only to get the pediatricians, it is to get the pediatricians, the obstetricians, the internists, at the same time dealing with the family as a whole, because each of them, for reasons of there training and background, tend to identify with a particular part of the family's needs, without understanding that the family should be, at least, an intact unit, and we

put our pediatric initiatives in the context of the family focus, both with respect to clinical and case management initiatives. It is a healthy structure.

CHAIRMAN OSBORN: Larry?

COMMISSIONER KESSLER: I have first a comment to Dr. Rango. I thank you for your comments about the Commission and I thank you. One of the reasons it is easier to come to New York City is that we get the frank information from your department that isn't necessarily glossing over the bad parts, and we certainly have some models there that encourages that and we are able to talk about them we go across the country, and I hope that that frankness and honesty continues, because it is really valuable to us.

Dr. Rodriguez, I appreciate your comments, and I guess I am stuck, because I have a feeling that we have a chicken and an egg syndrome in your report. What would the incentives be, I guess, that would get us more Hispanic physicians to join the front lines and do the kind of education?

As we have gone around the country, we keep hearing over and over that Hispanic and black physicians are extremely hard to recruit for the front lines in this epidemic, for a

variety of reasons. They often have a disproportionate share of non-paying patients or patients who are Medicaid and so on. But on another level, I suspect that there is some of the same thing going on that we find in other groups, a resistance to getting involved in the epidemic, period, because it's a -- it's difficult to say that, but I am wondering if there are some other biases or fears that make the Hispanic physician distinct and different than a physician of other groups.

DR. RODRIGUEZ: Specifically, in the survey that we did, we asked a lot of the physicians that were the focus group if they fear treating patients with AIDS, and they really didn't care. None of them have any fears to treat patients with AIDS. Their main concern is they felt that they were not capable to treat patients with AIDS, because they don't know enough about it.

And when we asked how would be the best way to learn about it, they say that they would love to get courses, but, you know, most of the course have been designed for AIDS, most of the money that has been given have been given to the big universities and the big, you now, what they call the ivory tower institutions and these institutions never try to

reach the black or the Hispanic physicians. Whenever they have a meeting, they invite -- the information goes out to everybody, but there is not an effort to try to recruit these physicians to make them feel like a part of the epidemic that they are going to treat.

COMMISSIONER KESSLER: So we need more outreach?

DR. RODRIGUEZ: Excuse me?

COMMISSIONER KESSLER: So, we need more outreach, is what you are saying?

DR. RODRIGUEZ: Exactly, more outreach. The other thing that I would like make comment to is what Dr. Rango said. I think that it is very good to try to reach more doctors and to get them more involved with AIDS, but I don't think that to try to make AIDS another specialty, I think that would be a disaster, because I think we will be doing exactly the opposite. With the amount of resources that we have today and the information, I think that every physician should be able to treat an HIV patient. But once we make another specialty, then there will be less and less people to be able to treat those patients.

CHAIRMAN OSBORN: Dr. Rogers?

COMMISSIONER ROGERS: Dr. Rango, I am glad that you

have been compliment by your friends. I would simply point out that I would feel better about it after you first berate me for my failure as a foundation president, that my failure is as an academician.

[Laughter.]

You have persuaded me of the importance of a fellowship program, in terms of putting more physicians, more nurses, more other health professionals into AIDS care. Could you give this Commission some kind of a word picture of how the shortages in that area are impacting in New York, use New York City as an example? You have quite graphically before, I know, told me about how many beds are closed, how many things we are not doing, because we simply don't have people who are taking care of patients today.

DR. RANGO: Lincoln Hospital, a beautiful setup, has been vacant in terms of HIV for the last year and a half, because of an inability to recruit physicians. Bushwick Clinic, run my some excellent minority physicians, has been for the last year and a half unable to recruit additional physicians out to the Bushwick area of Brooklyn.

All of the drug treatment programs, and I am referring particularly to the leadership of drug treatment,

which has very solid community works and credibility, has a disastrous record in terms of recruiting doctors and nurses and social workers to work in those community based centers.

Even though there are some very, very dedicated people, I am absolutely convinced that, in addition to providing financial salaries that are attractive to doctors and nurses, until we crack the nut that, in essence, any doctor and nurse who is primarily or exclusively associated to HIV and substance abuse, there are a lot of enormous risks, in terms of career enhancement, of all kinds, financial, they are stigmatized by their colleagues, and, finally, in nearly every instance save one that I am aware of in New York, no academic support, no promotions, no opportunity for publications, no prestige, et cetera, et cetera.

I identify strongly with the community outreach approach taken by my colleague, but I again speak forcefully, that unless we are able to turn the situation around, that the fire is burning out there. You can talk about getting all of these physicians, but until we create careers for people to go out there to the communities and have a base to return to, we are going to be in the same situation five years from now that we are today, only there will be four

times the number of patients.

CHAIRMAN OSBORN: Thank you very much, and let me express our appreciation for your very important testimony.

My understanding is that Dr. Malveaux is not here and I am advised that Ron Jerrel will join this panel, along with Charles Helms and Caitlin Ryan. So, if we can proceed to the next panel.

Thank you again for your excellent testimony.

COMMISSIONER ROGERS: Madam Chair, may I make a comment here. As is apparent, Commissioners really learn an enormous amount with interactions with you. We do have your written testimony. If you can punch home the points you would like to have us hear, and then let the Commission react, I think that works most eloquently for us.

CHAIRMAN OSBORN: Dr. Helms, you may proceed.

DR. HELMS: Thank you very much for inviting me here. I trust I carry the short distance.

My name is Charles Helms. I am Associate Dean at the University of Iowa College of Medicine, and I am a site director for one of the 15 AIDS education and training centers nationwide. I am the site director the Iowa site of the Midwest AIDS Training and Education Center.

I think I have been asked here primarily to sort of give a rural perspective on recruitment and retention of physicians in the fight against AIDS. I feel a little bit humbled in this approach, because I would like to stress this point, number one, with you that rural is not singular, rural is plural. I am a white, middle-class American, living in the Midwest.

Rural also includes the Southeast, it includes the Southwest, it includes Puerto Rico. It has a tremendous color differential, tremendous inherent problems, each distinct, each unique, and, therefore, the problems related to HIV infections in "rural America" are going to be multiple, they are going to be different from site to site, and the solutions may well be different, in addition.

Point two that I would like to stress with you would be the paucity of information available to us rural people in dealing with AIDS. We don't have much in the way of base-line epidemiological information. This puts us to a real disadvantage, I think, in manipulating within a state to determine where the problem is and where we might place our resources.

In addition, there is very little in the way of

nationwide understanding of the health resources that are available for the fight against AIDS in rural areas, where are the resources, are they matched with the problems in rural areas, and really only continued research, more information emerging at the epidemiologic level and at health resources level is going to help us to address that problem.

Now, in terms of more specific comments about manpower or person power, primary care practitioners in rural America are going to be critical to handling the AIDS problem. This has been lent emphasis by the fact that we can now treat AIDS, patients who are asymptomatic with AIDS and such individuals must be diagnosed early and treated early.

The appropriate place for such early diagnosis and treatment to occur is in the office of the primary care physician. Since in rural America, 77 percent of physicians in non-metropolitan counties, that is, with populations under 10,000, are primary care physicians, it becomes clear that primary care physicians are going to be critical here.

In addition, they have another role to play, I believe. If I concentrated on physicians, I don't mean to concentrate completely on physicians, I want to talk about primary care providers, as well, nurse practitioners and so

forth.

A great role to play in education, I think in probably the great majority of rural American, when it is looked at epidemiologically, there may be presently, as described by Verghese, is window of opportunity, the sera-prevalence levels of HIV positivity may be so low in high-risk populations, that the chance to really prevent the disease exists out there, and our primary care providers may be in a very important position to engage in educational efforts designed to prevent the disease.

Now, what do we do about what is out there already? I believe that, in order to supply primary care personnel capable of providing early diagnostic counseling and treatment services to HIV infected individuals, that the rural providers currently in place must be trained and, in some circumstances, new providers recruited.

Now, not all rural areas will have AIDS problems and, frankly, not all physicians and providers in a problem area will wish to care for HIV infected patients. It may sound heretical for an educator to say this, but I think we have to face the fact that some people are going to be more enthusiastic about such care than others.

Therefore, it is my estimation that some sort of focusing of training in rural areas, where there is a problem, on those practitioners, be they physicians or otherwise, who are interested would be of import to maintain them, first, to get their baseline information and, secondly, to keep them up to date on what is going on in the area of AIDS care.

Now, there are going to be some barriers to overcome, to assure a supply of rural care providers who can take care of HIV infected individual. You have heard about them, I am sure, in previous testimony. Some of these are fairly AIDS specific, and they include the fear of the physician of cotangent, prejudice, concerns about competency and concerns about being designated the AIDS doc in the area and losing patients as a result of that.

Some of these problems can be approached through education and training, particularly of motivated individuals, and I believe that the AIDS training and education centers, which are currently nationally positioned, are in position to try to do something along those lines.

There are other AIDS specific barriers that we could talk about, more of a systemic nature, related to the

comfort of the physician out there taking care of AIDS patients, does he or she or does the provider have available appropriate consultations of experts elsewhere, also do they have available the appropriate services to make them feel like they are doing a good job taking care of AIDS patients.

Now, there are non-specific barriers, and, frankly, I am more concerned about these than I am about the AIDS specific barriers, in the long run, that stand in the way of an adequate supply of rural primary care providers, and these have been prevalent for years and have made recruitment to rural America difficult for the same period of time.

First and foremost, the pool of primary care providers, including minority providers, a very important group here, available nationwide is still too small. Other non-specific barriers include lower reimbursement levels for physicians out in the countryside, a lack of practice coverage -- just that relief they need to get away from the pressures -- the lack of easy continuing education opportunities for them, high malpractice insurance rates for some of them, the struggling rural hospitals whose facilities may not be up to their standards, and then, an important one, sometimes overlooked, family dissatisfaction and the quality

of rural life as it presently exists.

The AIDS epidemic, therefore, in my opinion, has highlighted longstanding weaknesses in the rural health care delivery system. Recruitment and retention of rural primary care practitioners to fight HIV infection and other pressing problems of rural health will depend, in the long run, on successfully addressing these deep-seeded problems which existed before the AIDS epidemic.

In the meantime, what we have available to us is continued Federal and state support of those established health service, public health system programs in place, and hopefully such support will continue and may increase in amount.

Thank you.

CHAIRMAN OSBORN: Thank you very much. That is important testimony.

Would you like to go ahead with your testimony, before we follow up on the testimony, and after the three of you have had a chance to each talk as succinctly and briefly as you can, if you want to summarize, that would be fine, because then we will have a chance to interact.

MS. RYAN: My name is Caitlin Ryan. I am here to

talk to you about social work. Thank you.

Obviously, I don't have time to say what I need to say about social work, and I think you have heard about social work from other disciplines, but I want to tell you about another perspective.

My testimony is comprehensive and is based on my job and issues of social workers all over the United States. We have some serious underlying problems before we can get to AIDS. There aren't enough of us in the United States. There are only 500,000 trained social workers, but we provide 75 percent of the mental health services in this country, and we are the primary provider of mental health care in rural America. We also work in hospitals and clinics, child welfare policy in schools, in legal services, everywhere, but we have a very poor public image.

Most people don't know what we do or who we are. We are the patients advocates and the point person. We counsel in connection with whatever their needs of management lives. We invented the concept of case management. We are with the patient the other 24 hours when the doctor isn't there, when they are hopeless, fearful, suicidal, acting out and hard to take, but are paid astonishingly low.

The average social worker, with a master's degree, with additional specialized training and years of experience, makes $22,000 to $27,000 per year. So, recruitment is difficult anyway, and burnout was a significant problem even before AIDS.

We have made an enormous contribution in the AIDS epidemic, developing many of the early models of AIDS services and community care. We provide all levels of care for patients and families. But social workers need more AIDS training. They are fearful of the emotional drain. They don't have enough resources. They are seriously affected by budget cutbacks. They have staggering caseloads. Without support, we can't do the work that is needed for AIDS, and our work is very important.

I was going to do something different and share excerpts from the life of a typical AIDS social workers, and I guarantee by the time I was finished, you would be overwhelmed. But I don't have time for that. It is in the testimony.

In the average day, we deal with the death of a patient, with the family, with the survivors. We deal with family members of former patients who continue to contact us

for emotional support, because we are the one they developed the relationship with and they have nowhere to turn, and those calls come in from all over the country.

We mediate conflict between staff. In these centers where AIDS work is done, conflict between staff erupts daily. We mediate conflict between patients and family members and staff. We respond to crisis calls, come in early and stay late. We deal with outside agencies who can't help, don't want to help, and don't have the resources to help. Our caseloads are enormous, 150 families, 600 patients, 120 children. We provide all the social support.

In a city like New York, there are now 10,000 AIDS affected orphans who need bereavement counseling and our support. AIDS jobs are going unfilled into the second year for social work. The pressure is increasing on those who stay. We can't find enough social workers, especially minorities. We can't find the students, and we need your support to help with improvement.

I have three recommendations, and they are outlined in my testimony. Very simply, we needs more AIDS training. We need social worker recruitment, training for AIDS and for substance abuse. We need a demonstration project for burnout

prevention and to deal with this issue in an interdisciplinary way.

We need support from the government, through existing educational programs and campaigns, and this won't cost any money, to develop a more positive and accurate image of social work, to bring young people into the field. Those are my recommendations, and I will be happy to respond to questions.

Thank you.

CHAIRMAN OSBORN: Thank you for exceptionally succinct and helpful testimony.

Ron Jerrell, thank you for joining this panel and we would be glad to hear from you.

MR. JERRELL: Thank you very much. I will try to keep this very short.

My basic association, as President of the National Association of People With AIDS, I will elaborate further in my biographical statement. I will cut my remarks as short as possible. It will be difficult for me, due to the emotion that surrounds this issue.

The attention and education efforts, especially those related to health care professionals, in the last five

years have proved to be most productive in challenging fear and attitudes and promoting prevention techniques for people with HIV and AIDS.

In rural areas, an understanding and compassionate response to a disease that is many times regarded as deserved on the part of the sufferer can only be viewed as exemplary. This is not to say that HIV and AIDS has completely surpassed that level of thinking in all areas, but that there are people, institutions and agencies working very hard to abolish those stereotypes.

In "our" metropolitan areas of Louisville and Lexington, in Kentucky, the delivery of care has in most cases evolved to a more understanding and compassionate level. We still hear of physicians refusing to see people with HIV and AIDS, but their refusal is most times related to their own feelings of inadequacy in providing the necessary care for those patients.

This inadequate feeling on the part of not only physicians, but other health care providers is a defined problem for rural areas. Many general practitioners are unwilling to see people with HIV and AIDS, due to the fear that they will be labeled as the "AIDS doctor" in their

communities. Specialists in the area of infectious disease are few and far between and nowhere is that more apparent than in rural areas.

In the State of Kentucky, we have five infectious disease doctors carrying a tremendous load. For people outside our larger cities, commutes of two and one-half hours to an infectious disease doctor is an unfortunate reality. People in this situation find themselves requiring the services of two or more doctors, a local physician to follow them monthly with labs and curative care for minor infections, and a specialist some distance away to follow the progression of their HIV infection. Any major complication of HIV will require more specialists, many of whom are three or more hours away.

The resulting strain on the person with HIV and AIDS is multi-faceted. The indigent status of many people with HIV and AIDS is the most apparent. Without private insurance and often without Medicare or Medicaid, specialized care is often difficult to obtain.

Lack of transportation and other associated costs cause additional problems. Unfortunately, for those who do obtain care, the distance that they must travel creates a

significant barrier between them and their established support system. This often leaves the patient feeling alone and deprived of the psychosocial elements of the healing process.

The distance between infectious disease specialist and the patient often results in increased inpatient hospitalizations. Any indication of a possible opportunistic infection results in the physician in most town requiring the patient to be hospitalized, so that his or her condition may be followed more closely.

Similar situations involve other areas of health care provision in rural areas. Dentists in rural areas who will see people with HIV and AIDS are very rare. In Kentucky, we tried to develop a list of dentists willing to see people with HIV and AIDS. That list contained one name.

I personally needed a six-month checkup from a dentist and could find only two dentists in my town, Owingsboro, Kentucky, with a population of 50,000, who would, first of all, accept Medicaid. However, neither one of them would see me, due to HIV Infection. One dentist told me that his office was carpeted and he would not be able to sterilize the room after my visit.

A second dentist told me she had plants and could not take the risk of my infecting her plants and her plants then infecting her other patients. I did find an oral surgeon, who was recommended to me by the dentists, who would see me under certain conditions, and these included that I would come after-hours, come in the backdoor, and not tell anyone I had been there. For me, I chose to look another place for my dental care.

Finding a respiratory therapist in a patient's local area to administer aerosolized pentamidine treatments is often difficult. Following hospitalization, home health care may not be available to the patient, for various reasons. In some cases, home health agencies are unable to find a nurse who will see HIV infected people.

One specific example is a friend of mine in Greenville, Kentucky, who recently was in the hospital and the discharge planner went through 15 different home health nurses, before they found one who would see him on a regular basis.

HIV specific counseling to address the many psychosocial issues surrounding the disease may not be available in rural areas. Maintaining trained HIV testing and

counseling nurses at the 120 sites, for example, in the State of Kentucky is very difficult.

The lack of funding for HIV and AIDS in rural areas only accentuates the gaps in care and, most specifically, the ability to access the limited number of health care providers who will see HIV infected persons. Federal funding is currently based upon the number of recorded cases in a state, which usually precludes rural areas from funding.

In a state like Kentucky, our statistics will never adequately indicate the actual situations which exist. The availability of testing in surrounding states with larger metropolitan cities often encourages our residents to go out of state for testing and medical care, due to the risks of confidentiality. Our statistics also will never reflect the ever growing number of people who "come home" from the larger metropolitan cities after HIV infection or an AIDS diagnosis.

Specific areas of concern as far as financial barriers for people with HIV and AIDS, one is the AFDC level mandated by the Federal Government in relation to Medicaid eligibility, which further complicates the provision of care. For example, in Kentucky, the monthly income cap for Medicaid eligibility for a one-person household is $217. This

eliminates eligibility for all but the extremely indigent. The two-year gap between acquiring disability and Medicare eligibility is another financial barrier to care that needs to be changed dramatically.

The low levels of funding, inadequate funding allocations, and the financial barriers to established government programs only encourages the states not to get involved with the provision of care and services. The states see the Federal system shirking fiscal accountability and responsibility for people with HIV and AIDS, and they, therefore, model their response similarly. For the first time ever, the State of Kentucky, in fiscal year 1991, has allocated money for HIV and AIDS services, $100,000 has been allocated for the indigent AZT Program, another $250,000 has been allocated for a case management system in the State of Kentucky. This is a small, but progressive step for a rural state that must be followed in other states.

Residents in rural areas believe that the community should take care of its own and provide care through primary relationships and informal networks, rather than through formal bureaucratic systems. These characteristics influence the delivery of health and social care to persons with AIDS

and their families in rural areas.

An area often overlooked regarding available personnel in rural areas is the community based volunteers and those community based organizations. These volunteers, with astounding credentials and eagerness to help, become understandably frustrated with the lack of funds available to community based organizations to implement needed programs in local areas.

State and Federal Government have yet to consider these people and organizations as tremendous assets, of which they are capable. When these people and groups are identified, the government responds by withdrawing it support and shoving the responsibility off onto the volunteers. It has to be realized that, although volunteers are great, they cannot be and should not be expected to be completely responsible for the situation.

Instead, the government should regard volunteers as a valuable resource to consult with regarding education and services needed in specific communities. Volunteers have fulltime jobs and responsibilities of their own and cannot be expected to carry the full weight of AIDS education and service provision in their communities.

Kentucky has eleven community based organizations, sharing $35,000 in 1990 to carry out all of the programs for their communities. That funding was distributed to the organizations by the State via a pass-through program from the CDC. In 1991, that small amount, $35,000, has been completely cut from the CDC budget. It is easily predicted that several of our organizations will become defunct without this funding. This further complicates the problems in rural communities.

Homophobia also has forced AIDS service organizations to struggle with how they identify themselves, as a gay organization provided services to all persons with AIDS, or as an AIDS organization. Such organizations are aware that their identity influences funding, community support, and referrals. Many agencies work very hard to maintain a gay neutral identity, but are still perceived as a gay organization. This significantly reduces the number of referrals of non-gays.

Religion is another important characteristic of rural communities that heavily impacts the ability of AIDS service organizations to provide for the needs of people with HIV and AIDS> In rural communities, religious values and

groups affecting other aspects of community functioning, such as the delivery of community health and social services. Congregations act as support networks for people in need and help people to find their problems, discuss their fears, get their assistance, and build support systems and coalitions.

The Church also could prevent disease by educating and advising members about health risks and available services by promoting healthy community environments and the discussions of preventative measures regarding disease. This understanding and compassion on the part of the church in rural areas is still far from being realized.

Structural barriers to health care and social services in rural areas are longstanding and likely will not be overcome without major economic changes and new directions in the health care policy and delivery.

People with HIV and AIDS in rural communities are confronted with many geographical barriers to health care, but they also have hopes and needs very similar to those of people with HIV and AIDS in larger cities. People with HIV and AIDS do not want to be treated special, above and beyond health care available to people facing other potentially terminal diseases.

We do not feel that cancer, leukemia and heart disease, to name a few, are more important than AIDS. We do feel, however, that extraordinary steps have to be taken in order to provide us the same quality health care available to people with those diseases. HIV and AIDS has a much different stigma associated with it than do cancer or heart disease.

AIDS was ignored by the government for the first half of the decade of this epidemic. If adequate education and prevention guidelines had been realized by the government in the beginning of this epidemic, when the disease predominantly affected homosexuals and IV drug users, maybe we would not be here today.

But since that did not happen, I feel that the government must be held accountable to make every effort possible, no matter how extreme or special, to insure that people with HIV and AIDS are afforded prompt and quality health care and services. We must view these extraordinary measures as necessary and affirmative action for the disconcern and oppression afforded this disease and the people affected by it during the early years of the AIDS epidemic.

Thank you for your attention and commitment to people with HIV and AIDS and your intention to redefine the

government's response to this epidemic.

CHAIRMAN OSBORN: Thank you for an exceptionally fine statement. We appreciate that very much.

I think we will take some time, because three very important individuals gave testimony for us today and we will certainly study it. Are there questions? Larry?

COMMISSIONER KESSLER: Caitlin, I want to acknowledge, on behalf of the Commission, all of the great work that you and your governmental group at George Washington have done over the years in terms of keeping us aware of the importance of social work.

I am a bit embarrassed and am afraid that we may have once again done what the rest of the society tends to do, and that is give you short shrift here in not giving you enough time to articulate your position. We will read the testimony, which looks excellent.

MS. RYAN: Thank you.

COMMISSIONER KESSLER: One of the things that concerns me is that earlier today we heard, and we have heard this before in other hearings, that physicians and nurses are finding that one of the reasons they claim that they are backing away from AIDS care is that they also don't have time

to deal with the psychosocial issues. Yet, I suspect that, in this tight fiscal climate, hospitals are coming back to social workers, that the low pay that you cite is a factor in recruitment and so on. Can you elaborate on that, or am I off-base?

MS. RYAN: That's a terrible problem. In fact, I got a call, in preparing this testimony, from a physician in rural Illinois who cited his problems with not being able to find enough social workers to help. DRG's don't reimburse for social work. Social work positions in hospitals have been cut back repeatedly.

Social workers have been in the hospital for over 30 years or more and retired, those positions are not filled. That's one of the things accounting for the enormity of the caseloads. The typical caseload now for somebody doing AIDS related social hospital work is 120 families and patients. There just is not enough time, there aren't enough resources, and we have really got to do something about that.

The other terrible problem that I have uncovered in doing this testimony is the closing of hospital social workers across the United States, the closing of those departments of social work. The departments are being closed

and what is happening is hospital administrations are getting enough social workers to meet JCH and Medicaid requirements. That means that those social workers who are JCH affiliated will only do discharge planning. They can't meet the needs, the psychosocial needs of the patients in the hospital who are hospitalized for various ongoing problems. They can only meet them in terms of discharge planning, especially if you have got a caseload of 300 or even more.

We are seeing the spillover into community health, we are seeing the spillover into all these social workers and there are many, many of them who also volunteer, after they work in the workplace, in the community as its counselors, providing lots of program services. We are hearing from more and more doctors and nurses that they can't manage it. We are running support groups. We are feeling overwhelmed. Again, you know, you have heard time and time again and you will continue to hear about the interconnectedness of all of these issues.

The other serious problem my testimony speaks to is that, in 1980, all the recruitment programs for social work that were initiated after World War II were very successful in bringing minority social workers. Many of them are working

in AIDS today, but those with graduate degrees, those are drying up. As a result, how can you bring in a bright, young person and come out with a $30,000 debt and start a new job that is going to pay $20,000 a year? This is a very, very serious problem for the future, not only in terms of AIDS, but also in terms of social services and psychosocial support, in general. Because, as you know, social workers deal with society's victims, we deal with the homeless, we deal with the poor, we deal with the low-income, we deal with multi-problem families, and we have dealt with them any way.

But now, with AIDS, we are getting this spillover from the other professions, because they can't continue it any more, and they also can't contain their grief. The other thing we do is help find the grief of our colleagues who are losing more and more patients and can't deal with the anger and the rage and the acting out. We are becoming therapists on the job for our colleagues, as well as ourselves and our patients.

CHAIRMAN OSBORN: Harlon?

COMMISSIONER DALTON: I have a comment for Ms. Ryan and a question for Mr. Jerrell.

I would like to share Larry's embarrassment, not

simply for giving you short shrift today, but you are quite right about the social work profession in the last 11 months or whatever, it has been reflected through people involved i other professions, and I would like someone to speak about the profession directly, and I understand why you are very tempted to read excerpts from "A Day in the Life of The Social Worker."

I did take the time to sort of skim through the day to 3:00 in the morning, which my fellow Commissioners know, is a frightening thought. I mean I have trouble starting my day at 9:00. It begins at 3:00 in the morning and ends at 4:40 the next morning, but that's not what is important. It is the content, and I just want you to read through it. It is a very powerful stuff, talking about -- it runs along for a couple of pages and really gives a flavor of what is important, 500,000 people, which is not really very many, so I just want to underscore --

MS. RYAN: Well, we are also supplemented by the background of the mental health services in hospitals who are supplemented by interns, by the way. They are unpaid, like-minded interns in psychiatry and psychology, and there are many men and women out there.

COMMISSIONER DALTON: Mr. Jerrell, it is nice to meet you at this meeting. Something that sort of struck me in your testimony, and I have sort of wondered about it before, and maybe you can help. You mention that your statistics in a rural state like Kentucky, a predominant rural state like Kentucky, don't really do you justice, when we have a system of funding that tends to look at statistics.

Now, I assume I share with you the gut feeling that it shouldn't be determined just on the statistics anyway, but given that dollars often follow numbers, what are we going to do about a situation where folks often find it, if not more convenient, in their better judgment it makes sense to go across the border to Iowa and Tennessee for care, or at least for diagnosis elsewhere and come home? What can you do, so that you can get a true picture of the people who come from or come back to, say, Kentucky? How can we get an accounting or how can we get a real sense of the size of it?

MR. JERRELL: Well, I think one of the ways that we would be able to identify the population more readily, more accurately, is increased contact and affiliation with community based organizations and people that do case management on a local level.

You know, our statistics in the states are reported by the health departments, private physicians and hospitals. We have a large majority, like I said, going outside of the state for their hospitalization, their health care, and people that will go outside the state for their testing, and so, therefore, their health department never see it, so we have a lot of people that we don't see, due to that system.

But the community based organizations usually do have contact with these people, because they are interested in the confidentiality afforded to them by support groups in their local or near-local areas. Just like, for instance, in my city of Owensboro, we have, according to the state, one person living with AIDS in Owensboro, and we are providing case management for up to 50 people just in the city, not counting the outlying communities around us.

So, that would be my recommendation, is to work more closely with community based organizations. I can't stress that comment strongly enough, because to me there is support and services provided by community based organizations that are the backbone to care for people with HIV and AIDS, because people with HIV and AIDS tend to trust people in the service organizations, people who are giving of themselves

and who are deeply involved with the subject, not just because it's their job or its 9:00 to 5:00, but it's a tremendous difference for people affected by the disease.

COMMISSIONER DALTON: That makes sense to me, that recommendation. That, of course, assumes that community based organizations will be there. I must tell you that I was struck by your comments about the $35,000 total, I guess that was from the state through the Federal pass-through, and that has been cut out, and that is being replaced with what?

MR. JERRELL: Nothing. Our only hope is our state epidemiologist. I had a meeting with him on Friday and he had just gotten back from the CDC, a meeting down there, and the CDC has proposed, and it is in front of Congress now, what is called the Hope Formula, for the provision of dollars to states. The new figures, looking at the Hope Formula, if that is approved by Congress, Kentucky will be a winner, we will get increased funding, but, of course, that is tentative as of now.

CHAIRMAN OSBORN: Mr. Goldman?

COMMISSIONER GOLDMAN: This is a question that is directed to you, doctor, and to you, Ms. Ryan. Would you just briefly -- are there special problems relating to the

provision of social work and the supply of social workers in rural areas that are different from that which apply in urban or metropolitan areas?

MS. RYAN: There are a number of them, and, again, they are interconnected. We are now in a position as NASW or some of the other health related national associations, in order to apply for NIH training grants for our association at this time of this was available. As a result, many, many, many and probably most social workers in rural areas have not been trained. Because of our low salaries, we have very little money to train ourselves, and those agencies with facilities or hospital social work departments don't have budgets for training, so they are not as knowledgeable.

The other problem that is happening, and we experience this in the rural communities, because of the problem of confidentiality, many people want to go to the large teaching hospitals in another part of the state for those services. So, what is happening is the social workers in those large teaching hospitals in major AIDS centers are becoming profoundly overburdened with the need for providing services for the individuals in those communities.

If they go across the state lines to try and qualify

someone for Medicaid is a nightmare, or get all of their needs met. Going back into their communities, contacting the normal resources, trying to get them to provide services, cajoling them to providing the support. They are very reluctant, and those providers in those communities continue to provide with that feeling, giving of the sense of response of social workers and say, well, it's very difficult to take this patient on, because I feel like you have so much more experience and I don't know what to do, and the underlying issues are also homophobia, which is very pervasive, and fear of AIDS.

Fear of AIDS, even in trained, knowledgeable social workers who have been working with patients for a long time, is still very high. It has to do not just with the actual fear of being involved with patients, but the issue of emotional drain and burnout, and we can't always do a good job. We go into the situation with our hands tied. We can't help this person, because the resources are not available. The minute your caseload has expanded by three or four or five, because you are also serving people in attachment areas that aren't yours, it becomes a nightmare, more so, I think, in the large centers than the rural communities.

DR. HELMS: The potential for education resources for social workers is, there again, in the teaching and education centers. For example, in our state, we are now working with the social worker at university hospitals who have been I think past president of the State Social Workers Association, Jay Ceynor, to set up a statewide program for training and education along those lines. To what other states within the education and training centers have reached out that way, I don't know, but the potential is there for such training.

CHAIRMAN OSBORN: Let me ask Charlie Konigsberg, briefly, if we can, and Jim Allen, as Director of the Program Office, who have some comments to make about this.

COMMISSIONER KONIGSBERG: The last point, Ron Jerrell and I called attention to the World AIDS Conference that was put on by the Office of World Health Policy, on Monday and Tuesday, which I think was really the first opportunity that probably a number of us have had to really start bringing out the special issues with regard to rural AIDS.

I think Ron's point about the real numbers out there is something that I have a notion of in Kansas, but I

don't have a handle on. It's extremely important, in terms of service delivery.

The last point, which is the Hope legislation, which a number of are already aware, adversely affects 37 states, including my own State of Kansas. I think it would be an extremely unfortunate piece of public policy, if this were allowed to go through. Perhaps if I were in an urban state or a high incidence state, I should say, I might feel differently, but we are not going to get a handle on the whole AIDS issue in rural states by moving backwards with parts of the CDC funding, so I am really glad that was brought out publicly.

DR. ALLEN: Let me just respond very quickly to that, because I think it's important to recognize that the Hope bill was passed and signed into law in November 1988, and that formula is mandated in that piece of legislation, so it is something that Congress has passed and CDC has been severely criticized by Congress for not having implemented it earlier.

To the extent that that formula is there and that it differs from what CDC has used in the past, the Congress is now considering the 1991 appropriations bill, and the

language that the Appropriations Committees put into the bill report will determine exactly how that is expended, so there is an opportunity to influence that.

Dr. Helms, I wanted to thank you, in particular, for your testimony. I wish we could have a book written by you that would expand on some of the educational needs. Could you just briefly, not necessarily from your personal perspective in Iowa with regard to the ETC's, but looking more broadly from your experience with the ETC's and the program, what changes would you recommend, what additional factors, other than more money, would you want to put out? Is this the best way for us to go, to try to educate the physicians, social workers and other health care providers, or could we be doing this more effectively?

DR. HELMS: You have put in a difficult position of making sure the grant comes through again. But let me comment on -- I have to flavor it with my own experience, as well, and I think you must recognize that my experience is from a rural state in connection with CDC, so I am not the major project director for my particular region. I know that those project directors meet and interact with HRSA people frequently, and information is passed back and forth.

I think that having regional centers in place is critical at this particular point in time. There is definitely a difference of opinion in varying parts of the country as to how effective their particular ETC is operating. There is no question that there has been some concern expressed at the AIDS Advisory Committee for HRSA about how effective certain of the training and education centers are.

I believe they become more and more important, as time goes on, and that they should be viewed as evolutionary in character, where it looks like the first effects of these ETC's are getting everybody up and off the ground, moving, educating the multiple health care providers in basic AIDS, and hopefully getting everybody speaking the language and interacting with one another.

In the long run, I believe that it has got to move more and more, in my estimation, toward a focused approach towards those individuals who are not only in the trenches, but those individuals who are particularly active in prevention and education.

The problem in rural Iowa is not going to be solved by shifting funds from a rural state to the urban centers, where, frankly, at this point in time it may be more needed.

The problem in rural areas is going to be one of continuous education, ongoing cajoling of physicians, to make sure they are aware of what is going on.

We have had interesting difficulty getting into some communities in Iowa to bring the word to them, and nothing turns a community off more than a group of propagandists coming in with information, so we have very patiently and slowly worked through the structure of the community to try to get them interested in the idea, to work through appropriate people to bring the information to them. That type of effort isn't going to be stopped over a two or three year period. That must continue, otherwise I think people just tend to slip back.

In the long run, to give you a bottom line, I think that we have got to focus in the future -- now, it may vary in time as to when centers should begin to focus, have their met their primary obligations of educating all of the health care providers or not, number one, then, number two, have they identified where the focusing might occur. I think in the long run, though, we might be thinking along those lines.

CHAIRMAN OSBORN: Thank you very, very much for this excellent testimony. We appreciate it.

I also again appreciate the patience of the last panel, Harvey Makadon, Rose Walton, and David Henderson. Thank you for joining us.

You have probably heard David and me both say, if you can give us the high points of your testimony and let us interact, we find that is a particularly rewarding opportunity for us.

Dr. Makadon, you are listed first. Welcome.

DR. MAKADON: Good afternoon. My name is Harvey Makadon. I am primary care physician at Beth Israel Hospital, in Boston, which is not unexposed to the New York franchise. We have integrated the care of HIV infection or general medicine group practice in our hospital where I work.

I have been involved in AIDS education for primary care physicians in my role as chair of the AIDS Task Force of the Society of General Internal Medicine and my work with the New England AIDS Education and Training Center.

I am pleased to be here to speak today, because of my concern that we can do far more in this area. Developments of the past year regarding early intervention against HIV infection and expanded access to clinical trials have provided us with concrete opportunities to advocate practicing

primary care physicians, to prepare them to care for people with HIV infection.

In order to realize these opportunities, we will need to develop a comprehensive educational strategy as a central piece of an overall strategy to improve access to care. And I think it's important to recognize that this strategy really must recognize the need for additional resources, as well as the need to better integrate traditional medical services with supportive community-based services.

I do want to comment briefly on these latter points. First, we need resources to provide care, if we are going to succeed in expanding access. I think there has been a tendency to attribute the paucity of physicians willing to see AIDS patients to their attitudes towards people with HIV. However, the explanation may lie more in the realities many physicians face carrying on their medical practices.

The Boston Aids Consortium has examined problems of access to care for people with AIDS in our neighborhood health centers. When we recently began meeting with the primary care physicians, nurses and social workers working in the centers, as opposed to the center administration, we found that there many providers eager to see people with AIDS

and to consider how to provide care in concert with treatment fore other problems, such as substance abuse. But this group is extremely frustrated by a state reimbursement system that does not recognize the cost of caring for AIDS patients, particularly in our neighborhood health centers. And I think Nick Rango's points about the need to develop an infrastructure based on reimbursement before we think access to care and education is extremely important.

The notion of the parallel track to expand access to clinical trials places the problem of need for resources in clear relief. We are faced with many creative new ideas on expanding access to drugs being tested in clinical trials, by allowing administration and primary care physicians' offices, on the one hand, yet we are not really talking about how we are going to pay and support primary care physicians for the time necessary to do that. And regardless of how many meetings I have been to with respect to parallel tack, that issue is never really discussed.

The second issue which affects our ability to expand access to care that is integrally related to education is the need for health professions to work on such efforts, along with community-based organizations. Community-based organiz-

ations have been leaders in developing support for many people with HIV infection. Often, this has occurred with little contribution from organized medical providers.

Yet, I have also been concerned that in too many conferences recently, new prospects for early intervention and treatment and involvement of physicians are referred to as the unfortunate medicalization of AIDS. To be honest, I am pleased that we can now talk about the medicalization of AIDS, particularly if it means that health professionals now have ways to effectively treat various manifestations of HIV infection.

It is extremely important at this point that traditional health professionals work together with those who have long been active in providing care in the community, so that we can all understand both the potential and the limitations of traditional medical care, as well as the potential to provide complimentary community-based services.

Turning now to the issue of developing educational strategies to meet the needs of primary care physicians, I believe it is fair to say that AIDS education is a paradigm for general medical education, and that if we seize the opportunity to develop a well thought-out program addressing

the needs of educational needs of those caring for people with AIDS and HIV infection, we will be making a wise investment in the general education of primary care physicians.

But AIDS raises many unique educational challenges, based not only on the professional attitudes towards people with HIV infection and concern about personal risk, but also on the rapid expansion of new basic scientific and clinical information about HIV and the concomitant expectation that this knowledge can and will be applied almost immediately in practice.

While we must continue to work with attitudinal issues, there is an urgent need to develop ways to synthesize new information and disseminate it to practicing physicians. It is interesting to think back over the past year and consider how primary care physicians were informed about various aspects of early intervention. Essentially, we watched events unfold in the newspaper.

In August, the New York Times was the source for important information concerning the 019 trial of asymptomatic individuals who summarized the data. The earliest syntheses for this information came from alternative journals and bulletins, such as Positive Directions and AIDS Treatment

News.

It wasn't until March that the National Institute of Allergy and Infectious Disease met to make some recommendations regarding early intervention. Their document, "AZT Therapy for Early HIV Infect," is extremely good and comprehensive. it incorporated educational materials and clinical algorithms for early intervention. It was distributed nationally to practicing physicians.

Unfortunately, there was no attempt to coordinate this distribution with other governmental programs or professional organizations, such as the AIDS Education and Training Centers. Such coordination could have led to a more productive use of this excellent material as part of an ongoing educational program, rather than distribution of the brochure to be a one-time event. I phoned last week to get copies of these materials for house staff, as it came into the hospital in July, and was told that they are currently out of print.

Finally, it was not until May 1990 that the early intervention trial results were finally published in the New England Journal of Medicine, which was the real first formal release of this information. I believe that, with the

combined efforts of agencies such as HRSA, the NIH, CDC, AIDS, CPR and other agencies of the Public Health Service working together with national professional organizations, we could be extremely effective in developing a dynamic approach to education around the care of people with AIDS and HIV that truly meets our needs.

I have recently been asked to chair an advisory panel for the Bureau of Health Professions on AIDS education for physicians. We have made recommendations for the Bureau's AIDS Education and Training Centers. While these recommendations are not yet finalized, I believe they represent a good beginning to developing such a policy. I would like to highlight these.

First, given the rapid expansion of scientific knowledge concerning care of people with HIV infection and the growth in diagnostic and therapeutic approaches to providing care, we feel that the Public Health Service should place emphasis on the developing of clinical algorithms to guide primary care physicians on basic are, and should develop mechanisms to disseminate these. These should include approaches to early intervention, but also should encompass evaluation of common clinical syndromes. In addition, we feel

that it is extremely important to develop the capability to rapidly disseminate state of the art information from clinical trials.

Currently, although the National ACTG has meetings to talk about recent information, advocates and researchers are invited, but as a primary care physician, we are really not allowed to go to those meetings, so it is very difficult to find out what is, in fact, happening during the state of current trials.

To avoid duplication of efforts by various agencies, we believe the Public Health Service should coordinate activities among its constituent agencies. To the greatest extent possible, professional organizations, such as the Society of General Internal Medicine, Teachers of Family medicine, the ACP, the AAFIP, should be involved in both the development and dissemination process. While general distribution of this level of information to all primary care providers is of utmost importance, we feel that special attention should be paid to primary care providers serving vulnerable and hard-to-access populations.

We are very concerned that the development and dissemination of state-of-the-art information is seen not as

an end, but as part of a dynamic process that would be built into regional and local educational activities with opportunities for ongoing discussion and follow-up.

A second major goal outlined by our advisory panel is the importance of facilitating links between primary care sites and tertiary care centers -- again, I think a theme that Nick Rango talked about -- in order to create opportunities for co-management people with HIV infection. These connections would enable primary care professionals to provide ongoing care and consultants to provide them backup and technical support.

We recognize that these would need to be both structural, as well as educational, but feel they are essential in order to involve more primary care providers, particularly regarding use of rapidly changing technologies, investigational agents, and the management of the multiple complications of HIV. We believe these links should mirror lines of consultation which primary care physicians generally follow, rather than set up new referral patterns.

Finally, we recognize that caring for AIDS patients is difficult, and while personally satisfying, can often seem less professionally less rewarding than other work. We feel

there should be specific recognition of AIDS efforts by creation of career development awards for generalists who wish to spend more time doing clinical research and teaching in AIDS.

Professional enhancement opportunities to promote higher levels of competence are integral to assuring adequate numbers of quality physicians throughout the country who can manage the full spectrum of HIV related illness. These fellowships or training awards would help build a positive image for individuals who make care of AIDS patients a major part of their professional lives. Award recipients would become role models for postgraduate trainees and medical students. Such training awards would also enable fellows to spend time working on AIDS education strategies or research in primary care, to enhance the supply of physicians and the care of patients with HIV.

In closing, I would like to reiterate my concern that we need national leadership in developing educational strategies, and that we can do much more with more focus and direction.

I appreciate the opportunity to be here today and hope your efforts will help all of us achieve our common

goals. Thank you.

CHAIRMAN OSBORN: Thank you.

I think we will hear from all three of you and then get a chance to interact, if that is all right, in whichever order seems more convenient.

DR. HENDERSON: Dr. Osborn, Commissioners, my name is David Henderson, and I am from the Clinical Center at the National Institutes of Health, and I am honored to have the opportunity to testify before this Commission, to discuss the issue of the risk for occupational infection with HIV in the health care setting.

What I would like to do in my few minutes before you this afternoon is to address three questions: First, what different types of data are available regarding the risk for occupational infection; secondly, what does each of these types of data tell us about this risk; and, finally, what do we know about the magnitude of risk for occupational infection in the health care setting.

To attempt to approximate numbers of occupational infections with respect to this issue, one can assess three quite different types of information: We can first talk about documented seroconversions, chosen to define a document

seroonversion as an instance in which a health care worker experiences an adverse exposure to blood or body fluids from an HIV infected patient in the health care setting, goes down to his employee health service, is documented to be HIV seronegative, and is followed over time, and then, in temporal association with his exposure, is found to be infected.

Documented seroconversions remain the goal standard against which other types of information about HIV infection in the health care setting are measures. Through July of 1990, 29 such cases have been reported in varying detail in the medical literature.

In addition, a small number of health care workers have been identified as prevalent seropositive, that is, they are not known to have been seronegative at the time when these events occurred. Some of the individuals recall an adverse exposure to blood or body fluids from someone known to be HIV infected, others do not.

The majority of these infections occurred prior to the availability of the HIV-1 serologic test, and were only identified as the tests became widely available. I am aware of 35 such cases that have either been reported in the

literature or reported to the Centers for Disease Control. The majority of these infections were detected as a result of the health care workers' voluntary participation in sero-prevalence studies. Such studies assess a defined population for a particular variable, in this instance, HIV infection, at a given time.

Several investigators have attempted to measure the prevalence of HIV infection in cohorts of health care workers, in an attempt to provide information about the occupational risks. In 13 prevalence studies conducted between 1985 and 1988, 6,619 health care workers were tested for serologic evidence of HIV infection. Of those 6,619, 21 or 0.32 percent, were found to be HIV infected. Of those 21 individuals, 12 acknowledge participation in community-based risk behaviors associated with increased risk for HIV infection. Of the remaining 9, 8 deny these community-based risk behaviors, 1 was reported anonymously.

National AIDS surveillance activities comprise the third major source of information about HIV infected health care workers. The Centers for Disease Control routinely receives and systematically tabulates data from standardized case reports for individuals meeting the surveillance defini-

tion criteria for AIDS in the United States. Patients are asked to provide their physicians with information about social and risk factors for HIV infection. The standard questionnaire also asks whether the patient has ever worked in a health care or clinical laboratory setting since 1978. Each case of AIDS is then classified into an exposure category which correlates with community-based risk behaviors. Approximately 95 percent of cases reported to the CDC can be so classified into one of those traditional transmission categories.

Since 1981, 4,802 health care workers with AIDS have been reported to the CDC. The majority of these, that is, 89.6 percent, were classified into one of the traditional transmission categories, as well, on the initial case report form. Only 463 of the 4,802 health care workers with AIDS were initially reported as having no identified community-based risk behaviors.

For these 463 individuals, information is still incomplete for 191 of them, and the majority are still under investigation by the Centers for Disease Control. Some of these individuals died before an investigation could be conducted, some refused to be interviewed, others have been

lost to follow-up. I will refer to these 191 cases as no identified risk information, incomplete. Because of the extremely limited information about these case, I think we can't draw any conclusions about the source of their infection.

Of the 272 remaining health care workers whose cases have been further classified or further investigated, 204 or 75 percent of those have been reclassified into one of the traditional transmission categories, leaving only 68 health care workers in the no identified risk investigation completed category. Two of these are health care workers who seraconverted and then developed AIDS that I described earlier and, thus, I won't talk about them in any more detail. Combining the 68 cases with the 191 cases for whom the investigation is incomplete leaves us, then, with a total of 259 cases in the CDC no identified risk category.

An analysis of the demographic characteristics of the 66 health care workers who have AIDS in the no identified risk investigation completed category, supports the contention that confounding non-occupational risks are present in this population, as well. The demographic data from these 66 cases are more similar to the demographics of the total

population with AIDS in the U.S. than they are to the total population of U.S. health care workers.

For example, 71 percent of the 66 health care workers in the NIR category are men. Conversely, the U.S. health care workforce is primarily female, with approximately 77 percent of all U.S. health care providers being women. These data suggest that non-occupational behaviors may be important components of the transmission of HIV infection in the sub-population of health care workers.

Based on these demographics, the likelihood is extraordinarily high that, while some of these health care workers probably did acquire occupational infections, non-occupational risks are highly prevalent in this population, as well.

In the community, HIV infection is primarily a sexually transmitted disease, but can also be spread by direct inoculation, such as might occur as a result of sharing needles in the process of intravenous substance use, or through receipt of transfusion of blood or blood products that are contaminated with HIV.

In the health care setting, the major risk for transmission is associated with percutaneous exposure to

blood or blood-containing body fluids contaminated with HIV-1. Although other types of exposures may be occasionally responsible for occupational infections, the relative risks for transmission by these routes is likely to be substantially smaller than for percutaneous exposures.

HIV-1 has been cultured from blood, semen, tears, saliva, vaginal secretions, breast milk, spinal fluid, urine, alveolar fluid, and synovial fluid. Further, it seems entirely plausible that careful study of other body fluids will eventually yield HIV-1 in culture.

In the community,however, transmission of HIV-1 has been associated with blood, semen, vaginal secretions, and, to a lesser extent, breast milk. In the health care setting, almost all of the cases of occupational infection with HIV-1 have been associated with exposure to blood.

Three instances of occupational infections have been associated with something other than blood. In two of these instances, scientific laboratory workers were exposed to culture fluid containing quantities of HIV-1 far in excess of what would be encountered in a clinical setting.

In the third instance, a clinical health care worker sustained a needlestick injury contaminated with

bloody pleural fluid from a patient who had AIDS. Thus, the major risk for infection in the hospital is through percutaneous exposure to blood from an HIV-1 infected patient. Although other routes of transmission may rarely be involved, the risk for occupational infection associated with these other routes of exposures is so small that we cannot yet measure it.

Let's turn now to the issue of magnitude of risk for occupational infection. The information that we have just gone through, that is, the number of cases that are out there, really tells us that occupational infection can occur. These case reports, however, give us no insight into the magnitude of risk associated with a single occupational exposure.

If one combines the data from published perspective studies, 1,905 health care workers have reported a total of 2,008 parenteral exposures to blood of blood-containing body fluids from patients known to be infected with HIV-1. Assuming that each exposure is associated with equivalent risk, an unlikely but I think fair assumption at this stage of the game, a single exposure is associated with the risk of .3 percent, that is, there were 6 infections associated with

these 2,008 occupational exposures, with 95 percent confidence intervals between .13 percent and .70 percent.

Twelve of these longitudinal studies are also evaluating the risk for transmission associated with mucous membrane exposures. No infections have been documented following more than 1,000 such exposures in any of these studies, with the upper bound of the 95 percent confidence interval, falling at about .3 percent per exposure, but the actual risk is likely to be much smaller. Risks associated with other types of occupational exposure, for example, getting blood on intact skin, exposure to body fluids other than blood, are too small to be estimated currently.

It is important to emphasize that risks of similar magnitude have long been present and continue to be prevalent in the health care setting. For a blood-borne infectious disease, the risk for HIV-1 transmission following an occupational percutaneous exposure is relatively small.

For example, the risk for transmission of HIV-1 following a percutaneous injury is approximately .30 percent, while the risk for infection with hepatitis B virus following a similar injury from a patient known to be infectious for hepatitis B, has been estimated to be between 27 and 43

percent.

Despite the availability of a safe and effective vaccine, the Centers for Disease Control estimates that approximately 12,000 new aces of occupationally associated hepatitis B infection occur annually, and, as many of you are aware, the Occupational Safety and Health Administration estimates that approximately 200 American health care workers die annually of occupationally acquired hepatitis B. Perhaps most tragically, OSHA also estimates that only 30 to 40 percent of the at-risk health care worker population have received the hepatitis B vaccine.

Although the risk for occupational HIV-1 infection is by no means trivial, the magnitude of risk is consonant with other risks that have long been present in the health care setting. Keeping these data in perspective may make it easier for health care providers to give us the support and care for all HIV-1 infected individuals that we will need as our country faces the gale force of this epidemic in the 1990's and beyond.

Thank you.

CHAIRMAN OSBORN: Thank you very much, Dr. Henderson. I particularly like to follow the statistic you just

gave of 200 instances of hepatitis B associated occupational with the 1987 total of about 400 occupationally associated deaths among health care workers, 200-plus hepatitis B, 19 associated with electrocution and none having anything to do with HIV. I think that's a very helpful bit of perspective to keep in mind, as we deal with the fear that has mushroomed over this.

Dr. Walton?

DR. WALTON: Thank you for inviting me to speak today. I come from Long Island, which is the suburb with the greatest number of cases in the United States, and it is indeed suburban and rural.

I commend the Commission for your work and look to you for leadership and encourage you to continue to pressure the government for proper response to the epidemic of HIV and AIDS. I am honored to join this distinguished panel to discuss health care recruitment, retention and educational concerns for allied health professionals.

As my testimony describes, there is much concern and confusion about who those people are. They are indeed those careers in the health field providing services in health promotion, disease prevention, diagnosis and treatment,

restoration of optimal physical, emotional and psychological help. They have specialized educational programs of a minimum of 2 years beyond secondary level, and they are certified and have a definite scope of practice.

The best guesstimate of numbers of allied health personnel in the health workforce today range from 800,000 to 5 million. That represents about one- to two-thirds of the health workforce. Perhaps the numbers are not as important as the realization that this category of health providers is extraordinarily significant to the delivery of health care in the United States and, therefore, has a definite impact on the delivery of care for people affected by HIV.

Imagine, if you could, what would happen in the next 3 days if all allied health professionals chose to take a vacation day or called in sick. Who would in those 3 days draw blood for HIV antibody tests or blood or serum tests for other reasons? Who would process those tests? Who would perform the respiratory function tests and provide respiratory therapy for patients with PCP? Who would develop nutritional therapy for the HIV infected patients with wasting syndrome or chronic diarrhea? Who would provide physical therapy for patients with peripheral neuropathy? Who would conduct

intake histories and physical or arrange case management for patients ready to leave an acute care facility?

I believe that the chart in my testimony graphically illustrates why some researchers say that the nursing shortage is but the tip of the iceberg, and we have heard today, or at least since I have been here, much discussion about physicians and nurses, and no one yet has mentioned allied health professionals, but the allied health profession shortage is going to be greater. Many factors influences these shortages, and there is no data to suggest that the phenomena of HIV infection has any effect on the shortage in health care, at least not documented.

We do have studies, however, that suggest that health care workers may elect not to care for people with HIV, if they have a choice. Negative attitudes exist by health care workers. There are a few studies that report about attitudes of health care workers, and many of those are negative about people affected by HIV.

Those negative attitudes expressed by health care workers toward people with AIDS seem to center around homophobia and racism, in other words, attitudes of otherness, and, of course, the feelings of fear are real in every

category of health profession. Those feelings and attitudes cannot be addressed, in my opinion, through lectured discussion types of education. Educational programs must engage the learner. It is difficult in health profession education, which is built on the medical model of old, most times, to use learner-centered participatory experiential strategies. We need, as educators -- and I take some of that responsibility -- to take a little previous time to document the difference we believe that we make with these strategies.

At the AIDS Education and Resource Center at the University at Stony Brook, which I direct, we use these principles of adult learning in our programs, that is with rare exception. Our Train the Trainer Program shows the most positive results. After participation in the program, health care providers reported to us that they felt better equipped to provide care, better equipped to be sensitive to the needs of people, better equipped to provide psychological support for their coworkers and to implement programs of education for other health care workers in their institutions.

Analysis also revealed decreases in the fear of HIV infection, in the belief in the need for mandatory testing, and in negative attitudes toward gay men and negative

attitudes toward IV drug users.

And so if the epidemic of HIV and AIDS has anything to do with the shortages that will exist, we not only need more definite studies to determine the effect, but we need educational programs for all health professionals, to reduce the fear and to improve the quantity and quality of care provided for people affected by HIV. That care ought to be delivered in the on-judgmental atmosphere.

It is my firm belief that education makes the difference. If the epidemics of HIV and AIDS have any effect on recruitment and retention, we must provide effective education to meet that need. So, in summary, I would highlight the following concerns to you to consider in your deliberations and in making your recommendations about programs for HIV services and education for allied health professionals and the services they deliver.

Allied health professionals can and do make a significant contribution in research, in care and treatment, in service, and in education for people affected by HIV and AIDS. There is clear evidence that many of the 85 professions -- and the definitions in my testimony describe more clearly who they are -- are experiencing shortages in person power

and will continue to do so through the year 2000.

We do not have clear evidence that the effect of HIV and AIDS on those shortages. Therefore, research initiatives should be developed to determine the influence on recruitment and retention. The American Society of Allied Health Professions, based here in Washington, might be an appropriate institutional sponsor for such an effort.

Requests for proposals from governmental agencies for HIV and AIDS research initiatives, for service and care and treatment demonstrations, and for educational efforts must be written to include allied health professionals as full and equal partners on the team. Educational programs for health care providers must recognize allied health professionals as important members of the team. These professions should not be categorized as "others" following physicians, dentists and nurses.

I believe that all the Regional AIDS Education and Training Centers established by the Health Resource and Service Administration are including some education for allied health professionals, but they are strongly encouraged to focus those programs toward physicians. The Federal support for educational efforts provided through the Bureau

of Health Professions must be more equitable.

I do not believe that medicine, dentistry and public health deserve 320 times the amount given for all 85 professions in the allied health fields. More equitable support will assist schools in the recruitment and retention of allied health professionals, and provide for continuing education to retain and update practicing professionals. It would also provide monies for research initiatives which will allied health professionals to document their contribution in the health care arena.

This epidemic knows no boundaries. Our fears and judgment and latitudes cannot create boundaries to protect us. For communities which have not yet experienced the overwhelming numbers of cases of HIV infection, the effective use of time to plan is of utmost importance. We can learn from those who have faced the onslaught of the epidemic in the early days and set our agendas in proper priority.

Those agendas must include the provision for care of our under-served fellow citizens, whose voice is seldom heard and who, even before AIDS, appeared and had the least access to care and the least amount to help profession education.

The allied health professions hold the potential for being a major resource in the Nation's response to this burgeoning need for HIV and AIDS care.

Thank you.

CHAIRMAN OSBORN: Thank you. That is a superb statement. I thank all of you, really.

We will now take some questions. Charlie?

COMMISSIONER KONIGSBERG: I would like to talk with Dr. Henderson just for a second. I wish we had more time to spend on the occupational risk. I know you had to hurry through that very excellent testimony, but I would certainly urge the Commissioners to read it, and I think Dr. Osborn's points were really hitting home there.

You may recall, David, that I called you several months ago about a situation. I want to bring it up as illustrative and try to gloss over names and places, so we can protect the innocent or the not so innocent.

I was made aware of a situation in a large urban area in my state some time ago about a need for approval for the rapid latex test, our state health agency being the ones who would approve that. The reason for this was that they wanted to use in emergency room in trauma cases in relation

to -- we weren't sure what, but certain kind of clinical decisions. It is likely that that test will be approved, because it had already been approved by the FDA.

So, I am wondering if you could comment on that type of issue, in light of your testimony, and discuss just a little bit the current protocols that are used in the whole issue of early AZT treatment for health care workers who feel they may have been exposed.

DR. HENDERSON: I was absolutely certain that you would ask me about that, Dr. Konigsberg, because it is a question for which there is currently still no answer, and, unfortunately, it is one of the scientific issues that I think we are not likely to resolve, that is, is azidothymidine effective as a post-exposure chemo prophylaxis.

We have placed ourselves in a position at the Clinical Center of offering the drug to health care workers who have occupational exposures, if they wish to take it. We do not make that recommendation or recommend that they take it, simply because the data just don't exist to make the recommendation.

The use of the latex test, as I recall in our conversation on the telephone, in that setting was to try to

find out very quickly whether the source of an exposure was HIV infected or not. We have chosen not to take that approach. Our approach is, rather, to say to the health care worker, if you want to take the drug, we will go through our usual pathways, given our usual high-quality serology, if you want to take the drug, take the first dose now and then we will sort out the serologies in the next day or so. The health care worker then goes on to take the drug for a day or two, until w find out whether the person was, in fact, the source of an occupational exposure to HIV.

Other places have taken different approaches. I am very comfortable with the approach we are taking currently, and I think that, as more data becomes available, we may lose AZT by default. There are now two reports of failures with AZT. One of them is not the best -- neither of them, actually, is the best case, that is, one is a direct intravenous injection, the other the drug was not given until 4 hours after the exposure. If we eventually lose it in that way, I hope that the network we have established in the process will allow us to study other drugs as they become available, for the possibility of finding effective post-exposure chemo prophylaxis.

CHAIRMAN OSBORN: Belinda and then Harlon.

COMMISSIONER MASON: Dr. Walton, until today, this is the honest truth, I always thought Allied Health had something to do with occupational safety or chemicals or -- what is that stuff now that they find now in old buildings, asbestos or something. You know, I suspect that is not an unfairly well read carcinogen and I suspect that is really not uncommon. So, it seems to me that you have got to have a major marketing job.

[Laughter.]

It seems to me, from what you said, that in some ways you all are just sort of the true workhorses of the situation. You know, at least from me, I am certainly more aware of what you are and your value. I think you are so important and we have to take care of you.

I like to hear stuff like what Dr. Henderson said. I appreciated that. That is always good ammunition for people like June and I. We are trying to go out and convert behavior.

Dr. Makadon, I hope you won't think I am being factitious, but I missed what you said at the very beginning. I suspect it was some sort of inside northeastern -- and I

like about your --

DR. MAKADON: People always think I am from New York City, because I work at Beth Israel Hospital. There is another hospital in New York with the same name, so I just wanted to be clear that I was from Boston, and not New York City, that is all.

[Laughter.]

CHAIRMAN OSBORN: You're right, it's a northeastern joke.

Harlon?

COMMISSIONER DALTON: Belinda, when she uses inside hill-billy Kentucky humor, she never bothers to translate it for us. That is part of the test, I think.

I, too, want to thank Dr. Walton. Belinda and I were actually sitting here asking each other what is Allied Health, and I was looking at those definitions which are not evident, but I actually started to listen to you, rather than try to think of the definition, and you so wonderfully, skillfully talked about what would happen if allied health workers sort of disappeared or everyone got sick one day, and you really got the point across about what this collection of several, 85 or whatever, professions, so I too have been

educated today.

I wanted to ask you, though, in your testimony, written as well as your oral testimony, you talk about how homophobia and racism prove to be barriers to the willingness or state of willingness of allied health professionals, as well as others, to work in the area of AIDS. But then you said something in your written testimony, you said it wonderfully well, basically, you prefer this weren't so, but it is a challenge to do something about it.

I must say, there are many times when people identify these particular problems, but then sort of go on to the next point. You talk a little bit about how it's not possible to do didactic lecturing to people about these phenomenon and that you much prefer learning in participatory education. I guess I want to know if you will just give us a little sense of how that operates, with respect specifically to thinks like homophobia.

DR. WALTON: I have never believed -- and I have been in education about 30 years -- that you could walk in and tell people what to do. I have never described myself as what I used to call the Bible supplement teacher, but, rather, I want to facilitate learning and, therefore, I want to walk

in and challenge that student.

One of the things, for example, that we do, we know that confidentiality issues are a big thing in health care provisions today, and in the Train a Trainer Program, for example, I can describe one day that we walked in and said, well, today we have a question or a statement that we want all of you to respond to, the people who really strongly agree with this statement, go to this corner, the people who strongly disagree go over here, and the people who sort of agree go here, and there are no neutral places, you must take a corner.

The statement that we gave them was "I have the right to know the HIV status of my patient." The discussion that followed that movement of the room was absolutely fantastic that day, because there were indeed three or four people who really strongly agreed that they had the right to know, and there were about 10 who disagreed vehemently that they should not. Yet, there was a kind of respect for both these positions that was created by the discussion.

I think that only by involving that kind of participation to make people aware of what they think and what they are really feeling, and, of course, you can do that

once in a while. I joke about physician education being didactic and going and tell, but once in a while when you get physicians behind closed doors and you tell them it's okay to say what they think, they even respond to that kind of education, but we don't get that opportunity very often, I must admit. But that is the kind of education I am talking about.

CHAIRMAN OSBORN: Dr. Allen.

DR. ALLEN: I would like to thank you all for what I think is very rich testimony. I am sorry that we are running an hour and a half behind and don't have time to extend our discussion.

Your last comment, Dr. Walton, raised sort of an extra question to which I want a very brief answer. Did you ask the question in reverse: Do you believe that your patients have the right to know your HIV status?

DR. WALTON: We have done that on occasion, but not that day, but we have indeed raised that similar question. In fact, that's the kind of issue and discussion that allows them to understand why their need to know is not the same.

DR. ALLEN: It seems to me that question is one that is going to need a lot more discussion in the time ahead.

My main question I want to direct to Dr. Henderson. You have worked, along with colleagues around the country, with assessing the risk of HIV infection in health care workers for years. We have heard others give testimony today about the concern of operating room nurses, whether real or perceived, that they were at risk for HIV and that's the reason that there is currently a dearth of operating room nurses.

Have you, in any of the work that you have done, or are you aware of others who have taken on concerted efforts to try to change the attitudes and beliefs of physicians and have been successful in doing so, or what do you think we ought to be doing in this area nationally?

DR. HENDERSON: Absolutely, Jim, I think that all of us have taken that on in a variety of different ways, I think most effectively when it's interactive, and my favorite way of dealing with this topic is to start by asking an audience, if you stuck yourself with a needle that has been used on someone who is HIV infected, what do you think your chances are of getting infected. In variably, even in great places, the assessment is a log higher and sometimes two logs higher, if it could be, than you would find if you studied

the issue.

I think that there are several problems out there. One is that our teaching doesn't stick. I continually go around the Clinical Center telling the same people the same thing over and over and over again, as each new piece of information is uncovered. I think, in part, that is because they read the numerators for these fractions in the lay press and the numerator is presented in such a way that you never see the denominator, and so if a health care worker gets blood on his or her hands and gets infected -- which surely will happen if we wait long enough, if you study anything long enough, you will find one -- the denominator of a zillion exposures is not presented in the paper, and then health care workers are galvanized to think that, oh, my god, I had blood on my hand eight times last year, and so on.

So, I think that the medical community and the lay press, if you will, are at cross purposes. We are educating them and they are uneducating them at about the same rate. I think all of us have the feeling, anyone working in the trenches, that there isn't enough solid information about any given topic, and so there is always scientific question. Some things, the way science perceives, is you define 70 or

80 percent of something, and then somebody works on the rest of the 20 percent and defines 60 percent of that, and as those things are unwound, sometimes they look like they are opposites, when in point of fact they are really not, if you are looking at the data, but people are confused by that general approach.

I don't know any obvious suggestion to try to convince people or to systematically convert people, as Ms. Mason suggested, but I think that we have to stay after it. I think that persistence in this business is helpful, and as I have gone around, and I know that David Bell from CDC and Julie Gerber from San Francisco General have been very effective in dealing with health care providers, and at least if not putting the fire out, getting it down to a manageable level, such that routine business can take place.

CHAIRMAN OSBORN: And an enormous service it is, too.

Eunice?

COMMISSIONER DIAZ: Dr. Walton, I am going to ask you this today, because I will not be here tomorrow. Coming from a history of having been in the allied health profession for over 10 years in the field of physical therapy, I am

impressed that you have stated that this represents the allied health field over 85 different groups.

I am concerned that, with the scarcity of training monies, this may not be enough resources, economic and otherwise, to train all of those individuals right now in the kind of mass numbers that we need in HIV care, and I am wondering what your thoughts are about really the implementation of team training within the AIDS ETC mechanism which would really facilitate a large number of those people seeing their role in a broader perspective of team practice, rather than physical therapists learning what there is to know about AIDS, or respiratory therapists learning everything about the world out there, if you could just give your thoughts on that.

DR. WALTON: Well, I believe that one of the thing -- and certainly, Ms. Mason mentioned the difficulty with our diversity and also allied health's difficulty in understanding is unity, its need to be together.

I represent a subcontract with the New York ETC, and we do training, as I know that all other ETC's do, with multi-disciplinary groups, and so it's not a case of a need to go in and educate physical therapists as such, but, rather, this overlay of HIV-AIDS information can be given to

a multi-disciplinary group probably much more efficiently and effectively than it could be if it were profession-specific. It is being done, we just need to equalize the monies available to do that.

CHAIRMAN OSBORN: I want to thank you very much for your excellent testimony. Just to reassure -- I am sure Dr. Walton knows this -- to reassure some of my fellow Commissioners, a very anecdote.

I was on a group for the two family trusts that was to look at the future of health professions, and I always referred to it as my "Noah's Ark Committee," because there were two of each kind of dean, I being on of the public health deans, there were two of us, and then two medical school deans, and so forth, and there were two allied health professions deans, so they are not under-counted in some circles.

[Laughter.]

We will now recess for an hour. Thank you very, very much.

[Whereupon, at 2:04 p.m., the Commission was in recess, to reconvene at 3:05 p.m., the same day.]

AFTERNOON SESSION

[3:40 p.m.]

DR. ROGERS [presiding]: Our overworked Chairman has suggested I might try this particular exercise.

What we want to end up the afternoon with is a work plan, or Diane will kill me.

COMMISSIONER AHRENS: You see I am sitting on his right.

[Laughter.]

COMMISSIONER ROGERS: You have before you, though I will read it to you, a Commission statement that Harlon and I put together, but it's got a few errors in it and I will try it again in a moment for you. Let me first give you my suggestion on how we might proceed, and let's take a little time with this to see if it's something you would buy.

If you have it before you, you have the areas of interest statement that we spent quite a bit of time putting together, but in no necessary priority or order. It's the B section of the A, B C, in terms of areas of interest.

Here is my suggestion, if you think it would work, and if you feel comfortable, it would run as follows:

First, after we have done the mission statement

thing that I ask each of you to go through, taking the big dots, just the big dots under B, and you will rank them in terms of they are of high interest to you, they are of medium interest to you, or they are of low interest -- let me say of interest and importance to the Commission, from whatever point of view you want to come at. That's one rank you give them.

You give them a second rank, which involves some of the things we discussed yesterday, which is an A, a B, or a C, and I will go back through it, if you think it would work. An A would mean full Commission attention, if it was something that required some action of all of us, and that might involve site visits, it might involve a meeting, it might involve a hearing, it is whole Commission attention.

A B is a staff report, if you feel staff could put together something, with whatever kind of help they decided is needed, to inform us about an issue; and C would be farm out to an outside group of experts.

What we would then end up would be each of you would have ranked a 1 A, B, C, 2 A, B, C, 3 A, B C. We would then collect those, give you all a break, and we would put up on the board, really -- I am trying kind of a modified delphi

thing. Everybody ranks something as a 1, it would come out 1. Obviously, it would come out between 1 and 3. It would come out as an A, B, or C, which I think we would rank the same way.

COMMISSIONER KONIGSBERG: Is high one?

COMMISSIONER ROGERS: Yes -- well, we will go back through it. Let me just try the system out and then we will worry about how we do it.

COMMISSIONER KONIGSBERG: David, one thing that will bias this a little bit is that some of these things have already been dealt with.

COMMISSIONER ROGERS: I was going to point out that you're going to rank some -- I would suggest two things: One, if I had my way, I would say you cannot rank more than 5 as a 1, at the maximum. I would prefer to make it 4, but let's say 5, because we've only got about six sessions and we've got to be selective.

COMMISSIONER DIAZ: But does that devoid already committed? For example, suppose prison was one, we don't mark it, because we are going in a few weeks, so do you see what I am saying?

COMMISSIONER ROGERS: I do.

COMMISSIONER DIAZ: Homeless, there's no use marking 1, because we have dealt --

COMMISSIONER ROGERS: Because we are already going.

COMMISSIONER DIAZ: Yes.

COMMISSIONER ROGERS: I would say we are ranking to develop a work plan that is not already on the scene --

COMMISSIONER DIAZ: On the schedule.

COMMISSIONER ROGERS: -- that is not already scheduled.

COMMISSIONER DIAZ: Okay.

COMMISSIONER ROGERS: Consequently, things you feel we have already covered or things that you feel are already on the agenda.

COMMISSIONER KONIGSBERG: We should do what with things already covered or already --

COMMISSIONER ROGERS: Ignore them.

MS. DIAS: Ignore them. Skip them.

COMMISSIONER KONIGSBERG: It might be useful, David, if we went through and agreed as to what has been taken are of.

COMMISSIONER ROGERS: All right. Fine.

COMMISSIONER KONIGSBERG: I have a question about

the working groups.

COMMISSIONER ROGERS: All right.

COMMISSIONER KONIGSBERG: Is that an A or a B, or where is that?

COMMISSIONER ROGERS: I really need a D.

COMMISSIONER KONIGSBERG: It probably needs to be a B, in between.

COMMISSIONER ROGERS: All right.

COMMISSIONER KONIGSBERG: And then B to C and C to D.

COMMISSIONER ROGERS: Okay. In a moment we will put these down, but we need the options of full Commission, a working group, a staff report, or an outside group of experts who bring something to it.

COMMISSIONER KONIGSBERG: Now, in each and every case, whether or not we are talking about a -- even in the options of farming it out or a staff report, ultimately, if any recommendations are mae, the full Commission will have to review those recommendations, so we are not talking about abdicating responsibility for decision-making. We are just talking about the manner of fact-finding, in effect.

COMMISSIONER ROGERS: That's right, what's the work

plan, so that over the next five sessions, one might be a staff report on Area X or whatever, but we would limit the number of things that we tried to do. As I would say, you could only rank 5 as a 1.

COMMISSIONER MASON: Dave, I'm sorry, but I don't get the 1 and the -- I don't get about that. Now, where does the 1 and 2 and 3 go?

COMMISSIONER KESSLER: You need to put a 1 beside the --

CHAIRMAN OSBORN: Instead of H and L, it should be 1, 2 and 3.

COMMISSIONER ROGERS: Why don't we start a new sheet?

COMMISSIONER KONIGSBERG: Okay. Put a D or put a B?

COMMISSIONER MASON: If you want staff, do you put C or is it a B?

CHAIRMAN OSBORN: No, no, no.

COMMISSIONER ROGERS: B, it's a working group.

COMMISSIONER KONIGSBERG: Right, that's it.

COMMISSIONER MASON: But I didn't understand what we were supposed to do with the 1, 2 and 3 on this page.

COMMISSIONER ROGERS: You're going to put two

things next to them.

Let me try it gain. What I am suggesting is that, before we have -- Charlie, perhaps your discussion we need to move through first, which is have we covered or have we not covered, so we eliminate some, and then with what is left, we say this is of high importance to me, medium importance to me, or I don't care, but I don't think the Commission should deal with it. You are limited in the number of one's you can put, because we have got a limited amount of time.

We would then say here's the way -- let me add one other thing to confuse you completely. If you say it is no importance, as you know, we can decide how to go about, it's your high importance and medium importance. You say here is how I would like to deal with it, I'd like to deal with the full Commission, whatever we then discuss and decide, I'd like to deal with it with a working group of the Commission, I would like it to be a staff generated report to the Commission, we then decide how we are going to deal with it, or it is farmed out to a group of outside experts.

COMMISSIONER KONIGSBERG: I guess I don't read low as being of no importance, number one. Number two, just because I rank something low, somebody else may rank it high,

so I personally would like to put on there, if it was done, it ought to be full Commission, working group, staff of farm out, and probably staff is what would go on a lot of low things.

COMMISSIONER ROGERS: Fine. Fine. Okay. So, you will rank A, B, C, D for every single one of them.

COMMISSIONER DIAZ: Except the ones we've done.

COMMISSIONER ROGERS: We will all do that first and we will all agree on which ones we have done. Have I got you completely confused?

COMMISSIONER ALLEN: Shall I confuse you more? What about adding items?

COMMISSIONER ROGERS: Of course, and Don makes the point that we ought to have the opportunity we've had, what, six more months of adding items to the list.

COMMISSIONER ALLEN: Do you want the rank on the dominants only?

COMMISSIONER ROGERS: Yes.

COMMISSIONER ALLEN: Or do you want also the --

COMMISSIONER ROGERS: Yes. As I looked through this, for example, the effect of the HIV epidemic on various communities, we have to deal with all of those, and I would

guess that if that's a 1, it shouldn't be 1 on hemophiliacs, it ought to be a 1 on -- we are documenting all of them.

COMMISSIONER AHRENS: We are going to now decide which ones to --

COMMISSIONER ROGERS: Now my suggestion would be that do what Charlie suggested and we come through and say have we covered that or have we not, or is it planned to cover it. Maureen, we will need your input here, too, in terms of is that something that's on our agenda that is being done.

COMMISSIONER ALLEN: Would you limit that to the number of one?

COMMISSIONER ROGERS: I've limited the numbers of 1 to 5. Would anybody like to comment on it? I did that, because I haven't got enough sessions to --

COMMISSIONER GOLDMAN: Well, the number of sessions ought not to be the limiting factor, because it could be a 1, but it is something that ought to be done by outside experts, which does not necessarily that it would be a staff report.

COMMISSIONER DALTON: Can we just say that that is what the general norm is, if somebody wants to go -- nobody is going to break your arm, if you --

COMMISSIONER ALLEN: It is going to be difficult to get good discrimination, Harlon, if you go much beyond that.

COMMISSIONER DALTON: Yes.

COMMISSIONER ROGERS: That was my feeling, was to try and discriminate, but I thought people ought to be able to say here are the five things. It seems to me that we already agreed, as a group, that at the end of 18 months wee are not going to -- we do not wish a report that has 50 things, we want to punch hard on five or six or three, or what have you, so that was my reason for limiting it, and also Jim's reason, which was I thought, in terms of getting some sort of spread, that we would then look at and we will say here is what we did collectively, here were the top five, either the top five for all -- obviously, there won't be, but can we reach some agreement on that and can we reach some agreement on how we will go, and then we will say, staff, take this and give us that working plan for the next 14 months.

COMMISSIONER ALLEN: You're actually going to come up with 10.

COMMISSIONER ROGERS: Yes.

COMMISSIONER ALLEN: I would think so, just about

that.

COMMISSIONER ROGERS: Diane, does that have your approval?

COMMISSIONER AHRENS: Admittedly.

COMMISSIONER ROGERS: All right. First, let's come through the areas of concern and decide whether it's something we have or that it remains here, or we've already covered it.

COMMISSIONER AHRENS: Wonderful.

COMMISSIONER ROGERS: Okay. Financing of care.

COMMISSIONER AHRENS: No.

COMMISSIONER ROGERS: I agree, we have not. Structural, bureaucratic areas in current system to accessing already available funds, accessibility to people with HIV -- well, it's entitlement programs, it access to care.

COMMISSIONER AHRENS: I think that would be covered in financing.

COMMISSIONER ROGERS: They're not covered.

COMMISSIONER KONIGSBERG: There are some things, David, that probably can be consolidated in this --

COMMISSIONER ROGERS: Yes.

COMMISSIONER KONIGSBERG: -- but I assume that could be done later.

COMMISSIONER ROGERS: That would be my feeling, that we use what we've got here, because we spent a fair amount of time just putting the laundry list together, and then we ask staff to -- well, we will decide as we come through whether we can group some.

COMMISSIONER KONIGSBERG: Right.

COMMISSIONER ROGERS: Service delivery, a continuum of care, including health, social and psychosocial services and housing.

DR. ALLEN: Some of what the working group is doing, I don't know if it's all what the working group is doing, but we are looking at continuum of care and service delivery issues.

COMMISSIONER ROGERS: My reaction is this we have covered. We have not put together everything we want to say about it, but in terms of our hearings, in terms of that we have covered, but others may disagree. So, is that --

COMMISSIONER ALLEN: In point of clarification, that is what we are doing in the working group, so we are in the midst of covering it, not --

CHAIRMAN OSBORN: -- could we pull housing out as a separate thing? It is probably something that could lend

itself to a staff report or something, but it hasn't been covered in the same way that other things have, and the rest of it looks quite familiar, other than this, and the homeless, which is the far end of the --

COMMISSIONER ROGERS: What's your pleasure?

CHAIRMAN OSBORN: Eunice says it is going to be done in Seattle.

COMMISSIONER ALLEN: I think that we directed the staff to do that, but if you're talking about housing plus the site visit in New York with the homeless issue is completely different -- not completely, but that you may want to say it's covered under the New York visit, if you think it was covered enough, or the homeless issue, housing. But we were going to plan on touching upon that -- I don't know how in-depth we could get with it.

COMMISSIONER ROGERS: Do we hear it --

CHAIRMAN OSBORN: Why don't we circle that, rather than putting it into this system, just circle --

COMMISSIONER ROGERS: Circle it and come back.

CHAIRMAN OSBORN: It's an area that we may not be able to completely finish with what we have done so far.

COMMISSIONER ROGERS: Substance use.

COMMISSIONER DALTON: That's ambiguous. I don't really think we have covered that. We should hear from Don, but I don't feel that we --

COMMISSIONER GOLDMAN: We certainly touched on it, and we are going to have to touch on it again. I don't think we have covered it sufficiently to say that it's done.

COMMISSIONER ROGERS: Leave it as is.

Prevention and education strategies.

COMMISSIONER KONIGSBERG: That's part of what's planned for September.

CHAIRMAN OSBORN: And it was part of it in Dallas.

COMMISSIONER KONIGSBERG: Whether that's enough or not, I don't know.

COMMISSIONER GOLDMAN: Are we going to be dealing in September with the education strategies and are we going to be dealing with recalcitrant individuals and --

COMMISSIONER KONIGSBERG: In the discussions that I have had with Jane, we had talked about getting the behavioral aspects as part of that session. We had not talked about recalcitrant. It was probably sort of a -- I'm not sure how major an issue that is for this Commission to deal with, quite honestly. We are sort of passive, leaving it alone.

COMMISSIONER DALTON: We can scratch it, but I would like to at least registration on the record my objection to the use of the term recalcitrant, but scratch the issue.

COMMISSIONER KONIGSBERG: You know, I can't say that one of the testifiers won't bring up the issue of the willfulness of the disease,but we didn't put it down as an objective.

COMMISSIONER ROGERS: I am beginning to realize, just going through this process is helpful, because my feeling is both the next one, examination of the public health system and the prevention issues are clearly a major -- those are the guts, are they not, of our September meeting?

COMMISSIONER KONIGSBERG: Yes.

COMMISSIONER ROGERS: So, I would say both of those are out, because that's going to be our September meeting, prevention and examination of the public health system.

CHAIRMAN OSBORN: Leaving people that are --

COMMISSIONER ROGERS: So, we have left on the first page financing --

COMMISSIONER KONIGSBERG: Dave, just on quick thing. I have some slight anxiety, that may not prove to be true, that we may not in the sessions in September adequately

deal with prevention and education. I think we can. I am confident, what I have seen on examination of the public health system, that that will be adequate attention, but I agree, they are both on the agenda.

COMMISSIONER GOLDMAN: But are we going to be dealing with that thing, for example, with the issue of some of what I have read about the kinds of regulations dealing with community approval of educational materials and things of that nature? Is that planned to be part of that September meeting or --

COMMISSIONER KONIGSBERG: It could be. I hope so.

COMMISSIONER GOLDMAN: Well, I am concerned about sitting here and deciding to scratch it, because it could be, having no mechanism to deal with it, if the "could" turns out to be a "no."

CHAIRMAN OSBORN: Could I make a comment here? I think it is very likely that we will have a somewhat better budget to work with in the second fiscal year of this Commission. Right now, we are not very used to thinking about these things that don't quite get touched in a hearing, of getting a group of experts and so on.

David's D there is something we just haven't been

able to use very much, and if we got done with September and decided, boy, we have really not touched this area, it's a point of high concern to the people, let's get some people who can study it, particularly the ones we are talking about right now, where there actually is a lot of written and real expertise that we could tap. Those finishing off details are something that we could keep on adding to our meeting, especially if we use experts --

COMMISSIONER ROGERS: I would also feel that we are not casting this in concrete. We are trying to develop a work plan which you might wish to modify at any session, but something so that people can see what we have got coming down the pike.

Harlon?

COMMISSIONER DALTON: I was just going to say that, particularly the things that we have sort of scheduled for the future, we can't predict now how they are going to turn out, and so I think we can relax about that.

COMMISSIONER KONIGSBERG: I agree. I think we are all, including me, worrying too much about it.

CHAIRMAN OSBORN: The outside expert mechanism is very useful.

COMMISSIONER KONIGSBERG: Yes, I can see that in that area particularly. I think we ought to mark those two, then, as September or will be done.

DR. ALLEN: Let me just go back, though. I agree with the last one, examination of the public health system. I think prevention is not something that can be dealt with in two days. We are talking about prevention of sexual transmission, prevention of drug abuse transmission, and that's going to come across with the substance abuse above. We are talking about the need for continuing education in our schools for our youth, reaching high-risk youth that are out of school systems.

We are talking about special populations, and I think the military is an example of that, where even though they have had declining rates of incidence of new infections among the active duty military, among the white and to somewhat lesser degree about the Hispanic active duty populations, they have got an increasing rate of infection among their black active duty -- I think that we can't begin to deal with this in September, and I would argue that it ought to be left there as something that needs to be disposed of in --

COMMISSIONER KESSLER: I think the way to do it is to use your mission statement here. The mission statement highlights education and comprehensive care, and I think in every session we are going to have components, whatever the sub-topic of that session is, we can look to the educational component of that and sort of blend it in our testimony, then I think we will cover the bases, you know, when we look at this. We have to talk about adolescents at some point and we need to talk about education.

DR. ALLEN: Education is sort of an open --

COMMISSIONER KESSLER: I'm suggesting that it is throughout the rest of the year, in some ways we have to keep looking at the education piece in that day or two days, with the needs of the --

DR. ALLEN: And it still may need to be dealt with my a work group or somebody who is pulling it together and is picking up the bits and pieces here and there. I think it's too big, too important an area not to --

COMMISSIONER ROGERS: I would say when in doubt, leave it in. So, we change our minds, thanks to Jim's eloquent --

[Laughter.]

Now, my reaction on the next page is that the first diamond and the third diamonds are really --

[Simultaneous discussion.]

COMMISSIONER KONIGSBERG: Where are we now?

COMMISSIONER ROGERS: We have number one, financing of care. We have number two, barriers in the current system. We have number four, substance abuse. We have number five, prevention and education. We have five left on the first page.

CHAIRMAN OSBORN: Wait a minute.

COMMISSIONER GOLDMAN: Four, because you dropped over and three is out, so you have one, two, four and five, and it adds up to four.

CHAIRMAN OSBORN: Yes.

COMMISSIONER ROGERS: Thank you. Four. Thank you, Donald.

CHAIRMAN OSBORN: That is what we need lawyers for, is to count.

[Laughter.]

COMMISSIONER GOLDMAN: At least that's a harmless activity.

COMMISSIONER ROGERS: Could I capture your attention

for the second page? My reaction is that number one diamond on the next page is really subsumed under number three, which is really the same thing, but broader. The impact and response of the African-American community, I would like to just broaden number three, the effect and response to the HVI epidemic of various communities.

COMMISSIONER DALTON: We had a long conversation about this at the prior luncheon meeting, and those are not the same thing, since you got into that issue, whether or not -- and I have to say so many experiences, including that luncheon meeting, where I heard someone else say that special attention needs to be paid on the particular impact on the African-American community, and someone else says, well, what about Polish-Americans, what about this, what about that, and that's what happened and we have this laundry list of what about the rural, what about the homeless.

The reason I put on the list impact on response of the African-American community was not because it -- I understand there are other affected populations, number three could be even longer than it is, if one wants to break that out ad infinitum, but there is something particular about the experience of people who live on one side of the divide and

the dominant society that needs thinking about that particular characteristic that is important in looking at AIDS.

So, the question, to put it simply, is whether we simply want to focus on AIDS in African-Americans and Hispanics or not, but simply putting it in number 3 is not the same thing. It is so different than saying we're just not going to treat it.

MR. PERNICK: You see, each of the dots in number 3 should be given basically its own uplifting, and so you don't lump African-American communities in --

COMMISSIONER GOLDMAN: I have no problem with that, but we were told before not to do that, so all I am saying is that is the issue.

COMMISSIONER ROGERS: That is what we want to decide. Maybe we will find out that there's a surprising consensus on that issue.

COMMISSIONER DALTON: All I am saying is that's the issue, that if you frame it in terms of lumping all the dots together, then you don't get the answer to that question.

COMMISSIONER DIAZ: They are separate dots, is what you're saying?

COMMISSIONER GOLDMAN: Yes.

COMMISSIONER DIAZ: I would agree with that.

COMMISSIONER GOLDMAN: And I would agree that IV drug users be taken out, though, because we have revised substance and other abuse elsewhere.

CHAIRMAN OSBORN: We have got homeless, and we're going to have housing and we are --

COMMISSIONER GOLDMAN: We've got housing and --

CHAIRMAN OSBORN: -- rural, I think we are going to have --

COMMISSIONER ROGERS: Let's deal with Harlon's point. I agree with Irwin, but my feeling is if we don't come out with a clear section on the problems of the Afro-American or the Hispanic community, we will have not done our job.

CHAIRMAN OSBORN: Correct.

COMMISSIONER ROGERS: I think the same is true of the gay and bisexual community, but I probably would give it a different kind of twist. The problems are different.

Mr. DALTON: Yes, but there are questions of whether we feel we need to inform ourselves in some way or just what we individually or collectively bring into the room. The question is whether we could write them for

tomorrow and address one or another aspects of this, or whether we need to have the benefit of testimony before the Commission or evidence collecting by a working group or staff or other experts. I agree that every one of these things needs to be dealt with by us.

COMMISSIONER DIAZ: But I don't think that is the same.

COMMISSIONER ROGERS: Let me try to -- I am sensitive to what Harlon is saying -- let me try it another way. My suggestion, Harlon, would be that we leave in the effect on and response on various communities, but when we find how things are ranked, we might well come back and decide if we wanted special -- maybe this would do it: I was wondering if, in terms of how you wanted to deal with these different groups -- no, I think I am going to screw myself up here. Shall we wish to leave all three in, impact on the Afro-American community, impact on the Hispanic and impact on each of these groups? It seems to me they say the same thing.

COMMISSIONER GOLDMAN: Wait a minute. I thought what we were going to do was basically, when we are talking about the effect, we're talking about the effect and the impact on the response of with respect to all other groups,

and then just deal with the groups.

COMMISSIONER DIAZ: Each one individually, rank them.

CHAIRMAN OSBORN: In other words, taking your point into account, Harlon, that there is both a direct and an indirect.

COMMISSIONER GOLDMAN: Right.

CHAIRMAN OSBORN: -- but then having that pertain to the --

COMMISSIONER ROGERS: And you want to break out the Afro-American and Hispanic communities into two separate, so we have to add the two Hispanic somewhere. Just for uniformity, how do we --

COMMISSIONER GOLDMAN: That's correct.

COMMISSIONER ROGERS: -- and what you're suggesting, if I understand it, is you would rank each one of these.

COMMISSIONER GOLDMAN: That's correct.

COMMISSIONER ROGERS: You would rank Afro-American, Hispanic, Asian and Native, gay, women and children, adolescent --

COMMISSIONER GOLDMAN: Right, both criteria, right.

COMMISSIONER ROGERS: Rural?

CHAIRMAN OSBORN: I would say I thought we have been hitting that --

COMMISSIONER GOLDMAN: Yes.

COMMISSIONER KONIGSBERG: I am not comfortable ranking those particular groups.

COMMISSIONER MASON: I hear that, Charles. This is too much like, you know, what is the next step after that.

COMMISSIONER KONIGSBERG: I don't want to get put in that position.

COMMISSIONER ROGERS: Pardon?

COMMISSIONER KONIGSBERG: Even though we are not signing it in blood, I just don't think that's appropriate.

COMMISSIONER MASON: You know, we're always saying that we can't let people be pitted off against each other.

COMMISSIONER GOLDMAN: I don't think we're pitting people off, I think we're talking about which groups would benefit the most from what kind of staffing and work plan, and we're also assigning priorities in terms of dealing with it, and I think that we can -- I don't see any problem in doing that, and it's not cut in stone.

COMMISSIONER KONIGSBERG: That's a problem.

COMMISSIONER MASON: Why can't we just have a

measure for dealing with each -- you know, why can't we just leave them all the same priority, just figure out the best way to work on each of them?

COMMISSIONER GOLDMAN: Because I don't think -- and I will use an example -- I do not think that it makes any sense at all for this Commission to devote any more than a minimal amount of resources to the problems of AIDS in the hemophilia community.

COMMISSIONER MASON: Correct.

COMMISSIONER GOLDMAN: As a person, I can say that very easily and quickly, and I don't think that merely because it's another group that it ought to be -- and so that is my perspective, and I would assume that there are others that may feel different ways, different things, and I think the issue is not so much as to all of these groups and all these people are important, the issue is what kind and how much resources of the Commission, in its last 14 months, ought to be devoted towards dealing with them, and I think we have to make at least a tentative decision along that way, understanding that if those problems appear to be more complex or more involved with respect to any given community, that doesn't cast in stone to say that we can't reorder those

priorities and devote more resources in a different way later on. But I think we have to make some tentative decisions as to which way we are going to begin to go.

COMMISSIONER DALTON: I think, conceptually, it's no different than breaking out substance abuse, which you seem to have no difficulty doing, substance abuse and hemophiliacs. The conception is no different, to say you want to give special attention to one of those, and we might have different views, as Don has expressed about those two categories.

Let me say this, and then I will be quiet about this until we do our voting: My concern about -- the reason that I initially want to break out, but I am perfectly happy to do it this way, Afro-Americans and Latinos, is that by the time our report goes to bed, half the people in this country come from those two groups, and so I think, as a symbolic matter, that we don't spotlight and try to figure out how the world is going to be different, when that is the case. We are going to look really rather silly.

Secondly, I believe that the people around this table, including myself, need to be more informed. I don't want a meeting in which people simply say we need to be culture sensitive and linguistically appropriate or we need

more money or -- I think we need to move beyond that, or I'm not interested in the meeting.

But I do think that we have to move beyond that, beyond the problems with something of that sort, but to move beyond that so that I think it is something that we need to do. Again, those are the reasons that I wanted to put this on the table. I don't think we should assume that the world looks the same to people of good-will, without regard for where the resources are situated.

COMMISSIONER AHRENS: I think if we rank these, if that is what we decide to do, what has sort of played into my judgment, too, is have we heard a lot about this group, and not that that is not a key group or important group, but do I feel I need more information about another group as over against someone else, some other --

COMMISSIONER ROGERS: Bear in mind, we are not writing the final report here. We are saying here are some things we want to try to cover in more detail before the end of this 14 months.

CHAIRMAN OSBORN: Perhaps, in the interest of simplifying this list, Don has suggested hemophilia come off the --

COMMISSIONER GOLDMAN: No, I haven't suggested that. I did not suggest that it come off. Please, I hope that nobody took me to say that.

CHAIRMAN OSBORN: Well, what I was going to get at is that, in the same sentence that I thought you meant, I think listing women and children is somewhat redundant, in epidemiologic terms, about the Afro-American community and the Hispanic community, because if half of the country is going to be one of those two groups, it is already the case that 80 to 90 percent of women and children are in one of those two groups, and you put it in to talk about the impact on the community, without focusing sharply.

I will let you say what you want to about hemophiliacs. I was going to suggest as a separate category, in prevention we want to talk about prevention in women in a very different sense, but that will come up in another kind of context. In the sense that I think these are listed, women and children go into two very dominant categories and not elsewhere, and, as such, that would simplify you both a little bit.

COMMISSIONER GOLDMAN: Fine.

COMMISSIONER ROGERS: Then, if I am hearing you all

correctly, we will rank these separately --

COMMISSIONER MENDEZ: Excuse me. I am basically not in favor of ranking. I agree with Harlon, with a totally different reason. I am not in favor of ranking one, two, three, four. Now, we can deal scientifically with the problem, which would not be a scientific ranking of the problem, but ranking in terms of what we consider people -- the reason I agree with Harlon is a completely different reason.

There is a segment of American society that at this point in our history has expression of the disease, because of a multiplicity of effect that culminate in the behavior of that segment of American society, and that segment of American society happens to be black -- men, women and children. That segment of American society represents a significant portion of the statistics of this country, in terms of this disease. I have absolutely no problem in my head saying that this constitutes a significant mandate to this Commission to give particular attention, special attention, and that's exactly the way I see it.

The reality of that is that that segment at this point in time is disadvantaged for a series of reasons, all

of which I am not going to go into. But it is the multiplicity of those reasons, not one, not one aspect of behavior, not one specific piece of that society, but indeed, within its total expression, has now derived for itself a significant niche in the expression of what we call AIDS, and to that effect I think -- and even without looking at the statistics of the year 2025 or what have you, I think it is very much deserving of that type of teasing apart of that type of thing.

So, I see it differently than other things. I see it differently for that reason, that it encompasses the totality of the people that are a significant segment of our society at a specific point in our history.

DR ROGERS: Dr. Mendez has just written an eloquent part of our final report right there. Bear in mind, what we are trying to do here now is to decide what more information, what is our work plan, not what is in our final report, which, as I gather, if we ignore these groups and the fact that the disease is moving this way, we will have done a dreadful job.

COMMISSIONER GOLDMAN: I would just say that I think that the doctor has set forth an eloquent set of why that ought to be an extraordinarily high ranking, but --

COMMISSIONER ROGERS: In the report.

COMMISSIONER GOLDMAN: In the report and perhaps even in terms of the resources that the Commission --

COMMISSIONER ROGERS: What you decide to do.

COMMISSIONER GOLDMAN: -- what you decide to do, but I don't think it serves the rationale for simply omitting it from the schedule of what we have to decide in terms of priorities. And with respect to what June said about women and children, I think if somebody feels that women and children will be adequately covered inherently in the matters of other arenas and other areas that we have already dealt with and there is no real need for any special focusing on women and children specifically as women and children, then that would be a good reason not to vote them a high priority, not that women and children are not important, but that the anticipation is that they will be covered in other arenas. Again, that is why this is not really a prioritization, as more of a work plan kind of thing, and it is not saying that women and children are less important than others, it's saying that in a work plan the areas involving women and children are likely to get covered in other arenas and, therefore, there is no reason to focus on them directly.

COMMISSIONER ROGERS: Harlon?

COMMISSIONER DALTON: Tell me if I'm wrong, I thought I heard Dr. Mendez say that the reason he didn't want to rank things is that, even if we were ranking things for scientific reasons, reasons that made perfect sense to everyone in this room, someone reading this might not read it the same way and might read other reasons into why we scratched some group or other. I don't know if that is what you meant.

COMMISSIONER MENDEZ: You know, I think --

COMMISSIONER ROGERS: Well, I don't think we need to argue the groups. Bear in mind that what we are -- and I am pushing just a little bit, because I think what we want to do is find out where do we need more information, what hearings do we wish, what work groups, what -- and I am persuaded that this is an area of high concern, let's leave these groups in and let people rank, so I would say we have Afro-Americans, Hispanics, Asian and Native Americans, the gay and bisexual community, women and children, adolescents, hemophiliacs, and omitting IV drug users, homeless, rural, the special problems.

COMMISSIONER KONIGSBERG: Wait a minute, omitting

what?

COMMISSIONER ROGERS: I would omit the IV drug users, we have already put them --

COMMISSIONER KONIGSBERG: That's a separate category.

COMMISSIONER ROGERS: -- the homeless we have circled on the first page to come back to --

COMMISSIONER KONIGSBERG: That was housing.

COMMISSIONER ROGERS: Housing, excuse me. The homeless, my feeling was we have already done quite a bit.

COMMISSIONER ALLEN: I have a question about that. Do we have enough information, does the staff have, on the site visits to incorporate in the report, so we have some excellent testimony at the beginning of the site? I am just wondering what kind of material the staff has to --

CHAIRMAN OSBORN: We have all kinds of material.

COMMISSIONER ROGERS: Oh, yes, we've got a huge amount.

MS. BYRNES: Would it help if we said number one means needs most information, number two means needs more information, number three means needs less information, number four means needs least information? If the ranking correlates

to needing information about a particular topic or focus, does that get at some of the concerns about the language related to ranking?

COMMISSIONER AHRENS: I would support what she is saying, because when you look at these groups, that's the way I guess I would be looking at them, that in these areas I need more information in these areas.

COMMISSIONER DIAZ: I think that would argue against that. I see your point and it's very valid, we may have to have another third imposed ranking for that, but let's just drop down a little bit to media. We haven't really discussed the role of media here, but when we are ranking now what I think I am being asked to do, is to state within the next 14 months of this Commission's life and work, are we going to give that high priority, medium priority, little priority or no priority, and not do we need more information on the media, because if it were that, I would have to rank it one. We have no information on the workings of the media.

Nobody has testified about that specifically, that I remember -- maybe I am wrong -- so it wouldn't correlate. But I think that's a wonderful idea, because some of these

topics, we could get around by saying this is the amount of work that would have to be done to gearing us up to being able to make a recommendation, but I think that, as you started today, we were talking about where we see this in terms of the priority of time, and I think from what we learned yesterday, we can do it in 14 months.

COMMISSIONER ROGERS: I think I would prefer to leave it the way it is. If we flop on it, we will get back and try it again.

COMMISSIONER DIAZ: Yes, but I think it really is a good idea.

COMMISSIONER ROGERS: All right, so you will have everything except IV drug users, the homeless, and rural, and you will rank them.

COMMISSIONER GOLDMAN: And adding Hispanic after Afro-Americans.

COMMISSIONER ROGERS: Yes, Afro-Americans, Hispanics is number two and --

COMMISSIONER GOLDMAN: There will be a total of eight.

COMMISSIONER ROGERS: We will have a total of eight, we agree.

MR. PERNICK: We have already heard a lot of testimony and we have been to Georgia on this rural versus urban problem, but it seems to be something that has to be looked at separately. Because of the impact of rural areas in terms of numbers is small, it may be that the care is less, the attitude --

COMMISSIONER ROGERS: Yes.

MR. PERNICK: -- the sociopsychological attitudes are much different, community support is a hell of a lot different, so I think --

COMMISSIONER ROGERS: No argument. I would say we have done and we now have collected a great deal of information there. It has clearly got to be an important part of our report. We heard some more of it today.

MR. PERNICK: Two days.

COMMISSIONER ROGERS: But I don't think we need to go to rural Kentucky --

MR. PERNICK: That's fine.

COMMISSIONER ROGERS: -- except to see Belinda.

[Laughter.]

COMMISSIONER MASON: For my house-warming party.

COMMISSIONER ROGERS: All right. Now, I am going

to --

COMMISSIONER AHRENS: We are going to pull all of these out and put them over here?

COMMISSIONER ROGERS: You are going to get rid of the first diamond.

CHAIRMAN OSBORN: The first two.

COMMISSIONER ROGERS: Impact on response of the Afro-American, because you are going to get rid of the second diamond, impact and response of the Hispanic community. You are then going to have eight diamonds, which are really the impact and response on any one of those.

COMMISSIONER KONIGSBERG: I think we are right back to ranking, and what have done now, it looks to me, is to get these groups lumped in with major subjects. I think we have got apples and oranges and it's going to be real hard to come up with five one's. I thought the idea was to --

COMMISSIONER KESSLER: You don't have to come up with five one's, because you can have five one's and five two's. Two's still get attention, but to a lesser degree.

COMMISSIONER DES JARLAIS: If I can make a procedural comment, the whole way the delphi procedure is supposed to work is you sit down and you make your rankings,

realizing that it's apples and oranges and kangaroos that are being compared, then you look at the results and you think about it and you go through a couple iterations and you get to consensus. You don't try to discuss things in detail to get consensus, because it takes all day.

COMMISSIONER ROGERS: That's what I was trying to move to.

COMMISSIONER KONIGSBERG: Yes, I understand that about discussing the details, but the problem is that we're discussing the process, which I think we have a right to discuss.

COMMISSIONER DES JARLAIS: We do, but we're discussing the process and we're not doing it and we're not going to get around to doing it.

COMMISSIONER KONIGSBERG: I'm going to tell you right now, I'm real confused.

COMMISSIONER ROGERS: Let's try it. I agree --

COMMISSIONER KONIGSBERG: I will try anything, as long as I know what I'm trying.

COMMISSIONER ROGERS: You're going to rank the four on the first page, you've now added things which concern you, you have added eight more that you feel might be subsets of a

single one, rather than eight, but the general consensus around the table is keep it eight. I could argue very effectively on your side, but I --

COMMISSIONER KONIGSBERG: I guess I wasn't sure I heard a consensus.

COMMISSIONER ROGERS: I thought I heard a consensus.

COMMISSIONER GOLDMAN: I did. It's broad agreement, without vehement disagreement. If you're expressing vehement disagreement, then we don't have a consensus.

COMMISSIONER KONIGSBERG: We did have some vehement disagreement, so on that basis, we have a difference opposed to a vote.

COMMISSIONER GOLDMAN: Then we ought to vote, if you have--

COMMISSIONER ROGERS: Would you like to vote?

CHAIRMAN OSBORN: Why don't we vote? It is just the question of a modified delphi procedure, I think it's the question for a vote.

COMMISSIONER GOLDMAN: We started out and we were going to do it, and we're moving further and further away from it.

COMMISSIONER ROGERS: Let me try and carry it

through here.

CHAIRMAN OSBORN: We are dealing with a disagreement of we don't like this idea at all of a delphi, and that we haven't heard. We have heard as to whether we know when we get to writing these down, and that was just immediately before we start writing, we can run through that one more time, but I think that the topic should be the consensus.

COMMISSIONER KESSLER: I think what is confusing people is, you know, we have more than six, when you look at them, possibilities. We have six --

CHAIRMAN OSBORN: True.

COMMISSIONER KESSLER: We may have six site visits, we may have six outside groups or we may have six open groups.

COMMISSIONER ROGERS: We are going to see, when we get things up on the porch, how much have we got on our plates.

COMMISSIONER KESSLER: I agree that choosing five will be difficult, but it will help to narrow how much --

COMMISSIONER KONIGSBERG: Could we review the bidding on what the eight are under that?

COMMISSIONER ROGERS: One, African-American; two, Hispanic; three, Asian and Native American; four, gay and

bisexual community; five, women and children; six, adolescents; seven, hemophiliacs; eight, allied health, all others.

COMMISSIONER KONIGSBERG: There's no one here that would probably be in a position to want to express this, but we've lumped Asian and Native Americans as one. Why?

COMMISSIONER GOLDMAN: We were just talking about it. There's no rationale for it, but it's not worth spending our time about dealing with.

COMMISSIONER KONIGSBERG: I would say I agree with that.

COMMISSIONER ROGERS: All right. I am going to suggest or at least I would propose the Commonwealth of Puerto Rico and HIV in the prison systems are both on our agenda.

CHAIRMAN OSBORN: Yes.

COMMISSIONER ROGERS: Whether we do that well or not is not the subject of debate right now, so we will cross out the Commonwealth of Puerto Rico and we will cross out HIV in the prison system.

I will be interested to hear you discuss what you wish to do with the media.

COMMISSIONER DIAZ: We haven't done it.

COMMISSIONER ROGERS: No, we haven't.

COMMISSIONER KONIGSBERG: Leave it in there.

COMMISSIONER ROGERS: All right, we leave it in. Fine, then you rank it according to your prejudices.

CHAIRMAN OSBORN: According to your conscience.

COMMISSIONER ROGERS: Or your prejudice.

[Laughter.]

The role of the religious community, we have not dealt with.

CHAIRMAN OSBORN: We have not dealt with.

COMMISSIONER ROGERS: Personnel --

CHAIRMAN OSBORN: We did today.

DR. ROGER: -- I would say that's what we have been about today and will be about tomorrow, and we would take it out.

Research of development and the role of government. I would say we have done it.

COMMISSIONER MASON: I don't think we have done much on it.

COMMISSIONER ROGERS: But would you want more hearings on it?

COMMISSIONER MASON: No, I wouldn't want any more hearings on it.

COMMISSIONER ROGERS: But you want to be sure that it is adequately covered in our report.

COMMISSIONER GOLDMAN: Right, but I don't think that --

DR. ALLEN: One wonders if that may be one, however, where you want additional outside experts or --

COMMISSIONER GOLDMAN: Leave it in.

COMMISSIONER ROGERS: When in doubt, leave it in. Did you want to leave the whole bit, or just parts of it?

COMMISSIONER GOLDMAN: I think the whole thing, as one item.

COMMISSIONER ROGERS: Discrimination, confidentiality, due process, equal protection.

COMMISSIONER KONIGSBERG: We keep hearing about it, but we haven't dealt with it.

COMMISSIONER ROGERS: I think about it in everything we do.

COMMISSIONER GOLDMAN: Except for one item, and that is that I don't know whether or not we have dealt with the issue of what do we do about a post-ADA. The past

Commissions have always said as the recommendation they pass, that now the ADA has been passed and now what do we say.

DR. ALLEN: I will tell you my response to that, and that was hearing this morning about the discrimination by health care workers, which is absolutely not going to be covered by ADA.

COMMISSIONER ROGERS: Let's leave it in.

Workplace issues?

CHAIRMAN OSBORN: No. We need to go look at the whole thing from the point of view of the workplace. For instance, there is a very productive thing to be done there, because a lot of AIDS education should be being done in the workplace, and right at home, what it is is medical education is being done in the workplace. If that were turned around, we would have a lot easier time on our hands, so --

COMMISSIONER KONIGSBERG: We haven't done that, that's for sure.

COMMISSIONER ROGERS: I don't think we have, either. The Bi-State Commission has put out a nice bill of rights of principles of the workplace.

All right, on this page we have --

COMMISSIONER GOLDMAN: Wait a minute. We have the

next item also, don't we?

COMMISSIONER ROGERS: No, there's where you are stopping.

COMMISSIONER GOLDMAN: But how about monitoring the Presidential Commission report? That's different.

COMMISSIONER ROGERS: We are most certainly going to do that.

COMMISSIONER GOLDMAN: Well, should that be done by staff, outside experts or working group or the full Commission?

CHAIRMAN OSBORN: It's being done.

COMMISSIONER KONIGSBERG: The staff.

COMMISSIONER GOLDMAN: Okay.

COMMISSIONER ROGERS: They are doing it, and I had thought we would start with these areas of concern would be, and I would forget the rest.

COMMISSIONER AHRENS: It see to me -- I know we haven't done this with anything else, but it seems to me that the workplace issues of education and prevention are really one.

COMMISSIONER ALLEN: No. No, workplace also has to deal with the loss of personnel, how one is treated if they

are ill in the workplace --

COMMISSIONER AHRENS: Oh, I see.

COMMISSIONER ROGERS: What you're going to do in the grade schools and the other is what you're going to do at IBM.

COMMISSIONER GOLDMAN: I have no feelings about it one way or the other, I am just trying to be sensitive to some of the things that I have heard from others. But do you think people would feel more comfortable about some of the questions that have been raised about ranking, if everybody take a blank sheet of paper and put numbers, I think there are 17 down, and simply did it anonymously, without name attached and people would --

COMMISSIONER ROGERS: I wasn't going to in any way suggest that people be identified with their ranking.

COMMISSIONER GOLDMAN: Okay.

COMMISSIONER ROGERS: To make it easy -- well, I don't know, do we have more copies of these? I was going to suggest --

COMMISSIONER GOLDMAN: I have counted 17.

COMMISSIONER ROGERS: All right, why don't we go through and just number them, and then you can put it on a

yellow sheet of paper: One is financing of care; two is bureaucratic barriers; three is substance abuse; four is prevention and education; five is African-American oranges; six is Hispanic apples; seven is Asian and Native Americans; eight is gay and bisexual community; nine is women and children; ten is adolescents; eleven is hemophiliacs; twelve is all others; thirteen is media; fourteen is the role of the religious community; fifteen is research, drug development, et cetera; sixteen is civil rights, et al; and seventeen is workplace issues.

COMMISSIONER GOLDMAN: What do we do about items we want to add?

COMMISSIONER ROGERS: And eighteen, of course, you can add.

Now, you are going to rank each of these in two ways and -- what are you doing?

COMMISSIONER GOLDMAN: But where is our crib sheet, with --

COMMISSIONER ROGERS: Now, reverse that order. One is high priority; two is still on the list; my own feeling is three would mean I personally don't think that is something I want to see the Commission spending any more time on.

CHAIRMAN OSBORN: Three, no?

COMMISSIONER ROGERS: No.

COMMISSIONER GOLDMAN: Do you want priority first on the list?

COMMISSIONER ROGERS: Priority first. Priority comes first on the list.

CHAIRMAN OSBORN: On the top of your yellow page, write priority and then, to the right of that, write method, and write it up there, so nobody --

COMMISSIONER GOLDMAN: I need a pencil, because I may want to erase afterwards.

CHAIRMAN OSBORN: And then we go 1 through 17 down in the margin.

COMMISSIONER GOLDMAN: And 18, if there is anything else that you want to add or comment on.

COMMISSIONER KONIGSBERG: What's the method, A is full Commission?

COMMISSIONER GOLDMAN: Yes, could we have our crib sheet back?

COMMISSIONER ROGERS: Yes, you will in a minute.

COMMISSIONER GOLDMAN: Okay.

COMMISSIONER ROGERS: I was just going to show you,

here you are going to put A, a one, a two, or a three, and here you are going to put an A, B, C or a D.

We will have a break, as soon as you turn your sheets in.

COMMISSIONER GOLDMAN: Having a full Commission report does not -- obviously, if we had a full Commission hearing, we would having outside experts coming before the Commission and doing reports and testifying, so A almost implies D.

COMMISSIONER ROGERS: To follow Don's reasoning, we will see what we can -- you can only rank it A, B, C or D. When we get to see what we have got on the board, you might decide that we are choosing A, the way we are going to do it, because we didn't have enough expertise and we're going to ask for an outside working group.

[At this Commission, a vote was taken, by paper ballot.]

COMMISSIONER ROGERS: All right, we will now take a short break.

[Short recess.]

COMMISSIONER ROGERS: Back on the record.

Thank you very much. It is absolutely fascinating.

We have a startling unanimity on what you would put highest and here you are just ranking. The lowest scores are those that are the winners, if you will, and I simply want to show you that there are about five that are quite low, and there are groups that are way up there. I am about to tell you what they are, but I thought it might be easier to do it from this second sheet, which is Larry's genius here.

I just wanted to show you the numbers. There are some very low numbers, which are the ones where you would, ion essence --

COMMISSIONER GOLDMAN: Could I suggest that you draw a double line between 6 and 16, because that represents the break.

COMMISSIONER ROGERS: It's a big break.

COMMISSIONER GOLDMAN: Yes.

COMMISSIONER ROGERS: It's a big break. If we plotted this, it would be a bi-modal curve. There would be a few over here and then it goes way up, in terms of where the numbers go.

Let me just read them off. Your first five are: one, financing of care; two --

COMMISSIONER GOLDMAN: Dave, why don't you read

them also in rank, rank full Commission.

COMMISSIONER ROGERS: Both at the same time?

CHAIRMAN OSBORN: Both at the same time.

COMMISSIONER ROGERS: Fine.

The financing of care, that this deserves full Commission -- help me, Larry -- this deserves full Commission attention, and that was overwhelming. These are people who thought an outside group, the staff --

COMMISSIONER GOLDMAN: No, B is a working group.

COMMISSIONER ROGERS: -- a working group --

COMMISSIONER GOLDMAN: And C is staff.

COMMISSIONER ROGERS: -- and C is staff. But, in essence, the majority said this is important, it deserves full Commission, but bear in mind we're going to ask staff and others to decide what does that mean.

Next is substance abuse, that's number 3, full Commission, review of staff.

CHAIRMAN OSBORN: Full Commission.

COMMISSIONER ROGERS: Four is --

COMMISSIONER KESSLER: What happened to two?

CHAIRMAN OSBORN: Two didn't make it.

COMMISSIONER ROGERS: Two is down here, we will get

back to it. These are the ones that you really --

COMMISSIONER KESSLER: All right.

COMMISSIONER ROGERS: -- in essence, the overwhelming view.

Number 4 is prevention and education, full Commission.

Number 5 is African-Americans, full Commission.

Number 6 is Hispanics, full Commission.

Then we drop down quite a ways, but we picked the top 10, and it's interesting how you begin to decide you might deal with these in a different way.

Number 6 is civil rights, again full Commission, but these columns come out there to where it seems to be the staff might think hard about are there other ways we can obtain the information the Commission wants.

COMMISSIONER GOLDMAN: In all the other cases, the vote for full Commission either equals or exceeds the vote for all the others combined.

COMMISSIONER ROGERS: Overwhelmingly full Commission.

Number 15, which is research, drug development --

COMMISSIONER KESSLER: Outside group.

COMMISSIONER ROGERS: It's interesting that they have said here let's have an outside group work on this.

COMMISSIONER GOLDMAN: 16 is civil rights.

COMMISSIONER ROGERS: I'm sorry, did I miss that?

CHAIRMAN OSBORN: You did it right.

COMMISSIONER ROGERS: It's Commission, but there's some debate as to how they would like that done, whether it would be a working group or a staff paper.

16 we have done, so we are going to come back to number 2, which is the bureaucratic barriers to access.

COMMISSIONER KESSLER: Some report outside, but it has some weight, an equal amount of weight total between --

COMMISSIONER ROGERS: No, not full Commission, we want more information, we need more in our report on this, but we don't want to take the full Commission to do it.

Number 10, adolescents, and that this should be an outside group. Having just put together a group on that, there are some real experts out there and it is a critical thing for us to do.

Number 14 is the role of the religious community, and we are saying a working group. How about that?

COMMISSIONER KESSLER: The others we didn't do, but

I think we need to do and the staff can do that and discuss those --

COMMISSIONER ROGERS: Display them back to us, but I am just going to go back to that and show you how striking the drop is. These are the big five, and then, as I say, you plotted it out. It is well over, but in part I think because of the feeling -- that's not full Commission, that's where we want more information. I don't think it devalues those, it just says that's not where we want to spend a lot of Commission time.

DR. ALLEN: Larry, go back to the next page again and just show me the -- okay, number 14 is the -- all right, that's fine, 10 and 14, and 14 had how many, 30?

COMMISSIONER GOLDMAN: 14 had 30.

COMMISSIONER ROGERS: 10 and 14 were tied 30. Number 6 is 19, which you can see is a great big jump. Number 16, as you can see down here --

DR. ALLEN: We have got 3 with 31, so you have got some others that are very, very close in rank. There's 8 --

COMMISSIONER KESSLER: I don't think it is necessary to do it today, but we can do it in the same grid and it will show that -- it will also come out with a recommendation about

whose working on it. In some cases, it might come out full Commission, although I doubt that.

COMMISSIONER ROGERS: My feeling is we do that with a Commission statement and give you all a blessing. I think we have done a really good job.

CHAIRMAN OSBORN: Remarkable.

COMMISSIONER GOLDMAN: But we still have to put this together in terms of a work plan.

COMMISSIONER ROGERS: The work plan, I would say, is a staff plan proposal to put this together. Maureen, would you agree, from this data you put together a work plan in terms of saying this is the sequencing and so on?

MS. BYRNES: That is the intent, to work with us on Wednesday.

COMMISSIONER KESSLER: The yellow tally sheets, somebody has to hold onto these until we complete the grid.

COMMISSIONER ROGERS: Keep all the yellow sheets and keep those two big sheets, too, so you won't have to do that again. Actually, no nonsense, I am really delighted that we really do agree pretty much on where we want to go, and, even more surprisingly, we kind of agree pretty much on how we might do it, with enough variation so that.

Belinda, I think your earlier comment about could you put down two, full staff, but you might want an outside group to advise the full Commission, could you put an A and a D, I think that's one of the things for the staff to try and decide as they make their recommendations about how we go.

COMMISSIONER KESSLER: I think that the grid actually in the issue statement should become part of what they will be needing, because there may be something that will happen, and then something that is unforeseen at this point, say next January, it gives you the flexibility to switch gears and to pump it up or down or laterally to another group, because it is conceivable, in some cases, you might end up with an issue that is going to be looked at by the staff and an outside group, depending on the weight of importance as the year unfolds.

COMMISSIONER ROGERS: Not only the grid and that first sheet, but give us a plot, give us a graph, because I think you are going to see a few that are way over here to this side, that are over the 16 thing, and that there are some that are way out on the end.

COMMISSIONER DIAZ: In view of the five or six areas, recognizing we have, as the Commission, the next five

or six gatherings together, the full Commissions, about how early could you begin to give us a sense of who the staff person working on the planning --

MS. BYRNES: I don't know. We will need to do that and --

COMMISSIONER DIAZ: -- after what plans?

CHAIRMAN OSBORN: We will be working with Marianne Heather next Wednesday, and before that would probably be premature.

COMMISSIONER ROGERS: I think everybody is pretty dead-tired after today, and now they need to take this and adjust it and put it together and begin to develop a work plan for us.

You have got in front of you, but I am going to read with a few edits, because it is awkward and I think we have got some good editors around, but here is the statement that we all struggled with and that Harlon and I have agreed to put before you. I have got it edited some:

"The National Commission on Acquired Immune Deficiency Syndrome exists to create a broad public agreement on the magnitude, scope and urgency of the HIV/AIDS epidemic; to inspire leadership at all levels in both the public and

private sectors" --

COMMISSIONER GOLDMAN: In, instead of "of"?

COMMISSIONER ROGERS: Yes.

COMMISSIONER GOLDMAN: Semicolon?

COMMISSIONER ROGERS: Semicolon is the way June has suggested it. We can argue this.

COMMISSIONER GOLDMAN: Okay.

COMMISSIONER ROGERS: -- "to put in place effective, cooperative and non-discriminatory systems and resources that will be required for preventive education, comprehensive care, and the research necessary to halt the epidemic."

DR. ALLEN: Dave, let me raise a question about the word "put in place." That is an active program development sort of a phrase, and I don't think that the Commission really can put in place.

CHAIRMAN OSBORN: Recommend.

COMMISSIONER ROGERS: That's why I was trying to encourage the public and private sector to put in place, and it changes the --

DR. ALLEN: Yes, it does.

COMMISSIONER ROGERS: That's where June's semicolon changes, and I'm not sure she recognized that changed the

meaning here a bit.

CHAIRMAN OSBORN: It certainly does.

COMMISSIONER ROGERS: I'm suggesting that the public and private sector, we are inspiring leadership in the public and private sector, to put --

DR. ALLEN: For them to put in place.

CHAIRMAN OSBORN: Right.

COMMISSIONER ROGERS: That's what I have. I have "to put in place, to inspire leadership at all levels of both the public and private sector to put in place."

DR. ALLEN: Yes. Okay.

COMMISSIONER GOLDMAN: So we strike the word "and" and we strike the semicolon.

COMMISSIONER DES JARLAIS: Preventive education is somewhat misleading. I think prevention is a much better term, because it is --

COMMISSIONER ROGERS: Require more prevention, fine.

COMMISSIONER DES JARLAIS: There are a lot of things that need to be done that go well beyond education.

COMMISSIONER ROGERS: Education is part of it, but prevention is a much broader term. Prevention, comprehensive care and research necessary to --

CHAIRMAN OSBORN: Do you want to say prevention and education?

COMMISSIONER DES JARLAIS: Just say for prevention, that covers education and goes -- the other wording change is --

COMMISSIONER KESSLER: Why do we have the "a" in the second line?

COMMISSIONER DALTON: We don't.

COMMISSIONER KESSLER: Are we taking it out?

COMMISSIONER DES JARLAIS: I'm not certain that we're really trying to create agreement on the magnitude of the epidemic, as opposed to awareness of it.

CHAIRMAN OSBORN: We discussed that yesterday and I think there was as feeling that agreement was indeed what we want to do, to go beyond awareness, because there is so much rejection of --

COMMISSIONER DES JARLAIS: Okay.

COMMISSIONER ROGERS: The National Commission on Acquired Immune Deficiency Syndrome exists to create broad public agreement on the magnitude, scope and urgency of the HIV/AIDS epidemic; to inspire leadership at all levels in both the public and private sector to put in place effective,

cooperative, and non-discriminatory systems and resources that will be required for prevention, comprehensive care and research necessary to halt the epidemic."

COMMISSIONER GOLDMAN: Sectors.

MR. PERNICK: After HIV/AIDS epidemic, is that --

CHAIRMAN OSBORN: To inspire.

COMMISSIONER ROGERS: We've got a semicolon.

MR. PERNICK: All right.

COMMISSIONER ROGERS: He's a good editor, so we will listen to one more edit before Larry's motion.

MR. PERNICK: -- "to create broad public agreement, and" -- this is after AIDS epidemic -- "and to inspire leadership at all levels," because you are asking, we exist, one, to crate, and the other to inspire, and those are the functions of the --

COMMISSIONER GOLDMAN: And to inspire, and strike the semicolon.

MR. PERNICK: Strike the semicolon, absolutely.

COMMISSIONER KESSLER: I move we accept this statement.

COMMISSIONER ROGERS: Larry, there is a motion on the floor to accept this as our mission statement.

COMMISSIONER MENDEZ: I second it.

COMMISSIONER ROGERS: Is there discussion?

[No response.]

Hearing none, all in favor, raise your hands.

[A show of hands.]

COMMISSIONER ROGERS: It is unanimous.

We are now adjourned.

[Whereupon, at 6:00 p.m., the Commission was adjourned.]

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