ROBERTTS SB 1251 SIGNED INTO LAW
Additional $5 million for AIDS Programs

Last June Governor Deukmejian cut $11.6 million out of the state budget that had been earmarked for AIDS research, education, treatment and care. Recognizing that AIDS is a public health crisis that affects us all, Senate President pro Tempore David Roberti worked to restore funding needed for AIDS programs through SB 1251.

After passing both houses of the Legislature SB 1251, which appropriates $4.9 million, went to the Governor's desk. On September 18th Governor Deukmejian signed SB 1251 into law. SB 1251 provides funding in the following areas:

Clinical Research - Most people with AIDS or AIDS Related Condition (ARC) don't have the option of flying to Paris to try experimental drugs which slow the destructive spread of the virus. SB 1251 provides $2.3 million for clinical research, which will include antiviral drug trials in California.

Home Health Care - People with AIDS or ARC suffer from the lack of adequate health care services between hospitalizations. Supervised attendant care, which is usually not covered by Medi-Cal or insurance providers, is frequently the most humane and cost effective kind of care for these patients.

SB 1251 will fund demonstration projects to show the cost effectiveness of in-home care over hospitalization for people with AIDS or ARC. The $1 million provided by SB 1251 will pay for home health aides, attendant care, hospice care and other direct services to patients during acute phases of their illness. The Administration has agreed to include additional funding in next year's budget for these programs.

Cost of Care Study - To date, there have been over 3,056 AIDS cases reported in California. It has been estimated by the Centers for Disease Control that the average cost for medical care for each AIDS case is $140,000. At that level, the cost of medical care for the current AIDS cases in California may top $400 million.

SB 1251 provides $200,000 for the first year of a comprehensive study of the health care costs associated with AIDS so that the State can plan for and fund necessary treatment programs. The Administration has agreed to include funding in next year's budget to complete the two year study.

AIDS Mental Health Program - SB 1251 provides $600,000 to establish an AIDS Mental Health Program. The program would include a statewide needs assessment of AIDS mental health issues, education and training of mental health professionals, and public service announcements.

Educational Programs - SB 1251 provides $250,000 for education of hospital, home health agency, and attendant care workers; $150,00 for an evaluation of the educational programs funded by the state and $400,000 for pilot programs for education and detoxification of intravenous drug users with AIDS or ARC.

Discussion between the Legislature and the Administration has been helpful in releasing additional funds for AIDS for the current fiscal year, bringing the total amount allocated to fight AIDS in California to over $20 million. The groundwork has also been laid for a more responsible and responsive AIDS budget for fiscal year 1986/87.
AIDS Funding in California for 1985

<table>
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<tr>
<th>In Millions</th>
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<td></td>
<td>the 1985/86 State Budget</td>
<td>SB 1251</td>
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<tr>
<td>Research</td>
<td>$4.9</td>
<td>$2.3</td>
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<td>Education</td>
<td>$5.12</td>
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<td>Surveillance &amp; Administration</td>
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In addition to the $14.98 million outlined above, $5 million was appropriated by AB 488 last spring to fund testing for antibodies to the AIDS virus at sites in 31 counties and health districts.

AIDS-RELATED LEGISLATION INTRODUCED IN 1985

SB 678, Roberti (D-Los Angeles)
Extends the sunset of the State AIDS Advisory Committee to July 1990, adds representatives of the University of California AIDS Task Force and State Department of Mental Health to the committee as ex officio and non voting members.
**Status:** SB 678 was signed by the Governor.

SB 1251, Roberti (D-Los Angeles)
Restored $4.9 million of funds eliminated from the State Budget last June to fund AIDS research, education and direct service programs.
**Status:** SB 1251 was signed by the Governor.

SB 292, Marks (R-San Francisco)
Strengthens confidentiality protections for AIDS researchers and participants in AIDS research studies.
**Status:** SB 292 was signed by the Governor.

SB 1328, Marks (R-San Francisco)
Would establish Medi-Cal eligibility for victims of catastrophic illness and establish a formula for determining the share-of-cost for eligible individuals.
**Status:** This 2-year bill has not yet been assigned to a policy committee but should begin moving in January.

AB 403, Agnos (D-San Francisco)
Protects the privacy of individuals tested for AIDS antibodies, prevents the antibody test from being used as a condition for insurability or employment, established penalties and created new misdemeanor for negligent or willful disclosure of antibody test results.
**Status:** AB 403 was signed into law last spring.

AB 488, Roos (D-Los Angeles)
Provided $5 million to establish alternative test sites for individuals wishing to be tested for AIDS antibodies and specified that tests be performed in an anonymous manner.
**Status:** AB 488 was signed into law last spring.

SENATE REFORMS IMPROVE LEGISLATIVE PROCESS

The Legislature establishes the rules and procedures that govern a bill's travel through the legislative process into law. The Senate, in particular, has been responsible for a series of procedural reforms which have served to open up the lawmaking process to the public and to make the process more efficient.

The Senate introduced reforms that forbid conference committees from "hijacking" bills (introducing substantial policy changes never heard by a policy committee), that require adequate public notice of when and where conference committees will be meeting, and that ensure that legislators are fully informed before they vote on conference committee reports.

There was a 25% reduction in the numbers of bills sent to conference committee this year compared to the end of session in 1983. Clearly the Senate reforms resulted in fewer "hijack" attempts and a more orderly and open process during the last days of the legislative session.
ROBERTI RECEIVES
OUTSTANDING SERVICE AWARD

Senator David Roberti, D-Los Angeles, was honored by Aid For AIDS, Inc. with a "Community Service Award." The award was given to recognize outstanding service on behalf of persons with AIDS.

"Senator Roberti was selected for the award because of his contribution toward furthering the fight against AIDS", said Aid for AIDS spokesperson Donald Snow.

Aid for AIDS was initiated in Los Angeles in 1983 to provide direct financial assistance to persons with AIDS to help pay for medical insurance, medication, transportation, rent, food and other necessities. The organization also provides education through printed material, a speaker's bureau, social service referrals and organizational assistance to Southern California groups attempting to form their own AIDS response projects.

Contact: Aid For AIDS, Inc., 7985 Santa Monica Blvd., Suite 109-171, Los Angeles, CA 90046

INSURANCE INDUSTRY SEEKS OVERTURN OF CALIFORNIA LAW

Insurance companies are taking steps to reduce the financial impact of AIDS on the insurance industry. A lobbyist for the Association of California Life Insurance Companies has started an effort to change a California law that forbids use of an AIDS antibody test in determining insurability.

Some companies have placed options on group health insurance policies that exclude AIDS coverage. During September the American Council of Life Insurance stated that insurers want to require blood testing of prospective clients.

The insurance industry would like to require the HTLV-III antibody test for applicants for life, health and disability insurance in order to deny coverage to those testing positive, even though a positive test does not necessarily indicate that someone will develop an AIDS-related illness.

California law currently forbids insurers from demanding the blood test, and Assemblyman Agnos, D-San Francisco, has stated he will resist attempts to change his legislation. State lawmakers passed AB 488 last spring in order to protect the privacy of individuals and to avoid discrimination.

Assemblyman Art Agnos responded to an insurance industry position paper on AIDS and insurance issues saying he was "stunned and appalled that the insurance industry not only proposed to make an unapproved use of the AIDS antibody test, but wants the permission of the California State Legislature in the bargain."

SENATE'S 1985 ACCOMPLISHMENTS

A series of 18 reports describing the 1985 legislative accomplishments of the California State Senate in various policy areas have just been published.

These reports cover topics such as: Contaminated Food & Water, Acid Rain and Smog, AIDS, Worker Health and Safety, Toxics, International Trade, Fish and Wildlife Protection, Human Rights, Offshore Oil Development, Streets and Roads, Child Care, California Schools, California Agriculture, Housing, Tax Reform, Crime, etc.

Individual reports are available for $1.50 or $20 for the entire set. Please make checks payable to State of California. To order copies or receive the complete list of report titles, please contact: Joint Publications Office, Box 90, State Capitol, Sacramento, CA 95814. 916-445-4874.
RESOURCES

Hemophilia AIDS Project

The Hemophilia Council of California has been funded by the California Department of Health Services to establish a statewide Hemophilia AIDS Project. The project provides information, education and psychosocial services to members of the hemophilia community. In addition, the project provides information on AIDS and hemophilia to community groups and organizations such as schools, public service agencies, and the media.

These activities are implemented by regional staff located in Sacramento, Oakland, Pasadena and San Diego. The focus of the Hemophilia AIDS Project is to enhance the health and well being of members of the hemophilia community.

The Hemophilia Council of California is a non-profit organization functioning as a consortium of local hemophilia foundations and chapters in California. It is consumer oriented, and is sensitive to the needs of people with hemophilia, their families and loved ones.

Contact: Northern/Central California
Les Norman, M.A.
916-448-7444 in Sacramento
San Francisco/Monterey Bay Area
Paul Murray, LCSW
415-548-8357 in Berkeley
Los Angeles Basin/Desert Area
Peggy Streid, MPH
818-739-6192 in Pasadena
San Diego/Imperial/Orange County
David Hubley, MSW
619-543-1355 in San Diego
G. W. Levi Kamel, Ph.D.
Project Coordinator
916-448-7444 in Sacramento

HTLV-III Testing

Adair Films has developed video presentations on HTLV-III testing for the San Francisco AIDS Foundation. Designed for use before testing occurs, the tape provides easily understood information that can help an individual decide whether to take the test or not.

Contact: Adair Films, 2051 Third Street, San Francisco, CA 94107.
415-621-6500.

Volunteer Counselor Training

Groups wishing to provide volunteer counseling to people with AIDS and their loved ones may find videotapes of the training program used by the Shanti Project useful. These tapes are designed to be used both as a resource by the organizers of new groups and in the training of volunteer counselors.

The Shanti Project provides services to persons with AIDS and their loved ones, individual counseling, support groups, residence programs, practical support and hospital counseling.

Contact: Shanti Project, 890 Hayes Street, San Francisco, CA 94117.
415-558-9644

Computerized AIDS Information Network

The Computerized AIDS information Network (CAIN) provides up-to-date, easily accessible information specifically dealing with AIDS. CAIN is designed to assist in educational, referral, and research efforts. CAIN is a nonprofit enterprise. It is an "at cost only" service which has received funding from the State of California Department of Health Services.

Contact: Russ Toth, P. O. Box 38777, Hollywood, CA 90038. 213-464-7400, ext. 277.

For The Health Care Community

Inservice Video Productions has developed a series of videotapes entitled "AIDS: Putting the Puzzle Together." The tapes share the knowledge and experience of professionals currently serving the needs of people with AIDS, and are designed with the needs of the health care community in mind.

These tapes were developed by the Santa Clara County Health Department AIDS Teaching Project and the Pacific Center for Human Growth in Berkeley. The programs in this series are accredited and count towards continuing education licensing requirements.

Contact: Inservice Video Productions, 1191 Carey Drive, Concord, CA 94520. 415-827-2711
Dear Senator Roberti,

Yes, I would like to continue receiving periodic updates on AIDS legislation introduced in the California Legislature.

Name

Address

(please attach label)

Comments or suggestions for future issues of AIDS UPDATE

______________________________

______________________________

AD
MEMORANDUM

TO:        Don Embinder
FROM:      Bruce B. Decker
RE:        Safe-Sex Video

In talking with Marc Conant and others, several themes seem to be developing:

First: We need to be emphasizing sex between two men in which one actively lives out elements of the other's fantasies. The example: one asks the other what fantasy turns him on. The other answers that he has always wanted to be come on to by a cowboy/football player/prep type/etc. Using convenient costumes/props the one acts out the other's fantasy but without actually coming in contact with him while the other jacks off. Lots of verbal dialogue.

Second: We need to be emphasizing foreplay as a means to have contact without either oral or anal contact. We can show a wide variety of stimulation, massage, touching, mutual masturbation. Everyone has erogenous zones (neck, groin, tits, feet, etc.). We need to help people feel good about finding them in one another and using them to stimulate ejaculation.

Third: We need to demonstrate the sensual aspects of including a rubber in sex. We may even want to suggest use of a lubricant with Nonoxinol 9 in it, the spermicide that kills the virus. This can be a long sexual sequence but we have to watch out for any violent sequences as we should be emphasizing the erotic pleasure of screwing/being screwed. Due to possible rips in the anus/sphincter we should not have the largest cock possible be the one doing the screwing (may be a long and thin one, or very active).

Fourth: I think we can do cocksucking as long as they come outside. Evidence seems to be moving to the area that says that oral transmission is clearly difficult, if not highly unlikely.

I think we need to emphasize loving sex as opposed to anonymous sex. We may want to create the illusion that the couple has been together for several years and still enjoy sex with one another. Another way involves the same couple with a younger third party, but again, in a family way and not in some cheap trick way.

I also think we have to emphasize intimacy and fantasy as alternatives to getting screwed. It is becoming increasingly clear that anally receptive men who have active sex lives are most at risk.
I think we can use moderately sized dildos if we emphasize cleaning before and after and the lubricant with Nonoxinol 9 type lube.

Clearly we have to emphasize non-contact fantasy-related masturbation as the safest and even getting screwed with a rubber presents potential dangers.

We may want to talk about the warning signs (weight loss, diarrhea, cough, flu-like symptoms), lifestyle problems (rest, nutrition, drugs, alcohol, etc.), and actual symptoms of the opportunistic diseases.

I think the porn stars should do the talking.

NOTE: I had Steven process this document from my notes, and was unable to review it before I left for the East. Please forgive any errors in its content.
August 20, 1985

Hon. Alfred H. Kingon
Cabinet Secretary
The White House
Washington, D.C. 20500

Dear Mr. Kingon,

My good friends Dixon Arnett and Pete Hannaford suggested that I should write to you in that I may be of assistance in helping to develop the President's position on AIDS. I am a conservative Republican, and a long-time supporter of President Reagan.

As Governor George Deukmejian's appointee, and Chairman, of the California AIDS Advisory Committee, I have assisted him in developing a comprehensive, cost-effective statewide response to the AIDS crisis.

Recently, Senators Pete Wilson and Alphonse D'Amato hosted a briefing I conducted for Republican Senators and Health Legislative Aides on the AIDS crisis.

Given the recent revelation of the President's good friend Rock Hudson's AIDS diagnosis and the resultant surge in media attention on AIDS, I believe that the President has the opportunity to demonstrate his courage and compassion by meeting with a trustworthy group of AIDS experts (both governmental and non-governmental), at the conclusion of which, he could release or make a statement recapping the Administration's response and reviewing the anticipated action plan.

I may be able to assist in developing strategy, identifying trustworthy invitees (who will not use this as a forum to criticize the Administration), and proposing pro-active, cost-effective future measures.

In preparation, should you feel it necessary, I am sure we can set up a confidential senior staff level briefing.

This is not an issue we are going to be able to avoid much longer. The financial impact alone, if we could divorce the sorrow and suffering issues, of over a million Americans incubating a disease which costs almost $150,000 each to deal with from diagnosis to termination, requires our immediate response.

Sadly, Mr. Hudson will not live much longer. Without some significant gesture, the President may be put in an embarrassing position.

Sincerely,

BBD/smp

cc: Don Clarey 450-2800
     Bill Roper

3516 twenty-first street  san francisco, california 94114  415 / 824-2424
Dear Hume/Deke/Herman,

I believe I can be of some assistance to Pres. openly gay ambassador.

Governor Deukmejian - Chair Advisory Comm. Skel/Allen 2.

Senior WLC - Briefing senior leg Health Meet. Deke/Bob White.

Secretary Hécker - try to avoid. DLA

Advance staff/White House.

Kleber, Rilling, Krony.

Mike Goldsch - UCLA/Whelan. For approval.

Media profile/Whelan -> Pres. Respond.

Most political bombshell/historical retrospective.
August 21, 1985

Congressman William Dannemeyer
1235 North Harbor Boulevard
Suite #100
Fullerton, California 92632

Dear Congressman Dannemeyer,

As a fellow Republican as well as Chairman of, and Governor Deukmejian's appointee to, the California AIDS Advisory Committee, I head the group responsible for advising the Legislature and the Governor on matters relating to the AIDS crisis.

In light of the severity of the crisis, particularly here in California where we have been hardest hit, the eyes of the nation are turned to us for guidance. Accurate and timely information has proven the most crucial tool we have at our disposal in combating the epidemic. The Committee's topmost priority is assembly and dissemination of such information.

As evidenced by his expulsion from the American Psychological Association and repudiation by the Nebraska Psychological Association, Paul Cameron is clearly not a credible source of information in this area and its many sensitive ancillary aspects. He has repeatedly issued inflammatory and misinformed statements of inappropriate nature.

Serving with me on the Committee also as Governor Deukmejian's appointees, are: William J. Filante, M.D., who is the Assemblyman from the Ninth District (Marin and Sonoma Counties); Michael Gottlieb, M.D., Chief of the AIDS Research Unit at UCLA; and Richard Hamilton, M.D., a private physician in San Francisco. Any or all of us are balanced, competent men who stand ready to serve you in an advisory capacity, thereby bringing the scope of the subject into better perspective.

It is time that we realize that AIDS is not a partisan issue; not a political issue; nor a sexual issue; it is a public health issue. Democrats must not resort to demagoguery over it and, conversely, we Republicans must not manipulate the issue to our own ends.

Recently, Senators Pete Wilson and Alphonse D'Amato hosted a briefing on the AIDS crisis that I conducted for Republican Senators and their Legislative Health Aides in Washington. The success of this event has encouraged us to conduct a similar briefing for the Republicans in the House. Should you wish to co-host such a meeting, I'm sure you would find it both enlightening and beneficial.
Please let me know if there is any way I, or other members of the Committee might be of service to you. In the meantime, my best wishes for your continued good health.

Sincerely,

Bruce B. Decker
Chairman,
California AIDS Advisory Committee

BBD/smp

cc: Governor George Deukmejian
    Senator Pete Wilson
    Assemblyman William J. Filante, M.D.
    Michael Gottlieb, M.D.
    Richard Hamilton, M.D.
September 5, 1985

Mr. Bruce B. Decker
Chairman
California AIDS Advisory Committee
3516 Twenty-First St.
San Francisco, CA 94114

Dear Mr. Decker:

I was pleased to hear from my new Press Secretary, Duane Crumb, that you and he had a very constructive telephone conversation. It is important that we work together to stop the spread of AIDS and not allow this to become a partisan issue. This country cannot afford the delays in the vital efforts to find a cure and effective preventative measures that would result from losing sight of the real issue.

As Mr. Crumb explained to you, my recommendation to Secretary Heckler was motivated entirely by my desire to protect the blood supply of this country from contamination with the AIDS virus. We are not picking on male homosexuals because of their sexual preferences. We merely want to see to it that we make every reasonable effort to insure that those who receive blood transfusions are not taking an undue risk of contracting AIDS.

I applaud the work that has been done to develop tests, like the ELISA and Western Blot, for detecting antibodies in the blood. There is no doubt that they are a major step in the right direction. However, as long as there are significant incidents of false negative results from available tests, other steps must be taken to reduce the number of blood donors who carry the virus. That is the intent of my proposal to H.H.S.

Your suggestion that recipients of blood transfusions should be added to the list of individuals who are not allowed to donate blood appears to be a very good one. We are now researching the implications of such an action. If the results are what I expect them to be, I will soon be drafting another letter to Mrs. Heckler incorporating that concept. This is the kind of valuable input that can only come as a result of the open, nonpartisan discussion of issues of public interest.
It is sad that very little attention has been given to the message itself as a result of so much discussion revolving around a messenger who played a small part in bringing this issue to light. I hope that you and others will be able to help us to focus the attention of the public, and especially the press, on the real issue here, protection of the blood supply for all Americans through cutting down the number of members of high risk groups who donate blood for transfusions.

Thank you for making yourself available to me as a source of information on this vital issue. I look forward to having the advantage of your counsel in the future.

Very truly yours,

William E. Dannemeyer
Member of Congress

WED/dc:ps

cc: Governor George Deukmejian
    Senator Pete Wilson
    William Filante, M.D.
    Richard Hamilton, M.D.
    Michael Gottlieb, M.D.
September 11, 1985

Congressman William Dannemeyer  
1235 North Harbor Boulevard  
Suite #100  
Fullerton, California  92632

Dear Congressman Dannemeyer,

I appreciate your following up so quickly my conversation with your Press Secretary with your letter of September 5, indicating some areas where your beliefs lie. While on balance, it seems we are working towards a common goal of vanquishing the AIDS challenge, I must point out several serious contradictions.

In your letter to me, you acknowledge that "this kind of valuable imput can only come as a result of the open non-partisan discussion issues of public interest." You will certainly elicit no disagreement from me on that, however, you then stated to reporters three days later in San Diego, that the deadly AIDS epidemic is "related to Mr. Cranston" because "throughout his career as a senator he has been supportive and sympathetic to the male homosexual community." Crediting the spread of the disease to your possible future opponent amounted to nothing less than extreme partisan rhetoric.

Globally, a majority of diagnosed AIDS cases are in the male and female heterosexual community. Only in this country, where it happened to be introduced into the homosexual community, is it viewed as a "gay" disease. I am confident that should it have been introduced into another community (the wives of elected officials, for example), our response would be somewhat more positive.

AIDS is not a political, partisan nor a sexual issue; it is a public health issue. Neither is AIDS discriminatory: it cannot tell the difference between black and white, nor does it differentiate between male or female, gay or non-gay, or rich or poor, Republican or Democrat.

Also in the same letter, you state that "we are not picking on male homosexuals because of their sexual preferences." Why then the declaration as quoted in the San Francisco Chronicle of September 7, that "God's plan is Adam and Eve; not Adam and Steve."? This clearly contradicts your assurance to me of having no intention of singling out male homosexuals for chastisement or discrimination.

Unfortunately, your conflict of resolve is creating the perception that your actions are an attempt by a senatorial hopeful to cynically manipulate the enormity of the AIDS issue to his own benefit. You risk reinforcing the unfair image of Republicans as opportunistic bigots and uncaring, finger-pointing cowards.
When you asked what qualified me to be involved in meeting the AIDS challenge, I hope my experience and advisors satisfied you. I must now pose the same question: What qualifies you to interfere in strictly medical matters, such as the San Francisco General Hospital matter, where personal opinion has no place alongside that of hard medical research? It appears that your hunger to capitalize politically on AIDS has led you to interfere in the decisions regarding the wearing of masks/gloves by health care workers. You will note that the California Occupational Safety and Health Administration has voted against your position not once, but twice, reinforcing the Center for Disease Control's and the California AIDS Task Force's position on the matter. There is quite enough fear and misinformation circulating without a public figure like yourself fanning the fires of hysteria.

As I well know, especially during a hectic campaign, sometimes information gets misrouted or misstated. I appreciate your indication to me that you wish to avoid unnecessary focus on the mistakes when there is still so much to be done in a positive vein. So I ask you:

How do you explain these contradictions?

Sincerely,

Bruce B. Decker
Chairman,
California AIDS Advisory Committee
WILLIAM E. DANNEMEYER 39TH DISTRICT, CALIFORNIA

COMMITTEES:
ENERGY AND COMMERCE
JUDICIARY

Congress of the United States
House of Representatives
Washington, DC 20515

September 24, 1985

LEGISLATION TO PROTECT PUBLIC HEALTH FROM AIDS

Dear Colleague:

As a Member of the Energy and Commerce Subcommittee on Health and the Environment, I am committed to finding a cure for AIDS as well as taking precautions to safeguard public health. In this spirit I am introducing five bills to curtail the spread of this deadly disease. Your original cosponsorship is requested.

Background

Since 1982, $407 million has been expended on AIDS research. In 1982, only $5.6 million was appropriated for research. In 1986, just under $200 million has been earmarked, indicating a response to the need for intensive effort. This level must be maintained.

On August 3 I wrote to Secretary Heckler asking that all "males who have had sex with another male since 1979" be prohibited from donating blood. At that time Public Health Service guidelines allowed "monogamous homosexuals" to donate blood. On September 8, the Public Health Service responded by revising its guidelines to request that "any male who has had sex with another male since 1977" refrain from donating blood.

While encouraged by this action, I am still concerned with the inaction of public health officials in responding to the spread of what can only be termed, this century's version of the Plague. More than 1 million Americans have been infected with the AIDS virus and there are 13,000 confirmed cases of this incurable disease, in over half of which the patient has died.

The social, legal and medical responses to this situation are grossly inadequate, given its severity. The Centers for Disease Control (CDC) has issued guidelines which do not propose significant solutions for curtailing the spread of this disease in schools and hospitals. The guidelines suggest that protective clothing is not necessary for health care professionals when dealing with AIDS patients and that the patients should not be isolated, but rather dispersed throughout hospital. CDC says children should be allowed to attend school absent any "special" conditions or tendencies of that child. CDC claims that the disease cannot be spread casually and yet the live AIDS virus has been found in blood, semen, serum, saliva, urine and tears.

If the virus exists in this myriad of fluids, logic dictates the possibility of transmission through a variety of means not yet understood. The AIDS virus may have an incubation period of up to eight years, raising the possibility of inaccurate data when studies report that no "known" cases of AIDS have resulted from "casual contact". Medical science is confounded by this virus, which is only partially understood, presently untreatable and invariably fatal. Yet the political, medical and social reaction has been one of avoidance of taking reasonable precautions out of fear of discriminating against the unfortunate victims of this disease. AIDS is not about civil rights or political power, it is a disease of a magnitude "unparalleled in human history" (see attached article by Dr. Richard Restak, a neurologist, which appeared in the Washington Post and Los Angeles Times). Due to uncertainty on transmission and cure, it seems only prudent that we take all precautions and not make the general population into guinea pigs for determining transmissibility of the AIDS virus.
Summary of Legislative Package

The first bill would make it a felony for a person in an AIDS high risk group to knowingly donate blood. CDC defines "high risk group" as those with AIDS, intravenous drug users, homophiliacs, those who have received a transfusion within the previous year, or males who have had sex with another male since 1977. This is to give teeth to the Public Health Service guidelines with a criminal penalty.

The second bill forbids discrimination against nurses, or any health professional, in using protective garments when treating AIDS patients. The impetus comes from a situation at San Francisco General Hospital, where nurses are prohibited from wearing protective clothing when treating AIDS patients while doctors, janitors and x-ray technicians are allowed to do so. The hospital says this denial is based on CDC guidelines and the sensitivities of AIDS patients. Cal-OSHA ruled in favor of the nurses right to wear protective garb at their discretion EXCEPT when the doctor indicates it is not appropriate. Following this ruling, doctors reportedly made a notation on every AIDS patient's chart that the nurses were not to wear such clothing and while making such a notation were themselves wearing protective garments.

While I acknowledge the existence of medical data suggesting that protection is unnecessary, common sense dictates allowing these health professionals the option of taking additional precautions rather than prohibiting standard safety measures. Nurses should not be subject to a different standard than doctors. The bill prohibits any hospital receiving federal funds to practice discrimination with regard to wearing protective garments when dealing with AIDS patients.

The third bill prohibits persons with AIDS from practicing in the health care industry. Again, common sense dictates that a doctor, nurse, dietician or technician with AIDS should not come into contact with other individuals in a medical setting.

The fourth bill addresses halting the transmission of AIDS through sexual contact. This bill provides that any city throughout the United States which fails to shut down its bath houses will be denied federal funds. The medical community is in full agreement that AIDS is transmitted through promiscuous homosexual contact which flourishes at these facilities.

The fifth bill concerns the school attendance of students with AIDS. I believe such school children should be prohibited from attending school. Although CDC has promulgated contrary guidelines I believe they are inadequate to deal with the special circumstances attendant upon the classroom situation. Children come into close contact with one another during the course of the school day and cannot be expected to shoulder the burden of taking necessary precautions in dealing with another AIDS child.

Please call Missy Hancock in my office at XS-4111 to cosponsor any or all of the bills in this package. Your support would be most appreciated.

Sincerely yours,

William E. Dannemeyer
Member of Congress
Worry About Survival Of Society First; Then AIDS Victims' Rights

By Richard Restak

Paradoxically, the truly humanitarian position in the face of an AIDS plague is that we not identify with the victims and instead cast our lot with what in earlier times was dubbed the "common good."

More than 1 million Americans may have been infected with the AIDS virus. And the 33,000 Americans with confirmed cases of the disease, whose number is doubling every year, should be treated with the care and compassion due to anyone who is ill with a so-far incurable and invariably fatal disease. This shouldn't be confused, however, with a refusal to make painful, sometimes anguish¬ing but nonetheless necessary distinctions in the interest of diminishing the likelihood that this awful disease will spread further.

Plagues are not new. They have been en¬countered in every age and among every na¬tionality: syphilis among the Spanish, bubonic plague among the French, tubercu¬losis among the Eskimos, polo in America.

What is new are efforts by medically una¬sophisticated politicians and attorneys to dic¬tate policy in regard to an illness that has the potential for wreaking a devastation such as has not been encountered on this planet in hundreds of years.

Also differing is the response that, in some quarters, is being suggested: Accept the AIDS victim into our schools, place little or no restrictions on employment or hous¬ing. The AIDS victims' "rights" in these areas, we are told, should take precedence over the so-far incompletely determined potential for these victims to spread this dread illness.

But what some are describing as "dis¬crimination" and "segregation" has a long and not altogether hagiographic history in medicine. Quar¬antines have been very effective in beating outbreaks of scarlet fever, smallpox and ty¬phoid in this century. Indeed, by protecting the well from the ill we follow a long established sensible and ultimately compassionate course. Throughout history true humanitar¬anism has traditionally involved the compas¬sionate but firm segregation of those af¬flicted with communicable diseases from the well. By carrying out such a policy, diseases have been contained.

Only sentimentality refuse to make any distinction between the victims of a scourge and those not presently afflicted. Scientists still are unsure why the AIDS virus targets the white blood cells that are the one indis¬pensable element of the body's immune sys¬tem. But the threat of AIDS demands from us all a discrimination based on our instinct for survival against a peril that, if not somehow controlled, can destroy this society. This is a discrimination that recognizes that caution is in order when knowledge is incom¬plete so that the public interest can be pro¬tected. This argument is not a counsel against good medical care or proper concern for AIDS victims.

Richard Restak, a Washington neurologist who has been studying AIDS as a brain¬related disease, is the author of "The Brain."

See AIDS, C4, Col 1
AIDS, From FT

Nor is it a suggestion that we curtail any civil rights which don't potentially impinge on the lives of others.

It is a suggestion that the humanitarian response to AIDS is exactly the opposite of a humanitarian response to sex and racism. In the presence of considerable ignorance and prejudice and effects of the syndrome, the benefit of the doubt should not be given to the victim of AIDS. This is not a civil rights issue, this is a medical issue. To judge that the AIDS virus must not be graduated is not to make judgments on morals or lifestyles. It is to say that the AIDS virus has no civil rights.

At the moment, social and legal solutions to the AIDS problem are provided, creating at a pace disproportionate to the knowledge that experts presently possess, concerning the illness.

For instance, on Aug. 14 the Los Angeles City Council unanimously approved an ordinance making it illegal to discriminate against AIDS patients in regard to jobs, housing and health care.

"We have an opportunity to set an example for the whole nation, to protect those people who suffer from AIDS against insidious discrimination," said the councilman who introduced the measure.

Councilman Erma Bernardi said the ordinance was meant to educate the public to prevent hysteria.

Preventing hysteria is good, but this ordinance, passed despite discrimination being very much at the center of the debate and the degree of contact required for the disease to be spread from one person to another, may not be strong enough. One study found that the varied and partly contradictory measures put into effect across the country in response to the recent discovery that the AIDS virus can be isolated from a victim's tears.

At Boston University, when an AIDS patient is examined, "We are not using the application programmer [a device that tests for 'viral' or antibodies] because we don't feel we can adequately sterilize it," said the chairman of the department of ophthalmology.

The Massachusetts Eye and Ear Infirmary specialists plan to "review our technique," while we're not sure yet what we're finding.

or not a child should be admitted to school.

Spokesmen from the CDC and other AIDS authorities including Dr. Arne Folsom, who treats the largest group of children with AIDS, may be correct in noting that there is an "overwhelming evidence that AIDS is not a highly contagious disease." However, in a combined interview, they then gave the following responses to the interviewer's questions.

Q: Suppose my child gets into a fight with an AIDS victim and both begin to bleed?

A: That kind of fight with a possible exchange of body fluids would arouse some concern about transmission of the virus.

Q: What if my child is in a classroom with an AIDS victim who lives up or had diarrhea?

A: Each such case would be a matter of concern. In its guidelines, the CDC said that AIDS victims who cannot control bodily secretions should be kept out of ordinary classrooms.

Q: Suppose a child with AIDS hits my child?

A: Again, a bite would arouse concern.

Any grade-school teacher can attest that "body-fluid contamination" in the form of scratching, throwing up, diarrhea, biting and spitting are everyday fare within a normal schoolroom. That's why infectious diseases like the flu spread through schools like flash fires.

It is difficult to imagine how the CDC or anyone else is going to make policy determinations under such circumstances.


In this sentiment, he echoes the concern of parents everywhere: What if future research shows that AIDS can be transmitted in other ways, for example, by mere casual contact with the virus-infected person? What if this exposure can be long-term and cause adverse scientific developments?

AIDS is not about civil rights, political power or "alternative lifestyles." It's a disease, a true plague that already, in the words of infectious disease expert Dr. John Scale, writing in the August issue of the Medical Journal of the Royal Society of Medicine, is capable of producing "a lethal pandemic throughout the crowded cities and villages of the Third World of a magnitude unlike any known virus." Further, this disease is only partially understood, is presently untreatable, and is invariably fatal. For these reasons alone, caution would seem to be the better part of wisdom to the public to those suffering from this illness.

But in addition, the incubation period is sufficiently lengthy to cast doubt on any proclamation in no matter how seemingly authoritative in regard to the transmissibility of the illness: "The virus may be transmitted from an infected person many years before the onset of clinical manifestations," according to Dr. Emery, editor-in-chief of the Journal of the American Medical Association. "Latency of many years may occur between transmission, infection and clinical manifestations."

Indeed, truly authoritative statements regarding AIDS cannot presently be made. "The eventual mortality following infection is unknown," according to the CDC that AIDS cannot be evaluated on an individual basis in order to determine whether...
Republicans Gather In San Diego, Toss Barbs at Cranston

By Larry Liebert
Political Correspondent

San Diego

California Republicans are going to spend the weekend in San Diego rhetorically bashing Democratic Senator Alan Cranston — and he is coming to town to reply.

More than 1700 delegates and alternates arrived yesterday for a state Republican Party convention that may be short on action and long on ringing oratory and political hoopla.

Rather than endure the expected nastiness silently, Cranston has scheduled a press conference tomorrow at a hotel just down the street from the Republican convention headquarters.

By yesterday evening, the Republican convention center was decked out in posters blasting Cranston and promoting some of the 10 or so Republicans who want his job.

Representative Bobbi Fiedler of Los Angeles put up signs with the slogan: "Time has run out for Alan Cranston."

The sharpest criticism of Cranston came from a Senate candidate who is campaigning on evangelical moral issues, Representative William Dannemeyer of Fullerton. He told reporters that the deadly AIDS epidemic is "related to Mr. Cranston" because "throughout his career as a senator he has been supportive and sympathetic to the male homosexual community."

Another Senate hopeful, Assemblyman Bob Naylor of Menlo Park, hired a double-decker bus to give delegates free rides from the airport to the convention hotel.

Representative Ed Zschau of Sunnyvale may not receive a warm welcome from the Republican Party insiders because most of them are staunch conservatives who tend to view him as a liberal. To protect against a cool reception, Zschau imported 200 of his friends and supporters from the Bay Area.

State Senator Ed Davis of Chatsworth is using a nautical theme in this seaport city with "S.S. Ed" buttons. Davis also will promote his ballot measure to toughen the state's death penalty law.

Only one of those interested in running for the Senate will get a chance to address the convention formally — Los Angeles County Supervisor Mike Antonovich, who will get to give a talk in his role as state Republican chairman.

Despite grumbling by some of his Senate opponents that he is misusing the chairman's job to promote his own ambitions, Antonovich has said he does not plan to step down as party chief until he formally announces his Senate candidacy at year's end.

There is also some grumbling behind the scenes about Bill Park, the party vice chairman who will become chairman if Antonovich resigns. Park is viewed as a liability by some Republicans because he is facing federal charges for alleged shortcomings in operations of a toxic waste dump he owns.
Congressman Seeks Masks for AIDS Nurses

By Maitland Zane

Nurses caring for AIDS patients at San Francisco General Hospital should be permitted to wear protective masks, gowns and gloves, a Southern California congressman said yesterday.

U.S. Representative Bill Dannemeyer, R-Fullerton, said he has written to Secretary of Health and Human Services Margaret Heckler asking that a regulation be issued "requiring all hospitals receiving federal funds to allow nurses the option of wearing appropriate protective clothing when caring for AIDS patients."

Dannemeyer was joined at a press conference at the Press Club by two San Francisco General nurses who were reprimanded for wearing masks while treating AIDS patients. The two are among four nurses who have complained to the state about allegedly "unsafe and unhealthful" working conditions.

"I have nothing but compassion and sympathy for victims of AIDS," said Dannemeyer, who last month proposed a ban on blood donations by male homosexuals. "But until we know more about how this disease is transmitted, we cannot, in good conscience, prohibit hospital employees from taking the steps they deem necessary to protect themselves."

Dannemeyer is seeking the Republican nomination for the U.S. Senate on a fundamentalist platform that includes his belief that "God's plan is Adam and Eve, not Adam and Steve."

Nurses Julie Bernales and Norma Watson said they had received formal reprimands for wearing masks.

The "no masks" policy recently was defended by Dr. Donald Abrams, assistant head of the hospital's AIDS clinic, on the grounds that the disease can be transmitted only by intimate sexual contact.

Bernales, who has worked at the hospital for seven years, said her union refused to intervene. She and the other three nurses then appealed to the California Department of Industrial Relations, which is reviewing the dispute.
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The state labor commissioner ruled on Tuesday that there was insufficient evidence to connect the nurses' transfers to their complaints about working with AIDS patients.

The issue sparked a Cal-OSHA investigation into the hospital's AIDS care guidelines and whether they present health or safety hazards to the hospital staff.

Hospital guidelines discourage personnel from wearing protective garments around AIDS patients unless they are coming in contact with bodily secretions or blood.

Concluding its investigation yesterday, Cal-OSHA ruled that it "did not find any violations of existing occupational health and safety standards. San Francisco General Hospital's policies and procedures for health-care workers caring for AIDS patients are in accordance with the recommendations of the Centers for Disease Control and the state of California AIDS Task Force."

An attorney for the nurses declined to comment.

None of the four nurses worked in the hospital's AIDS ward.
A study conducted a couple of years ago in over 100 California hospitals showed that certain unsafe nursing practices were common. They may, in fact, have caused many nurses to become disillusioned and leave the profession.

The employment scene has changed in the state since then, but the need to watch for such practices is still as great. Wherever you practice, you can benefit from this eye-opening research...and help improve the quality of care.

Is Patient Care—and patient safety—deteriorating? Three years ago, several California nurses who'd left their hospital jobs told us they'd left because patients were endangered by unsafe nursing practices.

We wondered how accurate their criticisms were. Was nursing care as bad as they described?

To find out, we decided to study actual nursing practices.

Designing the study
Based on the nurses' complaints, we made a list of 27 unsafe nursing and management practices that fit into four general categories:

1. Medication management
2. Nurse-patient relationships
3. Unit leadership
4. Management policies.

We deliberately limited our study to:

• nursing practices we felt any nurse would recognize and stop
• management practices we were sure no hospital would routinely permit.

Choosing our research team
Twenty-five skilled, concerned nurses did the field work on our study, collecting data for nearly a year. Nineteen of them worked for registries, which gave us access to a great many hospitals.

For 50 weeks in 1980 and 1981, they observed nursing practices in 110 California hospitals and collected data on 1,150 shifts.

In every hospital, nursing managers supported our doing the study. As a professional courtesy, we told supervisors and directors of nursing about the study before we collected data at their hospital. All of them were pleased to be part of the study and said they hoped our results would help their administration identify problems. They agreed not to bias the study by telling staff nurses about it.

For the same reason, our observers didn't mention the study unless staff members questioned them. When that happened, our observers explained exactly what they were doing and reassured them that we wouldn't show our specific observations to the administration or nursing service.

Thus reassured, staff members also supported the study. Like their supervisors, these nurses said they were glad we were taking a look at dangerous nursing practices.
We kept our promise to protect everyone’s confidentiality. We identified each observer and hospital by code number. We didn’t tell our observers the names of other observers or the names of other hospitals being studied.

Results showed widespread problems
As the accompanying graphs show, we found that many of the 27 unsafe practices were common. Many occurred on more than half of the shifts we observed. Some occurred on all the shifts.

Actual occurrences were probably more common than our study showed. For one thing, our research nurses were too busy with their own duties to observe all the time. For another thing, we recorded each behavior simply as occurring—or not occurring—on each shift. Even if a behavior occurred several times on a shift, it showed up in our results as a single occurrence.

Dangerous medication practices were common
In 63 percent of the hospitals, Kar dexes weren’t kept up to date on almost all shifts. (For brevity, we’ll use the term “almost all shifts” to mean 90 to 100 percent.) This tardiness certainly provided the potential for medication errors. And we found a startling number of examples.

Bar codes show how frequently practices occurred in hospitals observed.

- None of the shifts
- Less than half (1%-49%) of the shifts
- Half or more (50%-89%) of the shifts
- Almost all (90%-100%) of the shifts

Narcotics were improperly given on many shifts. For example, narcotics were given after the narcotic order expired on at least half the shifts in every hospital we observed. Some patients received narcotics for many days after the order expired. (Our statistics don’t include any cases in which nurses—out of concern for a patient in pain—knowingly gave a narcotic after the order expired.) The observers suspected that nurses habitually gave medications without checking expiration dates on the orders. In other cases, they thought nurses didn’t know when narcotic orders had to be renewed.

These and other medication errors should have been reported as incidents. But they rarely were. Such errors were consistently reported in only 10 percent of the hospitals. In 45 percent, incident reports weren’t prepared for reportable errors that occurred on almost all shifts. In some cases, charts were falsified to cover up the mistakes.

In 37 percent of the hospitals, our observers found failures in giving prescribed medications on time on almost all shifts. Most of these hospitals had the unit-dose system. And the pharmacy usually caused the delay.

The delay sometimes had far-reaching effects: The nurse usually had to spend time repeatedly contacting the pharmacy, trying to get the medication. During this time, she got behind in her own duties. Later, she had to hurry through them, increasing the likelihood that she’d make mistakes.

In 28 percent of the hospitals, antibiotics were given after the order expired on almost all shifts. In another 36 percent of the hospitals, they were given after it expired on at least half of the shifts.

In 20 percent of the hospitals, the medication cart was left unlocked and unattended in a hallway on almost all shifts.

In 9 percent of the hospitals, the key to the narcotics drawer or cabinet was accessible to everyone on almost all shifts. In another 27 percent of the hospitals, it was left out on half or more of the shifts.

In 36 percent of the hospitals, patients received the wrong intravenous (I.V.) fluids or continued to receive I.V. fluids that weren’t ordered on over half of the shifts observed.

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Inappropriate nurse-patient relationships were common

Observers noted inappropriate (sarcastic or silly) behavior on almost all shifts in 65 percent of the hospitals. Our observers jotted down comments like these:

- When a patient asked for juice: “What do you think this is, a hotel?”
- When a patient asked for something for a headache: “How about a hammer?”

Such remarks weren't common, but in none of the hospitals were all nurses consistently polite and caring toward patients.

Observers saw nurses who simply put off answering the call lights. They saw many patients who were clearly intimidated by their nurses and who felt guilty asking for care.

In 36 percent of the hospitals, on almost all shifts, at least one newly admitted patient had to wait for staff attention for over 30 minutes. (This was a problem particularly at change of shift.) In these cases, no one checked vital signs, gave any care, or brought water or a food tray.

The reason for these practices?

These practices probably weren't deliberate, of course. We interviewed nurses who left their jobs because of such practices: They say nurses get frustrated, then take the frustration out on their patients.

They say some of the practices occur because constant stress makes nurses feel they've lost control over the situation. Feeling out of control, they become mechanistic in their work—operating out of habit, not analyzing their choices and the consequences of them.

Examples of poor unit leadership

Poor leadership was the rule rather than the exception in the units we observed. Many head nurses and team leaders seemed unaware of the importance of assessing their staff's strengths and weaknesses, getting an overview of the unit's problems, then making careful assignments to correct them. Some examples of the problems we saw:

- No walking rounds. Initial walking rounds were always done in only 11 percent of the hospitals we observed. In the rest of the hospitals, nurses got to their assigned patients as soon as they could.

- Delayed report. We considered a report delayed if it started more than 30 minutes after the shift started or if it lasted more than 30 minutes. Both conditions might increase the likelihood that medications and other treatments would be delayed.

  In 17 percent of the hospitals, report ended late on almost all shifts.

- Unclear responsibility. On every shift, in every hospital, our observers noted the charge nurse's failure to review the team nurse's or primary nurse's responsibilities—or to define terms used on the unit—to float and registry nurses. As a result, role confusion was common.

- Unclear assignments. In 36 percent of the hospitals, nurses left report on almost all shifts uncertain of their patient assignments.

- Incomplete report. Observers also evaluated the completeness of the report given on
each patient. Did it include all the vital information the oncoming nurses needed—such as new orders, laboratory results that affected treatment plans, changes in condition, and special treatments for the day?

In all hospitals, reports were considered inadequate on half or more of the shifts. In 72 percent of the hospitals, they were inadequate on almost all shifts.

- **No assessment of float or registry nurses’ skills.** Charge nurses and team leaders rarely asked pool nurses, float nurses, or registry nurses even the most basic questions about their skills. Such skill assessments were routinely done in only 10 percent of the hospitals.

- **Ill-considered assignments.** Patient assignments were often made randomly, with no effort to match patients’ needs with nurses’ skills.

In 27 percent of the hospitals, head nurses failed to assign the most difficult patient to the most skilled nurse on almost all shifts, according to observers’ judgments.

Sometimes patients requiring a great deal of care were assigned to the nurses least likely to complain—registry nurses who’d be on the unit for 1 day only, for example. “Easier” patients were assigned to nurses who did complain.

In some hospitals, charge nurses posted assignments instead of giving them verbally. Our observers suspected that some of them chose this practice to avoid being confronted by staff nurses unhappy with their assignments.

- **Changed assignments.** Changes in assignments after the shift starts obviously increase the risk of confusion, frustration, and interruptions or delays in patient care. Despite these negative results, 47 percent of the hospitals changed assignments on almost all shifts observed.

**Examples of poor management policies**

Nursing administration policies apparently contributed to unit leaders’ difficulties:

- **Unqualified nurses temporarily assigned to the unit.** In 82 percent of the hospitals, almost all shifts contained at least one unqualified nurse.

These nurses were pulled from other units or called in from registries despite their lack of experience in caring for patients on the unit.

- **Unfamiliar charge nurses.** Some 38 percent of the hospitals regularly used registry nurses as charge nurses, even though these nurses couldn’t know the individual skills and experience of the nurses they took charge of.

- **Majority of staff from a registry.** To make the charge nurse’s task even more difficult, a third of the hospitals had to fill in over 50 percent of a unit’s staff with registry nurses on almost all of their shifts. And another factor: In 28 percent of the hospitals observed, the entire staff on a given unit was composed of registry nurses on at least half of the shifts. (Note: Most California hospitals are no longer using such high percentages of registry or agency nurses. So this problem may not be as acute as it was when our study was done.)

- **Inadequate orientation.** Despite guidelines from the Joint Commission on Accreditation of Hospitals (JCAH), few hospitals provided orientation for registry nurses. In 72 percent of the hospitals, on almost all shifts, registry nurses were expected to start working without understanding the hospital’s philosophy or knowing the location of supplies, emergency equipment, or diagnostic departments.

- **Mixed systems of care delivery.** Providing good patient care was complicated by many hospitals’ practices of mixing functional nursing, team nursing, and primary nursing on the same unit.

In units where this occurred, observers reported confused lines of authority and responsibility. On over half the shifts in all hospitals, team leaders also acted as a primary nurse to one or two patients. Confusion—and mistakes—resulted.

- **Mixed nursing schedules.** Patient care also suffered when hospitals used a mixture of shift lengths on the same unit. In units that mixed 8-hour, 10-hour, and 12-hour shifts, the nurses spent more time in report, which took time away from patient care.

Nurses sometimes became confused about patient assignments when shifts overlapped. When this happened, some patients got lost in the shuffle.

This was a particular problem on 3-to-11 shifts. Some patients weren’t assigned to a 3-to-11 nurse when the 10-hour and 12-hour people went off duty at 5 p.m. and 7 p.m.

- **Careless screening of outside nurses.** Finally, many hospitals showed a disturbingly careless attitude in checking out registry nurses. Only 35 percent of the hospitals routinely requested proof of licensure from registry nurses. And only 18 percent asked for a driver’s license or other identification!

**Why were these practices so common?**

Our experience as nurse consultants for several hospitals suggests several likely causes of these problems:

- **The nurses didn’t realize the practices were wrong.** This is probably
the least likely explanation for most of the poor practices we observed. For one thing, we deliberately chose practices that discontented nurses had described to us. And we have no reason to believe those nurses knew more than the nurses who’ve kept working.

For another thing, we saw a disturbing pattern in some of the hospitals during our 50-week study. During this time, several hospitals were surveyed by JCAH. During the JCAH survey, hospitals with severe nursing problems would “clean up their acts.” After the survey, they’d revert to their former practices.

- **The nursing shortage made good practices impossible.** The shortage clearly played a role in many of the hospitals we observed during our study, although today this problem is less severe. Instead of closing units that had inadequate staffing, hospitals would pull nurses from another unit. This occurred in almost all of the shifts in 80 percent of the hospitals.

  These nurses were sometimes unprepared for the work of the unit. Many were angry and frustrated at being pulled. And some took out their anger on the patients.

  Staffing shortages probably directly led to some of the practices we observed. For example, leaving the narcotics key out or leaving the medications cart untended in the hall were possibly considered short-term solutions in some understaffed units.

- **Nurses were poorly prepared for leadership positions.** Our study showed that many unit leaders didn’t seem to know how to organize an effective unit, how to communicate to their staff, how to assess nurses’ strengths or patients’ relative needs, or how to distribute work loads.

  In our work as management consultants, we frequently see such problems because nurses haven’t had adequate management training.

- **The practices arose out of frustration and poor morale.** In a 1980 survey report, Lynn Donovan (RN, June 1980) reported that 92 percent of nurse respondents rated a sense of achievement as a very important goal, but only 32 percent felt they’d achieved that goal. Of course, your feeling of achievement is related to others’ recognition of your achievements. Some 45 percent of nurse respondents in that 1980 study said recognition was poor from their administration.

  What happens when the goal of achievement is frustrated over and over? Our studies and others show that some nurses leave nursing. Others quit setting goals. They’re the nurses who eventually burn out, who quit caring because caring hurts too much.

  Psychologists also know that motivational patterns can change as a de-
fense against frustration. And that brings us to our next theory.

- Nurses need social approval more than they need achievement.

Nurses we interviewed in a 1981 study were more motivated by the need for social approval than by the need for achievement. These goals may have shifted because the nurses' need for achievement was frustrated for so long. Whatever the explanation, a strong need for approval could explain some of the leadership problems we observed.

Unit leaders and staff nurses who have a strong need for approval are less likely to report incidents, make unpopular patient assignments, and require excellence from the staff they supervise.

Some proposals for better patient care
We hope that you'll see our results as a challenge—not as a disparaging look at nursing. We've discussed some serious problems here because they need to be examined.

We need to analyze why they occurred and whether they're symptomatic of larger problems. Then, we need to figure out a better way to handle them.

How can you meet the challenge? Here are some tips:
- Look at your own unit in terms of the 27 problem behaviors we looked for in our study. Which ones do you need to work on? Which must your administration solve?
- Document the problems, and communicate your findings—to your peers and your supervisors. Make your comments objective and impersonal to reduce the chance that others will reject your results.
- Try to analyze why the problem behaviors developed. Are they attempts to solve other, more basic problems? Are they the consequences of other problems? Or are they poor practices that developed gradually because no one corrected them?
- Tell your nursing administration what support you need. And offer support to those you supervise. We've seen dramatic changes in hospitals that provided management training for their nurses—and encouraged the nurses to use management skills.

Hospitals that had apathetic, frustrated staffs who displayed many of the undesirable behaviors turned into motivated, professional organizations when communication and support increased.

- Encourage others to change by changing your own behavior. You can be not only a good nurse, but a good role model as well.

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May/June 1983 NursingLife 45
Demotivation in the nursing profession: Its causes and its cure.

by Genevieve Clavreul, RN, MS, MPA
Sue Caviness, PhD

The First of a Four Part Series

The "D-Syndrome", or nursing demotivation, has affected hospitals from coast to coast in epidemic proportions. In fact, it should be noted that attempting to recycle nurses who have once left the nursing profession by reason of job dissatisfaction has only led to an exacerbation of the "D-Syndrome".

This demotivation is caused by feelings of helplessness and powerlessness within the organizational structure—the inability to either effect change within a system or realize professional or personal growth as a result of interacting within a system.

We have often heard the phrase, "You can’t beat City Hall". It is also true that both hospital organization as well as its management systems and practices are often, in fact, antithetic to not only the personal, but also the career growth needs of the staff nurse. This produces apathy and demotivation in the nurse.

Let's look at the characteristics of hospital organization and management and focus on why such characteristics lead to demotivation. The typical hospital organization chart is authoritarian in nature. This means that decision-making power is reserved strictly for higher echelons within the structure and, depending on the hospital itself and its general organizational climate, only certain individuals within those echelons. The result of this is that the staff nurse at the lowest echelon is cut off from the decision makers and hence the decision-making/planning process. For example:

You are the head nurse of a medical floor. The ICU has had two unexpected admissions. The house supervisor informs you she is pulling Mary Jones from your floor to go to ICU.

Continued on page 2
Demotivation in the nursing profession: Its signs and symptoms.

by Genevieve Clavreul, RN, MS, MPA
and Sue Caviness, PhD

The 2nd of a Four Part Series

The "D Syndrome", or nursing demotivation, is affecting nurses across the country. In part one of this four part series, we examined the hospital organization and management systems that are often antithetic to the personal and career growth needs of the staff nurse, often leading to apathy and demotivation.

Let us move on then to a brief discussion of what typical signs the alert observer should look for. One of the areas where dysfunction resulting from demotivation is most obvious is patient care. It is true that the quality of care is directly related to both the nurse's sense of achievement and job satisfaction. Clearly, if the demotivated nurse has lost control of her sense of duty as well as lost interest in herself, patient care is affected.

The most obvious sign of demotivation here lies in the nurse's inability to make proper judgments related to medication management. Specifically, both poor hospital management and poor nurse performance combine to result in truly hazardous medication management. For example: One of our field studies (published in Free Inquiry Sociological Journal, November, 1982) shows that in all the hospitals under observation, in at least one unit, narcotics were given after the orders for that narcotic were expired. Sometimes the patients received the narcotic for many days after it should have been stopped. Again, we found frequent mismanagement of intravenous (IV) fluids where IV fluids started in the emergency or operating room were continued in the unit but without specific orders from the attending physician to do so. In addition, the patient may have received the wrong IV fluid because the person starting it made a mistake. And the problem is often further complicated when the nurse on the next shift continues to give the wrong fluid without checking the orders. This type of error is prevalent when antibiotics are continued and not checked against orders. It is the responsibility of the nurse to be aware of the expiration time of orders for specific medications, and to have the knowledge base to know the side effects otherwise. It goes without saying that the demotivated nurse will not exercise such caution.

Another area where demotivation manifests itself most clearly is nurse-patient relations. When demotivation has taken its toll on a nurse, there is an increasing loss of interest in the total recovery of the patient. The nurse's loss of self-esteem and her general feelings of helplessness, it is obvious that the resulting behavior will frequently manifest itself in repressed anger and aggression.

In our studies we found that sometimes the situation had so deteriorated that the nurse was rude or hostile to patients or deliberately ignored their requests. What was observed more commonly was signs of boredom or disgust from the nurse when answering a patient or putting off answering a call bell when patients' needs were oftentimes very important. Our study indicated such inappropriate comments as: Patient requests a glass of juice—nurse responds, "What do you think this is, a hotel?"; or patient requests something for a headache—nurse responds, "How about a hammer?" With this attitude it is not surprising that we found that patients had increased anxiety as they sat in their rooms with no vital signs taken, no care and no food for a prolonged period of time. It goes without saying that a management system that requires long shifts for already overworked nursing staff only contributes to the already unproductive, inefficient and dangerous situation.

Withdrawal can also be observed in the demotivated nurse by such characteristics as tardiness or absenteeism, poor grooming, focusing on personal rather than job related matters and overall disorganization.

Consider the change of shift report. The function of report at the change of shifts is to give the oncoming nurses appropriate information so they can take care of the patients accordingly and adequately. Often, however, vital information is not covered as the outgoing and demotivated nurse either rushes through the report or spends inordinate time talking about things that are not important, or expressing

Continued on page 6
The “D-Syndrome”...
Continued from page 1

Unfortunately, Mary Jones has fears of working in ICU even though she has been pulled to go there before. She is excellent in medical but does not do well in emergency situations that call for fast judgment. She is the best person on your team. Now both units will have ineffective staffing. The supervisor has no awareness of these dynamics; she just looked at staffing numbers and decided your unit was .5 nursing care hours over your needs. Statistics ruled over communication of real needs and participative management. How will you feel about your authority? What will happen with your frustrations? How will this event affect the morale on your unit? What are the legal implications? How long will Mary Jones stay in nursing?

The above example demonstrates how the demotivation process is often triggered by the multiplicity of frustrations created as a result of having little or no control over what to do and how to do it. This bears a striking resemblance to the very mode in which nurses have been taught; that is, independence of action and creativity are not rewarded. And it doesn’t take much imagination to project from this combination the manifestations of powerlessness that can ensue in time. For example:

Sally Smith was the best student in her nursing class—alert, quick to learn and eager to take responsibility. Her teachers encouraged her leadership. When she took a staff position in the SICU Memorial Hospital, she was enthusiastic about good nursing care and innovative programs. Her head nurse felt threatened by changes and having one of “her little nurses” getting more attention than she did. Sally Smith favorably impressed the physicians when they made rounds on the unit because she was very knowledgeable about the patients. They started asking her about the patients, ignoring the head nurse. Sally did not seek out this attention; the physicians started asking for her when they were on the unit. The head nurse was jealous and started trying to undermine Sally’s initiative by giving her less challenging assignments and taking her off committees and special projects. It was not long before Sally became confused, angry, and then apathetic about nursing. In time, she left to go to work for a registry.

Another contributor to the demotivation process lies in the very nature of the hospital’s management system and concomitant practices. It is, in fact, the management system that (1) conveys policies, procedures, standards and responsibilities as well as, (2) monitors and controls how such policies, procedures, standards and responsibilities are administered. Two key issues in basic management style then are communication and administration. What too often happens, however, is that management is either often inadequately trained to either communicate decisions related to systems and procedures and/or effectively monitor and interpret feedback from its administrative staff. Therefore, the demotivation process is further aggravated when the staff nurse is caught up in an administrative web whereby she must fulfill her “helping obligations” with only partially communicated and understood procedures and often without a very clearly defined set of responsibilities related to her role within the organization. This not only alienates the staff nurse from the fundamental structure of the hospital, but, more importantly, also alienates her from a basic understanding of what her role is and how to perform her basic functions. For example:

The physician in charge of the diabetic clinic decided to start the patients on a program with the Intermittent Insulin Infusion Pump. You are a staff nurse in the medical unit who provides inpatient care for these patients. The physician notified the head nurse of the change in June. It is now July. A patient is admitted to your unit with a pump. It is 10:00 p.m. You have never been inserviced on how to regulate the pump. The head nurse has not yet written policies and procedures for this new technique. What do you do? Do you go to the supervisor for help? She will discover no policies and procedures. Your head nurse will not appreciate this action on your part. Do you call her at home to come and help you? You don’t want to look stupid. Surely you should know how to do this procedure, you think. Do you ask the patient to show you what to do? What will this do to her confidence in your skill? You are truly powerless and helpless.

We see then that demotivation is synonymous with helplessness and powerlessness. In the next issue we will look at the stages by which the nurse progresses from a motivated (that is, wants to both help and achieve) person to one whose behavior expresses a complete, “I don’t care anymore, what’s the use” attitude.

About the authors:
Genevieve Clavreul, RN, MS, MPA, has formerly been a director of nursing where she implemented the principles of this alternative to the clinical ladder. The effect was reduced, lower turnover, increased morale, and better patient care. As a management consultant she has developed this alternative to the clinical ladder for major medical centers and smaller hospitals.
Sue Caviness, PhD, is a medical sociologist specializing in management models for health care settings. She and Ms. Clavreul consult with hospitals across the USA in developing productive nursing reorganization plans and staff and management development programs. The company is CCMC (Clavreul-Caviness Management Consultants), 4119 Los Feliz Boulevard, Suite 10, Los Angeles, California 90027 (213) 650-9336.
Demotivation...

Continued from page 4

her hostile feelings toward the hospital, other departments, physicians, patients, other nursing staff members, and even visitors. The report should cover vital information such as new orders, lab work results which affect treatment plans, changes in condition, and special treatments for that day. When this information is not given in the report, the patient care suffers due to the lack of proper information flow.

Cutting off communication is a common behavior pattern coming from those who are frustrated, angry or anxious. When the staff nurse begins to delay, distort or withhold vital information altogether, it is a warning sign that the person is experiencing demotivation. It is a warning sign that a solution must be found to salvage not only the staff and its professional viability but also the very management system that aggravates it.

Next time we will look at the four stages by which the nurse progresses from a highly motivated, determined graduate to a detached, withdrawn and demotivated “drop out”.

About the authors:
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T.H.E. R.&R.

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The Worldwide Healthcare Connection

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Tahiti

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SUMMARY

The complexities of the disease process known as AIDS (Acquired Immune Deficiency Syndrome) continues to unravel and the numbers and types of individuals affected are increasing daily. A recent analysis of some facts regarding AIDS patients from New York City demonstrates this—

30-40% of beds in Bellevue Hospital, in New York City are occupied by AIDS patients

and there is an average census of 250 AIDS patients daily in NYC hospitals. Of the deaths reported in NYC, a significant number of them were caused by AIDS, namely 20-30% of the males and 30-34% of the females.

In a study in New York in 1984, 60% of IV drug users carried the AIDS antibodies.

The figure is projected to rise to 60-80% in 1985, though the percentage affected in San Francisco and Chicago is only 10%. Another recent review of frozen blood samples from IV drug users kept since 1960 for historical studies, has found a significant increase in samples containing AIDS antibodies.

1979 showed 30% of the samples with AIDS antibodies present and 1982 revealed 50% of the samples with AIDS antibodies present. In 1984 fully 60% of the samples were found with the AIDS antibodies present.

T.H.E. R. & R. resort for the treatment of patients with AIDS will not only strive to be in the forefront of medical research efforts to impede the increase of such statistics, but will also provide the most current and comprehensive care to deal with the immediate and long term needs of clients with the AIDS diagnosis.
LA RENCONTRE DE L'ESPOIR

THE RESORT


Since the experience of AIDS not only involves the specifics of the disease itself, but also complex emotional and social factors, the goal of T. H. E. R. & R. is to provide the ultimate quality of medical/nursing care in a milieu of strong emotional support to clients with AIDS.

The ultimate quality of client care will be delivered by a professional medical/nursing staff whose selection, education and integration into the project will be on the basis of:

1. Their delivery of the highest levels of care.
2. Their high level of empathy and non-judgmental attitude.
3. Their knowledge of specific treatments, both established and newly discovered for AIDS.
4. Their research in the field of AIDS.

There will be not only initial evaluations and acute care, but also long term care with two options:

1. Total care during the non-acute stage can be combined with entertainment, social and physical activities provided at each T. H. E. R. & R. resort. Professional and business activities will also be supported at each resort through staff expertise and the facilities provided.

2. Total care during the need for acute therapy will be provided at La Rencontre de l'Espoir. The client may choose to remain or return to this facility during the non-acute stage or transfer to any other T. H. E. R. & R. between treatments. Travel and touring options with friends and family will also be possible and coordinated through our staff.
Personal clothing will be worn whenever possible to reinforce normal daily living activities.

HPA 23, a treatment that prevents the virus from reproducing by blocking the transcription of its genetic code and previously only available in France, has just been approved by the Food and Drug Administration of the U.S. government. Awaiting such approval often causes delays with many new treatments and drugs. Consequently, a center located and established in France will guarantee rapidity of access to such new discoveries and therapies.

Monoclonal Antibody Therapy, which has been effective in some cases, will be available in conjunction with the use of an antivirus medication and immunological stimulant such as Seramin.

AIDS causes a nearly complete breakdown of a person's natural immune system. The victim becomes prey to opportunistic infections (such as Kaposi's sarcoma) that a healthy person would often be able to ward off. Traditionally AIDS patients are provided care in the infectious wards or placed on med/surg units, in private or semi-private rooms of hospitals. They are no longer put in isolation units, but are subject to contact with patients with infectious disease processes such as pneumonia and staph, etc. which places them in higher jeopardy. To maximize maintenance of the health and well-being of AIDS clients and to enhance their survival potential until a cure for AIDS is identified, the clients would best be maintained in a disease free environment. At T. H. E. R. & R. resort, La Rencontre de l'Espoir, one of the main aims will be to keep the environment as infection free as possible. The emphasis will be to prevent cross-contamination and to protect the AIDS client, in his immuno-compromised state, from additional opportunistic infections. Specific precautions will be taken in providing care to AIDS clients, as well as appropriate precautions for particular infections that concurrently occur in AIDS clients.

Due to the long period of immobility and weakness that often accompanies AIDS (especially during the advanced debilitating phase of the disease) the treatment plan will include an appropriate regimen of physical/occupational therapy, and measures to take care of special dietary and nutritional needs.

The AIDS clients also experience periods when they feel well and desire
activities such as tennis, strolling, swimming and other forms of physical activities as well as entertainment and recreation. T. H. E. R. & R. will provide for such needs and desires.

The psychological impact of an AIDS diagnosis can be devastating, not only for the AIDS client himself but also for his/her significant others. The AIDS client endures a great deal of suffering - emotional as well as physical. Hence, the need of psychological/pastoral support. This need will be met through the loving concern of our professional staff.

AIDS is associated, more than any other illness, with stigmas and misinformation. In order to overcome these problems, a well-designed and integrated educational system will be implemented for all levels of personnel. This will enable us to provide a therapeutic milieu where the staff fully understand all the aspects of the illness and its treatment.

Seminars/conferences will be organized in order to inform and educate those at risk, the general public, significant others, and those who provide medical, nursing, psychological and social services.

The above medical/psychological modalities of care are merely examples. Other medical/psychological modalities of care will be assessed and implemented, as research and clinical experience dictates. These will be established on a case-by-case basis.

THE RESEARCH CENTER

Since it is only by promoting intensive clinical and epidemiological studies that we can hope to find the cause and cure for AIDS, La Rencontre de l'Espoir will also be directed towards research for AIDS, taking advantage of a high concentration of scientists/specialists and the laboratory equipment necessary to assure support of such research.

The four areas of medical research on the subject of AIDS will be:

1. Clinical research-Definition and identification of signs and symptoms of AIDS, involving direct client observation and documentation. Apprehension of the pathways of transmission of the disease. A research group including physicians presently providing care to patients with AIDS, not only in France and the USA
but also in other countries (i.e. Belgium, Brazil...) will be established for these purposes.

2. Epidemiological/prophylactic research—Research on the origins of the disease. Study of the relationships between AIDS and various factors (i.e. lifestyle, sexual orientation, social milieu, economic factors...) which may have an impact on the incidence, frequency, distribution and evolution of AIDS. Research to identify prophylactic means to control the transmission of the disease.

3. Therapeutic research—Study and evaluation in the above mentioned countries focusing on a variety of actual treatments and utilizing sophisticated medical/nursing audits with well identified criteria for quality assurance to AIDS clients.

4. Psychological research—Many health care providers are not informed of the real risks of AIDS transmissibility and often add additional stress and trauma to the lives of people of with AIDS. Thus, there is a need for research in medical/nursing staff behavior and response to AIDS clients, in order to understand the best way to inform all health professionals and lay people of the facts about AIDS. Only then will AIDS clients receive the humane treatment they deserve. The psychosocial research will be similar to the continuing research presented at the National Health Institute (N.H.I.) in Bethesda, Maryland, U.S.A. This study will be duplicated in France at La Rencontre de l'Espoir, as well as in French acute hospitals where patients with AIDS have been or are currently treated. These studies will be presented, whenever possible for publication in the U.S. or at the next AIDS symposium in France. In order to maintain high medical standards, peer review will be conducted on randomly selected patients utilizing measurable parameters.

AIDS HISTORICAL BACKGROUND

The development of the AIDS epidemic stunningly parallels the first syphilis epidemic which struck terror into the world population. Five centuries later, the same curses are associated with a new communicable disease. Just mentioning that acronym (AIDS) arouses so much fear in the
population that an affected person is rejected from some of the general acute hospitals and even now from some schools.

The first case of AIDS dates back to 1981. By the beginning of 1983, the responsible virus was isolated and identified. It is a retrovirus that was labeled LAV (Lymphadenopathy Associated Virus) by the French research team. The same virus was identified as the HTLV III (Human T-Cell Leukemia Virus III), by an American research team.

The infection develops in three stages (1-incubation, 2-pre AIDS, 3-AIDS), but the conditions of passage from one stage to another remains poorly known.

An unknown disease is not an everyday occurrence. If it is also highly contagious and has extremely severe symptoms, such a disease represents a risk that has to be taken seriously. That is to say that men of science (clinicians and researchers) devote themselves to improving the prognosis as well as the treatments of that disease.
A FRANCO-AMERICAN FOUNDATION FOR AIDS RESEARCH AND TREATMENT

In order to ensure that the clients of T. H. E. R. & R. will not be the only persons to benefit from the discoveries of the research center, a foundation will be created to solicit funds. These funds will allow less financially fortunate individuals to have access to any new AIDS treatment or therapy which is provided at La Rencontre de l'Espoir.

The creation of such a foundation will permit more access to financial support. This foundation will have a specific legal structure to maximize tax benefits and advantages. This will probably be done using a California foundation, but this decision will be made only after our tax experts and international lawyers have studied all the options in depth, and after the board of T. H. E. R. & R. has analyzed and approved such options as being in the best interests of the corporation, investors and future clients.

The Foundation will also seek funds with special fund-raising events. These events will hopefully be sponsored and supported by well-known entertainment industry celebrities as well as benefactors. Other sources of funds may be accessed by applying for grants from established foundations and institutions. Donations and bequests will be encouraged and appreciated from our clients as well as from their significant others.

The by-laws of the Foundation will stipulate the manners in which the Foundation will be financed and how the funds will be allocated (i.e. what percentage will go to research, what percentage will go to provide care for less financially fortunate clients, etc.).

Admissions to our resort will not be refused on the grounds of ethnic or national origin, religious beliefs, sexual orientation or lifestyle.

The Foundation will utilize outside auditors to maintain and survey its financial records and operation. Updated information on the Foundation activities and funds will be submitted to our board of directors and will be available to the public upon request.
AN EVALUATION OF AIDS APPREHENSION AMONG NURSING PERSONNEL AND ITS OBSERVED EFFECTS ON LEVEL OF PATIENT CARE QUALITY

Studies using survey and direct observation methods have revealed that nurses within all age groups and religious backgrounds feel some level of discomfort when treating openly gay patients. (Nursinglife, 1983). Further research has suggested that nurses feel especially uncomfortable when administering care to identified AIDS patients regardless of their sexual orientation. (Clavreul, 1983). We propose that a) nurses at all levels of homophobia will express equal discomfort in administering care to identified AIDS patients; b) that the level of actual care given patients decreases proportionately with the discomfort level of the caregiver and c) that patients themselves accurately subjectively perceive lowered care treatment. 120 nurses in the greater Los Angeles area constituted the sample; these consisted of individuals of varying economic backgrounds, levels of education and sexual orientations. The sample was given a questionnaire providing for an index of homophobia. The same sample was then administered a questionnaire providing for an AIDS apprehension level. For a two month period, blind confederates observed the number of "non required" visits nurses gave to both non-identified and identified AIDS patients. Finally, all the patients within the unit were given a questionnaire designed to produce a subjective measure of perceived quality of care given. The results suggest that there is a low correlation between level of homophobia and quality of care given; nurses at all homophobia levels reported an increased apprehension when working with AIDS-identified patients. Nurses with a higher level of AIDS apprehension tended to pay fewer "non-required" visits to identified AIDS patients. AIDS patients were more likely to report a subjective perception of decreased quality of care given than non-AIDS identified patients in a unit. Through the open ended portions of the questionnaires given to nurses, factors such as "Overheard Negative talk Among Health Professionals regarding AIDS Patients" and "Adverse Publicity Generated by the News Media" were linked to the decreased quality of patients care by apprehensive nursing personnel. No experimental manipulation was performed to test the validity of these potential explanations for the problem.
INTRODUCTION

Thank you for answering our questionnaire. We suggest that you briefly read through the questionnaire before filling it in.

Please do answer all of the questions to the best of your knowledge without leaving any questions blank.

Your candor in responding and commenting on the questions are particularly important to provide a clear understanding of the situation. It is our practice in all such surveys to examine the detailed responses in order to understand properly and report adequately on major issues of impact. Therefore, we want to assure the confidentiality of your responses by retaining all questionnaires for our eyes only and by making our report in terms of grouped rather than individual responses.

Once your questionnaire is completed, please return it to our research delegate. Your openness and directness in your answers will be ultimately beneficial. Results of this study will be readily provided upon request.

Thank you.

SCALE: 1: Extremely Unrepresentative of me
2: Extremely Representative of me

1. I do believe gay people should have the same rights as straights. ______/_____/_____/_____/_____

2. I believe that lesbian gynecologists are unable to consistently maintain a professional rapport with their patients. ______/_____/_____/_____/_____

3. I would allow my son to participate in a high school gym class taught by an openly gay PE teacher. ______/_____/_____/_____/_____

4. Gay persons and homosexuality in general represent a threat to the perpetuation of our civilization. ______/_____/_____/_____/_____

(1) (2) (3) (4) (5)
5. It is my perception that all homosexuals and lesbians should seek behavior modification therapy in an effort to change their life preference.

6. I believe that gay behaviors can be taught and, that further, a gay person has the potential to evoke gay behaviors in his/her heterosexual counterparts.

7. I do not feel uncomfortable with the possibility that I may one day participate in gay or lesbian behavior.

8. I do not feel comfortable with the acknowledgement of my own past involvement in homosexual behavior (if applicable).

9. I have never made it a point to disassociate myself from persons that have demonstrated openly their gay feelings and behaviors.

10. My religious background prevents me from keeping identified gay and lesbian persons as close friends.

11. I don't mind if my children watch a movie or television program dealing with gay issues.

12. I think that an openly gay official in public office would mean unfair legislation for the heterosexual majority in favor of the homosexual minority.

13. I would feel at ease in relating to my parents the isolated homosexual incidents that I might have experienced.
14. In my opinion, the reason that promiscuity is so rampant among gay men is that they are unable to maintain long-range attachment in love relationships.
AIDS APPREHENSION INDEX

INTRODUCTION

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Thank you.

***

SCALE: 1: Extremely Unrepresentative of me;
5: Extremely Representative of me.

(1) (2) (3) (4) (5)

1. I believe there is a chance I may contact AIDS from an AIDS-identified patient if I happen to examine this patient or his belongings. _____/ _____/ _____/ _____/ _____/

2. I am convinced that the only way to contract AIDS is through blood or mucous membrane contact with an AIDS-identified person. _____/ _____/ _____/ _____/ _____/

3. I have consciously avoided paying unnecessary visits to the rooms of identified AIDS patients in my unit. _____/ _____/ _____/ _____/ _____/
4. I am not troubled by conversations among health care professionals on my unit warning against contacts with AIDS victims. 

5. I have been troubled by the reports on several facilities personnel in medical center being afflicted with AIDS. 

6. I do not think about taking particular precautions when I enter the room of an AIDS identified patient. 

7. I do not mind dealing with the AIDS patients assigned to my unit. 

8. I have restricted my sexual activities with partners that I perceive may be at high risk of contracting AIDS. 

9. I never noticed that I behave differently in the presence of AIDS patients (whether it has been extremely positive or negative reactions). 

10. I would prefer not to escort AIDS identified patients to the bathroom nor to assist these people with bathing when such assistance becomes necessary. 

11. I am not especially cautious about interacting with those AIDS patients in the advanced stages of the illness. 

12. I have found myself avoiding contact with doctors who have an unusually large caseload of AIDS identified patients.
13. I believe that Medicare should be applicable for use by AIDS victims. ___/ ___/ ___/ ___/ ___/

14. I do not believe that insurance companies should establish policies to specifically provide for the needs of AIDS patients. ___/ ___/ ___/ ___/ ___/

15. It is my opinion that the government should allocate additional funds for AIDS research. ___/ ___/ ___/ ___/ ___/

OPEN-ENDED ESSAYS

1. If you had a choice between caring for a heterosexual patient with AIDS and a homosexual patient with AIDS, which would you choose and why?

2. How aware are you of your patient's sexual lifestyle? In what ways does this awareness contribute to the quality of treatment you give that person?

3. Have you made any extra effort to be communicative with AIDS-identified patients on your unit? How do you feel about administering care to AIDS patients?
PATIENT QUALITY CARE INDEX - SELF-PERCEPTION

Respondent Code Number: ______
(Please Do Not Mark)

BACKGROUND INFORMATION

*PLEASE, answer all questions by placing an 'X' beside the answer that describes you best.

1. SEX  Female /___/  Male /___/
2. AGE  /___years
3. EDUCATION  Which level have you completed?
   Grade school /___/  High school /___/
   Community College /___/  Undergraduate degree (BA, etc.) /___/
   Graduate or Professional degree (MA, PHD, etc.) /___/
4. OCCUPATION: ____________________________
   Are you presently employed?  Yes /___/  No /___/
   What is your average annual income?
   Less than $10,000 /___/  $10,000 to $20,000 /___/
   $20,000 to $30,000 /___/  $30,000 to $40,000 /___/
   More than $40,000 /___/
5. RACE/ETHNIC ORIGIN  White /___/  Black /___/  Hispanic /___/
   Oriental/Asian /___/  Amerindian /___/  Other /___, __________/
6. RELIGION  Catholic /___/  Protestant /___/  Jewish /___/
   Orthodox /___/  Other /___, __________/  None /___/
7. How long have you been living in Southern California?
   /___ months, /___year(s)
8. *SEXUAL ORIENTATION
   Heterosexual:  totally /___/, predominately /___/
   more than homosexual /___/
   Homosexual:  totally /___/, predominately /___/
   more than heterosexual /___/
   Bisexual /___/
   *LIFESTYLE
   Openly gay /___/  Closeted /___/
9. Do you live by yourself /___/?
   Or with your parents /___/, your spouse /___/, a roommate /___/ who is /___/ or is not /___/ your lover?
10. At what date were you told you had AIDS? ____________
AIDS APPREHENSION INDEX

INTRODUCTION

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Thank you.

***

SCALE: 1: Extremely Unrepresentative of me; 5: Extremely Representative of me.

1. I believe there is a chance I may contact AIDS from an AIDS-identified patient if I happen to examine this patient or his belongings. ___/___/___/___/___/

2. I am convinced that the only way to contract AIDS is through blood or mucous membrane contact with an AIDS-identified person. ___/___/___/___/___/

3. I have consciously avoided paying unnecessary visits to the rooms of identified AIDS patients in my unit. ___/___/___/___/___/
4. I am not troubled by conversations among health care professionals on my unit warning against contacts with AIDS victims. (1) / (2) / (3) / (4) / (5) /

5. I have been troubled by the reports on several facilities personnel in medical center being afflicted with AIDS. (1) / (2) / (3) / (4) / (5) /

6. I do not think about taking particular precautions when I enter the room of an AIDS identified patient. (1) / (2) / (3) / (4) / (5) /

7. I do not mind dealing with the AIDS patients assigned to my unit. (1) / (2) / (3) / (4) / (5) /

8. I have restricted my sexual activities with partners that I perceive may be at high risk of contracting AIDS. (1) / (2) / (3) / (4) / (5) /

9. I never noticed that I behave differently in the presence of AIDS patients (whether it has been extremely positive or negative reactions). (1) / (2) / (3) / (4) / (5) /

10. I would prefer not to escort AIDS identified patients to the bathroom nor to assist these people with bathing when such assistance becomes necessary. (1) / (2) / (3) / (4) / (5) /

11. I am not especially cautious about interacting with those AIDS patients in the advanced stages of the illness. (1) / (2) / (3) / (4) / (5) /

12. I have found myself avoiding contact with doctors who have an unusually large caseload of AIDS identified patients. (1) / (2) / (3) / (4) / (5) /
13. I believe that Medicare should be applicable for use by AIDS victims. ____/ ____/ ____/ ____/ ____/

14. I do not believe that insurance companies should establish policies to specifically provide for the needs of AIDS patients. ____/ ____/ ____/ ____/ ____/

15. It is my opinion that the government should allocate additional funds for AIDS research. ____/ ____/ ____/ ____/ ____/

OPEN-ENDED ESSAYS

1. If you had a choice between caring for a heterosexual patient with AIDS and a homosexual patient with AIDS, which would you choose and why?

2. How aware are you of your patients' sexual lifestyle? In what ways does this awareness contribute to the quality of treatment you give that person?

3. Have you made any extra effort to be communicative with AIDS-identified patients on your unit? How do you feel about administering care to AIDS patients?
EMPATHY CONTRACT RATING SCALE

by
Elaine L. La Monica

Instructions:
The instrument contains 84 items that describe a way that a person may feel about another or act towards someone. Read each statement and decide the degree to which you perceive yourself (or another person#) as like or unlike the statement when applied to your present relationship. You are asked to please give an opinion on every statement according to the following scale:

- Extremely unlike - 1
- Moderately unlike - 2
- Unlike - 3
- Like - 4
- Moderately like - 5
- Extremely like - 6

Please read each statement carefully and completely. Circle one response for each item.

#e.g., a nurse, an associate, a helper, depending on the purpose for which the instrument is used.

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<table>
<thead>
<tr>
<th>No.</th>
<th>Items</th>
<th>Extremely unlike</th>
<th>Moderately unlike</th>
<th>Like</th>
<th>Moderately like</th>
<th>Extremely like</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Places herself/himself in another person's shoes.</td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Is able to feel with another person.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Encourages situations in which people can be open with their feelings.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Lacks understanding of another person's feelings.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Seems to understand even when people do not talk.</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</tr>
<tr>
<td>6</td>
<td>Attempts to communicate with each person on an individual basis.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>7</td>
<td>Feels that only her/his ideas are right.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Feels that the opinions and values of others should not be heard, much less respected.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td>Cannot accept individual differences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>Never helps another freely.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11</td>
<td>Does not wait for a person to ask for help, but anticipates needs and offers assistance.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12</td>
<td>Soothes people during stressful situations.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13</td>
<td>Is cruel to another because s/he seems unable to understand the other person's frame of reference or general state of being.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>14</td>
<td>Does not believe feelings are important; people should just &quot;do what is right.&quot;</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>15</td>
<td>Is tactless and curt.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16</td>
<td>Does not respect individual differences.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17</td>
<td>Never seems to be listening.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18</td>
<td>Shows an inability to be honest when interacting with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>No.</td>
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<tr>
<td>19</td>
<td>Allows people to cry and offers support.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>20</td>
<td>Helps a person realize that options are available.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>21</td>
<td>Is comforting during periods of stress and uncertainty.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>22</td>
<td>Protects the self-esteem and privacy of others.</td>
<td>1 2 3 4 5 6</td>
<td></td>
<td></td>
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<tr>
<td>23</td>
<td>Is not concerned with the feelings of others.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>24</td>
<td>Has firm harsh techniques.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>25</td>
<td>Does not appreciate individual differences.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>26</td>
<td>Is negative, cold, and rejecting, all of which are communicated to another.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>27</td>
<td>Is responsive to the needs of the whole person.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>28</td>
<td>Offers no support to others.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>29</td>
<td>Accepts the strengths and weaknesses of others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>30</td>
<td>Counsels others without imposing personal feelings or values.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>31</td>
<td>Emotionally understands others as they seek to understand themselves.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>32</td>
<td>Treats other people as if they were objects.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>33</td>
<td>Is verbally abusive.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>34</td>
<td>Can perceive a person's condition or reaction to situations.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>35</td>
<td>Seems inconsiderate of other people's feelings.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>No.</td>
<td>Items</td>
<td>Extremely unlike</td>
<td>Moderately unlike</td>
<td>Like</td>
<td>Moderately like</td>
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<tr>
<td>36.</td>
<td>Shows an inability to comprehend another individual's feelings.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>37.</td>
<td>Has no respect for the opinions of others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>38.</td>
<td>Shows no sympathy for others during a crisis or stressful situation.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>39.</td>
<td>Respects the values of others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>40.</td>
<td>Casts off important feelings of others with indifference.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>41.</td>
<td>Is impatient and seems abrupt.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>42.</td>
<td>Looks at a situation in light of the person's goals, strengths, and resources.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>43.</td>
<td>Never even tries to comprehend another person's situation.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>44.</td>
<td>Listens and hears what the other person is saying.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>45.</td>
<td>Communicates concern and warmth.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>46.</td>
<td>Uses a tone of voice that reflects warm feelings and understanding.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>47.</td>
<td>Seems hostile rather than sympathetic when another person is in a trying situation.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>48.</td>
<td>Remains in touch with another person's mood by being sensitive to nonverbal cues.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>49.</td>
<td>Feels that the opinions and values of others should be respected.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>50.</td>
<td>Is uncooperative.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>51.</td>
<td>Makes time in a busy work schedule to talk to someone who is upset.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>52.</td>
<td>Does not listen to what the other person is saying.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>No.</td>
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<tr>
<td>53.</td>
<td>Is arrogant and consumed with feelings of pride and self-importance.</td>
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<tr>
<td>54.</td>
<td>Is rude to others.</td>
<td></td>
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<tr>
<td>55.</td>
<td>Listens thoughtfully and patiently to another.</td>
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<tr>
<td>56.</td>
<td>Is cruel and heartless during a crisis.</td>
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<tr>
<td>57.</td>
<td>Helps people when they are unable to do something without being asked.</td>
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<tr>
<td>58.</td>
<td>Helps a person work through situations and problems/concerns.</td>
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<tr>
<td>59.</td>
<td>Listens and hears what another person is saying, without passing a value judgment.</td>
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<tr>
<td>60.</td>
<td>Shows consideration for a person's feelings and reactions.</td>
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<tr>
<td>61.</td>
<td>Respects others for what they are and not for what s/he feels others should be.</td>
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<tr>
<td>62.</td>
<td>Does not seem to accept responsibility for her/his actions toward others.</td>
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<tr>
<td>63.</td>
<td>Reaches out and touches another person in a soothing manner when it seems right.</td>
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<tr>
<td>64.</td>
<td>Understands the problems of others by putting herself/himself in their place.</td>
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<tr>
<td>65.</td>
<td>Shows readiness to listen by sitting down.</td>
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<tr>
<td>66.</td>
<td>Gives genuine consolation, advice, assistance, and support.</td>
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<tr>
<td>67.</td>
<td>Understands the &quot;human&quot; situation.</td>
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<tr>
<td>68.</td>
<td>Mentally places herself/himself in the position of others.</td>
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<tr>
<td>69.</td>
<td>Seems to understand another person's state of being.</td>
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<tr>
<td>No.</td>
<td>Items</td>
<td>Extremely unlike</td>
<td>Moderately unlike</td>
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<tr>
<td>70.</td>
<td>Actually seems to feel some of the emotions that another person is experiencing.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>71.</td>
<td>Gives freely without concern for what s/he is going to receive in return.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>72.</td>
<td>Respects what others say, do, feel, and how they act.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>73.</td>
<td>Does not respect the identity of others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>74.</td>
<td>Remains uninvolved with others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>75.</td>
<td>Uses different approaches to encourage a person to discuss feelings.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>76.</td>
<td>Allows people to act out during periods of stress.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>77.</td>
<td>Does not have a ready answer to problems but rather supports a person until s/he reaches a solution</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>78.</td>
<td>Is not interested in another person's emotional state of being.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>79.</td>
<td>Is kind, positive, warm, and accepting of others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>80.</td>
<td>Never seems rushed when talking with others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>81.</td>
<td>Responds immediately to another person's needs during a crisis.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>82.</td>
<td>Is accurate when reflecting the feelings of others.</td>
<td>1 2 3 4 5 6</td>
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<tr>
<td>83.</td>
<td>Checks to see if what s/he is perceiving is valid.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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<tr>
<td>84.</td>
<td>Accepts each facet of another person as the other presents these dimensions.</td>
<td>1 2 3 4 5 6</td>
<td></td>
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</tbody>
</table>

Thank you...
October 6, 1985

Re: AIDS Center in France

Dear Bruce,

It was a pleasure to be seated at your table last evening. I wish to compliment you on your awareness of the need for more research and that this is a vital and necessary component of dealing with the AIDS epidemic.

Enclosed you will find a summary of the AIDS Center in France. I would appreciate your comments and recommendations. We have made further agreements to co-ordinate the medical care between the two countries with physicians in Los Angeles, and that will be reflected in the revision of this summary.

How would you suggest pursuing the issue of establishing a Foundation that would provide funding for joint research and patient care dollars?

I will look forward to hearing from you again soon, and would like to arrange a meeting to discuss further details of the center.

Yours sincerely,

Genevieve M. Clavreul M.P.A.

Enclosure