

**CMA COMMITTEE ON AIDS AND
STDs; MINUTES AND OTHER
DOCUMENTS, 1/27/86**

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CALIFORNIA MEDICAL ASSOCIATION

44 Gough St. • P.O. Box 7690 • San Francisco, CA 94120-7690 • (415) 863-5522

January 23, 1985

TO: Members of the Ad Hoc Committee on Acquired Immune Deficiency
Syndrome (AIDS)

Dear Doctors:

Thank you all for arranging your schedules to accomodate the change in our
meeting date. We will meet

MONDAY, JANUARY 27, 1986

(not January 30 as originally scheduled)

The time and place of our meeting remain the same -- 7:30 p.m. at the Symphony
Restaurant, 298 Gough Street, San Francisco. Dinner will be served.

Your agenda books are enclosed. We have a full agenda, and have been asked
to comment on a variety of issues.

Should you have any questions, or desire additional information, please call
me.

Sincerely,

Mark L. Madsen, MPH

MLM/sdc
Enclosures



CALIFORNIA MEDICAL ASSOCIATION

44 Gough St. • P.O. Box 7690 • San Francisco, CA 94120-7690 • (415) 863-5522

January 15, 1986

TO: Members of the Ad Hoc Committee on AIDS

SUBJECT: Next Committee Meeting

Dear Doctors:

The next meeting of the Committee will be held in San Francisco

at the Symphony Restaurant
 298 Gough Street (corner of Hayes)

on Thursday, January 30, 1986

at 7:30 p.m.

We met there for our last meeting, and since the price is right, the food good, and parking convenient, I decided to keep it simple and go there again.

Enclosed are the draft minutes from our September 12, 1985 meeting and the report to Council which resulted from that meeting. Also enclosed are the revised Health Tips on AIDS, which have been printed and are now in use. Please feel free to comment on the Tips further, as I would like to update them regularly.

As a result of the suggestions from our last meeting, our resource packets are fairly complete. We have been responding to a variety of interested groups, including CMA's Auxiliary, school districts, hospitals and medical staffs and the California Youth Authority.

For the next meeting, please consider the following issues:

1. Originally the Committee was appointed to review and comment on legislation regarding AIDS, and to formulate a policy by which future bills could be evaluated. As the concern and hysteria over AIDS grew, the Committee was asked to comment on specific issues in order that staff could respond appropriately to many and varied inquiries. Accurate public information and provider education surfaced as the most common demands. Given CMA's resources, what direction should the Committee now consider in order to have the greatest impact on AIDS?

Ad Hoc Committee on AIDS
January 15, 1986
Page Two

2. CMA has long held a leadership role in the area of maternal and child health, child sexual abuse, and neonatal/infant mortality and morbidity. As there has been an increase in the number of issues that relate to AIDS and children, does it seem reasonable that CMA address these issues through a statewide conference or conferences?
3. Contagibility appears to be the main issue through which most other concerns can be effectively addressed, i.e., hospital infection control, children with AIDS and schools, AIDS in the workplace, etc. Would a conference to address some basic questions about contagibility, with California's experts in this field, serve a multitude of purposes?

We have a fairly well developed agenda, which you will receive several days before our meeting. Please contact me or Sam Cox if you have items that you would like to add to the agenda.

Cordially,



Mark L. Madsen, MPH

MLM/sdc
Enclosures

AD HOC COMMITTEE ON AIDS

Minutes

September 12, 1985
7:30 p.m.

Symphony Restaurant
San Francisco

I. Attendance

The meeting convened at 7:45 p.m. over dinner. Present were: Mervyn F. Silverman, MD, Chairman; M. Glenn Molyneaux, MD, and Laurens P. White, MD. Paul A. Volberding, MD, was out-of-town. Mark Madsen, staff to the Committee, was present.

II. Position Statement on AIDS

The position statement was referred back to the Committee by Council for further clarification of the last paragraph, concerning financial resources used to care for AIDS patients. This paragraph was revised to read:

When an individual's private resources and other resource avenues have been depleted, local communities should provide for the necessary care and services such as food stamps, hospice, home meal and home care programs, counseling services, etc. When other available funding sources have been exhausted, AIDS patients should be cared for in a manner similar to other programs for the medically indigent.

III. AIDS Information, Guidelines and Protocols

The Committee reviewed the many requests received for information on AIDS. It was agreed to review, modify, select and/or develop diagnostic guidelines, treatment protocols, and patient service guidelines. An approved set of information resources will then be developed for dissemination to public institutions such as schools, jails and hospitals. Staff will contact the University of California at San Francisco, San Francisco General Hospital, and staff of the San Francisco Public Health Department for infection control and other other guidelines. The Committee reviewed the packet of materials prepared for the State of Florida and endorsed it as suitable for dissemination. The Medical Practice Question on asepsis techniques in CPR training was also mentioned as a possible resource.

It was suggested that perhaps a statewide AIDS information program should be developed for employees of such institutions as schools, prisons, hospitals, and public safety agencies.

The Committee also reviewed a letter from Clarence Avery, MD, to the presidents of the component medical societies, which asks them to implement a resolution approved at the 1985 session of CMA's House of Delegates. The resolution encourages component societies to identify those physicians willing to care for patients with AIDS and make that information available through local referral sources and AIDS resource organizations. The letter also informs the societies that CMA's Department of Continuing Medical Education will provide information on diagnostic guidelines, treatment protocols, epidemiological data and research on therapy regimens. The Committee asked staff to prepare a follow-up letter to the component societies requesting copies of any physician lists they develop, and suggested that CMA act as a statewide clearinghouse for this information.

IV. AIDS in Correctional Facilities

A memo from Rebecca Craig, CMA staff, regarding AIDS patients in jails, was reviewed. In response to her request for treatment guidelines and protocols for jail medical staff, the Committee commented that jail staff should be using the same guidelines as those for any communicable disease. The Committee suggested that correctional facility health providers review the current various protocols on infection control and return to the Committee those deemed most appropriate for further study and possible endorsement. The infection control guidelines from the University of California at San Francisco and from San Francisco General Hospital and those contained in the Florida State guidelines should be used as reference material. The Committee also commented that an educational program for prisoners would be extremely helpful. Staff will investigate this.

V. Correspondence Regarding Blood Test Results

Two letters have been received, one from Harbor View Medical Center in San Diego and one from Bakersfield Memorial Hospital, regarding confidentiality of the results of HTLV-III blood tests. The Committee commented on the confusion that exists between the test results, which are strictly confidential under current law, and the diagnosis of AIDS in a patient, which is a reportable disease within the State of California. Staff was asked to develop appropriate responses to these letters for review by the Chairman.

VI. Other Contacts

Staff reported on contact with the San Mateo County Medical Society, which is concerned both with confidentiality and with AIDS in children attending school. A committee of the society had been

asked to provide guidance in a situation where a bisexual male, with a wife and a male lover, had apparently contracted AIDS. The patient's physician was uncertain as to the legal status of the diagnosis, and was concerned about any future vulnerability should either the wife or the male lover develop the disease. The Committee commented, again, that there was no basis for treating this situation differently from any other communicable disease.

In reviewing the matter of children with AIDS attending school, the Committee commented on the need for public education on this issue. There is no reason, the Committee felt, to keep children with AIDS out of school, unless the child has trouble controlling bodily functions and/or secretions, or has a history of biting.

VII. Health Tips

The Committee reviewed the two Health Tips on AIDS currently available from CMA, and made several revisions. These will be forwarded to the appropriate staff. Copies of the revised Tips are attached to these minutes.

VIII. Legislative Update

The Committee corrected the reported version of its comments on SB 1251 at the June 4, 1985 meeting. The Committee did not recommend that the California AIDS Project be raised to the department level. The Committee was in support of the bill as written.

The Committee briefly commented on SB 292 and SB 313, which had been referred to the Committee by the Commission on State Legislation, and reiterated its former views. The Committee supports SB 292 as is. With respect to SB 313, the Committee feels that the notion of an ombudsman should be dropped, as this type of liaison and information activity should be handled by a Director or Program Chief. It was felt that information supplied to the public is best handled by those intimately involved with the AIDS Project.

IX. Other Testing Issues

A memo from Roger Purdy, CMA staff, regarding donor insemination and AIDS was received for information. The Committee agreed with the State Department of Health Services' recommendation that the blood and serum of donors of organs, tissue and semen be tested for antibodies to the HTLV-III virus. The Committee also reviewed the August 13, 1985 memo from the California Hospital Association regarding HTLV-III testing in hospitals under the new laws.

X. Other Informational Items

The Committee reviewed two CMA projects: a CMA/Hospital Satellite Network production entitled "AIDS: Your Hospital's Responsibility", and an article scheduled for publication in the November issue of California Physician.

The Committee also reviewed the program for the presentation at the 1986 Scientific Assembly called "The AIDS Patient and the Primary Care Physician". This will be sponsored by the Section on Preventive Medicine and Public Health and the Task Force on Sexually Transmissible Diseases.

Finally, the Committee reviewed three resolutions of the AMA House of Delegates on AIDS as a serious public health problem, medical care for AIDS patients, and HTLV-III antibody testing.

XI. Adjournment

The Committee adjourned at 9:30 p.m. with no new meeting date planned.

Mervyn F. Silverman, MD
Chairman

POSITION STATEMENT ON AIDS

Acquired Immune Deficiency Syndrome (AIDS) has now reached epidemic proportions. It is estimated that 10,000 new cases will be reported nationwide within the next two years, with ten times that number of unidentified infected individuals. To meet this challenge, Federal, state and local governments must organize sufficient resources and services. The Federal government should be primarily responsible for AIDS-related research and also should support prevention, treatment and out-patient services on the local level. It is recognized that the fiscal demands of these services and programs are high. However, the eventual cost of a geometrically progressing epidemic would be astronomical.

Public education is the most important means of control of the AIDS epidemic, as the development of a cure and vaccine for AIDS may take many years. It is imperative that sufficient resources be provided now to ensure a comprehensive public health education program. The Federal government should be fiscally responsible for a national campaign, with state and local governments providing support for program implementation.

Treatment and care of AIDS patients demands a multi-faceted approach. It includes in-patient and out-patient clinical services, in-home services, community mental health services and hospice care. The quality and quantity of community-based care can help reduce hospital length of stay.

When an individual's private resources and other resource avenues have been depleted, local communities should provide for the necessary care and services such as food stamps, hospice, home meal and home care programs, counseling services, etc. When other available funding sources have been exhausted, AIDS patients should be cared for in a manner similar to other programs for the medically indigent.

Approved by CMA Council, October 12, 1985



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

October 7, 1985

Laurens P. White, MD
1580 Valencia Street, #707
San Francisco, California 94110

Dear Doctor White:

The following is the amended language for the last paragraph of the position statement on AIDS:

When an individual's private resources and other resource avenues have been depleted, local communities should provide for the necessary care and services such as food stamps, hospice, home meal and home care programs, counselling services, etc. When other available funding sources have been exhausted, AIDS patients should be cared for in a manner similar to other programs for the medically indigent.

Thank you for your help on the responses.

Yours,

Mark L. Madsen, MPH

MLM/sdc
cc: Linda Ramsey

FOR ACTION

REPORT TO THE COUNCIL

FROM THE AD HOC COMMITTEE ON AIDS
Mervyn F. Silverman, MD, Chairman

October 11 - 12, 1985

In order to respond to the variety of AIDS issues and legislation, Council formed the Ad Hoc Committee on Acquired Immune Deficiency Syndrome (AIDS) in April 1985. The Committee has met twice, and has considered a variety of legislative bills and other issues.

At its September 12, 1985 meeting, the Committee reviewed numerous requests for information and guidelines on the evaluation, care and treatment of AIDS patients. The Committee also considered requests for guidance on AIDS in correctional facilities and morbidity reporting in hospitals. Two CMA media productions were reviewed: an article scheduled for publication in the November issue of California Physician and a CMA/HSN video production (Attachments 1 and 2). The two "Health Tips" on AIDS were revised, and the Committee reviewed plans for an Annual Scientific Assembly program on AIDS (Attachment 3). Current legislation was also reviewed, and comments on specific bills have been forwarded directly to the Commission on State Legislation. In addition, the Committee considered Resolution No. 719a-85/G, adopted at the 1985 Annual Session of the House of Delegates, which encourages component societies to identify physicians willing to care for AIDS patients and make that information available through local referral services and AIDS resource organizations. In a letter to presidents of the component societies, CMA President Clarence S. Avery, MD, has requested implementation of this resolution, and stated the information regarding diagnostic guidelines, treatment protocols, patient services, epidemiological data and research on therapy regimens is available from CMA's Department of Continuing Medical Education. The Committee is therefore reviewing current information suitable for dissemination and will follow-up on this letter.

The Position Statement on AIDS, referred back to the Committee by Council at its June 28 - 29 meeting for clarification of the paragraph concerning financial resources used for the care of AIDS patients, was revised and is attached. (Revised material is underscored.) This statement is intended as a starting point for CMA policy in guiding responses to proposed legislation.

RECOMMENDATION: THAT THE COUNCIL ENDORSE THE PROPOSED REVISED POLICY STATEMENT (ATTACHED) AND USE IT IN GUIDING CMA'S RESPONSE TO PROPOSED LEGISLATION.

Fiscal note: None.

POSITION STATEMENT ON AIDS

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Public education is the most important means of control of the AIDS epidemic, as the development of a cure and vaccine for AIDS may take many years. It is imperative that sufficient resources be provided now to ensure a comprehensive public health education program. The Federal government should be fiscally responsible for a national campaign, with state and local governments providing support for program implementation.

Treatment and care of AIDS patients demands a multi-faceted approach. It includes in-patient and out-patient clinical services, in-home services, community mental health services and hospice care. The quality and quantity of community-based care can help reduce hospital length of stay.

When other funding sources have been exhausted, AIDS patients should be cared for as public charges in a manner similar to other programs for the medically indigent. When an individual's private resources and other resource avenues have been depleted, local communities should provide for the necessary care. This should be the determining factor in triggering the public provision of services.

OFFICE MEMORANDUM

Date: September 25, 1985
To: Mark Madsen
From: Kelly Guncheon
Subject: AIDS article in November **CALIFORNIA PHYSICIAN**

In the November issue of **CALIFORNIA PHYSICIAN**, we plan to feature a cover story entitled, "AIDS: out of the shadows." Written by CP editorial assistant Deborah Dakins and me, the article discusses some of the implications that accompany AIDS treatment, as seen through the eyes of physicians who have experience with AIDS treatment.

The impetus for the article came from the realization that the disease is being diagnosed in persons living outside of the major metropolitan areas and other localities in which the disease is typically found. Given the various stigmas associated with AIDS, we considered it valuable to publish an article that discusses the psychosocial aspects of treating people with AIDS, the administrative problems regarding confidentiality and support-personnel training, and how physicians have dealt with these and other issues. Included will be discussion about the myths and realities about AIDS, the issue of homophobia, confronting morality and mortality, and managing community response.

AIDS — YOUR HOSPITAL'S RESPONSIBILITY**A CMA-HSN Production****Purpose**

To emphasize the need for hospitals to prepare themselves to offer care to AIDS patients in this growing epidemic, and to outline the special needs of AIDS patients in the hospital setting.

Telling the Story

San Francisco General Hospital's experience with AIDS patients will be the focus of the program. The documentary will be directed to a broad hospital audience (physicians, nurses, administrators, housekeeping, etc.)

Program Outline**A. OPEN****B. INTRODUCTION (Silverman)**

1. "Where we're going in the next 60 minutes."
 - a. look inside a dedicated AIDS unit (SFGH)
 - b. am I going to get AIDS — fears, well-founded and irrational

C. OVERVIEW OF DISEASE

1. What is AIDS — how virus attacks body
2. What groups/how many affected
3. Transmission
 - a. what we know
 - b. myths
 - c. behavioral disease
4. Research
5. Treatment

D. PUTTING TOGETHER A DEDICATED AIDS UNIT

1. Multidisciplinary approach
 - a. who cares for AIDS patients and why
2. Nursing staff
 - a. selection and involvement
3. Administration
 - a. costs to provide care
 - b. who is paying
 - c. negative hospital publicity
4. Personnel management
 - a. dealing with anxiety about AIDS

E. INFECTION CONTROL

1. General approach — follow hepatitis B guidelines
2. Room assignments
3. Protective garments
4. Equipment (use & sterilization)
5. Linen & dishes
6. Accidental exposure to AIDS
 - a. needle stick, entry via open cut
7. Overly stringent precautions
 - a. demoralizing to patient

F. OUTPATIENT CARE

1. Treatment
2. Placement and care of AIDS patients ready to leave hospital but too ill to care for themselves

G. PSYCHOSOCIAL CARE

1. Special needs of AIDS patients
 - a. isolation, guilt, suicidal
2. Shanti project (Linda Maxey)
3. Support of health care team
4. Homophobia
 - a. not gay issue but human issue
5. Encourage treatment in patients own community

H. CLOSE

Section on Preventive Medicine and Public Health presents

*** The AIDS Patient and the Primary Care Physician**

Cosponsor:

Task Force on Sexually Transmissible Diseases

Program Planner and Moderator:

Sarah L. Miller, MD, Ventura

Educational Objectives: Physicians who attend this program should be able to identify patients who present with clinical evidence of HTLV III infections, AIDS in particular. They will be able to order the significant laboratory tests necessary to verify the diagnosis and will learn strategies necessary to manage patients with evidence of HTLV III infections and AIDS. In addition, the physicians will be able to counsel patients and families regarding this infection. They will be able to be a resource for other health care personnel who are concerned regarding the transmission of the infection, specifically hospital and emergency services' personnel.

- 8:00 Welcome and Introduction
Dr. Miller
- 8:10 Overview of HTLV III Infection and AIDS
Thomas Prendergast, MD, Orange
- 8:40 Clinical Presentations and Laboratory Evaluation of HTLV III Infections and AIDS
Michael Gottlieb, MD, Los Angeles
- 9:45 Break
- 10:00 Strategies for Managing Patients with Evidence of HTLV III Infections and AIDS
Thomas Cessario, MD, Orange
- 10:30 Managing Patients with Neoplastic Manifestations of AIDS
Alexandra Levine, MD, Los Angeles
- 11:00 Role of Primary Care Physician in Counseling Patients and Families
Dr. Cessario
- 11:20 EMS Personnel and Others in Care of Patients with HTLV III Infections and AIDS
Dr. Gottlieb
Dr. Prendergast
- 12:00 Adjournment

Acceptable for up to 4 hours of Category I Credit.

Approved for 4 contact hours, California Board of Registered Nursing provider number 00370.

*** Special interest to primary care physicians.**

HealthTips

44 Gough Street
San Francisco,
California 94103

A publication of the California Medical Education and Research Foundation, prepared and edited by
physician members of the California Medical Association

Index 426 - September 1985

Acquired Immune Deficiency Syndrome (AIDS): special update

Acquired Immune Deficiency Syndrome (AIDS) is a recently recognized medical condition associated with a loss of the body's natural immunity against disease. The severity of the disease and its sometimes mysterious occurrence have attracted the attention of the medical community around the world. Despite a great deal of medical research, much is still unknown and unexplained about AIDS and its cause. However, certain symptoms have been determined to be unique to the disease. It is important to be aware of these symptoms.

AIDS is characterized by an often fatal breakdown of the body's immune system -- the biological mechanism that helps protect us from contracting illnesses. Once the condition develops, a patient becomes susceptible to a variety of opportunistic infections, or illnesses that might not be a threat to people whose immune system is functioning properly. Kaposi's sarcoma, a rare cancer, and pneumocystis carinii pneumonia, a parasitic infection of the lungs, are perhaps the most serious of the diseases associated with AIDS. Other opportunistic diseases which this immune deficiency allows to occur include extensive yeast infections, serious cytomegalovirus infections, large herpes ulcers, and toxoplasmosis. (It is important to recognize that contraction of any of these infections is not necessarily cause for alarm, as many healthy people suffer from these diseases in the absence of AIDS.)

The exact cause of AIDS is not yet known. When first discovered in 1981, 94% of all cases were found among young homosexual males. As a result the disease came to be known as the "Gay Related Immune Deficiency". This early title has since become a misnomer. Although the majority of documented cases still occur among young, sexually active homosexual males (ages 25 - 44), the condition has also been increasingly diagnosed in heterosexuals. Nearly all instances of AIDS have been reported from five "high risk" population groups -- homosexual and bisexual males (73%), intravenous drug users (17%), blood transfusion recipients (1%), hemophiliacs (1%), and persons having heterosexual contact with a person with AIDS or at risk of AIDS (1%). The remaining seven percent of affected individuals have not been identified as being associated with a known risk

factor. Special studies are underway with each of these groups. The occurrence of the disease among hemophilia patients suggests that AIDS is caused by a virus which may be transmitted intravenously, as well as through transfusion or sexual contact.

AIDS has an extremely high fatality rate. Of the 12,599 cases of AIDS reported in the United States as of August 1985, there have been over 6,338 deaths. Early detection of the disease's symptoms is critical to saving the life of the patient and in preventing the development of additional cases. Medical attention should be sought immediately if any of the following symptoms develop:

- *rapid weight loss of unknown origin.
- *the appearance of swollen or tender glands (lymph nodes) for no apparent reason, lasting for more than four weeks.
- *Unexplained shortness of breath, frequently accompanied by a dry cough, lasting for one month and not due to allergies or smoking.
- *persistent diarrhea for no apparent reason.
- *intermittent high fever or night sweats of unknown origin.
- *a marked change in pattern of illness -- either frequency, severity, or length of sickness.
- *the appearance of one or more purple bumps on the surface of the skin.

If you develop any of these symptoms, see your physician. There is now a blood test for antibodies to the virus which probably causes AIDS, although this test cannot tell you if you have or will develop the disease. However, a careful history and physical examination, some routine lab tests, and biopsy of any suspicious skin lesions will help in the diagnosis of this complex disease. Although there is no known cure for AIDS as yet, medical advances towards understanding the disease are made each day.

Prepared by the California Medical Association.
Specific questions on the subject should be directed to your physician.

Index 439 - September 1985

Facts and fears about AIDS

The incidence of acquired immune deficiency syndrome (AIDS) continues to rise. AIDS is a newly discovered disease that causes a breakdown of the immune system, thus making the body susceptible to a variety of unusual infections and tumors (see Health Tip 426). Between June 1981 and August 1985, 12,599 cases of AIDS were reported in the United States and US territories, and approximately 250 new cases are reported nationally each month. About 73% of AIDS patients are homosexual or bisexual men. The remaining 27% include intravenous drug users, hemophiliac patients, recipients of blood transfusions, and heterosexual contacts of persons with AIDS or at risk for AIDS. As the number of AIDS cases has increased, so has fear and confusion among the general public about the illness and how it is transmitted.

Is AIDS contagious? Does the syndrome pose a risk to the general population? AIDS does not appear to be a risk to the general public. Studies suggest that AIDS is caused by a virus which attacks the body's immune system. This agent is transmitted primarily through sexual contact. Less commonly, it may be transmitted through blood or blood products by needles or transfusions. However, the incidence of AIDS transmission among blood recipients is very low (2%). Much of the evidence suggests that AIDS is difficult to transmit and cannot be spread by the air, by touching objects handled by AIDS patients, by riding a bus or being near a patient in a public place, or by other forms of casual contact with infected persons.

Despite the evidence on AIDS transmission there remains some concern among health care workers that they are at risk of contracting the disease. Thousands of health care workers have been caring for AIDS patients in hospitals for the past five years and not one has developed the condition as a result of patient care contact during this time. Nevertheless, as a precautionary measure, many hospitals are developing guidelines to protect health care workers from direct contact with the secretions of AIDS patients -- particularly blood, semen, body fluids mixed with blood, and mucus from the lungs or throat. These precautionary measures are very similar to those taken for hepatitis and other contagious diseases and are not necessary if the workers are merely in casual contact with patients in their rooms.

Fear surrounding AIDS transmission also threatens the nation's blood supply. Because AIDS appears to be caused by a blood-borne agent and may be contracted through contaminated needles, many potential volunteers mistakenly believe that donating blood can expose them to AIDS. This fear is unwarranted. Since a new disposable needle is used for each donation,

there is no chance of being exposed to AIDS through giving blood. Furthermore, to reduce the risk of AIDS transmission to blood recipients, blood banks now ask individuals from groups at high risk for AIDS to refrain from giving blood. Also, all blood now donated is tested for antibodies to the HTLV-III virus (believed to be the virus which causes AIDS).

There is as yet no cure for AIDS, and treatments are still in the experimental stages. However, the medical community and the government are working to discover methods for controlling and preventing the disease. In the meantime, be as cautious as possible. Educate yourself about the disease and its symptoms. Lower your risk of exposure to the disease by maintaining good health and nutrition and avoiding excessive use of tobacco, alcohol and recreational drugs that can damage the immune system. It is also recommended that you limit the number of sexual partners to the lowest number with which you can be comfortable and use a condom for all genital sexual contacts. Gay men are strongly urged to follow the safe sex guidelines, which are available from any of the gay activist groups. Consult your personal physician for any health problems that you feel may be related to the risk of AIDS.

Prepared by the California Medical Association.

Specific questions on the subject should be directed to your physician.

AD HOC COMMITTEE
ON
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

A G E N D A

Monday, January 27, 1986
7:30 p.m.

Symphony Restaurant
298 Gough Street
San Francisco

<u>Tab</u>	<u>Item</u>	<u>Status</u>
I.	Current Legislation	For ACTION
	AB	
	SB 1478	
	SB 1513	
	SB 1518	
II.	Joint Action With California Hospital Association	For ACTION
III.	HTLV-III Testing and Confidentiality Issues	For ACTION
IV.	Policy on Availability of Hypodermic Needles and Syringes	For ACTION
V.	AIDS Management Protocols for Inmates	For ACTION
VI.	AIDS Health Education Package	For ACTION
VII.	AIDS and Children	For INFORMATION
VIII.	CMA Projects and Correspondence	For INFORMATION
IX.	Activities of Component Medical Societies	For INFORMATION
X.	AMA Resolutions	For INFORMATION

CURRENT LEGISLATION

1. AB (Assemblywoman Allen)

No

Provides for gender labeling of blood, and allows patients to select "male" or "female" blood.

NOTE: CMA Council in January agreed to oppose any legislation supporting blood labeling with regard to gender. See attached correspondence with Ms. Leslie Dutton of the American Association of Women Voters.

2. SB 1478 (Senator Doolittle)

No

Provides for premarital testing for antibodies to the probable causative agent of AIDS.

3. SB 1513 (Senator Doolittle)

?

Provides for testing for "evidence of AIDS" of every person convicted and sentenced to a county jail or state prison, and disclosure of the test results to the sheriff or warden.

4. SB 1518 (Senator Royce)

No

Provides for notification (by the treating health facility) of emergency medical care personnel of their contact with persons afflicted with a contagious disease.

For your information, also attached is a copy of Senator Roberti's report on AIDS legislation introduced in 1985 and a recent report on federal funding issues.

AUTHOR'S COPY**LEGISLATIVE COUNSEL'S DIGEST**

Bill No.

as introduced, Allen.

General Subject: Blood: labeling: AIDS.

(1) Existing state law requires every person engaged in the production of blood to label each container designating whether it is derived from a volunteer donor or paid donor.

This bill would, additionally, require each container of blood, as defined, used in vivo in California to be labeled to reflect whether it is derived from male or female sources, as specified. When the blood is derived from male sources, the bill would require the container to also have a warning that use of the blood in vivo creates a higher risk for a person contracting AIDS, than blood derived exclusively from female sources.

Blood banks and plasma centers, as defined, would be required by this bill to do the above-described

labeling. To the extent that the blood bank or plasma center is a publicly operated facility this new requirement would impose a state-mandated local program.

This bill, with a prescribed exception, would also require each physician and surgeon or health facility which provides blood in vivo to a patient to provide the patient with the opportunity to select blood derived from female or male sources. To the extent the physicians and surgeons are employed by a local agency or the health facility is publicly operated, this requirement would impose a state-mandated local program.

Violation of the above-described requirements for blood banks, plasma centers, health facilities, and physicians and surgeons would be a misdemeanor. The creation of a new crime imposes a state-mandated local program.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed \$500,000 statewide and other procedures for claims whose statewide costs exceed \$500,000.

08086

86006 22:26

RECORD #

60 BF:

RN 85 024538 PAGE NO. 3

This bill would provide that reimbursement for costs mandated by the bill shall be made pursuant to those statutory procedures and, if the statewide cost does not exceed \$500,000, shall be payable from the State Mandates Claims Fund.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

08086

RECORD #

30 BF:

JAN 6 1986

86006 22:26

RN 85 024538 PAGE NO.

AUTHOR'S COPY

An act to add Section 1603.6 to the Health and
Safety Code, relating to blood.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1603.6 is added to the Health and Safety Code, to read:

1603.6. (a) Each container of blood used in vivo in California shall be labeled to reflect whether it is derived from male or female sources. When the blood is derived from both male and female sources, it shall be labeled to reflect this fact.

(b) When the blood is derived from male sources, the container shall also have a warning that use of the blood in vivo creates a higher risk for a person contracting acquired immune deficiency syndrome than blood derived exclusively from female sources.

(c) Each physician and surgeon or health facility which provides blood in vivo to a patient shall provide the patient with the opportunity to select blood derived from female or male sources. However, if an emergency exists, as determined by the health facility or physician and surgeon, and neither the patient nor a person authorized to provide medical consent for the patient is available or able to make the selection, the requirement of this subdivision shall not apply.

(d) A blood bank or plasma center, as defined in

subdivision (j) of Section 1603.1, shall do the labeling required by subdivisions (a) and (b) of this section.

(e) For purposes of this section, "blood" means "human whole blood" and "human whole blood derivatives," as defined for purposes of this chapter and includes "blood components," as defined in subdivision (1) of Section 1603.1.

(f) This section shall apply to all blood used in vivo in this state on or after January 1, 1987, even if its derived from out of state sources.

SEC. 2. Reimbursement to local agencies and school districts for costs mandated by the state pursuant to this act shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code and, if the statewide cost of the claim for reimbursement does not exceed five hundred thousand dollars (\$500,000), shall be made from the State Mandates Claims Fund.



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

January 24, 1986

Ms. Leslie C. Dutton
President and Executive Director
American Association of Women Voters
2210 Wilshire Boulevard, Suite 174
Santa Monica, California 90403

Dear Ms. Dutton:

Thank you for your letter expressing your concern over the safety of blood products. The California Medical Association is aware of this issue as well as several other important issues regarding AIDS. Recently CMA's Committee on Blood Banks, and the Committee on AIDS, addressed this issue and, as a result, CMA Council approved the following recommendation at its January 17 meeting:

That CMA oppose any legislation to support blood labeling with regard to gender.

CMA believes that blood labeling according to gender is not a scientifically sound policy. Obviously this policy is in opposition to your proposal and therefore CMA endorsement would not be forthcoming.

Currently CMA is involved in a variety of projects related to AIDS: a statewide referral system, identification of physicians with the expertise and willingness to treat AIDS patients, a videotape for training health care professionals in the care and treatment of AIDS patients are just a few. Unfortunately, funding for other groups also developing related AIDS projects is unavailable. The number of projects we have undertaken does not allow for support of either the workshop or luncheon you seek funding for, particularly in light of our position on blood labeling.

Please excuse the lateness of this letter. The issue of blood labeling required considerable study and the involvement of several committees.

Thank you for sharing your point of view regarding this public health crisis.

Sincerely yours,

Clarence S. Avery, M. D.
President

CSA/sdc

American Association of Women Voters

NEW YORK

WASHINGTON, D.C.

LOS ANGELES

Leslie C. Dutton
President & Executive Director

Mr. Machel Goldman
Sr. Vice President
Calif. Medical Assn.
44 Gough Street
San Francisco, CA 94103



2210 Wilshire Boulevard, Suite 174
Santa Monica, California 90403
(213) 395-0244

November 13, 1985

NOV 21 1985

Dear Mr. Goldman,

The AAWV has been referred to you by Mrs. Jeanne Hull, President of the California Medical Assn. Auxiliary for consideration of our proposal to label blood units "male" and "female" as a means of providing physicians and patients with the FREEDOM TO CHOOSE the safest possible blood during AIDS epidemic.

We are interested in making a presentation to your executive committee for the purpose of seeking an endorsement of our proposal for blood labeling and to gain approval for the CMA Auxiliary to work with us in accomplishing our goal.

Additionally, we are forwarding a copy of a proposal for funding of a "Safer Blood Products" public-policy workshop to be held next year in San Diego. As you will note from the format, we are including all viewpoints on the subjects and would love to have financial and participatory support for this project from the CMA.

The public education portion of the "Safer Blood Products" workshop involves printing and distribution of the transcripts and summary and which comes to approximately \$10,000. Also, the cost of underwriting the luncheon for health care consumers comes to \$10,000 also. Either of these particular portions of the workshop would be ideal for the CMA to fund.

We are most anxious to meet with the CMA on both of these issues, at the earliest time possible. Please let us know when we can expect to have a meeting or your response to this request.

Sincerely,

Leslie C. Dutton
President & Executive Director

LD/fr
enclosures
cc: Jeanne Hull, CMA-A

Introduced by Senator Doolittle

January 6, 1986

An act to amend Section 4300 of the Civil Code, relating to marriage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, as introduced, Doolittle. Marriage.

Existing law requires that in order to be issued a marriage license a person must file a certificate issued by a physician attesting to the results of tests relating to the presence or absence of syphilis, and, in the case of a woman, whether she has laboratory evidence of immunological response to rubella, except as specified.

This bill would require such a certificate also to state the results of a blood test to detect antibodies to the probable causative agent of acquired immune deficiency syndrome, as specified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 4300 of the Civil Code is
2 amended to read:
3 4300. (a) Before any person, who is ~~or may hereafter~~
4 ~~be authorized by law~~ to issue marriage licenses, ~~shall issue~~
5 ~~issues~~ any such license, each applicant therefor shall file
6 with him ~~or her~~ a certificate from a duly licensed
7 physician ~~which certificate shall state stating~~ that the
8 applicant has been given such examination, including a
9 standard serological test, as may be necessary for the
10 discovery of syphilis, made not more than 30 days prior
11 to the date of issuance of ~~such~~ the license, and that, in the

1 opinion of ~~such~~ the physician, the person either is not
2 infected with syphilis, or if so infected, is not in a stage of
3 that disease which is or may become communicable to
4 the marital partner.

5 (b) ~~Such~~ The certificate shall also state whether the
6 female applicant has laboratory evidence of
7 immunological response to rubella (German measles).
8 ~~Such~~ The certificate shall not contain ~~such~~ evidence of
9 response to rubella where the female applicant (1) is
10 over 50 years of age, or (2) has had a surgical sterilization
11 or (3) presents laboratory evidence of a prior test
12 declaring her immunity to rubella.

13 ~~This subdivision shall not become operative in a county~~
14 ~~until January 1, 1974; if the State Department of Health~~
15 ~~Services determines on or before the effective date of this~~
16 ~~act that there are not sufficient laboratory facilities in the~~
17 ~~county to perform the test required by this subdivision.~~
18 ~~In making this determination, the State Department of~~
19 ~~Health Services shall consider the number of people in~~
20 ~~the county, and the availability of facilities and qualified~~
21 ~~personnel.~~

22 (c) *The certificate also shall state the results of a blood*
23 *test to detect antibodies to the probable causative agent*
24 *of acquired immune deficiency syndrome. Consent to*
25 *release the results of the blood test for the purpose of this*
26 *section shall be in accordance with Section 199.21 of the*
27 *Health and Safety Code and shall be in a form which shall*
28 *be prescribed by the State Department of Health*
29 *Services.*

30 ~~(e)~~

31 (d) Any person who by law is validly able to obtain a
32 marriage license in the State of California is validly able
33 to give consent to any examinations and tests required by
34 this article. In submitting the blood specimen to the
35 laboratory the physician shall designate that this is a
36 premarital test.

Introduced by Senator Doolittle

January 8, 1986

An act to add Section 1202.1 to the Penal Code, relating to sentencing.

LEGISLATIVE COUNSEL'S DIGEST

SB 1513, as introduced, Doolittle. AIDS: testing of prisoners.

Existing law prohibits the testing of a person's blood for evidence of antibodies to the probable causative agent of acquired immune deficiency syndrome (AIDS) without the written consent of the subject of the test. Existing law also provides for a civil penalty, as specified, for any person who discloses the results of a blood test to detect AIDS without written authorization from the subject of the test.

This bill would, notwithstanding the above provisions of law, require every person convicted of a misdemeanor or felony who is sentenced to county jail for a term exceeding 3 days, or to a term in the state prison, which term is not suspended, to submit to a blood test administered by the county for evidence of AIDS and would also require that the results of the test be disclosed to the sheriff of the county jail or the warden of the state prison where the person is incarcerated, there by imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed \$500,000 statewide and other procedures for claims whose statewide costs exceed \$500,000.

This bill would provide that reimbursement for costs

mandated by the bill shall be made pursuant to those statutory procedures and, if the statewide cost does not exceed \$500,000, shall be payable from the State Mandates Claims Fund.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1202.1 is added to the Penal
2 Code, to read:
3 1202.1. (a) In every case in which a person is
4 convicted of a felony or a misdemeanor and is sentenced
5 to a term in the county jail exceeding three days or to a
6 term in the state prison, and the imposition or execution
7 of sentence is not suspended, the person shall,
8 notwithstanding Section 199.22 of the Health and Safety
9 Code, immediately submit to a blood test administered
10 by the county for evidence of antibodies to the probable
11 causative agent of acquired immune deficiency
12 syndrome (AIDS).
13 (b) Notwithstanding Section 199.21 of the Health and
14 Safety Code, the results of the blood test to detect
15 antibodies to the probable causative agent of AIDS shall
16 be disclosed to the sheriff of the county jail or the warden
17 of the state prison where the person is incarcerated.
18 SEC. 2. Reimbursement to local agencies and school
19 districts for costs mandated by the state pursuant to this
20 act shall be made pursuant to Part 7 (commencing with
21 Section 17500) of Division 4 of Title 2 of the Government
22 Code and, if the statewide cost of the claim for
23 reimbursement does not exceed five hundred thousand
24 dollars (\$500,000), shall be made from the State Mandates
25 Claims Fund.

Introduced by Senator Royce

January 9, 1986

An act to add Section 1797.188 to the Health and Safety Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

SB 1518, as introduced, Royce. Public safety: notification and medical treatment.

Existing law provides that health officers shall take necessary measures to prevent the spread of a contagious, infectious, or communicable disease. No existing law requires health facilities to notify emergency medical care personnel of their contact with persons afflicted with a contagious disease.

This bill would require notification, as specified, by the treating health facility of exposure to contagious diseases and advice as to medical treatment for Emergency Medical Technicians I, Emergency Medical Technicians II, Emergency Medical Technicians - Paramedics, lifeguards, firefighters, and peace officers who come in contact with persons afflicted with a contagious disease while providing their services. To the extent that this bill would apply to local publicly operated health facilities it would impose a state-mandated local program.

This bill would expressly limit the authority of the health facility and the emergency medical care personnel in disclosing confidential medical information.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed \$500,000 statewide and other procedures for

claims whose statewide costs exceed \$500,000.

This bill would provide that no reimbursement shall be made from the State Mandates Claims Fund for costs mandated by the state pursuant to this act, but would recognize that local agencies and school districts may pursue any available remedies to seek reimbursement for these costs.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1797.188 is added to the Health
2 and Safety Code, to read:

3 1797.188. All persons described in Sections 1797.170,
4 1797.171, 1797.172, 1797.182, and 1797.183, whether
5 volunteers, partly paid, or fully paid who, when
6 performing any of the functions described in the section,
7 have been in contact with a person afflicted with a
8 contagious disease, as defined by Section 2500 of Title
9 XVII of the California Administrative Code and as may
10 be amended from time to time, shall be notified of the
11 disease and advised as to the recommended medical
12 treatment by the health facility treating the afflicted
13 person.

14 The duty to notify, as prescribed by this section,
15 includes a reasonable investigation of whether one of the
16 persons described in this section may have been in
17 contact with a person afflicted with a contagious disease.

18 Nothing in this section shall be construed to authorize
19 the further disclosure of confidential medical information
20 by the health facility or any of the emergency medical
21 care personnel described in this section except as
22 otherwise authorized by law.

23 Health facility, as used in this section, means a health
24 facility, as defined in Section 1260, including a publicly
25 operated facility.

26 Notwithstanding Section 1798.206, violation of this
27 section is not a misdemeanor.

28 SEC. 2. Reimbursement to local agencies and school
29 districts for costs mandated by the state pursuant to this

1 act shall be made pursuant to Part 7 (commencing with
2 Section 17500) of Division 4 of Title 2 of the Government
3 Code and, if the statewide cost of the claim for
4 reimbursement does not exceed five hundred thousand
5 dollars (\$500,000), shall be made from the State Mandates
6 Claims Fund.

O

FOR YOUR INFORMATION

From California AIDS Update, October 1985, published by Senator David Roberti

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 1327, Marks (R-San Francisco)

Would require Medi-Cal to pay health insurance premiums for 36 months for eligible individuals with a catastrophic illness.

Status: This 2-year bill has not yet been assigned to a policy committee but should begin moving in January.

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.



JAN 15 1986

Jan. 13, 1986 - Vol. 40, No. 2



FOR YOUR INFORMATION

Medicine & Health

Originals to: Dr. Avery; Dr. Elliott; Jay Michael

cc: Elsner; Goldman; Mullins; Light; Jones/Beckert/Donaldson/Purdy/Hough; Strobel; Hassberg/Doha
Belser/Kennedy/Kesten/Lopp; Newhart/Soman/Smart/Tyler; Robinson/Snelson/Powe; Pross;
Craig/McFarlane/Maley

BOWEN REBUFFED ON KEY BUDGET APPEALS

HHS Secretary Otis Bowen, MD, lost his fiscal 1987 budget appeals to the Office of Management and Budget (OMB), Administration officials confirmed last week. Bowen had sought to overturn OMB proposals to slash funding for the National Institutes of Health and to make dramatic reductions in Medicare payments to physicians. OMB prevailed with the support of President Reagan's Domestic Policy Council. Bowen did manage to knock out OMB's proposal to take hospital occupancy into account in determining the size of a facility's capital payment.

ADMINISTRATION PLANS \$1 BILLION PHS RESCISSION

The Reagan Administration will seek to rescind as much as \$1 billion in fiscal 1986 funding for public health programs, including a sharp reduction in funds for biomedical research, Administration officials told MEDICINE & HEALTH last week. The White House expects to send the rescission request to Congress shortly after legislators return from their mid-session recess on January 21. Funding for the National Institutes of Health (NIH) would undergo the deepest cut, in the form of a planned \$359 million rescission. The Administration also will seek to rescind \$16 million provided by Congress for a new experimental treatment program for victims of acquired immune deficiency syndrome (AIDS). To become permanent, the rescission request must be approved by Congress, but the President can impound the funds for 45 working days while the request is pending.

STEELMAN NAMED AT OMB, BOWEN NARROWS CHOICES

Deborah Steelman has been selected by Office of Management and Budget Director James Miller III to serve as OMB associate director for human resources. She replaces John Cogan, who left that key post in early October. Steelman, 30, moves to OMB from the White House, where she was President Reagan's assistant for intergovernmental affairs. She has no previous health policy experience. Meanwhile, HHS Secretary Bowen is narrowing his choices to fill HHS vacancies. Bowen hopes to make some announcements in the next 10 days, aides said. Bowen met last week with Rand Corporation senior economist Paul Ginsburg to discuss the job of assistant secretary for planning and evaluation.

FOR-PROFIT COSTS HIGHER(p.2) ADMINISTRATION SEEKS '86 HEALTH CUTS(p.3)

CDC BANS EXPLICIT AIDS MOVIES(p.2) CATASTROPHIC INSURANCE STUDIED(p.3)

PERSPECTIVES -- 1985 INDEX (Insert)

JOINT ACTION WITH THE
CALIFORNIA HOSPITAL ASSOCIATION (CHA)

At its meeting in December, the CMA/CHA Liaison Committee considered a discussion paper on AIDS and referred four recommendations to the Committee on AIDS. These were that CMA and CHA should:

- ①. Develop joint guidelines for physicians and hospitals covering AIDS, precautions and guidelines.]
- ②. Support separate funding for the treatment of AIDS, primarily from federal funds generated from general revenues.
- ③. Oppose steps by private payors or others that would result in discrimination against AIDS patients or persons with AIDS virus antibodies.
- ④. Support the allocation of federal funds to educate and train health care workers in treating AIDS patients.

Attached for your information are the original reports to the Liaison Committee, and a follow-up letter from CHA.



California Hospital Association

1023 12th Street P.O. Box 1100 Sacramento, CA 95805-1100 916/443-7401

January 16, 1986

Mark Madsen, Director
Continuing Medical Education
California Medical Association
44 Gough Street
San Francisco, CA 94103

JAN 21 1986

Dear Mark:

As we discussed during our telephone conversation, CHA and CMA will be forming a joint committee on AIDS for the purpose of supporting the major recommendations which evolved from the December 18th CMA/CHA Liaison Committee Meeting, and to develop guidelines which will assist hospitals and physicians involved with the treatment of AIDS. It is my understanding that CMA currently has a small working committee of three physicians who meet regarding policies and legislation concerning AIDS treatment, and that their next meeting has been scheduled for January 30.

Pursuant to our conversation, I will expect to hear from you after that meeting regarding plans for the formation of a joint CMA/CHA Task Force on AIDS.

CHA plans to introduce legislation which will address some of the problems of AB 403 (confidentiality and HTLV III testing). Our legal counsel is working on this issue, and has reported that numerous physicians, as well as hospitals have contacted them for clarification on AB 403 since it went into effect last spring. I have contacted Bill Cleveland regarding our plans. I hope that CMA will support this effort, and I will keep you informed on our progress.

I am looking forward to working with you this year.

Sincerely,

Sally Linn

Sally Linn
Government Relations Coordinator

SEL:cb

STAFF ASSIGNMENTS RESULTING FROM
CMA/CHA LIAISON COMMITTEE MEETING

DEC 27 1985

December 18, 1985

6. AIDS.

Refer discussion paper on AIDS to CMA's Task Force for review and evaluation of accuracy. Proceed with recommendation # 1 and invite CHA representatives to meeting; develop recommendations on #s 2, 3 and 4. (Attachment B)

Madsen

December 10, 1985

TO: CMA-CHA Joint Liaison Committee
FROM: C. Duane Dauner and Robert H. Elsner
SUBJECT: Acquired Immune Deficiency Syndrome (AIDS)

AIDS is a societal health problem of huge proportions. Following are some points of interest.

- Of 14,862 reported AIDS cases in America as of November 1, 1985, 7,628 were already dead. (California with 3,378 reported cases represents 23% of the total.)
- The federal Centers For Disease Control estimates that 1 million Americans have now been exposed to the AIDS virus. (In California, 23% of the total means an estimated 230,000 infected individuals.)
- Of those exposed, 10% (100,000 in the U.S., 23,000 in California) are expected to develop AIDS over the next five years.
- Of those exposed, another 20% (200,000 in the U.S., 46,000 in California) are expected to develop AIDS-related diseases.
- Of those exposed, the remaining 70% (700,000 in the U.S., 184,000 in California) will show no symptoms but may unknowingly be carrying and spreading the virus for years.
- AIDS is silent over a long period of time. Individuals may carry the AIDS virus and infect others without ever coming down with the disease themselves.
- While most (73%) of the AIDS victims in the United States to date have been homosexuals, AIDS is not a homosexual disease. In Africa and Haiti and in the United States military, it is predominant among heterosexuals.
- AIDS is expected to continue spreading until the year 2000-- even if an effective treatment of a protective vaccine becomes available in four or five years.

AIDS patient care will consume tremendous health care resources for which neither the public nor private health sectors are prepared.

- The average AIDS victim is 34 years old, in his prime productive years and in the age category least expected to require health care services.
- The average cost of medical care for an AIDS patient in the United States is currently \$140,000. (Projected over the next five years for the estimated 23,000 AIDS cases in California alone, the medical care costs could be \$3,220,000,000.)
- Increased experience in the handling of AIDS patients should lead to more effective organization and management of the treatment process and lead to lower per case costs. On the other hand, new and experimental drugs and treatment modalities could in turn increase those costs.
- The cost of AIDS patient care was not anticipated in calculating the Medicare prospective payments rates, Medi-Cal rates or actuarial insurance tables.
- In California, the average length of stay for an AIDS patient per hospitalization exceeds 15 days compared to 6.3 for all other patients. (The AIDS patient usually experiences 2 or 3 hospitalization periods in the course of the illness.)
 - o The average cost per hospitalization for an AIDS patient exceeds \$16,000, more than three times the average cost for all other patients.
 - o The primary sources of payment to the hospitals for AIDS patient care are:
 - Medi-Cal25% of the patients
 - Medicare 3% of the patients
 - o The average uncollectibles (that is the revenue lost to the hospital) for the hospitalization of an AIDS patient is \$5,214 compared to \$1,546 for all other patients.
- The public and private hospital systems in California are having to absorb an average loss of \$5,214 on the 3,378 AIDS cases reported in the state to date. That is \$1,762,000.
- 23,000 AIDS cases in California over the next five years could result in hospital losses totaling \$119,922,000. Neither the public nor private hospital sectors can absorb this loss.
- Losses will be incurred by physicians treating AIDS patients as well.

Life and health insurance companies will endeavor to identify and isolate all potential AIDS victims who apply for insurance in order to protect against unexpected and unusual losses.

- Those denied health insurance for reason of a positive AIDS antibody test would not have insurance coverage for any of their other health care needs throughout their lifetime, thereby exacerbating the uncompensated care problem.

Health care professionals and their support staffs are being confronted with a disease entity with characteristics considerably different from that for which they were trained and, for some, with potential personal implications beyond that which they are prepared to take.

- Health care workers are especially caring people, but they are also human. While the evidence indicates that AIDS cannot be transmitted to another person by casual contact, the consequences of an accidental exposure are so severe as to cultivate deep personal concerns and warrant extraordinary precautions.
- As the number of AIDS victims rapidly expands in the next 2 to 5 years, it is expected that the number of health care workers confronted with serious personal dilemmas will likewise increase. Wrong decisions might be made by a large number of health care workers due to inaccurate or incomplete information.
- AIDS is different. From the standpoint of health care providers, the AIDS patient requires particular attention to those differences for significant personal, legal and patient treatment reasons, such as:
 - o Developing treatment guidelines and procedures and specialized care units or areas.
 - o Discharge planning and after-hospitalization care, especially including extended care services.
 - o Access to clinics and outpatient care.
 - o Mental health needs and family counseling.
 - o Protection against accidental exposure.
 - o Training, motivation and safety for high-risk employees.
 - o Management of employees with AIDS and employees who may test positive to the AIDS antibodies.
 - o Safety of pregnant employees and their fetuses.
 - o Responsibility to provide care versus the right to work in a safe environment.
 - o Patient discrimination and privacy rights.

- A program is needed to rapidly develop the tools from which those health care workers who may be exposed to AIDS patients can be trained on how to handle AIDS differences safely and with tenderness and confidence.
- A proposal for the training of 246,000 hospital workers in California is estimated to cost \$544,000. If funded, this project would provide training manual and lesson plan models for similar training throughout the country.

Liability issues are bound to emerge from all sides. Therefore, it is essential that physicians and hospitals take every reasonable precaution, including proper diagnosis identification, communication between physicians and hospitals, safety protocols and discharge procedures.

Attached is a background of CMA activities related to AIDS.

RECOMMENDATION: CMA AND CHA SHOULD:

1. DEVELOP JOINT GUIDELINES FOR PHYSICIANS AND HOSPITALS COVERING AIDS, PRECAUTIONS AND GUIDELINES.
2. SUPPORT SEPARATE FUNDING FOR THE TREATMENT OF AIDS, PRIMARILY FROM FEDERAL FUNDS GENERATED FROM GENERAL REVENUES.
3. OPPOSE STEPS BY PRIVATE PAYORS OR OTHERS THAT WOULD RESULT IN DISCRIMINATION AGAINST AIDS PATIENTS OR PERSONS WITH AIDS VIRUS ANTIBODIES.
4. SUPPORT THE ALLOCATION OF FEDERAL FUNDS TO EDUCATE AND TRAIN HEALTH CARE WORKERS IN TREATING AIDS PATIENTS.

CDD:1b
Attachment

BACKGROUND OF CMA ACTIVITIES

In order to respond to the variety of AIDS issues and legislation, Council formed the Ad Hoc Committee on Acquired Immune Deficiency Syndrome (AIDS) in April 1985. The Committee has met twice, and has considered a variety of legislative bills and other issues.

At its September 12, 1985 meeting, the Committee reviewed numerous requests for information and guidelines on the evaluation, care and treatment of AIDS patients. The Committee also considered requests for guidance on AIDS in correctional facilities and morbidity reporting in hospitals. Two CMA media productions were reviewed: an article scheduled for publication in the November issue of California Physician and a CMA/HSN video production. The two "Health Tips" on AIDS were revised, and the Committee reviewed plans for an Annual Scientific Assembly program on AIDS.

Current legislation was also reviewed, and comments on specific bills have been forwarded directly to the Commission on State Legislation.

In addition, the Committee considered Resolution No. 719a-85 (attached), adopted at the 1985 Annual Session of the House of Delegates, which encourages component societies to identify physicians willing to care for AIDS patients and make that information available through local referral services and AIDS resource organizations. In a letter to presidents of the component societies, CMA President Clarence S. Avery, MD, has requested implementation of this resolution, and stated that information regarding diagnostic guidelines, treatment protocols, patient services, epidemiological data and research on therapy regimens is available from CMA's Department of Continuing Medical Education. The Committee is therefore reviewing current information suitable for dissemination and will follow-up on this letter.

At its October 1985 meeting, the CMA Council adopted the attached policy statement on AIDS.

12/4/85
US/sc
Attachments

The above report was prepared for the CMA-CHA Liaison Committee.

HTLV-III TESTING AND CONFIDENTIALITY ISSUES

CMA's Committee on Blood Banks has been considering all aspects of antibody testing, and has forwarded a number of questions to this Committee for discussion.

1. What is a confirmed positive test result as it applies to the donor notification?
2. What is the definition of a non-reactive as it relates to AB488, Section 2, 1603.1(A) that reads "only units that are found non-reactive shall be used in vitro for humans in the state"?
3. Can pheresis products be released without completing an HTLV-III Antibody test, if the donor has tested negative on recent previous donations? What is considered an acceptable time interval?
4. Are members of health care teams to be informed of HTLV-III Antibody positive test results in a patient?

The Committee on Blood Banks also heard of a situation where a patient tested positive and the local blood bank asked for a release to notify the physician. The patient refused, and the local blood bank and component medical society is concerned not only with the health care team's exposure to the blood, but also with the exposure of the patient's spouse and any unborn children, in the event of a pregnancy.

Further, the Commission on State Legislation, at its October workshop, recommended

"That CMA support efforts to relax the confidentiality provisions of existing AIDS antibody testing statutes."

To guide you in dealing with these issues, attached you will find:

1. Report to the Commission on Community Health Services from the Committee on Blood Banks, December 17, 1985.
2. Confidential Report on ACCMA Council meeting of January 9, 1986.
3. Report to Council from the Commission on State Legislation, November, 1985.
4. San Francisco Medical Society Advisory Statement Regarding AIDS and HTLV-III Testing, December, 1985
5. Letter from legal counsel re: confidentiality of AIDS records, July 25, 1985.
6. Recent article from Professional Liability Newsletter.
7. Agenda for the Committee on Blood Banks, February 5, 1986.

Mark

Report to the Commission on Community Health Services
From The
Committee on Blood Banks

M. Silvija Hoag, M.D.
December 17, 1985

1. Resolution 113-85/A

Directed Donations

~~Resolution~~ No. 113-85 / A

Directed Blood Donations

RESOLVED: That the California Medical Association believes that blood banks should strongly discourage directed donations, except for those patients who wish to use their own blood for themselves, in elective surgery cases.

ACTION: Refer to Council with recommendation that designated donor programs be monitored by the appropriate CMA Committee(s) which should report to the House of Delegates next year.

Referred to: Committee on Blood Banks.

The Committee on Blood Banks has extensively studied this issue. During the course of their investigation, they discovered that the California Blood Banks System conducted a survey of the various blood procurement centers throughout California. On November 21, 1985 the Committee met and invited as their guest Carol Bell, M.D., Chairwoman of the California Blood Bank System's Scientific Advisory Committee. This advisory committee conducted the survey regarding designated donor programs. The summary of the survey is as follows:

- 51 survey questionnaires were sent out and 37 responses were received. 21 of these responses were from community blood centers which supply approximately 1 million units annually. Sixteen of the responses were from hospital transfusion services which represented 5900 beds.
- All respondents indicated that designated donor programs are costly in terms of personnel, time and effort. This cost is passed on to the recipients or is absorbed in general costs. The charges range from \$0 to \$26 per unit collected, plus additional charges by hospital transfusion services for handling designated units in some

instances. At this time, third party payments are not available for these increased costs.

- Concern was raised that designated donor programs create two classes of recipients for blood: those who cannot obtain designated donors due to the additional charges per unit of blood; and those who can pay for this service and have elective procedures. Another concern focuses on those individuals who do not have close friends willing to donate blood.
- Several logistical problems were noted, such as the necessity to change surgery dates; the necessity to change hospitals; a lack of physician understanding of the testing requirements; and severe questions regarding the ability to release unused units.
- Designated donors have made a limited contribution to available supplies. 30 percent of these donors are first time contributors, but continuation of volunteers to donate is very low. Currently, approximately 50 percent of designated donor units go into a general pool. The designated donor units drawn indicates an average of 2 units per patient. The ratio of donor deferral or unusable units is the same or higher in designated donors than in the general blood bank pool.
- All survey respondents indicated they would not have started designated donor programs if it could have been avoided.
- The greatest utilization of designed donor programs has been in high AIDS "awareness" metropolitan areas.
- The summary for the report indicates that the designated donor program is a pluralistic approach with only a few happy participants.

In addition, the Committee members extensively discussed various designated donor programs that operate in their respective counties. Currently, no scientific evidence is available that directed donor programs provide safer blood or improve medical treatment, except in some instances of kidney transplant patients or family members in pheresis programs. Blood testing requirements preclude the availability of designated donor blood in times of emergencies. Occassional delays have been recorded in transfusions while waiting for designated donor blood to be processed and have caused a prolongation in hospital stays, thereby adding another cost factor. Also, designated donations may not be advisable in some instances of husband to wife in childbearing age, or parent to low birth rate infant, unless that blood has been irradiated.

The Committee did note that no major problems have occurred as long as designated donors constitute a low percentage of overall collections. With few exceptions, designated donor units are used within a blood bank service area, and therefore shipping of units has not become an issue. The Committee is concerned that fear of HTLV-III/LAV transmission has not decreased appreciably since antibody testing has been implemented at blood banks. Apparently, many Californians remain unaware of the fact that this type of testing has rendered blood essentially "safe." Also, patients do not know that blood in California is obtained from volunteer donors, except when specified exceptions are noted as per California law. However, the Committee believes the provision of designated donor programs provides a perceived benefit to patients and their families, which may also create an equally strong negative emotional response in patients who cannot provide donors. Some patients believe that blood will not be available for them if they cannot find donors. Many physicians like designated donors because "it makes patients feel better" about receiving transfusions when autologous transfusions are not an option.

Since the inception of designated donor programs, several organizations have made statements discouraging their use. These organizations include the American Medical Association, the American Association of Blood Banks, the American Red Cross, and the California Blood Bank System. These organizations continue to discourage such programs.

Following this extensive discussion, the Committee voted to recommend the following statement:

RECOMMENDATION: • THAT CMA BELIEVES DESIGNATED DONOR PROGRAMS SHOULD BE DISCOURAGED; HOWEVER, THAT SUCH PROGRAMS MAY HAVE SOME LIMITED PSYCHOLOGICAL BENEFITS FOR THE RECIPIENTS.

revised

2. Summary Regarding the Current Status of HTLV-III Antibody Testing - For Information

The Committee discussed the development of a summary statement regarding the current status of HTLV-III antibody testing. Committee members have been gathering information and data regarding this testing procedure to develop an article. An outline has been developed which covers such items as the purpose of the test, description of the test, definition of a positive test result, requirements for testing, donor information, and several other germane items. An outline of this information has been included as an addendum to this report.

During the compiling of this data, it was discovered that there is no clear DHS definition for "reactive test result." This forces many blood banks to throw out initially reactive units of blood. The

Committee believes clarification is necessary. Therefore, the Committee voted that the following questions be referred to the AIDS Task Force:

1. What is a confirmed positive test result as it applies to the donor notification?
2. What is the definition of a non-reactive as it relates to AB488, Section 2, 1603.1(A) that reads, "only units that are found non-reactive shall be used in vitro for humans in the state."
3. Can pheresis products be released without completing an HTLV-III Antibody test, if the donor has tested negative on recent previous donations? What is considered an acceptable time interval?
4. Are members of health care teams to be informed of HTLV-III Antibody positive test results in a patient?

5. *Autologous Blood notification*

The Committee believes these questions will ultimately result in a more clear approach to the testing of blood for HTLV-III antibody. Therefore, the Committee voted that:

RECOMMENDATION: ● THE COMMISSION REFER THESE QUESTIONS TO THE AIDS TASK FORCE; AND THAT

- IF NECESSARY, THE AIDS TASK FORCE ACTIVELY COLLABORATE WITH THE BLOOD BANK COMMITTEE IN THE DEVELOPMENT OF A LETTER TO KENNETH KIZER, MD, MPH, DIRECTOR OF DHS, FOR CLARIFICATION ON THIS ISSUE.

yes - need to go to Council

3. Blood Labeling

The Committee reviewed unconfirmed information that the American Association of Women Voters has retained Doris Allen of the California Assembly to introduce a bill that would separate blood male and female. This assumes female blood is safer than male blood. The Committee felt strongly regarding this issue and approved the following:

RECOMMENDATION; ● THAT CMA STRONGLY OPPOSE ANY LEGISLATION WHICH SUPPORTS BLOOD LABELING WITH REGARDS TO GENDER.

4. Reporting of HTLV-III Antibody Reactive Tests to Personal Physicians

The Committee reviewed a report regarding the notification of physicians whose patients have received blood or blood components from donors who currently test HTLV-III antibody confirmed positive.

A limited study of patients who have received blood products from donors who subsequently have been diagnosed as having AIDS, indicates that such patients have an increased chance of having the HTLV-III antibody. Precaution and prophylactic measures can be recommended to blood recipients who are HTLV-III reactive. Therefore, there may be reason for informing the personal physician. Currently, blood banks have made a decision to implement such a policy. The information requires action on the Commission level, but the Committee believes you should be aware of this activity.

no

3

CONFIDENTIAL

CALIFORNIA MEDICAL ASSOCIATION

Interoffice Memorandum

To Bob Elsner
From Paul K. Strobel *Paul*
Subject ACCMA Council Meeting
January 9, 1985

Date 1/10/86

→ ETHICAL DILEMMA

Decided not to notify a surgeon and his surgical team that a patient undergoing elective surgery on January 10 tested positive to the HTLV-III antibody screen. The ACCMA Blood Bank requested a release from the patient (a young, married man with a child) to notify the physician. The patient refused and current state law prohibits disclosure, with monetary and criminal penalties for willfully breaching confidentiality.

The Council is not only concerned with the surgical team's exposure to the patient's blood, but is even more concerned with the wife's exposure because of sexual contact as well as the effect on an unborn child in the case of a pregnancy.

As legal counsel pointed out, "It's a lousy law and we should use this anecdote (and others) when we try to change it (the law in Sacramento)."

Extract from report to Council of the Commission on State Legislation,
November, 1985

VI. REPORTING LAWS/PHYSICIAN RESPONSIBILITY/RAW MILK

A. PHYSICIAN REPORTING LAWS

Physicians are subject to a variety of reporting requirements, including crimes of violence, negligence, abuse, and matters relating to Workers' Compensation injuries. CMA is unaware of new communicable diseases which require legislative consideration, but is concerned about existing legislative treatment of confidentiality issues associated with AIDS antibody testing. In addition, a recommendation has been made to merge the CMA ad hoc Task Force on AIDS with the CMA Committee on Sexually Transmissible Diseases.

RECOMMENDATIONS:

1. That CMA continue to approve efforts to increase funding for child protective agencies.
2. That CMA not sponsor legislation to repeal the reporting requirements concerning nonabusive sexual conduct in children until the results of pending litigation are known.
3. That CMA not consider sponsoring legislation to repeal the "healing by prayer" provisions of Section 270 of the Penal Code until the results of pending litigation are known, and that CMA consider filing an amicus curiae brief with the Walker case if deemed appropriate by Legal Counsel.
4. That CMA seek no change in mandatory reporting standards in the Child Abuse, Elder Abuse and the Dependent Adult Abuse Reporting Laws at the present time, unless unacceptable amendments are proposed.
5. That CMA support efforts to relax the confidentiality provisions of existing AIDS antibody testing statutes.



San Francisco Medical Society

**SAN FRANCISCO MEDICAL SOCIETY
ADVISORY STATEMENT REGARDING
AIDS AND HTLV-III TESTING
December 1985**

250 Masonic Avenue
PO Box 18719
San Francisco, CA 94118
415 567-6230

The following statement is the product of intensive review by the San Francisco Medical Society Bioethics Committee and AIDS Task Force and was approved by the SFMS Board of Directors in December of 1985. Representatives from a broad spectrum of private and governmental medical organizations participated in the development of the statement. The recommendations contained herein are intended as advisory guidelines to San Francisco for the continuation of the difficult battle against the spread of AIDS. They are in no way intended for use as coercive measures or by parties other than concerned individuals, their physicians, and recognized organizations serving the interests of public health.

WHEREAS the AIDS epidemic poses an extremely serious threat to the health of all individuals, and

WHEREAS the San Francisco Medical Society is deeply concerned about the health of all members of society, including those in groups at high risk for AIDS:

1. The SFMS fully supports the provision of all needed resources for the care of people with AIDS and AIDS-related conditions, and for research and treatment of this disease.
2. The SFMS strongly encourages all individuals in groups at risk for AIDS and anyone having sexual contact with those in high risk groups to be voluntarily tested for HTLV-III antibodies.
3. The SFMS strongly supports the continued confidentiality of the HTLV-III test and the continuance of the anonymous testing site program.
4. All persons at risk for AIDS are urged to practice safe sex (sexual practices that do not involve the transmission of bodily fluids) at all times. Sharing of needles and syringes among drug users is also an unsafe practice that should be avoided at all cost.
5. As AIDS is primarily a sexually-transmitted disease, all individuals, regardless of sexual orientation, who have had or currently have multiple sexual partners should consider themselves at risk for the disease. Anyone at risk for AIDS should eliminate those sexual activities that put him or her at risk.

The SFMS wishes to remind all interested persons that the HTLV-III test is NOT a test for AIDS itself, but is a test for the virus which can cause AIDS. Medical research indicates that only a minority of those infected with the virus (and thus testing positive) will subsequently develop AIDS. Thus it is extremely important that those at risk of becoming infected and those already exposed to the virus make every effort to avoid behaviors, conditions, and potentially infectious agents which might place unnecessary stress upon their health. People choosing to be tested are strongly advised to avail themselves of the educational resources provided by AIDS-aware community organizations such as the San Francisco AIDS Foundation and the Department of Public Health and to seek appropriate medical advice and care when indicated.

HOWARD HASSARD
ROBERT D. HUBER
DAVID E. WILLET
GLENN L. ALLEN
JAMES N. PENROD
A. ROBERT SINGER
ROBERT E. LUCKIESH
DAVID L. SUDDENHOFF
JAMES M. GOODMAN
JOHN H. CUMMINGS
DELBERT C. GEE
DAVID B. BELLINGS
MICHAEL L. DONOVAN
SARA A. KELLER
COLEMAN L. MUNCH
CRAIG S. SPENCER
TIMOTHY F. CLEARY
RICHARD R. SHERIDAN
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* PROFESSIONAL CORPORATION

July 25, 1985

Mr. Steven Heilig
SAN FRANCISCO MEDICAL SOCIETY
250 Masonic Avenue
San Francisco, CA. 94118

RE: Confidentiality of AIDS Records

Dear Steve:

You have asked for guidelines concerning the proper handling of medical records for AIDS patients.

As you are probably aware, the California legislature recently enacted legislation governing the confidentiality of the results of blood tests to detect antibodies to the probable causative agent of AIDS. These statutes, Health and Safety Code §§199.20, et seq., provide broad protection for the confidentiality of the identity of individuals who are the subject of such tests. Generally speaking, information which would identify or provide identifying characteristics of any individual who is the subject of such a blood test cannot be obtained by subpoena or other legal process, regardless of whether the action is civil, criminal, administrative, legislative, or some other type of proceeding. Moreover, physicians may disclose test results only on written authorization specifying to whom the disclosure is to be made, and a separate authorization form must be signed for each disclosure of identifying information. A copy of an authorization form satisfying this requirement is attached.

Although other limited exceptions apply to blood banks and hospitals, the only exception to these confidentiality requirements applicable specifically to physicians is the mandatory reporting obligation established by Health and Safety Code §1603.1(c). This section requires a physician to report to the county health officer all transfusion-associated AIDS cases. The law also permits reporting pursuant to requirements which may be imposed by DHS or the Centers for Disease Control.

Mr. Steven Heilig
July 25, 1985
Page 2

The law establishes specific penalties for improper disclosure. Health and Safety Code §199.21 provides a penalty not to exceed \$1,000 plus court costs for negligent disclosure of such information, or a penalty of from \$1,000 to \$5,000 plus court costs for willful disclosure. Any penalties and costs assessed for negligent or willful disclosure are to be paid to the subject of the test. Additionally, if the disclosure results in "economic, bodily, or psychological harm to the subject of the test", such disclosure may be punishable as a misdemeanor by imprisonment in the county jail not to exceed one year, or a fine not to exceed \$10,000, or both. Moreover, a person negligently or willfully violating these confidentiality provisions is liable for all actual damages, including damages for economic, bodily, or psychological harm sustained as a result.

Physicians must understand that the law imposes special restrictions upon information which discloses the results of a blood test to detect antibodies to the probable causative agent of AIDS. Although the law is not entirely clear, the law may be interpreted broadly to protect all medical information which discloses directly or indirectly the result of such blood tests, that is, all information indicating that an individual is an AIDS patient. Physicians should institute some system which adequately alerts the physician and appropriate office personnel to the confidential nature of this information. It is probably advisable to separate AIDS records physically from other information contained in the patient's chart by, at a minimum, placing it on a separate page. In addition, the physician's office personnel should be instructed concerning the importance of safeguarding this information, and the legal limitations on disclosure as discussed above. It should be emphasized that these limitations apply to all releases, transmissions, disseminations, or communications, whether they are made orally, in writing, or by electronic transmission, and supercede other laws authorizing or requiring the release of other types of medical information except, perhaps when due to a medical emergency, disclosure of information is necessary for treatment purposes before a signed authorization can be obtained.

There are two further areas which should be discussed in connection with AIDS patients. First, although the law does not specifically address cases involving minor or incompetent AIDS patients, we believe general principles of consent law should apply. Therefore, the individual with legal authority to make health care decisions for an incompetent, adult

patient should be located, and his or her informed consent to treatment obtained. Individuals who may have such legal authority include an attorney-in-fact designated in a valid durable power of attorney for health care or a conservator. In the absence of such an individual, there is legal authority suggesting physicians may properly rely on the informed consent of immediate family members or "significant others". In the event the physician believes that an improper decision is being made, or where there is disagreement among the affected surrogates, it would be advisable to seek a court order before treatment is withheld or withdrawn. In addition, the parents or legal guardians of a minor AIDS patient should be required to make treatment decisions and sign authorization forms before the minor's records are released except in cases where the minor is legally entitled to consent for care on the minor's own behalf. Minors authorized to consent to AIDS treatment include:

- 1) married (or divorced) minors; and
- 2) minors on active duty with the U.S. armed forces; and
- 3) minors emancipated by a court order; and
- 4) self-sufficient minors (minors 15 years or older living away from home and managing their own financial affairs); and
- 5) minors 12 or older seeking care for any sexually transmitted diseases or any infections contagious or communicable disease of the type which must be reported to the local health officer.

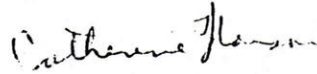
A physician treating a minor who falls within one of these provisions must obtain the minor's informed consent. In addition, the treating physician generally may not disclose medical information concerning such care to the minor's parents or legal guardian except pursuant to a written authorization signed by the minor. Of course, physicians may and should encourage minors to authorize appropriate disclosure.

Second, the law generally requires that the written consent of an individual be obtained before that individual's blood is tested for evidence of antibodies to the probable cause of AIDS, and that the test be performed in laboratories specifically approved by DHS to perform this test. Physicians planning to order these tests or considering providing testing services should ensure all legal requirements are met.

Mr. Steven Heilig
July 25, 1985
Page 4

I hope this information is helpful. Please don't
hesitate to call if you have questions concerning this material.

Sincerely,

A handwritten signature in cursive script, appearing to read "Catherine I. Hanson".

Catherine I. Hanson

CIH/syc

AUTHORIZATION FOR DISCLOSURE OF THE RESULTS OF A BLOOD TEST TO DETECT AIDS

A. EXPLANATION:

This authorization for use or disclosure of the results of a blood test to detect acquired immune deficiency syndrome (AIDS) is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, Civil Code Section 56 et seq. and Health and Safety Code Section 199.21(g).

B. AUTHORIZATION

I hereby authorize _____
[Name of Physician]

to furnish to _____
[Name or Title of Person Who is to Receive the Results]
the results of blood tests to detect acquired immune deficiency syndrome (AIDS) and medical records and information pertaining to the treatment of AIDS.

C. USES

The requester may use the information for any purpose, subject only to the following limitations: _____.

D. DURATION

This authorization shall become effective immediately and shall remain in effect until _____.
[Date]

E. RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

F. ADDITIONAL COPY

I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: ☐ Yes ☐ No Initial _____.

Date: _____ 19____ Signature _____

Printed Name

NOTE: This form must be in at least eight-point type.

AIDS ← SOME LEGAL ISSUES:

Will Acquired Immune Deficiency Syndrome prove to be the major public health problem of the twentieth century? Unless a vaccine or effective therapy is developed within the next few years, the answer is, "quite possibly." But the full scope of the problem will not be appreciated without extensive **epidemiologic studies**. This involves tracing the changing patterns of HTLV-III infection in various populations.

COMMENT: *While voluntary testing can yield significant information, it is compulsory testing which will provide the earliest and most complete epidemiologic data. So far, the California legislature has only mandated HTLV-III determinations for blood donors. Recent additional legislation, as discussed below, indicates a public policy in opposition to mandatory testing. The state policy on this issue can shift, however so it is worthwhile considering the constitutional impediments to compulsory testing ordered by a state.*

The major issue concerns the individual's constitutional **right of privacy**. This can be reduced to two considerations: first, the invasion of **bodily integrity** by drawing blood in order to test for HTLV-III infection. Second, the **dissemination** of this information to various health personnel responsible for followup and statistical analysis, plus the identification of sexual contacts. This last point is a particularly important public health concern, since the great majority of seropositive patients are infectious, presumably for life.

The United States Constitution does not specifically mention any right to privacy. However, in a line of decisions going back to 1891 the Supreme Court has recognized that a fundamental right of personal privacy, or at least a guarantee of certain areas or zones of privacy, does exist under the Constitution. These rights include activities relating to marriage, procreation, contraception, family relationships, child rearing and education. This list is not all-inclusive; it merely indicates the major thrust of these cases.

When governmental action is directed against an individual's fundamental rights, the Supreme Court has held that it may be justified only by a "**compelling state interest**." Therefore, in a constitutional test of a **state program** to establish an extensive, **compulsory** and ongoing epidemiologic survey of HTLV-III infection, the conclusions which can be drawn from presently known facts would be controlling. What are these facts?

As of September 23, 1985 the Centers for Disease Control had identified 13,402 cases of AIDS in the United

States, 6,830 of whom are dead. It is estimated that an additional 500,000 to 1 million Americans test seropositive for HTLV-III. Perhaps as many as 10% of seropositive individuals will manifest AIDS over a five year period, and 100% of those afflicted will die.

The rapidity of spread of the disease in a particular group is indicated by an article in the August 1985 issue of *Annals of Internal Medicine*, "The Acquired Immunodeficiency Syndrome in a Cohort of Homosexual Men: A Six-Year Followup Study" by Harold W. Jaffe, M.D. et. al. In a study **originally planned** to evaluate the incidence and prevention of hepatitis B virus infections, 6,875 homosexual and bisexual men in San Francisco were evaluated between 1978 and 1980. A blood specimen from each participant was obtained and the sera were frozen and **stored**. In 1984 blood specimens from a cohort of this original patient set were obtained. 4.5% of the stored sera from 1978-1980 were positive for HTLV-III. 67.4% of the smaller group studied in 1984 were positive.

However, it is **erroneous** to consider AIDS an **exclusively** homosexual disease. Only about 73% of AIDS patients have been homosexual or bisexual men. So perhaps the most critical question for the epidemiologist is how rapidly seropositive tests will accumulate in the general population.³

How might such an investigation proceed? Since prostitutes and intravenous drug users (and there is an overlap of these groups) are probably the most important initial vectors for heterosexual spread, a study of each group, extending over several years, is logical. But can these two classes of individuals be required to submit to study?

If one is considering a wholesale, compulsory gathering of presumed drug users and prostitutes for testing and followup, under **current** constitutional safeguards such an investigation would almost certainly be unconstitutional.⁴

Are there more restrictive circumstances which would permit a partial inventory of these high risk groups? Yes. Prostitutes present the most obvious case. Routine venereal disease testing of arrested and convicted prostitutes has been practiced in virtually all states for years. **Mandating** the test for HTLV-III would only be one more parameter of venereal disease investigation. The followup of those patients who tested positive would also be a routine and established public health measure.⁵

What about epidemiologic investigation of broader populations? Here the nexus for testing could be

premarital examinations, prenatal evaluations, and health exams for certain jobs such as teaching or child care. In each of these situations existing laws provide for mandatory venereal disease testing in most states.

DISCUSSION:

This article discusses what is constitutionally permissible if a state decides to pursue a policy of compulsory testing for HTLV-III among certain populations or classes. How likely is it that the California legislature will soon require HTLV-III testing for certain groups? Because of the risk to newborns if the mother is HTLV-III positive, required premarital testing seems especially reasonable. But it may be a long time before there is a broader, compulsory epidemiologic investigation. This is because of "urgency" legislation signed by the governor on April 3, 1985.

Assembly Bill 403 (codified in the California Health and Safety Code, Section 199.22) states, "No person shall test a person's blood for evidence of antibodies to the probable causative agent of AIDS without the **written consent** of the subject of the test..." The exception concerns the testing of donated blood.

Confidentiality with regard to blood test results is provided for by Health and Safety Code Section 199.21. Certain reporting requirements of the state and federal public health departments are exempted, but all disclosures (unless the patient consents) are forbidden and certain penalties are imposed. A cause of action is specifically created for improper disclosure, and the plaintiff may sue for "actual" damages. This includes both economic and psychological injury.

Section 199.21 of the Health and Safety Code states, "The results of a blood test to detect antibodies to the probable causative agent of Acquired Immune Deficiency Syndrome shall not be used in **any instance** for the determination of insurability or suitability for employment." A New York Times editorial on September 23, 1985 noted the problems for insurance carriers, especially life companies, created by this law.

COMMENT: *The new laws are detailed, and only the highlights are presented here. This urgency legislation was passed with little public discussion, out of concern for the often hysterical response of the general public to the AIDS epidemic. The concern for confidentiality seems perfectly justified, but the proscription on mandatory testing has serious implications. For example, tracing the development of seropositive reactions in the prostitute population could yield vitally important information to public health authorities, and the value of premarital testing is obvious. It will be interesting to see if legislative policy changes as the AIDS problem evolves.*

³ This September Belgian medical researchers reported that over 10% of the heterosexual adult population in Rwanda are seropositive for HTLV-III. Among prostitutes in Rwanda the incidence is about 80%.

⁴ In a state where prostitutes are licensed, the examinations could be a condition of licensure.

⁵ Considering the fact that a positive test indicates the likelihood on an infectious state, what could be done to control the prostitute? Most states make it a misdemeanor for an individual to intentionally expose another to the risk of contracting a venereal disease. The effort to control prostitutes' vocational behavior would prove difficult, yet this is one more traditional aspect of public health control of venereal disease that offers an approach to the public health problem.

⁶ The issue of specificity/sensitivity and false positive results in testing for antibodies to HTLV-III is outside the scope of this article. It is discussed in the JAMA for June 2 and October 4, 1985. The problem is especially significant in testing low risk groups. For premarital and prenatal exams, etc., the need for carefully retesting positive responses is obvious.

COMMITTEE ON BLOOD BANKS

Wednesday
February 5, 1986

2:00PM - 6:00PM

Los Angeles Marriott

AGENDA

- *1. Roll Call
- *2. Minutes
- *3. Alternative Test Site Program
 - Correspondence from Robert E. Anderson, MD, Chief AIDS Section, DHS
 - Drago M. Schmidt, MD's Personal Comments
 - AMA Resolution
- *4. Guidelines for Notification of Blood Donors Found to be Reactive for HTLV-III Antibody -- DHS Draft
- *5. Legislative Update
 - Designated Blood Donor Legislation
 - AMA Resolution
 - ARC Position
 - Blood Safety Articles
- *6. Miscellaneous Articles
 - Blood Transfusion Act of 1985
 - AIDS Update
- 7. Old Business
- 8. New Business
- 9. Next Meeting
- 10. Adjournment

*Indicates Materials Enclosed

Committee on Blood Banks

November 21, 1985

2:00 - 6:00 p.m.

San Francisco Airport Hilton

1. Roll Call

Members Present

R. Richard Adrouny, MD
Stanley A. Clark, Jr, MD
Hans H. Dibbern, MD
Myron Fisher, MD
M. Silvija Hoag, MD, Chair
Arvid R. Magnuson, MD
Emmett B. Reilly, MD
Dragutin M. Schmidt, MD
Edward E. Tueller, MD

Members Absent

Arnold R. Abrams, MD
Vincent Caggiano, MD
Robb Smith, MD
Takkin Lo, Student

Guest

Carol Bell, MD, CBBS

Staff

Catherine Maley, Coordinator
Mark Madsen, CMA AIDS T.F.

2. Minutes

The minutes were approved with the understanding that A. Richard Adrouny, MD, will be added to the "members present" list.

3. Directed Blood Donations

Dr. Hoag reported the Commission on Community Health Services, to which this Committee reports, has requested a report regarding directed blood donations, which would respond to Resolution 113-85. Carol Bell, MD, Chairperson of California Blood Banks System's (CBBS) Scientific Advisory Committee, was invited to give a report which is in response to this committee's letter asking for information from CBBS regarding this issue.

Dr. Bell reported survey results of CBBS members. 51 questionnaires were distributed to Institutional and Associate Institutional members to collect data relating to directed donor programs. Of the 37 replies received, the following was learned:

- the replies represent 21 blood centers supplying approximately 1,000,000 units annually and 16 transfusion services representing 5,900 beds;

- 2 of the major blood centers which account for 484,000 of the 1,000,000 units DO NOT have directed donor programs and actively OPPOSE the concept;
- the remaining 35 respondents draw 597,000 units annually and 28 offer directed donation programs; 7 do not;
- the above directed donor programs draw approximately 23,000 units/annually from directed donors;
- the patients generally receive 1/2 of the directed donor's blood and the other 1/2 goes into the general pool which means of the 597,000 units drawn, 12,000 - 14,000 units (annually) in the pool are from directed donor units NOT used by the designee;
- there is an increased workload:
 - recordkeeping;
 - inventory segregation;
 - patient identification;
 - surcharge to cover the cost for this service ranged from \$1 - \$26 per unit and additional charges at some hospital transfusion services;
 - Most respondents felt their costs were recovered;
 - third party payment not available for increased cost.
- the majority of respondents would not have begun a program if they could have avoided the community pressure to provide this service; one large blood center created their own publicity campaign to actively oppose the service; however, centers in areas with many potential high-risk donors were very enthusiastic for the program;
- 30 percent (average) were first time donors. One center commented that although 64 percent were first time donors, few (if any) could be recruited for a subsequent non-directed donation;
 - designated donor contribution to available supply is small;
 - since most are regular donors, it only erodes volunteer donor base.
- the problems of this service generally include:
 - designated donor not available for emergencies (lack of patient and physician knowledge of time requirements for processing;
 - increased workload complicated by:
 - rescheduling of planned surgeries, and hospital transfers; however, creates positive feelings in patients who believe

designated donations are safer, with equally negative feelings for those who cannot obtain designated donations for whatever reason.

Summary:

Designated donor program is a pluralistic approach with only a few happy participants.

Each committee member reported on directed donations in his/her individual area; the general consensus was:

1. There is no scientific evidence that designated donor provides safer blood or improved patient care, except for reported benefits for kidney transplant patients or family members in pheresis programs.
2. Blood testing requirements preclude the availability of designated donor blood in times of emergencies. Occasional delays have been recorded in transfusions while waiting for designated donor blood to be processed and have caused a prolongation in hospital stays, thereby adding another cost factor.
3. Also, designated donations may not be advisable in some instances of husband to wife in childbearing age, or parent to low-birth rate infant, unless the blood is irradiated.
4. However, there is a perceived benefit by patients and patients' families believing that designated donation blood is safer; the consensus seemed to be that it generally worked well in reassuring certain patients.
5. The Committee did note that no major problems have occurred as long as designated donors constitute a low percentage of overall collections. With few exceptions, designated donor units are used within a blood bank service area, and therefore shipping of units has not become an issue. The Committee is concerned that fear of HTLV-III transmission has not decreased appreciably since antibody testing has been implemented at blood banks. Apparently, many Californians remain unaware of the fact that this type of testing has rendered blood essentially "safe." Also, patients do not know that blood in California is obtained from volunteer donors, except when specified exceptions are noted as per California law. However, the Committee believes the provision of designated donor programs provides a perceived benefit to patients and their families, which may also create an equally strong negative emotional response in patients who cannot provide donors. Some patients believe that blood will not be available for them if they

cannot find donors. Many physicians like designated donations because "it makes patients feel better" about receiving transfusion when autologous transfusions are not an option.

The American Medical Association, the American Association of Blood Banks, the American Red Cross, CCBC and College of American Pathologists have made statements discouraging designated donations. This position has not changed.

Following this extensive discussion, the Committee recommended the following statement:

RECOMMENDATION: o THAT CMA BELIEVES DESIGNATED PROGRAMS SHOULD BE DISCOURAGED; HOWEVER, THAT SUCH PROGRAMS MAY HAVE SOME LIMITED PSYCHOLOGICAL BENEFITS FOR THE RECIPIENTS.

Supporting comments include:

1. No scientific evidence that it is safer or that it improves medical treatment.
2. Has psychological and emotional benefits perceived by the patient when they can provide their own donors and strong negative emotions when they are not able to obtain donors.
3. Official blood bank systems' positions have not changed regarding this issue, which is to discourage these programs.
4. Many physicians are pleased that their patients feel better about transfusions; autologous blood donations do provide greatest safety for recipient and should be encouraged whenever this option exists..
5. Has not created major logistical problems in most areas.

4. Current Status of HTLV-III Antibody Testing

The Committee discussed the development of a summary statement regarding the current status of HTLV-III antibody testing. Committee members have been gathering information and data regarding this testing procedure to develop an article. An outline has been developed which covers such items as the purpose of the test, description of the test, definition of a positive test result, requirements for testing, donor information, and several other germane items. An outline of this information has been included as an addendum to this report.

The Committee will review Dr. Hoag's draft summary and send their comments to staff. In addition, the Committee believes that clarification is necessary on various issues relating to HTLV-III testing and voted the following questions be referred to (and to work together with) CMA's AIDS Task Force to seek regulatory action by Public Health Division:

1. What is a confirmed positive test result as it applies to the donor notification?
2. What is the definition of a non-reactive as it relates to AB 488, Section 2, 1603.1(A) that reads, "only units that are found non-reactive shall be used in vitro for humans in the state (IR versus RR).
3. Can pheresis products be released without completing an HTLV-III Antibody test, if the donor has tested negative on recent previous donations? What is considered an acceptable time interval?
4. Are members of health care teams to be informed of HTLV-III Antibody positive test results in a patient? Or what type infection precaution notice should be applicable without breaking the confidentiality?
5. Release of test results for autologous donations - 60 day waiting period should not apply (Should authorization for release of information be obtained for autologous donors - testing at autologous units is not mandated at this time).

AB 403 prohibits the use of blood test results in determining insurability; however, in California this provision may be challenged in court. The alternative test sites advise those whose tests are positive to find out their physician's willingness to keep their positive test results out of their medical record. If they will not agree to that, the person should find another physician.

5. Title 17

DHS has sent out notice for proposed changes in regulations to amend Section 1002 (a)(3) of Title 17. The Committee made the following comments which will be relayed to DHS:

- 1002 (a)(2) change age from 18 to 17. This should be updated in accordance with SB 135.
- 1002 (a)(3) change sentence structure only so it now reads, "if he passed his 66th birthday except donors 66 or older may be accepted with approval..."

- 1002 (a)(5) This no longer applies because according to SB 488, persons are placed on the deferred donor list without listing the reason.
- This committee has many more changes to recommend in other areas of Title 17 which are in dire need of being completely revised.

7. Blood Labeling

The Committee reviewed unconfirmed information that the American Association of Women Voters has retained Doris Allen of the California Assembly to introduce a bill that would separate blood male and female. This assumes female blood is safer than male blood. The Committee felt strongly regarding this issue and approved the following:

RECOMMENDATION: o THAT CMA STRONGLY OPPOSE ANY LEGISLATION WHICH SUPPORTS BLOOD LABELING WITH REGARDS TO GENDER.

8. Disaster Plan for Acquisition and Distribution of Blood and Blood Products

The Committee was presented with the Emergency Medical Services Authority's (EMSA) Disaster Contingency Plan for the Acquisition and Distribution of Blood and Blood Products. In July, 1984, when the plan was being written, the Committee reviewed and made recommendations, so EMSA would like the Committee's review and any new recommendations that would be used for a rewrite of this document. The Committee will send their comments to Staff who will route them onto EMSA.

9. Reporting Donor HTLV-III Antibody Reactive Test Results to Personal Physicians of Previous Blood or Blood Component Recipients

The Committee reviewed a report regarding the notification of physicians whose patients have received blood or blood components from donors who currently test HTLV-III antibody confirmed positive.

A limited study of patients who have received blood products from donors who subsequently have been diagnosed as having AIDS, indicates that such patients have an increased chance of having the HTLV-III antibody. Precaution and prophylactic measures can be recommended to blood recipients who are HTLV-III reactive. Therefore, there may be reason for informing the personal physician. Currently, only three blood banks have made a decision to implement such a policy.

10. Next Meeting

The next committee meeting will be held on February 5, 1986 from 2:00 - 6:00 p.m. at the Los Angeles Marriott Hotel.

11. Adjournment

There being no further business, the Committee adjourned at 5:30 p.m.

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814AIDS Section
P.O. Box 160146
Sacramento, CA 95816-0146

December 16, 1985

(916) 445-0553

M. Silvija Hoag, M.D.
Medical Director
Blood Bank of the
Alameda - Contra Costa Medical
Association
6230 Claremont Avenue
P.O. Box 2895
Oakland, CA 94618

Dear Doctor Hoag:

MEDICAL DIAGNOSTIC USE OF THE HTLV-III TEST

Any licensed laboratory can offer the HTLV-III - EIA Antibody test for viral diagnostic purposes. They must meet the same requirements for this test as other non-syphilis serological procedures. Requirements would include establishment of normal values, performing the test with appropriate controls, written documentation of the procedure, and guidelines for interpretation. The fact that the FDA approved use of the test is for screening of blood does not limit its use for medical diagnostic purposes. Third party payers may not choose to reimburse for the procedure, however, until its utility for medical diagnostic purposes is well established.

Sincerely,

Robert E. Anderson for
Robert E. Anderson, M.D., Chief

STUDY OF HTLV-III ANTIBODY TEST RESULTS

Rate of Repeatably Reactive Donors by EIA from American Red Cross

Area: Los Angeles & Orange Cos. Period Ending: Aug. 5 - Nov. 25, 1985

Categories	Number			Reactivity		
	Male	Female	Total	Male	Female	Total
1) Total donor units tested in reporting period	66,539	47,863	114,402	xxx	xxx	xxx
2) Initial test non-reactive	---	---	113,332	---	---	99.06%
3) Initial test reactive; repeat test non-reactive	---	---	1,070	---	---	.93%
4) Initial test reactive; repeat test reactive	256	122	378	.384%	.254%	* .3304%

* 33 Donors per 10,000.

Blood Bank Note

Salvador,
this is the data from
LA. we haven't got enough
reports from elsewhere to
separate at present.

Bob Adams

12/18/85

ALTERNATE TEST SITES

The Incidence of Repeatably Reactive Test results have been published.

Follow-up, in most instances, at the state-approved alternate test sites is limited to providing advice regarding the significance of the test results. The significance or probability of the test's accuracy is directly related to the volunteer's risk group.

The high risk volunteer can learn that he is probably infectious or not yet infected. In either case, knowledge of safe sex practices is provided, in an attempt to educate so that the infected do not infect the uninfected, and that the uninfected may remain so.

Repeatably reactive volunteers are referred, as needed, for medical or psychological evaluation and assistance.

They are encouraged to notify their lovers themselves.

Special studies, such as "S.F. Women's Cohort Study," are recruiting bisexual males and reactive females for in depth follow-up.

AIDS Section
121985

A BRIEF HISTORY
OF THE
HTLV-III ANTIBODY
ALTERNATIVE TESTING SITE PROGRAM

Assembly Bill No. 488 (approved by the Governor on April 3, 1985 and filed with the Secretary of State on April 4, 1985) requires counties designated by the State Director of Health Services to establish a testing program for the detection of antibodies to Human T-Cell Lymphotropic Virus-Type III, the probable causative agent of AIDS.

The development of an Alternative Testing Site (ATS) Program was necessary to ensure the safety of the State's blood supply. A major concern was that persons who may be at risk of contracting AIDS would go to donate blood just to be tested, if blood banks were the only immediate source of free and easily accessible testing.

Assembly Bill 488 appropriated the sum of \$5,000,000 for a three (3) year period, to the State Department of Health Services for the purpose of administering HTLV-III Antibody Testing at the Alternate Test Sites. On April 22, 1985 the Department was also granted Federal funds of \$2,455,578 for this testing program for a three-month period from April 26 to July 24, 1985. A request had been granted to extend this funding to October 22, 1985, and a subsequent request for an extension has been granted through April 30, 1986.

As a result of AB 488, thirty-one (31) health jurisdictions were designated to provide non-blood bank (alternative) HTLV-III Antibody testing. Fifty-three (53) testing sites have been established within these jurisdictions. On May 13, 1985 San Bernardino County was the first Alternate Test Site to begin testing. Orange County followed on June 3, 1985. By the end of June, eight (8) jurisdictions were testing; and by the end of July twenty-four (24) jurisdictions were testing at forty-one (41) testing sites.

HTLV-III ANTIBODY TESTING SYNOPSIS

As of Thursday, December 5, 1985 twenty-nine (29) jurisdictions are testing, with 49 Alternate Test Sites in operation. A total of 21,044 people have been tested since the program began, with a current positivity rate of 19%.

The attached charts and figures (graphs) represent testing data obtained through the month of October 1985. Data depicted under the headings of "not stated" or "other" reflects information not categorized into specific risk groups by the volunteer. It should be noted that of the total number tested in this period (15,211), 5,044 (33%) were not identified by risk group. Of these 5,044, 3559 (71%) were reported by San Francisco County, which has not as yet initiated reporting by risk group.

Bob Hirsch
AIDS Section
12/11/85

HTLV-III ANTIBODY ALTERNATIVE TEST SITE REPORT CALIFORNIA

Period of Report: June-October 1985

RISK GROUP	SEX	TOTAL	AGE GROUP								RESULTS OF PRIOR TEST				TEST RESULT		PAST TEST		
			0-9	10-19	20-29	30-39	40-49	50-59	60+	UNK	POS	NEG	UNK	TEST	POSITIVE	NEGATIVE	IND	BLOOD DONOR	INTER-VIEWS
TOTAL	COMBINED	15,211	0	260	3,903	4,083	1,765	717	474	4,009	109	170	332	397	2,814	11,627	129	1,088	6,814
	MALES	12,765	0	218	3,291	3,313	1,461	602	371	3,509	100	158	274	318	2,679	9,397	109	934	5,678
	FEMALES	2,368	0	42	612	761	301	115	103	434	8	12	58	76	125	2,169	20	153	1,132
	UNKNOWN	78	0	0	0	9	3	0	0	66	1	0	0	3	10	61	0	1	4
HOMOSEXUALS (GAYS)	MALES	4,730	0	119	1,747	1,547	716	277	111	213	58	86	121	58	1,396	3,105	33	428	2,811
	FEMALES	138	0	5	62	61	6	0	0	4	0	1	3	0	4	129	1	7	62
IV DRUG USERS	MALES	375	0	10	147	168	39	7	1	3	7	1	10	9	35	316	5	32	174
	FEMALES	138	0	5	62	61	6	0	0	4	0	1	3	0	4	129	1	7	62
BISexuals	MALES	1,650	0	38	558	567	276	120	59	32	10	29	54	31	210	1,357	12	194	1,050
	FEMALES	12	0	2	1	8	0	0	1	0	0	1	0	2	3	6	0	0	7
HEMOPHILIACS	MALES	12	0	2	1	8	0	0	1	0	0	1	0	2	3	6	0	0	7
	FEMALES	254	0	4	31	57	28	40	84	10	2	2	8	9	10	228	3	13	170
BLOOD RECIPIENTS	MALES	254	0	4	31	57	28	40	84	10	2	2	8	9	10	228	3	13	170
	FEMALES	294	0	1	44	100	42	41	57	9	0	1	12	11	4	270	3	26	187
HETEROSEXUALS/ MULTIPLE PARTNERS	MALES	1,048	0	15	297	444	168	61	37	26	8	23	32	67	17	929	14	105	596
	FEMALES	364	0	3	123	139	76	17	2	4	3	2	9	10	4	316	4	22	202
SEXUAL PARTNERS OF THE ABOVE	MALES	602	0	13	210	221	90	34	20	14	3	5	20	22	25	520	6	55	393
	FEMALES	700	0	15	238	285	95	35	15	17	1	6	22	22	15	642	6	55	415
NONE OF THE ABOVE OR NOT STATED	MALES	4,094	0	17	300	301	144	63	58	3,211	12	11	29	120	983	2,936	36	107	477
	FEMALES	872	0	18	145	176	82	22	29	400	4	2	12	33	98	812	6	43	266
	UNKNOWN	78	0	0	0	9	3	0	0	66	1	0	0	3	10	61	0	1	4

Source: Department of Health Services, Acquired Immune Deficiency Syndrome Section

HTLV-III ANTIBODY ALTERNATIVE TEST SITE REPORT CALIFORNIA

Period of Report: October 1985

RISK GROUP	SEX	TOTAL	AGE GROUP								RESULTS OF PRIOR TEST				TEST RESULT				POST TEST	
											DE-									
			0-9	10-19	20-29	30-39	40-49	50-59	60+	UNK	POS	NEG	UNK	TEST	CLINED	POSITIVE	NEGATIVE	IND	BLOOD	INTER-
																			DONOR	VIENS
	COMBINED	6,188	0	118	1,616	1,689	746	324	214	1,481	44	94	143	136	1,124	4,842	55	427	2,812	
	MALES	5,149	0	100	1,347	1,365	611	272	173	1,281	40	87	120	100	1,020	3,876	47	364	2,305	
	FEMALES	980	0	18	269	322	133	52	41	145	4	7	23	34	98	918	8	63	505	
	UNKNOWN	59	0	0	0	2	2	0	0	55	0	0	0	2	6	48	0	0	2	
HOMOSEXUALS (GAYS)	MALES	2,004	0	48	693	630	275	122	54	182	24	51	53	14	584	1,340	16	175	1,094	
	FEMALES	169	0	8	65	69	22	3	0	2	3	1	3	4	15	140	2	16	81	
IV DRUG USERS	MALES	61	0	4	27	26	1	0	0	3	0	1	1	0	2	59	0	2	31	
	FEMALES	664	0	19	215	210	114	57	30	19	5	11	22	8	85	551	4	66	403	
BISexuals	MALES	4	0	0	1	3	0	0	0	0	0	0	0	2	1	1	0	0	1	
HEMOPHILIACS	MALES	106	0	2	17	19	15	17	33	3	1	0	5	3	2	97	3	5	69	
BLOOD RECIPIENTS	MALES	113	0	0	26	39	20	9	17	2	0	0	4	3	2	107	0	6	73	
	FEMALES	516	0	9	147	204	87	34	21	14	4	17	18	15	9	475	3	47	298	
METEROSEXUALS/ MULTIPLE PARTNERS	MALES	175	0	2	66	58	34	13	0	2	2	2	4	4	2	162	2	13	103	
	FEMALES	271	0	6	91	99	36	18	11	10	0	3	8	12	10	234	4	19	172	
SEXUAL PARTNERS OF THE ABOVE	MALES	306	0	8	97	118	47	18	9	9	0	3	9	7	4	283	3	26	176	
	FEMALES	1,415	0	8	118	131	62	21	24	1,051	3	4	11	42	314	1,038	15	36	187	
NONE OF THE ABOVE OR NOT STATED	MALES	325	0	4	53	81	31	12	15	129	2	1	5	20	88	307	3	16	122	
	FEMALES	59	0	0	0	2	2	0	0	55	0	0	0	2	6	48	0	0	2	
	UNKNOWN																			

Source: Department of Health Services, Acquired Immune Deficiency Syndrome Section

VISITS TO HTLV-III ANTIBODY ALTERNATIVE TEST SITES

California, by County

Period: June-October 1985

Total	15,211	Percent of Total
Alameda	809	5.32 %
Butte	142	.93 %
Contra Costa	219	1.44 %
Fresno	159	1.05 %
Humboldt/Del Norte	0	.00 %
Imperial	0	.00 %
Inyo	3	.02 %
Kern	170	1.12 %
Long Beach	2,847	18.72 %
Los Angeles	478	3.14 %
Marin	278	1.83 %
Merced	37	.24 %
Monterey	112	.74 %
Orange	1,289	8.47 %
Riverside	212	1.39 %
Sacramento	496	3.26 %
San Bernardino	267	1.76 %
San Diego	1,659	10.91 %
San Francisco	3,559	23.40 %
San Joaquin	129	.85 %
San Luis Obispo	124	.82 %
San Mateo	361	2.37 %
Santa Barbara	633	4.16 %
Santa Clara	620	4.08 %
Santa Cruz	137	.90 %
Shasta	0	.00 %
Solano	86	.57 %
Sonoma	77	.51 %
Stanislaus	101	.66 %
Tulare	64	.42 %
Ventura	143	.94 %

Source: Department of Health Services, Acquired Immune Deficiency Syndrome Section

VISITS TO HTLV-III ANTIBODY ALTERNATIVE TEST SITES

California, by County

Period: October 1985

Total	6,188	Percent of Total
Alameda	381	6.16 %
Butte	51	.82 %
Contra Costa	90	1.45 %
Fresno	46	.74 %
Humboldt/Del Norte	0	.00 %
Imperial	0	.00 %
Inyo	0	.00 %
Kern	70	1.13 %
Long Beach	1,073	17.34 %
Los Angeles	478	7.72 %
Marin	85	1.37 %
Merced	12	.19 %
Monterey	56	.90 %
Orange	572	9.24 %
Riverside	171	2.76 %
Sacramento	237	3.83 %
San Bernardino	105	1.70 %
San Diego	646	10.44 %
San Francisco	1,181	19.09 %
San Joaquin	49	.79 %
San Luis Obispo	58	.94 %
San Mateo	89	1.44 %
Santa Barbara	240	3.88 %
Santa Clara	261	4.22 %
Santa Cruz	37	.60 %
Shasta	0	.00 %
Solano	30	.48 %
Sonoma	43	.69 %
Stanislaus	37	.60 %
Tulare	29	.47 %
Ventura	61	.99 %

Source: Department of Health Services, Acquired Immune Deficiency Syndrome Section

VISITS VISITS TO HTLV-III ANTIBODY ALTERNATIVE TEST SITES

California, by County

Period: June-October 1985

	Total	15,211	Percent of Total	Percent Change From Previous Month
January	0		.00 %	N/A
February	0		.00 %	.00 %
March	0		.00 %	.00 %
April	0		.00 %	.00 %
May	0		.00 %	.00 %
June	237		1.56 %	.00 %
July	1,529		10.05 %	545.15 %
August	3,312		21.77 %	116.61 %
September	3,945		25.94 %	19.11 %
October	6,188		40.68 %	56.86 %
November	0		.00 %	.00 %
December	0		.00 %	.00 %

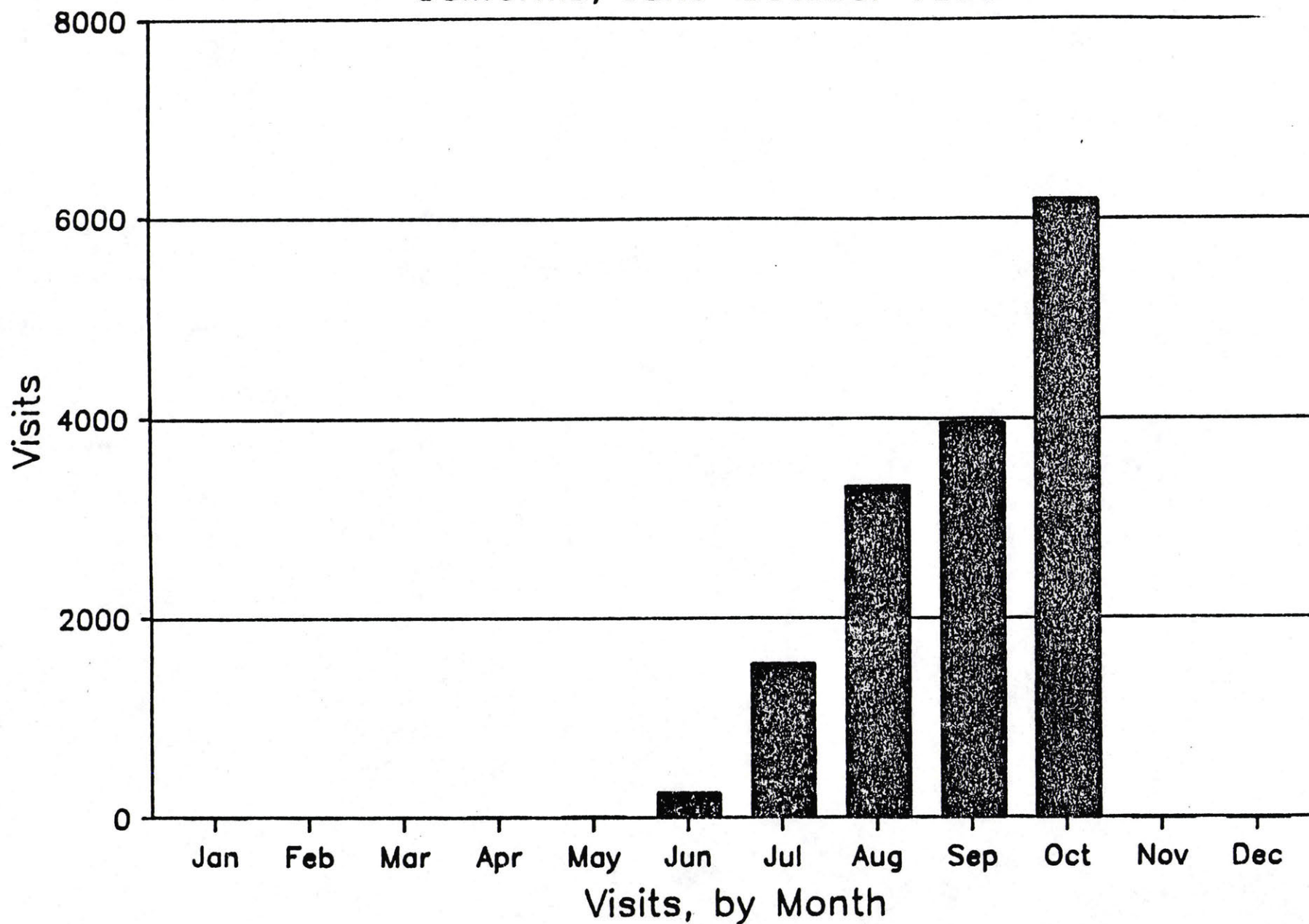
Source: Department of Health Services, Acquired Immune Deficiency Syndrome Section

• HTLV-III POSITIVITY RATES

	Jun 85	Jul 85	Aug 85	Sep 85	Oct 85	Nov 85	Dec 85	Jan 86	Feb 86	Mar 85	Apr 86	May 86	Jun 86
Total Results Completed	212	1441	3117	3779	6021	0	0	0	0	0	0	0	0
# Positive	48	328	629	685	1124	0	0	0	0	0	0	0	0
Rate (%)	23	23	20	18	19	0	0	0	0	0	0	0	0
Gay Male Results Completed	118	402	970	1104	1940	0	0	0	0	0	0	0	0
# Positive	38	140	312	322	584	0	0	0	0	0	0	0	0
Rate (%)	32	35	32	29	30	0	0	0	0	0	0	0	0
I.V. Drug Users Completed	7	44	91	130	218	0	0	0	0	0	0	0	0
# Positive	1	4	6	1	17	0	0	0	0	0	0	0	0
Rate (%)	14	9	7	0	8	0	0	0	0	0	0	0	0
Bisexuals Completed	28	133	365	413	640	0	0	0	0	0	0	0	0
# Positive	3	21	44	57	85	0	0	0	0	0	0	0	0
Rate (%)	11	16	12	14	13	0	0	0	0	0	0	0	0
Hemophiliacs Completed	0	1	0	6	2	0	0	0	0	0	0	0	0
# Positive	0	1	0	1	1	0	0	0	0	0	0	0	0
Rate (%)	0	100	0	17	50	0	0	0	0	0	0	0	0
Blood Recipients Completed	3	53	107	144	211	0	0	0	0	0	0	0	0
# Positive	1	0	5	4	4	0	0	0	0	0	0	0	0
Rate (%)	33	0	5	3	2	0	0	0	0	0	0	0	0
Heteros/Mult Partners Completed	17	120	196	298	653	0	0	0	0	0	0	0	0
# Positive	0	1	8	8	11	0	0	0	0	0	0	0	0
Rate (%)	0	0	4	3	2	0	0	0	0	0	0	0	0
Sex Partners of the Above Comp.	19	88	251	317	538	0	0	0	0	0	0	0	0
# Positive	1	1	13	11	14	0	0	0	0	0	0	0	0
Rate (%)	5	1	5	3	3	0	0	0	0	0	0	0	0
Others or N/S Completed	20	600	1136	1367	1819	0	0	0	0	0	0	0	0
# Positive	2	160	244	275	408	0	0	0	0	0	0	0	0
Rate (%)	10	27	21	20	22	0	0	0	0	0	0	0	0

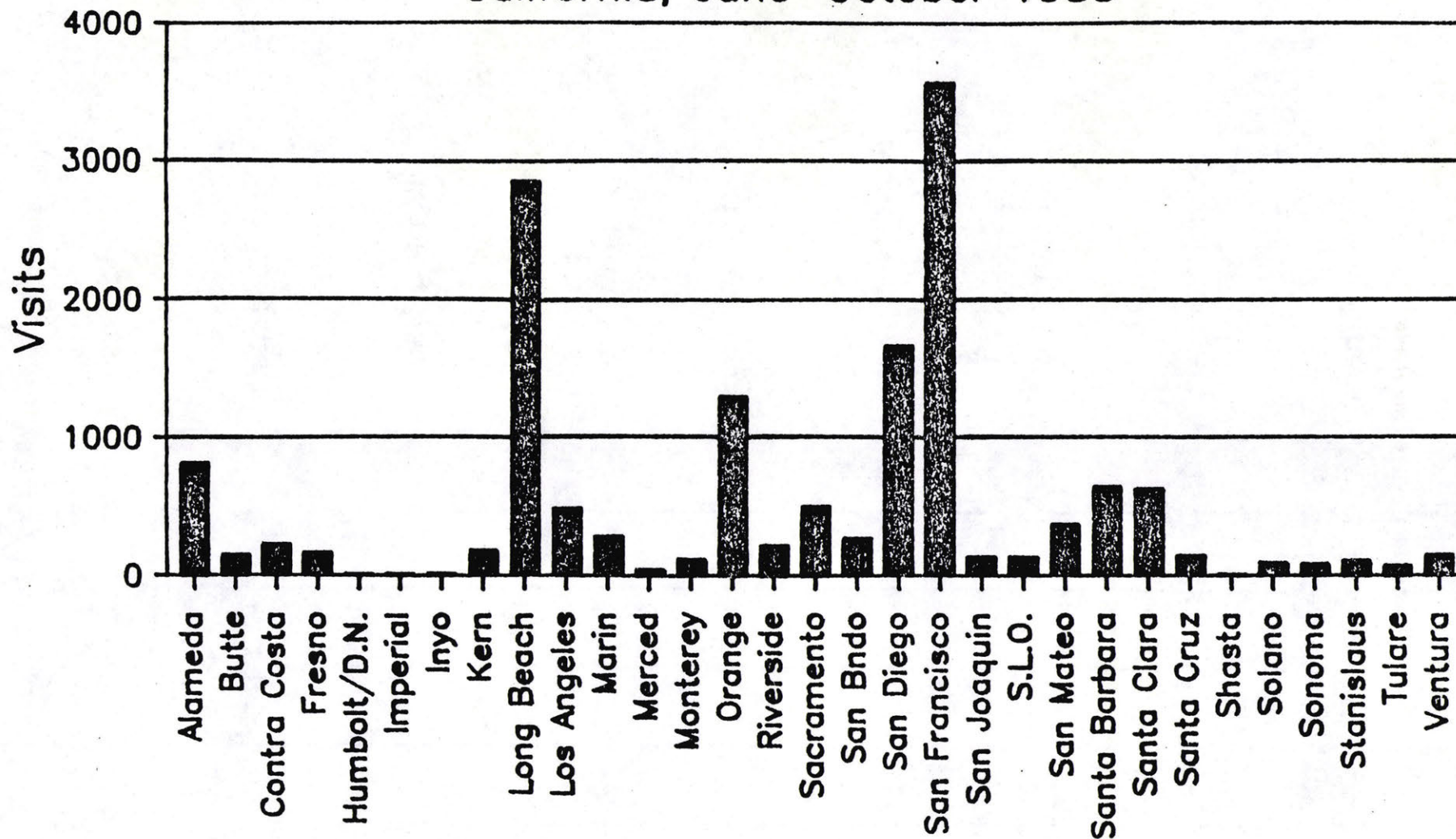
HTLV-III ALTERNATIVE TEST SITE REPORT

California, June-October 1985



HTLV-III ALTERNATIVE TEST SITE REPORT

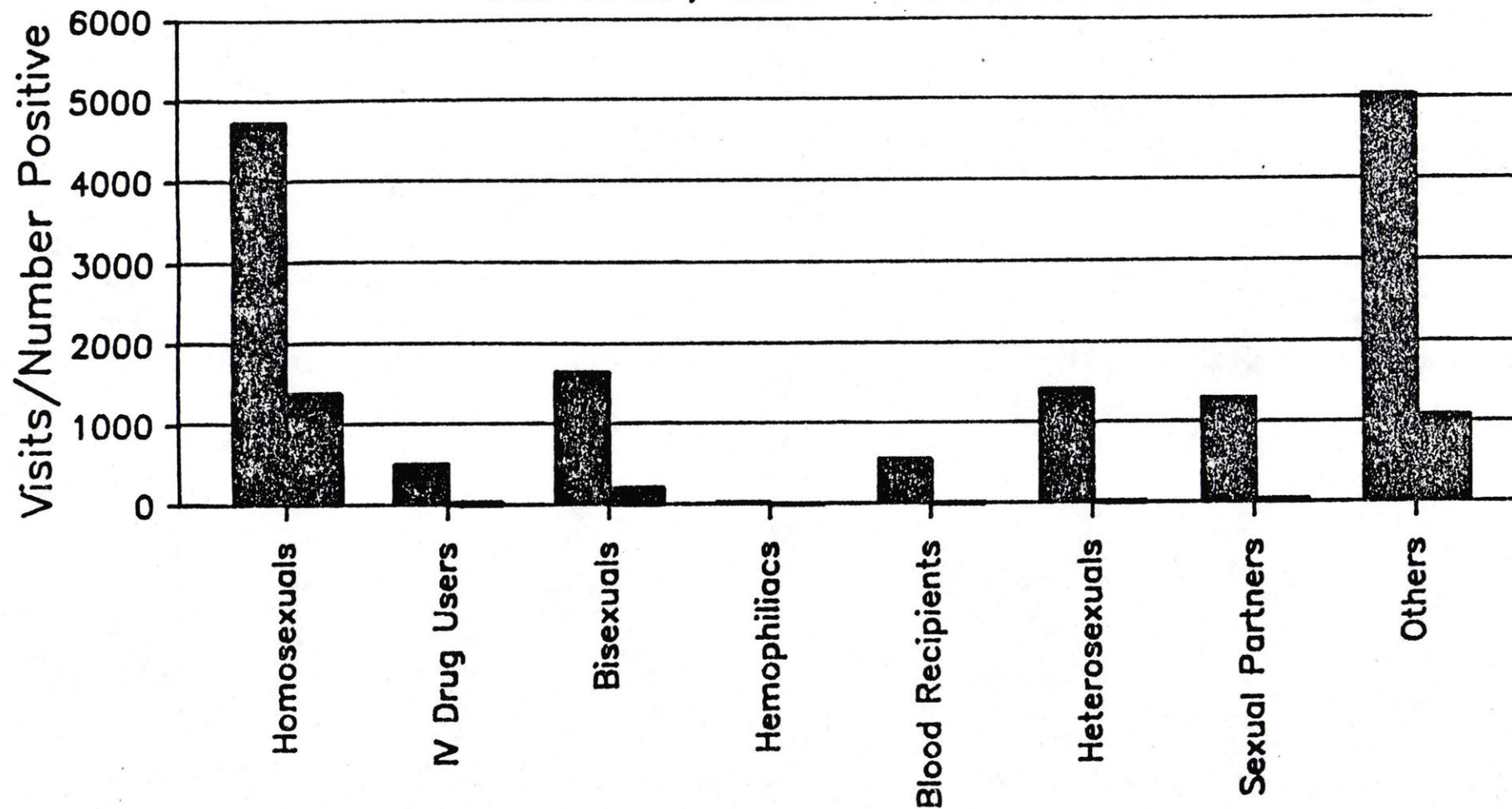
California, June-October 1985



Visits, by Testing County

HTLV-III ALTERNATIVE TEST SITE REPORT

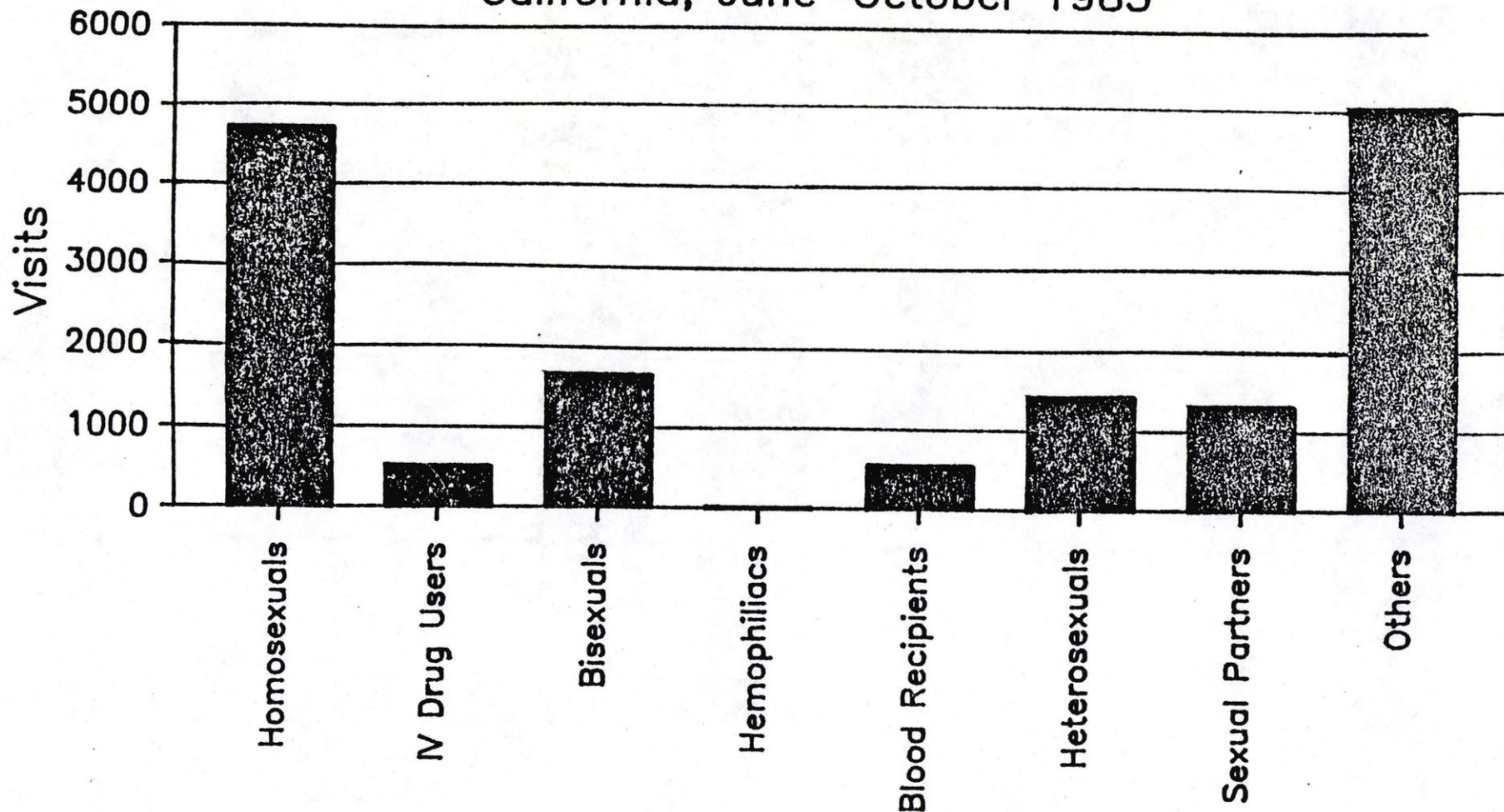
California, June-October 1985



Visits, by Risk Group/No. Positive

HTLV-III ALTERNATIVE TEST SITE REPORT

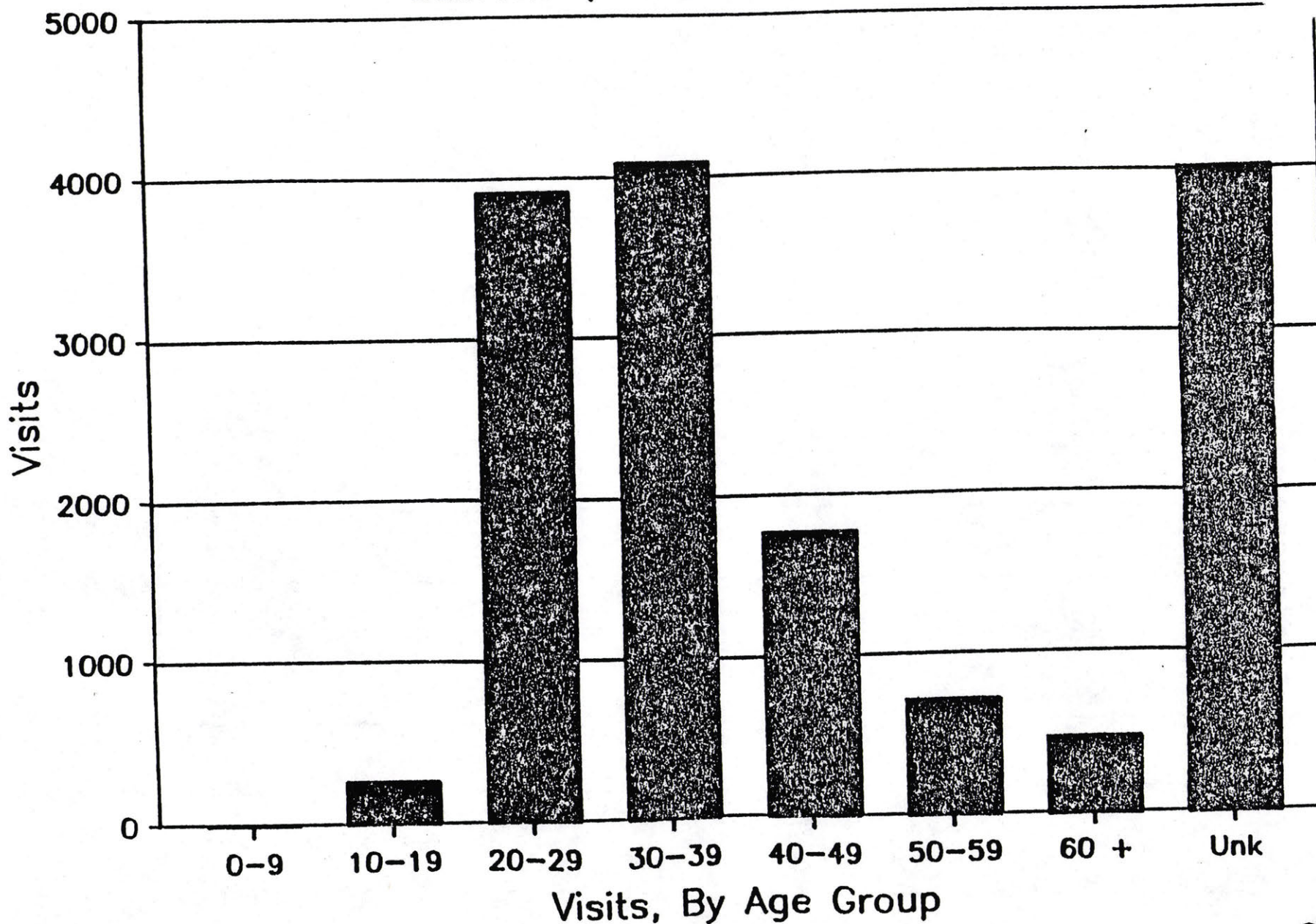
California, June-October 1985



Visits, by Risk Group

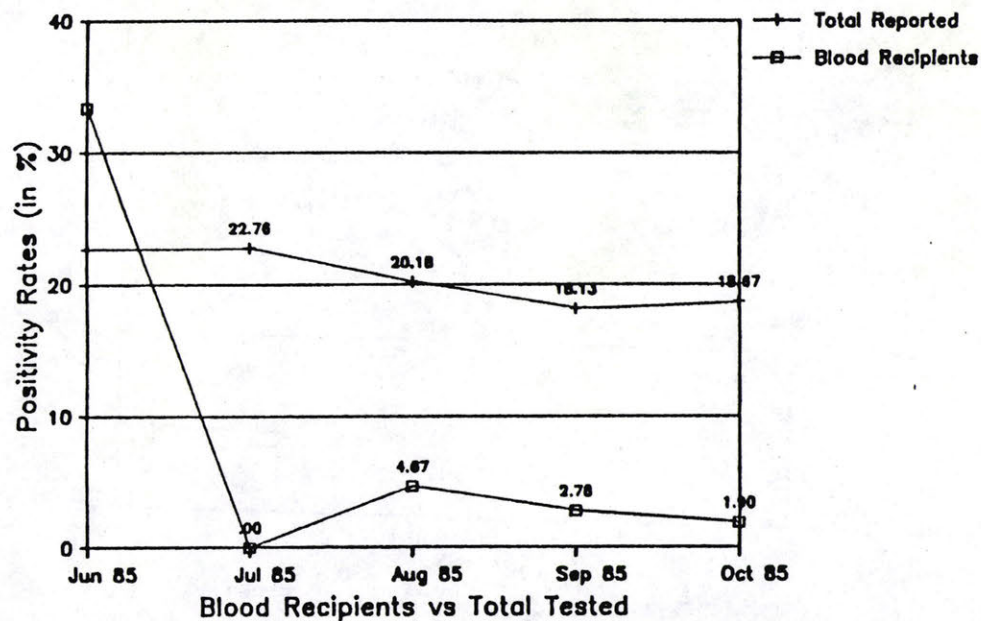
HTLV-III ALTERNATIVE TEST SITE REPORT

California, June-October 1985



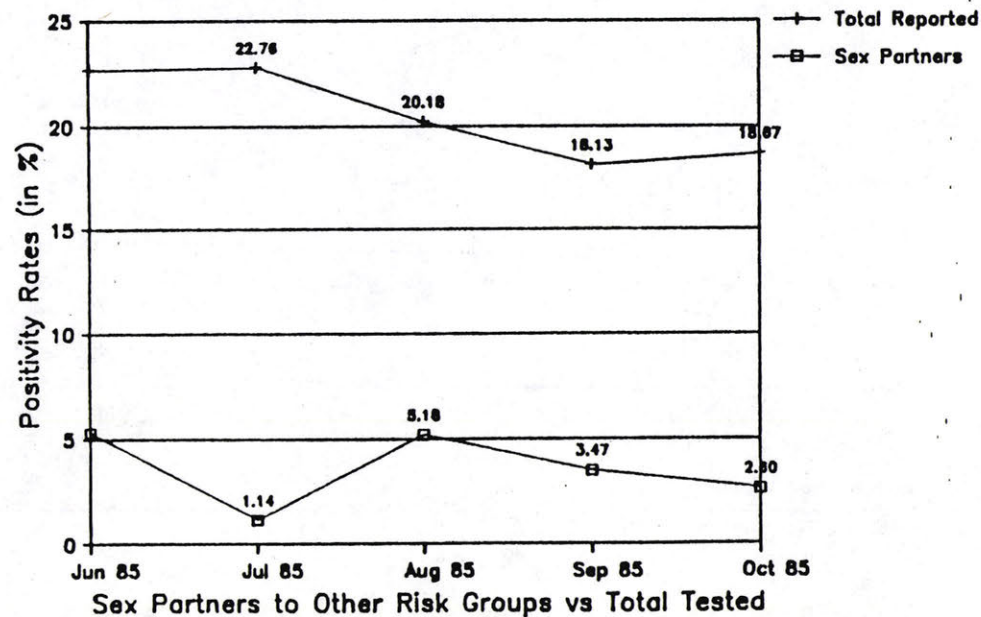
HTLV-III ALTERNATIVE TEST SITE

Positivity Report



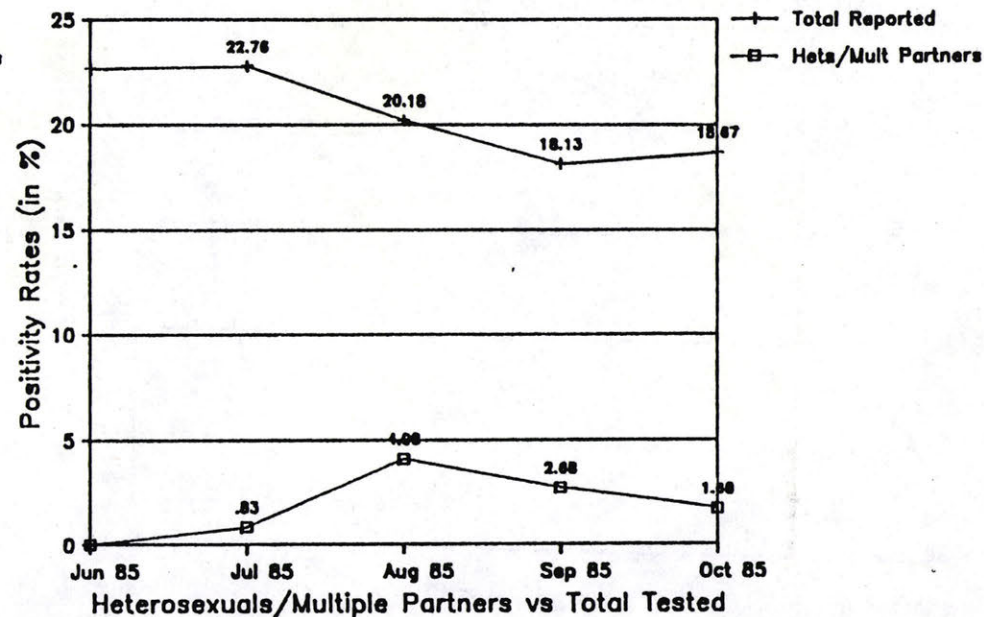
HTLV-III ALTERNATIVE TEST SITE

Positivity Report



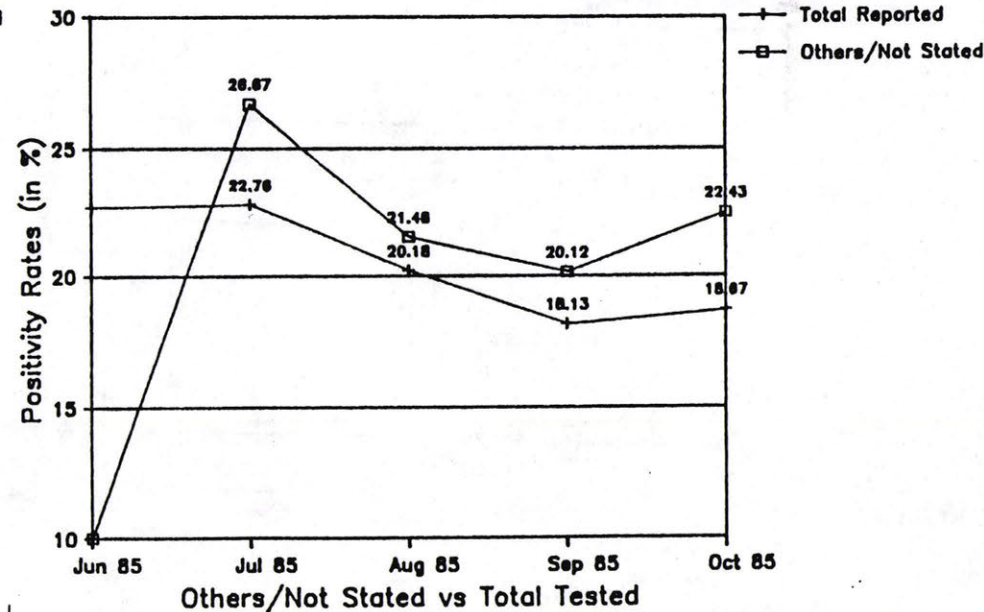
HTLV-III ALTERNATIVE TEST SITE

Positivity Report

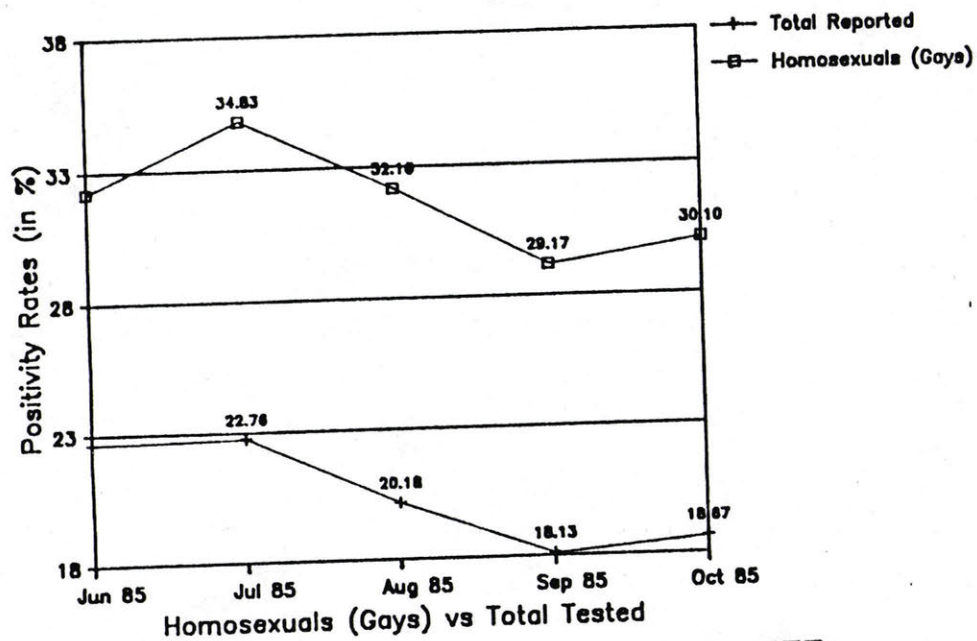


HTLV-III ALTERNATIVE TEST SITE

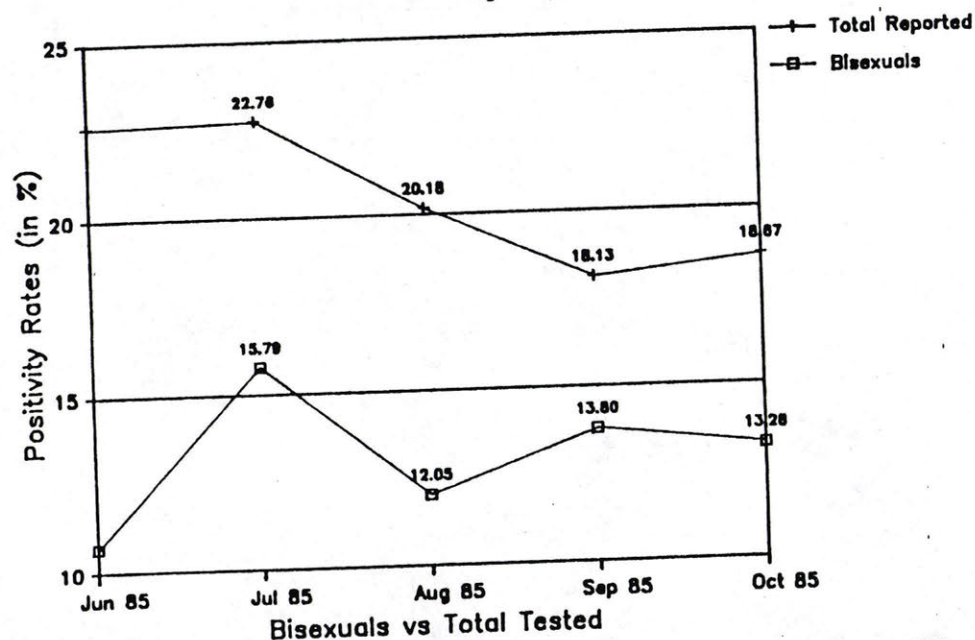
Positivity Report



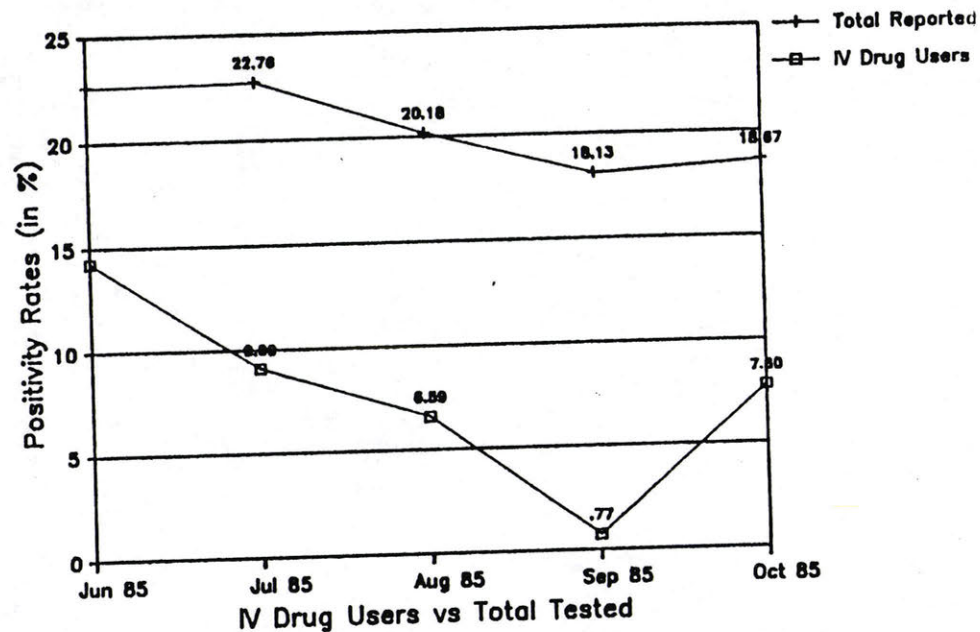
HTLV-III ALTERNATIVE TEST SITE Positivity Report



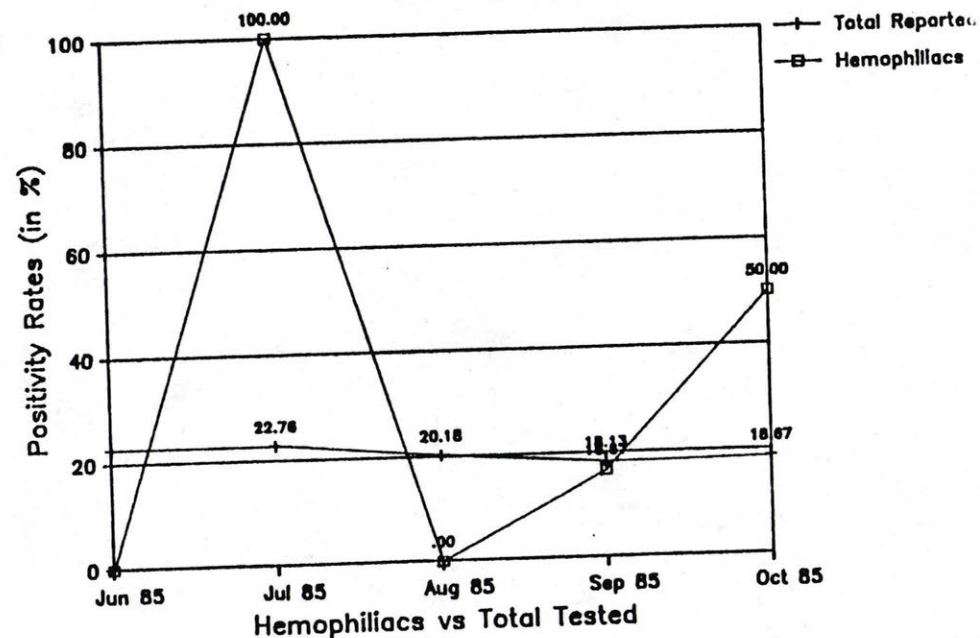
HTLV-III ALTERNATIVE TEST SITE Positivity Report



HTLV-III ALTERNATIVE TEST SITE Positivity Report

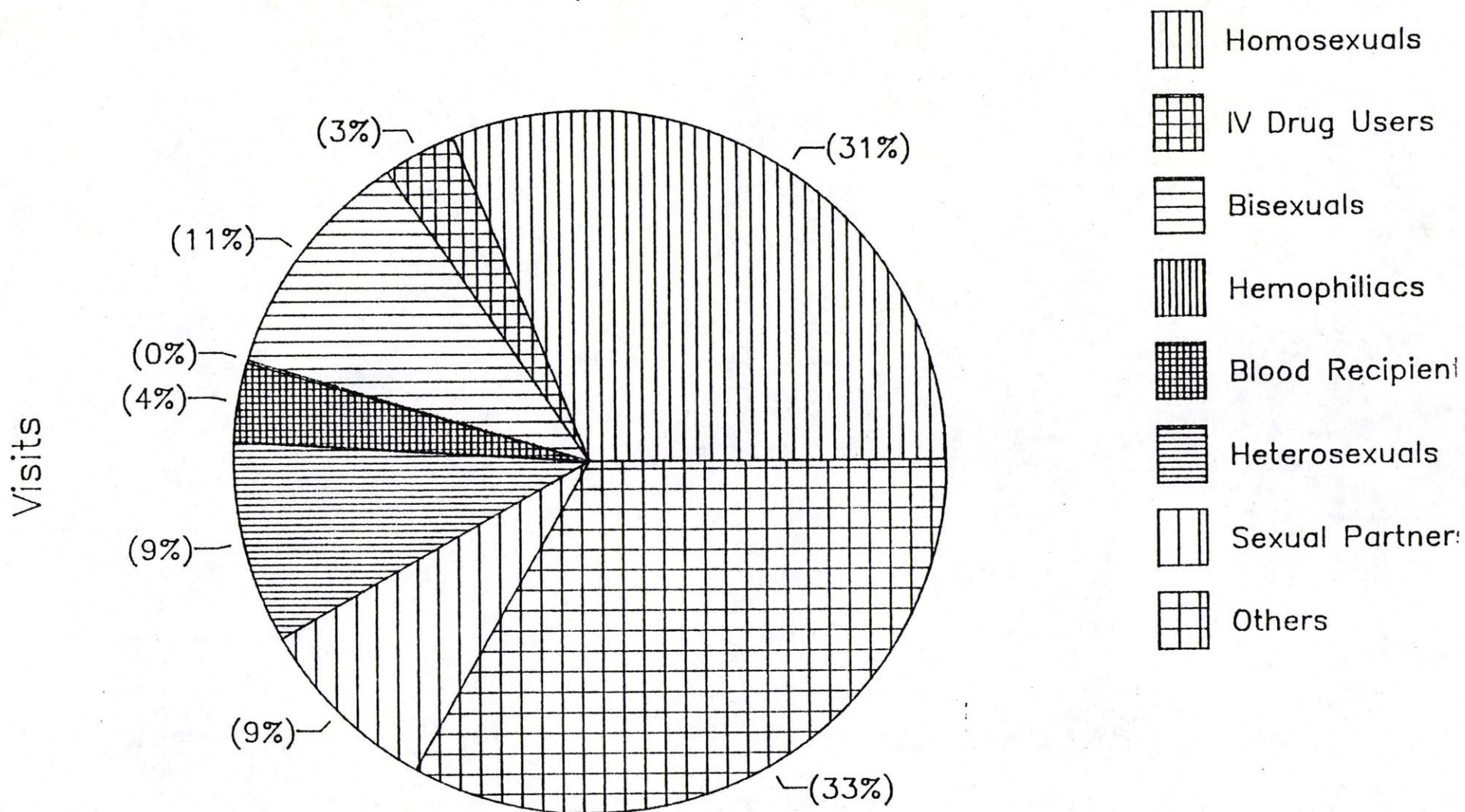


HTLV-III ALTERNATIVE TEST SITE Positivity Report



HTLV-III ALTERNATIVE TEST SITE REPORT

cALIFORNIA, June 1985-October 1985



Visits, by Risk Group

GUIDELINES FOR HTLV-III ANTIBODY TESTING
IN THE COMMUNITY

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
RECOMMENDATIONS	
I. General Principles	2
II. Public Information Recommendations	4
III. Recommendations for Notification of Positive Results	5
IV. Recommendations for the Establishment of Alternative Testing Sites	7
V. Follow-up Recommendations for High Risk Individuals With Repeat Positive Test Results	9
VI. Follow-up Recommendations for Low Risk Individuals With Repeat Positive Test Results	11

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
(JUNE 1985)

INTRODUCTION

To assist local and state health departments to respond to the licensure of the HTLV-III antibody test, the Association of State and Territorial Health Officials (ASTHO) convened a meeting on March 1 and 2, 1985, to develop national guidelines for the initial community use of this test. Participants at this meeting included the executive committee of ASTHO, together with state epidemiologists, private physicians experienced in dealing with AIDS, representatives of city and county health departments, gay rights groups, blood banks and staff of CDC.

The actual public demand for this test at sites alternative to blood banks is unknown. Actual experience will dictate the degree of necessary safeguards, and the number of alternate testing programs required. State and local health departments will need to monitor the situation closely and implement a program that best fits their needs and circumstances.

The following recommendations for HTLV-III antibody testing in the community were reviewed and adapted from the ASTHO recommendations, for use in California by the State AIDS Task Force and by the Department of Health Services. The only major difference from the ASTHO recommendations is that the California guidelines state that additional test(s) on a repeat blood specimen is not required if the person with a reproducible positive test is in a known risk group for AIDS.

I. GENERAL PRINCIPLES:

1. The HTLV-III antibody test is not a test to diagnose Acquired Immunodeficiency Syndrome (AIDS), but may be of assistance in confirming the diagnosis, especially in a person with no known risk of exposure to AIDS. The test can distinguish whether someone in a high risk group has or has not been infected with the HTLV-III virus.
2. The HTLV-III antibody test is a useful tool that can assist in protecting the nation's blood supply, and is a valuable test to assist research efforts into the AIDS problem.
3. At the present time, the HTLV-III antibody test is not recommended for any purposes other than those stated above. The HTLV-III test should not be used for generalized screening or as a precondition for employment, evidence of insurability, or admission to school or the military.
4. Because of the serious potential for harm to the individual resulting from misinterpretation of the HTLV-III antibody test results, great care must be taken to inform the public and health care professionals about limitations in current understanding of the test results and of the entire disease process labeled Acquired Immunodeficiency Syndrome.
5. Information gathered from the testing or counseling of individuals should be kept strictly confidential.
6. State and local health departments, working in concert with the private medical and hospital communities, university systems, blood banks and plasma centers should establish a network and referral system (where not previously established) of physicians and other health care providers with expertise in dealing with AIDS.
7. There is limited availability currently of tests to detect the virus itself. In the absence of such tests, it is useful to determine whether there is any clinical or epidemiologic evidence of exposure to HTLV-III (i.e., is the individual in an "at-risk" or "high-risk" group). If so, the predictive value of the positive result (or the likelihood that the positive result truly represents infection with HTLV-III may be about 99%). When such clinical or epidemiologic evidence is lacking ("low-risk"), interpretation of test results is even more difficult and the predictive value of a positive test may be less than 10%. In the latter circumstance, much attention must be paid to seeking or excluding additional evidence of infection, including confirmatory serologic testing, virus isolation (if possible), and evidence for spread to or from regular sexual partners.

For purposes of this document, persons tested for HTLV-III antibody will be classified in one of two ways prior to a medical assessment:

- High risk: Persons with known risk of exposure to AIDS. This group includes all men who have had sexual contact resulting in the exchange of secretions with another man, intravenous drug users, persons with hemophilia, and other persons who receive blood or blood products (excluding immune globulin and hepatitis B vaccine), and persons who have had sexual contact with a person who has AIDS or an AIDS-related condition or who is at increased risk of exposure to AIDS.
- Low risk: Persons with no known risk of exposure to AIDS or HTLV-III. This group includes all persons to whom the risk factors listed on the high risk group do not apply.

II. PUBLIC INFORMATION RECOMMENDATIONS

State and local public health departments, in concert with blood banks, plasma centers, community organizations, and private health care providers, as applicable, are urged to take appropriate measures to educate the public about the HTLV-III antibody test. More specifically, it is recommended that:

1. State and local health departments, together with blood banks, plasma centers, private providers and community groups, should strongly urge individuals not to donate blood or plasma for the purpose of determining their HTLV-III antibody status.
2. The HTLV-III antibody test is of value for screening donated blood and in some clinical and research situations as an adjunctive diagnostic test. In addition, it is useful in distinguishing whether someone in a high risk group has or hasn't been infected with the virus. An individual may want to know this to relieve his/her own anxiety and to avoid transmission to others if he or she is positive. State and local health departments, blood banks, plasma centers and organized medical groups should urge health care providers using the HTLV-III antibody test in these situations to explain the test's limitations and implications to their patients or clients prior to its use.
3. Where HTLV-III testing is performed in alternate testing sites, state and local health departments should assure that information is provided to the person prior to the test. This information should explain the intended use of the test, its limitations for other purposes, and the potential consequences to the individual of being identified as serologically positive.

III. RECOMMENDATIONS FOR NOTIFICATION OF POSITIVE RESULTS

State and local health departments are urged to work with blood banks, plasma centers, alternative testing sites, private providers, laboratories and others who may be performing anti-HTLV-III testing to assure that no results are released to an individual until the initial HTLV-III positive test result can be repeated. At a minimum, this requires another test on the same sample of blood.

After a test on the initial blood sample has been repeated and is again positive, state and local health departments are urged to:

1. Assure that blood banks, plasma centers and other providers using the HTLV-III test for primarily low risk groups communicate information concerning all positive results in person by an individual with an understanding of the implications of a positive test result, and who can explain the additional steps necessary to assess the meaning of such a positive test result. (See recommendation IV.(1) for the rationale for requiring a personal communication.)
2. Assure that the individual with a positive test result is either provided individualized medical assessment at the time of initial notification of positive results, or is referred to an organization or health care provider who can provide such an assessment. (See additional requirements for alternative screening programs in Section IV.)
3. Assure that for a person with a positive test result and with no known risk of exposure to AIDS that another test is performed on a different sample of blood, whether by providing the service directly or by referral.
4. Assure that if the repeat test is also positive on the second blood sample, a medical assessment is offered, either directly or by referral. Persons who are known to have some risk of exposure to AIDS, can be offered or referred for such medical assessment without a repeat test on a second blood sample. Included in the assessment should be the following:
 - a. A risk assessment to determine high risk or low risk sexual activity; drug use history, especially intravenous drug use; presence of hemophilia; blood transfusion receipt history; exposure to individuals that are in these high risk groups; and other potential risk factors.
 - b. A sign and symptom inventory and clinical assessment, with focus on general systemic problems, including unexplained weight loss, fever, diarrhea, dyspnea and dysphagia.

- c. A physical examination with particular attention to lymph node examination, oral examination for thrush, splenic palpation, genital, rectal and fundoscopic examinations, and special attention to skin or mucous membrane lesions suggestive of Kaposi's sarcoma.
- d. A minimal laboratory examination, including a complete blood count, differential, WBC, VDRL and sedimentation rate. (Enumeration of the T-lymphocyte subset is an expensive test and not felt to be essential in this initial assessment, although in some areas of the country the test may be available at a reasonable cost).

After this medical examination and counseling, patients with repeat positive HTLV-III tests should be divided into two groups:

- High risk -- those persons felt to be at high risk for developing AIDS based on risk assessment or symptoms.
- Low risk -- those persons with no apparent risk factors, normal laboratory and examination findings, and no symptoms.

Further medical follow-up is indicated for both groups, but as detailed in Sections V and VI, should be different as a result of this evaluation.

IV. RECOMMENDATIONS FOR ALTERNATIVE TESTING SITES

State and local health departments and agencies are strongly urged to work with blood banks, plasma centers, community groups, laboratories and private providers where alternative testing sites are established. The location and assignment of administrative responsibility for alternative sites must be determined within each jurisdiction to best fit local needs and circumstances. Where such sites are established, it is recommended that state and local health departments assure that the following conditions are met.

1. Each person tested for HTLV-III antibody at an alternative site should be provided the results in person during a scheduled return visit. A personal presentation of the test results (whether positive or negative) is the only method which:
 - o Does not involve potentially serious risk to the privacy of the individual;
 - o Permits an assessment of the individual's emotional reaction and provides an opportunity for a private and sensitive explanation of the implications of the results; and
 - o Permits persons in recognized risk groups for AIDS who have a negative test result to understand the limitations of the test, and to be informed of methods to reduce their personal risk, and the risk to others, of exposure to the HTLV-III virus.
2. Alternative site staff must be trained and experienced in assessing and responding to people about sensitive and potentially life-threatening issues. Such staff need not be persons with academic credentials. However, referral relationships with trained professionals should be established.
3. Strictest confidentiality must be maintained. This can be done in a number of ways, including use of the procedures followed for research protocols (including an Institutional Review Board protocol); strict adherence to standard procedures for confidentiality in clinical settings; or use of a patient number rather than name to assure complete record anonymity. No information about an individual should be shared with any other organization or individual without the signed permission of the individual who was tested. However, summary statistical information without individual identifiers should be provided to public health authorities if requested.
4. Persons should be fully informed about the limitations and implications of the test prior to providing the test. In addition, the person should be informed of how the results will be communicated or made available to him/her; how and where the results will be recorded; where the results might be reported; and

who may have access to them. Any possible future uses of the person's name for medical follow-up or research should require a signed consent and should be considered separately to avoid confusion.

5. A record of the information provided to the patient should be maintained in a confidential patient record containing the results of the HTLV-III testing.
6. All alternative testing sites for antibody to HTLV-III must be medically supervised. In addition, physicians, nurses and mental health professionals with additional specific training should be an integral part of a referral network.
7. All alternative test sites should have access to a referral list or a system of referral to physicians and other health care providers specializing in treatment of AIDS or AIDS-related conditions, and should establish, to the extent possible, working relationships with these providers.
8. Referral for medical follow-up for all persons with positive test results must be assured, and all persons at an alternative test site wishing further information should be informed of a referral network of health care providers with expertise in dealing with AIDS.
9. Charges for services provided at alternative sites, especially blood testing, should not be made if at all possible. Provision of low or preferably no cost services are an important incentive to keep persons from utilizing blood banks or plasma centers for initial testing. Costs and charges for the more expensive medical assessment recommended in subsection III(3) will have to rely, for the most part, on individual arrangements with private physicians and health care providers. However, consideration should be given to financial assistance for those persons in need of service and without adequate resources.

State and local health departments should compile and maintain a list of alternative test sites and make this information available to persons wishing access to those sites. State health departments also may consider establishing an "800" number to provide this information, as well as other general advice and referral services. Alternatively, a "900" number, which costs the caller 50 cents, may be considered.

V. FOLLOW-UP RECOMMENDATIONS FOR HIGH RISK INDIVIDUALS WITH REPEAT POSITIVE TEST RESULTS

State and local health departments are urged to work with blood banks, plasma centers, private providers, community organizations and others providing HTLV-III testing to assure that high risk individuals be advised to establish a relationship with a physician who can, by reason of training and experience, continue to evaluate the patient for signs and symptoms of AIDS or related conditions. If a person cannot be designated as at high risk or low risk for HTLV-III infection, then it is appropriate to provide follow-up recommendation for both high and low risk individuals. High risk individuals are defined as persons with known risk of exposure to HTLV-III, or of high risk of acquiring or transmitting the HTLV-III virus. This group includes all men who have had sexual contact with another man, intravenous drug users, hemophiliacs and other persons who have had sexual contact with a person who has had an HTLV-III infection or who is at increased risk of exposure to HTLV-III. It is also recommended that:

1. High risk individuals be advised of the early clinical manifestations of HTLV-III infection, AIDS, and AIDS-related conditions and advised to seek immediate medical attention if any of them occur.
2. High risk individuals be advised that the prognosis for an individual infected with HTLV-III (the probable cause of AIDS) over the long term is not known. However, available studies conducted among homosexual men indicate that most persons will remain infected, but asymptomatic.
3. High risk individuals be advised to seek medical evaluation and followup at least twice annually, and more frequently as indicated for an individual who develops signs or symptoms suggestive of HTLV-III infection, AIDS, or AIDS-related conditions.
4. High risk individuals be advised that although the person may be asymptomatic, there is risk of infecting others by sexual intercourse, sharing needles, and possibly through saliva or exposure through oral-genital contact or intimate kissing. The efficacy of condoms in preventing infection with HTLV-III is unproven, but the consistent use of them may reduce transmission.
5. High risk individuals be advised that blood, plasma, body organs, other tissue or sperm should not be donated.
6. High risk individuals be advised that toothbrushes, razors, or other implements that could become contaminated with blood should not be shared.
7. High risk individuals be advised that children born since 1979 to women with a positive HTLV-III test should be clinically evaluated.

8. High risk individuals who are women, or women who have a high risk sexual partner who has a positive test, be advised that they are at increased risk of acquiring AIDS, and that any offspring is at increased risk of acquiring AIDS.**
9. High risk individuals be advised that in the absence of close or intimate contact, household contacts need not be referred for testing at this time.
10. High risk individuals be advised that after accidents resulting in bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water.
11. High risk individuals be advised that devices that have punctured the skin, such as hypodermic, tattoo and acupuncture needles, should be steam sterilized by autoclave before reuse or safely discarded. Whenever possible, disposable needles and equipment should be used.
12. High risk individuals be advised that when seeking medical or dental care or illness, they should inform those responsible for their care of the positive HTLV-III results so that appropriate evaluation can be undertaken and precautions taken to prevent transmission to others.
13. High risk individuals be advised that most persons with positive HTLV-III test results need not consider a change in employment. However, if they are employed in medical, dental or other health care professions and performing invasive procedures or if they have skin lesions, they should take precautions similar to those recommended for hepatitis B to protect their patients or contacts from the risk of infection.
14. High risk individuals be advised that any sexual or needle-sharing partner of a person with a positive test should be advised to seek HTLV-III antibody testing and clinical evaluation of potential risk factors, symptom history, and physical findings.**

**Because there was no current consensus on recommendations 8 and 14, these decisions should be left to the discretion of the evaluating physician.

VI. FOLLOW-UP RECOMMENDATIONS FOR LOW RISK INDIVIDUALS WITH REPEAT POSITIVE TEST RESULTS

State and local health departments are urged to work with blood banks, plasma centers, private providers, community organizations and others providing alternative test sites to assure that low risk persons with repeat positive HTLV-III antibody tests be provided with counseling. These persons are defined as those with repeat positive results who are not members of known risk groups, have no signs or symptoms of immune deficiency disease, and have a normal physical and laboratory examination. It is recommended that:

1. Low risk individuals be advised about interpretation of these test results. This should include an understanding that the proportion of false positives in the low risk group will be high, and that the patient's particular result may be of questionable significance. The person should also understand that a positive test -- if it is not a false positive -- measures only antibodies to the virus which may indicate past or present exposure to HTLV-III or a related virus. In addition, the person should be counseled that he/she does not appear to have AIDS, and that the risk of developing AIDS in the future, if the test is not a false positive, is small.
2. Low risk individuals be advised that, as a precautionary measure, they should not donate blood, plasma, sperm or body organs.
3. Low risk individuals be advised that if no known risk factors are present, currently there is insufficient evidence to warrant a broad restriction on sexual relations. However, advice on sexual relations and practices should be individualized.
4. Low risk individuals be advised that until more is known about the status of a positive test in a low risk population, that testing the patient's regular sexual partner may provide better or more information to determine if the test result may be a true or false positive. However, testing of other family members of low risk patients is not advised.
5. Low risk individuals be advised that there is insufficient evidence to warrant advising blanket postponement of pregnancy at this time. However, each circumstance should be carefully evaluated.

6. Low risk individuals be advised that they should notify their personal physicians and dentists that they have had repeat positive HTLV-III screening tests but were considered as having no known risk of exposure to AIDS. Specific written information should be provided to these persons for this purpose.
7. Low risk individuals be advised there is no need for any restrictions on employment, education, or other social contacts.
8. Low risk individuals be advised that additional referral is available if they have further questions or concerns.
9. Low risk individuals be advised to seek medical follow-up assessment within six months in order to identify any potential changes in their medical status or recommendations.

The nine recommendations above apply only to individuals who have no abnormal physical or laboratory findings other than repeat positive HTLV-III tests, and are not in a known risk group for acquiring AIDS. All other individuals with repeat positive HTLV-III tests, whether with known risk factors (including being a sexual partner of a person in a high risk group) but otherwise free of findings, or with no known risk but some clinical findings, should be given those recommendations provided to "high risk" patients. There will be cases where low risk individuals desire to know all recommended precautions concerning the transmission of HTLV-III infection, AIDS, and AIDS-related conditions. In these cases, it is suggested that the recommendations for high risk individuals also be given to the individual. In addition, where the individual clinician is uncertain as to the risk status of the person who has been tested, it is suggested that both sets of recommendations be given to the individual.

ST. LUKE'S

DRAGO M. SCHMIDT, M.D., DIRECTOR
OTTO H. PFLUEGER, M.D.
MARTHE SMITH, M.D.

DEPARTMENT OF PATHOLOGY
AND
NUCLEAR MEDICINE

December 10, 1985

Catherine Maley, Staff Coordinator
California Medical Association
44 Gough Street
San Francisco, CA 94103-1223

Dear Miss Maley:

Enclosed is my proposed version of narrative information on HTLV-III antibody test, as discussed during our recent committee meeting in San Francisco.

HTLV-III ANTIBODY TEST

The test for antibodies to HTLV-III/LAV/ARV virus currently is licensed only for screening donated blood and plasma. It is a highly sensitive and specific test but with a low predictive value in a low risk population. Low level reactions however may be nonspecific but proposed refinements of the test may hopefully eliminate this problem.

According to FDA a positive result is a repeatedly reactive test sample that is reactive on two separate independent assays done as duplicates or single tests at different times. Repeatedly positive test is the one which is repeatedly reactive with enzyme-linked immunosorbent assay (ELISA test) or which on retesting with Western blot test is positive for HTLV-III antibody.

Western blot immunoelectroprecipitin test appears to be more specific but needs very careful standardization. It is often used to assay significance of positive ELISA test.

The State of California requires that HTLV-III antibody testing be done on all blood and plasma donors. This testing began in June of 1985 for units of blood collected in California and all units received from out of state have been tested since July 1, 1985. Only nonreactive units can be used for transfusion.

The incidence of repeatedly reactive tests in donor population is 1 in 400. Strongly reactive tests are found in 1 to 1,200. Such tests are also 94% positive with Western blot technique and 56% have positive virus cultures. No positive cultures or positive Western blot were found in samples with negative repeatedly reactive ELISA tests. In summary, HTLV-III antibody testing has been demonstrated as highly useful in screening donated blood or plasma. Combined with voluntary self exclusion by persons at risk of

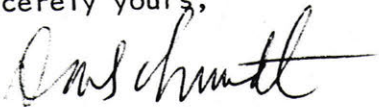
Page 2
Catherine Maley
12-10-85

being exposed to HTLV-III virus, the risk of transmission of the virus by transfusion has been virtually eliminated.

The donors are informed in writing that the test was done on every unit donated along with other currently required tests. The donors with confirmed positive results will be notified as specified in the law A8 488. The law requires that alternate test sites be established and functioning no sooner than 60 days post donation. Positive donors will require followup; most of them will be referred to their personal physician. The followup should include risk assessment, clinical assessments of signs and symptoms, laboratory studies including CBC and differential count and Western blot test if not done before. Counseling of such at-risk individuals should include advice about postponement of pregnancy and safe sex practices.

I hope this summary will be of help to Madam Chairman Dr. Hoag and the staff. If there are any questions regarding my comments please let me know.

Sincerely yours,

A handwritten signature in cursive script, appearing to read "Drago M. Schmidt".

Drago M. Schmidt, M.D., Director
St. Luke's Hospital Pathology Dept.

REPORT OF THE BOARD OF TRUSTEES

Report: PP
(I-85)

Subject: AIDS and HTLV-III Antibody Testing
(Resolution 9, A-85)

Presented by: William S. Hotchkiss, M.D., Chairman

Referred to: Reference Committee E
(John A. Martin, M.D., Chairman)

1 Resolution 9, (A-85), which was referred to the Board of
2 Trustees with a suggested amendment, reads as follows:

3
4 RESOLVED, That the American Medical
5 Association immediately request the U.S.
6 Department of Health and Human Services not
7 to proceed further on publishing the
8 information on AIDS and HTLV-III Antibody
9 Blood Testing found in the January 11, 1985
10 edition of "Morbidity and Mortality Weekly
11 Report" until the government has time to
12 consider valid objections to the language
13 therein; and be it further;

14
15 RESOLVED, That the AMA also urge the
16 Department of Health and Human Services to
17 permit blood collection centers to perform
18 HTLV-III antibody testing for their own use,
19 but to relieve the centers of any
20 responsibility for supplying test results to
21 test subjects until appropriate scientific
22 knowledge is available; and be it further;

23
24 The House of Delegates considered amending the resolution by
25 adding a resolve urging the government to "support studies to
26 determine the meaning, if anything, of HTLV-III positivity in
27 otherwise healthy people in non-high risk categories and to
28 determine what medical evaluation and recommendations should be
29 made."

Past House Action: A-85:254; A-84:343,345,349; I-83:121; A-83:240

1 Introduction

2
3 Acquired Immunodeficiency Syndrome (AIDS) presents a
4 significant challenge to the American medical community. This
5 challenge is being answered by intense research efforts seeking
6 improvement in medicine's capacity to prevent, diagnose, and treat
7 this syndrome. The nation's biomedical research community
8 identified the causal agent, the human T-lymphotropic virus type
9 III (HTLV-III) for AIDS and quickly developed a diagnostic
10 procedure to identify those who have been exposed to the virus.

11
12 The presence of antibodies to HTLV-III indicates exposure to
13 the virus and these antibodies constitute the basis for detection
14 by the diagnostic HTLV-III ELISA test. As presently performed,
15 the HTLV-III ELISA test does not discriminate between the presence
16 of antiviral antibodies and anticellular antibodies. Thus, the
17 specificity of this diagnostic tool has been questioned.

18
19 Notwithstanding the fact that a true positive ELISA test
20 indicates some exposure to the HTLV-III virus and not the presence
21 of AIDS, the severity of the disease coupled with the uncertain
22 implications of the HTLV-III ELISA test poses a difficult dilemma
23 for the practicing medical community with respect to interpreting
24 and acting upon positive test results. A confirmatory procedure,
25 the Western Blot Test, is available for individuals who initially
26 test positive with the HTLV-III ELISA test. However, the
27 availability of the confirmatory test to the practicing medical
28 community is limited and this situation is compounded by delays in
29 both the processing of test specimens and the communication of
30 test results.

31
32 The following is a brief exposition of the scientific evidence
33 that underlies uncertainty regarding interpretation of the results
34 of the HTLV-III ELISA test. The diagnosis of AIDS is discussed at
35 length in two recent reports of the Council on Scientific
36 Affairs.^{1,2}

37
38 Discussion of Scientific Evidence

39
40 Virus antigens used in the ELISA test are prepared from whole
41 virus grown in the leukemic cell line H9. Viral harvests from the
42 infected cells are "purified" by density gradient centrifugation
43 and are then disrupted prior to coating beads or microtiter
44 wells. If host cell antigen is incorporated into the virus
45 particle, "purification" by density gradient cannot be expected to
46 separate host cell and viral antigens. Even if host cell antigens
47 are not incorporated, density gradient centrifugation does not
48 assure the separation of these two groups of antigens. Thus, in
49 order to distinguish between antiviral and anticellular antibodies
50 in the ELISA test an uninfected cell control (H9 cells) is
51 necessary. None of the presently licensed HTLV-III test kits
52 contain an uninfected cell control.

1 At a recent Public Health Service workshop (31 July 1985),
2 "Experience with HTLV-III, Antibody Testing - Update on:
3 Screening, Laboratory and Epidemiologic Correlations," several
4 papers were presented that reported very high false-positive rates
5 (70% or higher) between initial and repeat ELISA test results, as
6 well as between repeatedly reactive ELISA test results and Western
7 Blot Test results. A number of ELISA positive sera were found to
8 be reactive with uninfected H9 cell antigens. The HLA antigens
9 H1, Bw62, Bw6, Cw3, DR4 and DQW3 have been identified in H9 cell
10 cultures (Weiss et al, Lancet 2:157, 1985). Using two commercial
11 screening assays, Kuhn1 et al (Lancet 1:1222, 1985) reported that
12 27% of DR4 typing sera scored as positive for HTLV-III antibody.
13 At the PHS workshop on HTLV-III antibody testing, Dr. J. Menitove
14 of the Council of Community Blood Centers reported finding not
15 only anti-DR4 antibodies in repeatedly positive ELISA test sera,
16 but also found anti-HLA DQ3 antibodies in some of the same sera.
17 At this same meeting a subset of the normal population having no
18 known risk factors for AIDS, multiparous females, was reported by
19 Dr. S.C. Lloyd of Serologics, Inc. to give equivocal ("biological
20 false positives") ELISA results using licensed HTLV-III antibody
21 test kits. These females gave negative Western Blot Tests and
22 were shown to possess antibodies to both leukocyte and
23 erythrocyte antigens.

24 25 Conclusion

26
27 The first resolve of Resolution 9 (A-85) deals with
28 information contained in the January 11, 1985 issue of Morbidity
29 and Mortality Weekly Report. It should be noted that the
30 recommendations made in this issue are provisional and it is
31 stated at the end of the article that, "Revised recommendations
32 will be published as additional information becomes available and
33 additional experience is gained with this test." The Board notes
34 that the Public Health Service is presently considering revising
35 these recommendations and a new set can be expected before the
36 next meeting of the House of Delegates.

37
38 The second resolve of the resolution seems to imply that blood
39 collecting centers are required by Food and Drug Administration
40 regulations to supply test results to test subjects. There is not
41 now, nor has there ever been, any FDA regulation requiring
42 notification of positive test results to donors. What is in
43 effect is a recommendation that they be notified. At a meeting
44 following the workshop on HTLV-III antibody testing, Dr. Harry M.
45 Meyer, Jr, Director, Center for Drugs and Biologics, Food and Drug
46 Administration stated that the FDA does not have any immediate
47 plans to require donor notification and would not consider doing
48 so until more is known about current tests.

1 The Council on Scientific Affairs, from whom the Board sought
2 guidance on this matter, believes that at present two important issues
3 among the many important issues surrounding HTLV-III antibody testing
4 are:

- 5
6 1. The number of positive results with the
7 HTLV-III ELISA test that have been reported
8 for individuals in non-high risk categories.
9
- 10 2. The number of false-positive results that
11 appear to be due to anticellular antibodies
12 (which may or may not occur together with
13 antiviral antibodies).

14
15 These issues increasingly are confronting the practicing
16 medical community which is faced with interpreting HTLV-III test
17 results and acting upon such results in the best interests of
18 individual patients. Therefore, the Board of Trustees recommends
19 that:

- 20
21 1. The AMA urge the government to continue to support
22 studies to determine the meaning of HTLV-III
23 positive antibody test results in otherwise
24 healthy people in non-high risk categories to
25 determine what medical evaluations and recom-
26 mendations should be made.
- 27 2. This report be adopted in lieu of Resolution 9,
28 (A-85).
29

REFERENCES

1. The Acquired Immunodeficiency Syndrome. JAMA 252:2037-2043
 Oct. 19, 1984.
2. Status Report on the Acquired Immunodeficiency Syndrome. Human
 T-Cell Lymphotropic Virus Type III Testing. JAMA 254:1342-1345,
 Sept. 13, 1985.

Some ethical issues remain unresolved

HTLV-III screening protects blood supplies

By late 1985, the threat of contracting acquired immune deficiency syndrome (AIDS) by transfusion had been nearly eliminated by a new test for exposure to the virus that causes AIDS. Thanks to this test, developed only last spring, blood suppliers now can screen donations and remove contaminated blood from the nation's supply.

Five companies were selected by the Dept. of Health and Human Services to work with the National Institutes of Health in developing a test to screen for blood-borne antibodies to the HTLV-III virus, which causes AIDS.

On March 2, Abbott Laboratories of North Chicago, Ill., became the first to receive approval from the Food and Drug Administration (FDA) to market its test kit. On the same day that it received FDA approval, Abbott began shipping HTLV-III test kits — which can test 100 blood samples at once — to customers nationwide.

Later in March, Electo-Nucleonics of Fairfield, N.J., received FDA approval, followed by Litton Bionetics of Charleston, S.C., in April. E.I. Du Pont de Nemours & Co. Inc. of Wilmington, Del., and Travenol/Genentech Diagnostics of Cambridge, Mass., received approval in September.

Approved companies can sell and distribute their test kits domestically and abroad.

CONCERNED THAT BLOOD banks would be inundated with people giving blood so that they could be tested for HTLV-III antibody, several state and local public health departments established "alternative test sites." In some areas,

these sites, many funded by the federal government, have saved blood banks from having to perform hundreds of tests for the "worried well." In Boston, for instance, up to one-third of those tested for HTLV-III antibody at alternate sites said they would have posed as blood donors to get test results.

In addition, directives from the Centers for Disease Control (CDC) and the FDA have asked people in high-risk categories — homosexual and bisexual men, intravenous drug abusers, hemophiliacs, and sexual partners of homosexual or bisexual men — to self-exclude from donating blood or plasma. In September, the FDA revised one high-risk category to include any man who has had homosexual contact since 1977. Haitians were removed from the high-risk list in March.

By summer, virtually all blood being collected, as well as that already stored, was being tested for antibody to HTLV-III.

In August, the Public Health Service recommended that HTLV-III testing be carried out on blood or serum from the donors of organs, tissues, or semen intended for human use.

ADVENT OF THE screening test gave rise to myriad administrative and ethical questions, such as: Who should tell a person that he is antibody positive? When should he be told, and how?

Several state legislatures have developed notification protocols, such as waiting 60 days after a confirmatory test before contacting the donor.

Still, no one knows for certain what a positive test result means. The incubation period for AIDS varies greatly from per-

son to person, and the disease may never develop despite a positive antibody test.

The procedure for HTLV-III testing at a blood bank involves performing the HTLV-III test on each unit of blood using the enzyme-linked immunosorbent assay test. If positive for antibody, the test is rerun. If the test is again positive, the donated blood unit is destroyed, and a blood sample undergoes a confirmatory test, most commonly the Western blot. Only after the three tests are completed is a donor notified and counseled as to the steps that should be taken. Generally, HTLV-III-positive patients are urged to visit a physician for further testing and diagnosis.

QUESTIONS CONCERNING THE legal liability of blood banks implicated in cases of transfusion-related AIDS have yet to be resolved. To date, none of the handful of lawsuits on the subject has been heard in court.

Other court tests yet to come may include individuals or groups bringing suit against an employer for dismissing, demoting, or otherwise recategorizing an employee on the basis of the blood screening test. One Texas firm, apparently the first in the nation to screen employees for AIDS, put its roughly two dozen food service workers through a battery of blood and other diagnostic tests, "for the good of all employees." That action drew fire from some national and local gay groups.

Although no one was fired from that company, the firm's management said the tests were a result of AIDS publicity.

THE HTLV-III TEST was heartily en-

dorsed by the American Assn. of Blood Banks, the American Red Cross, and the Council of Community Blood Centers as a tool to keep the nation's blood supplies safe.

In late August, the CDC stated that the HTLV-III test is very effective and efficacious. The director of the CDC's AIDS Branch, James Curran, MD, said that, because of the high efficacy of the test, "transfusion-associated AIDS will peak, then decline. We are doing an extraordinarily good job of screening the potentially infectious blood out of the nation's blood supply."

In September, the CDC reported a few cases of health care workers contracting AIDS from either needlestick injuries or some type of direct contact with blood from confirmed AIDS patients. The CDC quickly referred those concerned to its published sets of precautions — one for clinical and laboratory staffs, and the other for health care workers and allied professionals. In late November, the CDC developed new recommendations with particular emphasis on health care workers and others in related occupations, called "Recommendations for Preventing Transmission of Infection with Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus in the Workplace."

As the year came to a close, dozens of public and private facilities continued to perform small- and large-scale tests on the effectiveness of the HTLV-III screening test and on AIDS, the infectious disease that has killed 51% of its victims to date.

—Linda Bosy

DEPARTMENT OF HEALTH SERVICES

2151 BERKELEY WAY
BERKELEY, CA 94704

(415) 540-2488



January 8, 1986

M. Silvija Hoag, M.D.
Medical Director
Blood Bank of The Alameda-Contra
Costa Medical Association
6230 Claremont Avenue
Oakland, CA 94618

Dear Doctor Hoag:

Enclosed is a draft of permissive guidelines for notification of blood donors found to be reactive for HTLV-III antibody.

We would appreciate any comments that you may have regarding the content of these guidelines and their application to blood banks and plasma centers as soon as possible. Thank you.

Very truly yours,

A handwritten signature in cursive script that reads 'Ronald M. Harkey'.

Ronald M. Harkey
Examiner
Laboratory Field Services

RMH:bb
Enclosure

BLOOD DONOR SCREENING FOR HTLV III ANTIBODY (anti-HTLV III)

PERMISSIVE GUIDELINES FOR NOTIFICATION OF REACTIVE DONORS

I. Introduction

Legislation enacted in 1985 (AB 488, Chapter 23) concerning the prevention of AIDS virus (HTLV III) infection by transfusion of blood and blood products requires that the State Department of Health Services shall develop permissive guidelines for blood banks and plasma centers on the method or methods to be used to notify donors of test results, i.e., donors who test reactive for antibodies to the HTLV III virus.

The permissive guidelines which follow are based upon the best available data but because the state-of-the art in the serology of HTLV III infection is not yet definitive, revisions may be forthcoming as methods are refined to produce better test systems to differentiate false-reactive tests from true-reactive tests.

The suggested appropriate donor notification methods listed below are based on a joint statement of the American Association of Blood Banks, The American Red Cross and The Council of Community Blood Centers, "Recommendations for Notification of HTLV-III antibody Positive Donors and for Recipients of Products from Previous Donations" (June 7, 1985). Any notification method which satisfies the principles of notification in Section III should satisfy the permissive guidelines.

II. Requirements for Donor Notification by Blood Banks and Plasma Centers

A. Notification by the Local Health Officer that the Alternate Test Site(s) has been Functioning Adequately for 90 Days

B. Criteria for Donor Notification

1. Blood Banks and Plasma Centers Testing Blood/Plasma Units by EIA Method and Corroborating EIA Repeatably Reactive Results by a Supplementary Test Which is Highly Specific for anti-HTLV III.

At present, there is no universally accepted corroborating ("confirmatory") test but Western blot (WB) is the test most often selected and most widely available. Other acceptable corroborative tests would be immunofluorescence (IFA) or radioimmunoprecipitation (RIP) if the method is carefully standardized, controlled and shown to be sensitive and highly specific for detecting anti-HTLV III. As the status of confirmatory tests is not fully settled, what constitutes an acceptable supplementary corroborative or "confirmatory" test method may change as improvements are made.

DRAFT

- a. Notify all donors who are repeatably reactive for anti-HTLV III by EIA and who are also verifiable by a supplementary corroborative test method acceptable to the California Department of Health Services, e.g., WB, IFA or RIP.

All donors found to be anti-HTLV III reactive by EIA and a supplementary corroborative test must be reported to the Department of Health Services for inclusion in the State's Deferred Donor Register as required by State law.

- b. Notification of donors who are only repeatably reactive by EIA method but not verifiable by one of the corroborative supplementary tests is presently at the option of the blood bank/plasma center.

Blood or plasma from donors who are repeatably anti-HTLV III reactive by EIA but negative by WB or other corroborative supplementary tests must not be transfused or commercially processed, however no recommendation can be made at this time about the notification of donors who on repeat visits continue to show anti-HTLV III by EIA only.

Until further data are obtained to indicate how such donors should be managed, these donors should be entered on an in-house "retest" or "surveillance" list so that they can be readily identified at the time of any further donation. For the present, should such donors test EIA negative for anti-HTLV III at a subsequent donation, their blood should nevertheless be discarded and their names should remain in the in-house "retest" listing. As anti-HTLV serology is refined and made more specific, it may eventually be possible to correctly categorize such donors as HTLV III "safe" or "not safe".

2. Blood Banks and Plasma Centers Testing Blood/Plasma Units Only by EIA Method

- a. Notify all donors who are repeatably reactive for anti-HTLV III by EIA

All donors found to be repeatably reactive by EIA but who are not also tested by a supplementary corroborative test must be reported to the Department of Health Services for inclusion in the State's Deferred Donor Register as required by State law.

The Department of Health Services strongly recommends that all blood banks and plasma centers routinely test all anti-HTLV III repeatably reactive EIA sera by a supplementary corroborative test such as WB, IFA or RIP as the basis for notifying donors of their anti-HTLV III reactivity.

III. Methods of Notifying Donors Who Are anti-HTLV III Reactive

Notification of donors who test positive for anti-HTLV III should be done with great sensitivity and concern for the impact such information may have on such donors.

PRINCIPLES OF NOTIFICATION INCLUDE:

- 1) Confidentiality.
- 2) Conveying the test results to the donor in person whenever possible.
- 3) Provision for medical evaluation of the positive donor either by the blood bank or by referral to the donor's personal physician, or by prior arrangement by the blood bank or plasma center to physicians specializing in AIDS/infectious diseases, AIDS clinics, the local health department or the local medical society.
- 4) Provision of the donor with the written USPHS and/or ASTHO recommendations for asymptomatic blood and plasma donors found to be reactive for anti-HTLV III.
- 5) provision for immediate referral to persons trained in crisis counseling if undue anxiety is noted in the donor who has been notified of positive anti-HTLV III results.

There are several appropriate protocols for notifying donors who are reactive for anti-HTLV III. The mechanism of notification employed by a blood bank or plasma center will depend on several factors, including availability of trained staff, and accesability of the positive donors to the blood bank.

It has been suggested that at the time of initial intake donors be given a choice (e.g., letter or telephone call to home or work, etc.) as to how they would want to be notified if they are found to have a reason for followup tests, i.e. reactive tests that require confirmation (STS, HBsAg, anti-HTLV III, etc.)

A. APPROPRIATE DONOR NOTIFICATION METHODS INCLUDE:

1. OPTION ONE: A non-specific letter in combination with a personal interview.

This letter should be sent by the blood bank requesting that the donor return for a personal interview. The letter should indicate that one of the laboratory tests performed on the donor's blood requires followup, and a request that the donor telephone the blood bank to make an appointment (at which time information will be provided on the anti-HTLV III result). Depending on the availability of appropriate staff and convenience of interview location, this option is favored as the preferable method of notification. If the donor fails to contact the blood bank within a reasonable period, OPTION TWO should be exercised.

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2. OPTION TWO: A specific letter sent certified mail/receipt requested/restricted delivery.

A specific letter informing the donor of a verifiable repeatably positive anti-HTLV III test result should only be sent if there are steps taken to assure that the donor is the sole recipient of this information. Thus, specific notification should be sent certified mail/receipt requested/restricted delivery. The letter should inform the donor of the test results, state that the donor has been indefinitely deferred from donating blood and that his or her name and other identifying information will be entered into a donor deferral registry. Reactive donors should be strongly advised to contact their personal physician, or the blood bank physician without delay for information, further evaluation and appropriate referral if necessary.

3. OPTION THREE: Telephone notification, alone or in combination with the scheduling of an appointment for a personal interview.

Telephone notification may consist of providing non-specific information such as that recommended for the non-specific letter in OPTION ONE above, with a request that the donor make an appointment for a followup interview at the blood bank.

Specifically informing the donor of a reactive anti-HTLV III test result can also be done over the telephone. However, this method should only be used in situations where the other alternatives are not feasible. If anti-HTLV III specific donor notification takes place over the telephone, it should be followed by a certified/receipt requested/restricted delivery letter. Because of the concern for confidentiality, neither specific nor non-specific telephone notification should take place unless there is positive donor identification. If the telephone call is a non-specific one that requests the donor come to the blood bank or plasma center and he or she fails to appear within a reasonable period, OPTION TWO should be exercised.

For legal purposes, It is important that blood banks and plasma centers document all steps taken to notify each anti-HTLV III reactive donor.

4. Written Information To Be Provided To Notified anti-HTLV III Reactive Donors.

All donors who are informed of a reactive anti-HTLV III antibody test result should be given written information on the significance of their test result. One such explanation is contained in the Public Health Service document "Information for Persons Who Have a Positive Test for HTLV-III Antibody," previously supplied by the USPHS. Additionally, locally prepared informational materials of comparable content may be used.

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A nonspecific letter to be sent to repeatably positive donors, requesting they come into the blood bank for further information. This is the preferred method of notification if not precluded by lack of staff availability, location of blood bank, or other factors.

Dear _____

Following your donation of blood on (date) routine laboratory tests were performed on a sample of your blood. One of the test results warrants additional evaluation. Please telephone (name of person to contact) at (telephone number of contact) within the next several days for an appointment so that we may discuss the test results with you and provide additional information and recommendations.

Alternatively, you may wish to have a report sent to your private physician. If so, please complete and return the enclosed authorization form.

AUTHORIZATION FORM

/person center

I hereby give the (name of blood bank) permission to transmit to (name of physician) (address of physician) (telephone number of physician) information regarding the laboratory test results for the blood I donated on (date).

Signed _____ Print Name _____

Address _____

Social Security Number _____

It is important that you contact the blood bank or your personal physician for followup at your earliest convenience.

DRAFT

SUGGESTED SAMPLE #2

11 85

A letter specifically informing the repeatably positive donor on an HTLV-III antibody test result. This letter should be used in cases where difficulties would be posed in sending a nonspecific letter with a personal followup interview. To be sent certified mail/restricted delivery.

Dear _____

Following your donation of blood on (date), laboratory tests were performed on a sample of your blood. The results of one of these tests indicated that you have antibodies to the HTLV-III virus. Although HTLV-III is the suspected virus for Acquired Immune Deficiency Syndrome (AIDS), it is important that you know a positive antibody test indicates only that the individual with the antibody has been exposed to the virus at some time. It does not indicate presence of the virus itself. THIS IS NOT A TEST FOR AIDS. *necessarily*

Because this is a newly developed test, the implications of a positive result are unclear. However, as a precautionary measure, we are advising individuals with a positive test to seek medical counseling for information about additional testing or special precautions. Please consult your personal physician for further evaluation. Results of the tests performed by the blood bank will be made available to your physician on request, with your written permission. *

Although the meaning of a positive result is unknown, every precaution must be taken to protect the blood supply should a positive unit be infectious. Therefore, you must be deferred indefinitely from donating blood and your name, social security number, and other identifying information must be placed on a confidential list of deferred donors. This information will not be released without your permission unless legally mandated, or to prevent the transfusion of blood that may transmit infectious agents.

For your information, we are enclosing a copy of a document prepared by the United States Public Health Service, entitled, "Information for Persons Who Have a Positive Test for HTLV-III Antibody." (Or document of the blood bank's choice) **

Should you have any further questions about the information contained in this letter, please contact (name of person to contact) at (telephone number of contact).

* The "authorization form" in letter #1 may be used.

** This paragraph is optional.

A letter following a telephone conversation between the blood bank and the repeatedly positive donor specifically informing him of his HTLV-III antibody positive result, to be sent certified mail/restricted delivery.

Dear _____

This is a followup to our telephone conversation of (date). As stated at that time, following your donation of blood on (date), laboratory tests were performed on a sample of your blood. The results of one of these tests indicated that you have antibodies to the HTLV-III virus. Although HTLV-III is the suspected virus for Acquired Immune Deficiency Syndrome (AIDS), it is important that you know a positive antibody test indicates only that the individual with the antibody has been exposed to the virus at some time. It does not indicate presence of the virus itself. THIS IS NOT A TEST FOR AIDS.

Because this is a newly developed test, the implications of a positive result are unclear. However, as a precautionary measure, we are advising individuals with a positive test to seek medical counseling for information about additional testing or special precautions. Please consult your personal physician for further evaluation. Results of the tests performed by the blood bank will be made available to your physician on request, with your written permission. *

7 Although the meaning of a positive result is unknown, every precaution must be taken to protect the blood supply should a positive unit be infectious. Therefore, you must be deferred indefinitely from donating blood and your name, social security number, and other identifying information must be placed on a confidential list of deferred donors. This information will not be released without your permission unless legally mandated, or to prevent the transfusion of blood that may transmit infectious agents.

For your information, we are enclosing a copy of a document prepared by the United States Public Health Service, entitled, "Information for Persons Who Have a Positive Test for HTLV-III Antibody." (Or document of the blood bank's choice) **

Should you have any further questions about the information contained in this letter, please contact (name of person to contact) at (telephone number of contact).

* The "authorization form" in letter #1 may be used

** This paragraph is optional

LEGISLATIVE COUNSEL'S DIGEST

Bill No.

as introduced, ____-

General Subject: Blood transfusions.

(1) Existing provisions of law regulate blood donations.

This bill would provide that a patient in a health facility may specify that one or more designated individuals shall donate the blood for the patient's medical needs, if specified criteria are satisfied. Since an existing statute would make violation of this provision a misdemeanor, it constitutes a state-mandated local program. Moreover, since county hospitals, hospital districts, and other health facilities operated by local government could incur additional costs in complying with these requests, the bill constitutes a state-mandated local program for that reason. The bill would authorize a hospital, blood bank, or other facility incurring

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RN 85 024225 PAGE NO. 2

additional costs by reason of such a request to charge the patient therefor.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for specified reasons.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1627 is added to the Health and Safety Code, to read:

1627. A patient in a health facility, as defined in Section 1250, may specify that one or more designated individuals shall donate the blood for the patient's medical needs, so long as the donated blood is of the same type as the patient's and meets the health criteria for blood donations. The hospital, blood bank, or other facility incurring additional costs by reason of the request may charge the patient therefor.

SEC. 2. (a) No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because of the costs which may be incurred by a local agency or school district which will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction.

(b) No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because of additional costs, as a local agency or school district has the authority to levy

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service charges, fees, or assessments sufficient to pay
for the program or level of service mandated by this act.

- 0 -

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 39

(A-84)

Introduced by: Illinois Delegation

Subject: AIDS and Blood Donations

Referred to: Reference Committee E
(Hugh E. Stephenson, M. D., Chairman)

1 Whereas, The public blood donor population has expressed a fear of contracting
2 acquired immune deficiency syndrome (AIDS) by their donating blood; and
3

4 Whereas, The blood banking community of the State of Illinois has expressed its
5 concern about the usefulness, feasibility and effectiveness of utilizing "designated blood
6 donations," which creates inventories of blood which may be unavailable to other
7 patients if needed; therefore be it
8

9 RESOLVED, That the American Medical Association use its publications to assist
10 physicians to educate their patients that donating blood does not expose the donor to
11 the risk of acquired immune deficiency syndrome (AIDS); and be it further
12

13 RESOLVED, That the AMA adopt the position that "designated blood donations"
14 are an inappropriate means of dealing with the AIDS problem and inordinately ties up
15 blood supplies.

ADOPTED

AN EXPLANATION OF THE AMERICAN RED CROSS POSITION ON DIRECTED DONATIONS

Continued public concern regarding the possible transmission of AIDS and other infectious diseases through blood transfusion has resulted in requests for designating family members or friends as blood donors for individuals having elective surgery.

The American Red Cross has previously indicated opposition to the practices of designated or directed donations and reaffirms its position for the following reasons:

1. The risk of acquiring AIDS from the voluntarily donated blood that makes up the community blood supply has been virtually eliminated by introduction of the HTLV-III antibody test. Since March 18, 1985, this test has been performed on every unit of blood donated through Red Cross. Any unit that tests positive is destroyed. Practices such as directed donor programs that unduly heighten public concern are not warranted.
2. There is no evidence that individually directed donors provide safer blood. Several studies are reported to have shown that positive ELISA tests for HTLV-III antibodies are found among directed donations at about the same rate as with random volunteer donors. Further, there is no known reason to expect that selecting one's own donors lowers the risk of hepatitis transmission. Theoretically, directed donor blood might even be less safe because family members and friends under pressure to donate may not choose to make known certain risk factors that they consider to be of little importance.
3. The directed donor approach represents undue coercion and is contrary to the general principles of volunteer donation.
4. Trying to find his own donors places an unnecessary burden on the patient, leading him to believe that if he cannot find "safe" donors, he will have to settle for second best. Because of this pressure, donor clubs have been formed with donor members selected in questionable ways. Some patients have gone so far as to put notices on bulletin boards appealing for "directed donations."
5. Blood banking in its conventional sense is threatened when healthy potential donors elect to save their blood for a time when it might be needed by a family member or close friend. If the trend continues, serious blood shortages are inevitable.
6. Those blood banks collecting directed donations may be exposing themselves and the directed donors to additional liability. Yet unanswered are a number of questions. Who owns the blood? What if the unit of blood is given to someone else, either because of an emergency or by mistake? What about the patient who thinks he will receive blood only from his directed donations, but receives blood and components from others? What is the liability of a donor when the patient knows the donor's identity and some ill effect results from the transfusion?

In summary, there are flaws in the concept of designated or directed blood donations with several potentially serious consequences. The three

major blood banking organizations, the American Association of Blood Banks, the American Red Cross, and the Council of Community Blood Centers have considered this issue at great length and have reaffirmed their opposition. The College of American Pathologists and the American Medical Association agree. Blood banks that promote directed donations as a way of recruiting more donors may be misleading both patients and donors and be guilty of shirking their responsibility to provide full information to those they serve.

November 1985

San Jose Mercury News, 12/11/85

‘There’s a whole new group of what I would call blood suckers out there.’

— Dr. Seth Haber,
Kaiser-Permanente Medical Center

Brokerage dealing in ‘premium blood’

A Southern California doctor hopes to parlay public fear of AIDS into business in blood brokering.

Dr. Margaret Elfering, an orthopedic surgeon in Santa Maria, has launched the Donor Referral Service. According to a promotional brochure, the service rounds up donors who have “premium blood” for people requiring transfusions.

A membership organization, it relies strictly on female blood. For \$50 a year and a pledge to donate up to three times in that period, a woman may sign up and receive “premium blood,” if she needs a transfusion.

Men may join, too, but only with female sponsors. For a couple, the annual fee is \$100 and a promise by the woman to give blood as many as five times.

All donations are processed through local blood banks, and subject to routine screening tests. Mary Moulds, a registered

nurse who coordinates the program, says the service provides an extra measure of safety by excluding men, who represent 92 percent of the nation’s acquired immune deficiency syndrome patients, from its donor pool.

But Dr. Tom Peterman, a medical epidemiologist at the U.S. Centers for Disease Control in Atlanta, questions whether the measure is worth the cost, considering that the risks of contracting AIDS from blood, and the chance of requiring a transfusion in any given year, are low.

And Dr. Seth Haber, chief of pathology at Kaiser-Permanente Medical Center in Santa Clara, said the service is only feeding on fears.

‘There’s a whole new group of what I would call blood suckers out there,’ he said.

The service, which has recruited 30 members since its debut Oct. 1, hopes to operate statewide.

— Fran Smith

Continued from page 2

San Jose Mercury News, 12/11/85

Blood from strangers called safe as friends’

BLOOD, from Page 1A

ing AIDS, or acquired immune deficiency syndrome, from tainted blood ranked among the nation’s highest, all banks eventually backed down on prohibitions against directed donations.

The American Red Cross Blood Center in San Jose decided to allow the practice last December, after a flurry of publicity about a San Jose man who refused to undergo surgery if he couldn’t get blood from his relatives and friends.

Except for Stanford, however, area banks gave only grudging consent. They warned that their new policies could pose even

director of Irwin.

First-time donors generally have slightly higher infection rates than repeat donors, who already have made it through the bank screening process.

Among regular donors studied at Irwin, three per 1,000 harbored blood antibodies to the virus suspected of causing AIDS, a sign of infection, McDonough said. About 3 percent showed evidence of a prior hepatitis B infection, less than .5 percent had signs of a current hepatitis B infection and less than .25 percent tested positive for syphilis.

Whenever they detected tainted blood, bank officials discarded it and entered the giver’s name on a registry of unacceptable donors.

The bank plans to submit its research for publication in January.

In the Stanford study, researchers compared infection rates of blood from 1,300 designated donors with the entire donor pool — not just first-time givers. Statistics for designated donors were virtually the same.

The investigators studied the prevalence of hepatitis, syphilis and cytomegalovirus infections, but have not yet compiled data on AIDS.

As of Monday, the U.S. Centers for Disease Control in Atlanta have confirmed 15,403 cases of AIDS, including 7,827 deaths. More than 100 people have developed the syndrome after receiving blood drawn from ostensibly healthy donors who later turned out to be infected with AIDS.

Last spring, blood centers throughout the United States began checking all donations for signs of AIDS infection. The test, health officials say, will detect more than 95 percent of tainted blood.

Nevertheless, a growing number of transfusion patients opt to get blood from people they know.

At the San Jose Red Cross, 2 percent of donors direct their blood to acquaintances. The bank, which supplies blood to hospitals in Santa Clara, Santa Cruz and San Benito counties, tries to discourage the practice, going along with requests only when patients insist and their doctors certify that medical care is in jeopardy.

At Irwin, whose blood has been linked to 22 cases of AIDS, 12 percent to 18 percent of 9,000 donors a month designate recipients.

‘Psychologically, it’s more of a benefit than scientifically.’

— Roger Svoboda,
Stanford blood bank

greater health hazards, because donors facing pressure to give blood for acquaintances might conceal information — history of infections, perhaps, or homosexual activities — that would rule them out.

Blood banks nationwide cite the potential dangers of designated donations as the prime reason they still forbid the practice.

‘Psychologically, it’s more of a benefit than scientifically,’ said Roger Svoboda, administrator of the Stanford bank. ‘Their major complaints just are not founded on scientific data. They’re based on emotional reasons.’

The studies at Stanford and Irwin, the first scientific research on hand-picked donations, refute claims that such blood is more dangerous. But they also show that it may not be any safer.

At Irwin, which supplies blood to hospitals in San Francisco and scattered counties in Northern California, roughly 3,500 donors have designated their blood since May 1984. Scientists tested those donations for a variety of blood-borne infections, and compared the results with infection rates among first-time donors to Irwin’s general stock.

They found no significant differences between the two groups, said Brian McDonough, executive

San Jose Mercury News, 12/11/85

‘Hand-picked’ blood no safer, tests show

By Fran Smith
Mercury News Medical Writer

Blood drawn from a patient’s hand-picked relatives or friends is as likely to be infected by AIDS, syphilis and hepatitis B as blood from strangers, two new studies indicate.

In all cases, the incidence of contamination was extremely low, according to tests of thousands of donors at Stanford University Blood Bank and Irwin Memorial Blood Bank in San Francisco.

The differences between

all donors and those who earmarked their blood for a particular patient were not significant, the studies found, although researchers at Irwin refused to release specific statistics on the designated donors.

In April 1983, amid growing public concern about the safety of donated blood, the Stanford blood center became the first in the United States to permit transfusion recipients to line up their own donors. Around the Bay Area, where the risk of contract-

See BLOOD, Page 11A

Continued

THE BLOOD TRANSFUSION ACT OF 1985 PETITION

A special project of the American Family Association, Washington, D.C. 20069

Special Instructions

- STEP 1. Please read and sign your petition.
STEP 2. Do not detach your signed Petition from this page.
STEP 3. Make any corrections to your name and address below.

GB29

- STEP 4. The American Family Association needs your help to carry this fight to every corner of America. Please enclose with your signed petition your contribution of:

☐ \$1,000 ☐ \$500 ☐ \$250 ☐ \$100
☐ \$50 ☐ \$25 ☐ \$15 ☐ \$ Other _____

Please make your check payable to: AMERICAN FAMILY ASSOCIATION
Thank you for your support in this vital fight.

PETITION TO THE UNITED STATES CONGRESS

WHEREAS, 14 babies have died because they received blood transfusions contaminated with AIDS;

WHEREAS, 143 normal, decent, God-fearing Americans have died because of AIDS-infected blood transfusions;

WHEREAS, medical authorities predict the beginning of an AIDS epidemic with 1,000,000 Americans already exposed to the deadly virus;

WHEREAS, AIDS has now entered America's blood supply; and,

WHEREAS, there is no cure for AIDS,

NOW, THEREFORE, I PETITION the United States Congress to immediately pass a **BLOOD TRANSFUSION ACT OF 1985** so Americans like me can protect ourselves and our loved ones against ever receiving AIDS-contaminated blood transfusions.

The **BLOOD TRANSFUSION ACT OF 1985** must protect the right of individual Americans to donate specifically for family members and friends and no judge, hospital, blood bank, or medical personnel in any state can deny Americans the right to give blood for the exclusive use of family members and friends who have fallen ill or have been injured in an accident.

Signed _____

AMERICAN FAMILY



a s s o c i a t i o n

Washington, D.C. 20069

Dear Friend,

Jason is dead.

His parents are in shock. Shattered by grief. Their baby boy was only 15 months old.

The individual responsible for Jason's death was simply told:

"Please don't do it again."

But the really tragic thing is that if the proposed BLOOD TRANSFUSION ACT OF 1985 were already a national law, little Jason might still be alive today.

That's why the enclosed petition is so vitally important.

You see, according to TIME magazine, over the next 12 months one million Americans may die from the same hideous disease that killed little Jason.

And the families and friends of these one million Americans will be told by the hospitals and doctors:

"We're sorry. We didn't know the blood transfusion we gave your loved one was infected with AIDS. We had no way of knowing a homosexual had donated the blood."

My friend, never before in the medical history of our great nation have we faced a deadlier health hazard than AIDS.

Already 143 Americans have been killed by blood contaminated with AIDS. Already 14 babies like Jason are dead.

Will you be next? A member of your family? A friend? Not even the medical experts know for sure.

America's blood supply is now contaminated. Innocent Americans are dying!

Even so, the courts still say that no one can stop homosexuals from giving blood. Liberal judges say homosexuals have the same rights as you and me.

But does that include the "right" to kill innocent people?

The AIDS epidemic is here! There's no way to stop it.

The only way you can protect yourself -- the only way you can protect your children, your grandchildren, your friends, neighbors and relatives -- is to demand that the United States Congress enact

the BLOOD TRANSFUSION ACT OF 1985.

Please. I beg you. Sign the BLOOD TRANSFUSION ACT OF 1985 PETITION I've sent you today. You cannot afford not to.

Your life -- the very lives of all those you love and care for -- depend on what you do today.

If you become sick or have an accident -- don't you want to know the blood you're being given has been donated by family members or by your friends, rather than by homosexuals?

Think about this:

The way the "blood bank" system operates now in America you can't know it. Not even your doctor is allowed to know.

You see, the "blood bank" system is built on voluntary donations of blood.

When there isn't enough voluntary blood to go around, the blood banks have to buy it. One pint at a time. From whom?

You'd be shocked!

More often than not the blood banks buy blood from the so-called "street people." From derelicts. Drug addicts. Homosexuals. Prostitutes. Alcoholics.

You can't imagine what goes on.

A derelict staggers in off the street. A nurse wipes off a spot on his filth-encrusted arm, sticks a needle in, and draws a pint of blood.

Then this blood "donor" is paid \$7, \$10, \$15, \$20 or \$35 -- depending on his blood type.

Can you imagine the quality of these derelicts' blood?

Their veins run full with AIDS, alcohol, heroin, herpes and all sorts of diseases. What would you expect?

These are the lowest people on the ladder of life.

Can you imagine having to sell your own blood in order to live? To get a few bucks to buy more drugs or alcohol or even sex?

This is a world you and I don't want anything to do with, let alone become a part of.

But right now, the liberal judges and the so-called "Gay Rights" activists are telling you that you don't have any choice.

If you or someone you love becomes ill and needs a blood transfusion, wouldn't you want to have the right to know that blood is safe? That it is not infected with AIDS?

In a recent case in Florida, a mother and father wanted to make

sure of that for their infant daughter.

They asked that they be allowed to donate the blood for their daughter's operation, but it was against the hospital's "rules."

Perhaps the hospital felt it would be "too much trouble" to keep the records that would identify the mother's and father's blood as that to be given to their daughter.

And now their little girl is dead! She died of AIDS. Exactly what her parents had tried to prevent, but weren't allowed to!

That's just one case -- just one example of why it is so urgent and so important that the U.S. Congress enact THE BLOOD TRANSFUSION ACT OF 1985 immediately!

There are another 142 reasons -- the 142 normal, decent, hard-working Americans who have died because of AIDS-infected blood.

Including little Jason.

I say it's time you and I had legal protection to safeguard against this deadly risk.

But the hospitals and the "blood banks" say that it would be "inconvenient" to "disrupt" the nation's blood distribution system.

And the liberal judges say we can't "discriminate" against homosexuals by denying them the "right" to sell their blood to the "blood banks" -- even though that blood could be a death sentence to an innocent baby like Jason.

But I ask you: Since when is a hospital's or a blood bank's right to make money more important than saving the lives of innocent young children? Since when is the right of some derelict or pervert to collect "blood money" by selling their blood more important than saving the lives of innocent young children?

To my way of thinking, even one innocent life is too high a price to pay to protect the "right" of AIDS-infected homosexuals to sell their blood.

I believe normal, decent, God-fearing Americans like you and me must have the right to protect ourselves.

But the U.S. Congress isn't going to do anything to protect our rights unless there's a massive public outcry they can't ignore.

That's why it is vital for you to sign the enclosed BLOOD TRANSFUSION ACT OF 1985 PETITION and mail it back to me today.

It's up to Americans like you to force Congress to act.

You can be assured, my friend, the powerful "Gay Rights" lobbying groups and their many sympathizers in Congress will fight us tooth-and-nail. They will claim that their constitutional "rights" are being violated. They will claim that AIDS is not a homosexual disease.

But the 143 death certificates of innocent Americans with

"AIDS" written on them tell me differently.

The basic question is: Shouldn't Americans like you and me have the right to protect ourselves and our loved ones from the AIDS epidemic?

The first vital step you can take to force Congress to pass a BLOOD TRANSFUSION ACT OF 1985 is to sign your petition and return it to me today.

Time is critical. America's blood supply is contaminated. The AIDS epidemic is here!

And today there is no national law that gives you the right to protect yourself. Even when your very life is at stake.

So, please. Sign your BLOOD TRANSFUSION ACT OF 1985 PETITION and mail it back to me today.

The American Family Association is ready to carry this fight to every corner of America. No city or town is safe.

My friend, I need your help now. The American Family Association cannot do it alone.

Help me reach millions of other Americans with our petition to Congress.

Help me with the most generous tax-deductible contribution you can possibly afford.

Contributions of \$1,000, \$500, \$250, \$100 are desperately needed. So are contributions of \$50, \$25, and \$15.

In this fight to protect the lives of innocent Americans from AIDS-contaminated blood, no dollar amount is too large or small.

Please. Do not sit idly by and do nothing. Your life and the lives of all those you love depend on what you do right now.

Sincerely,



Dan Villanueva
Executive Director

P.S. Is a homosexual's "right" to receive "blood money" more important than your right to live? But even if for some reason you feel you can't send a contribution, won't you please at least sign and mail me your BLOOD TRANSFUSION ACT OF 1985 PETITION today? Your life may depend on it!

December 13, 1985



HEMOPHILIA
INFORMATION EXCHANGE

Medical Bulletin #33
Chapter Advisory #38

AIDS UPDATE

REDUCING THE RISK OF HETEROSEXUAL AND PERINATAL TRANSMISSION OF AIDS

The most common mode of spread for HTLV-III virus is through intimate sexual contact. Other less common routes include blood products (this problem is now largely solved), contaminated needles during I.V. drug abuse, and transmission from an infected mother to her newborn at or before birth. Many persons with hemophilia have been exposed to the HTLV-III virus through the use of blood products which were produced during the years before current screening and viral inactivation methods. Due to the multiplicity of studies which emphasize the transmission of HTLV-III virus by sexual contact, persons with hemophilia should now consider that HTLV-III virus is sexually transmitted.

Based on very early data on small numbers of persons, we can make an initial estimate that the risk of transmission of HTLV-III virus from a person with hemophilia who is HTLV-III positive to his wife, through normal sexual intercourse may be in the range of 1 to 5% per year. **THIS IS A VERY SIGNIFICANT LEVEL OF RISK, AND STEPS SHOULD BE TAKEN TO KEEP THE RISK AS LOW AS POSSIBLE.**

Information on other viruses spread by intimate sexual contact, such as herpes simplex and cytomegalovirus, indicate that regular use of condoms greatly reduces the risk of viral transmission. Although such studies with HTLV-III are not yet available, all medical experts expect the same results for this virus, and are urging regular use of condoms by all persons who may have been exposed to the AIDS virus, including all persons with hemophilia who have used significant quantities of blood products.

In addition, many physicians now recommend that women of childbearing age who are the wives of persons with hemophilia, and who are considering pregnancy, should consider the risk of perinatal transmission of AIDS. That is, the transmission of AIDS to the newborn of HTLV-III positive women. Consequently, given the risk of AIDS to the newborn of HTLV-III positive women, the wives of persons with hemophilia who are considering pregnancy should first receive specific education and counselling at their hemophilia center. They should also strongly consider having an HTLV-III antibody test performed before pregnancy occurs.

Multiple recent studies have further clarified the ways in which the HTLV-III/LAV virus is and is not spread. A total of more than 400 family members who have had intimate but non-sexual contact with a person who is HTLV-III antibody positive have been surveyed in various hemophilia treatment centers. In many of these family units, sharing of eating utensils, drinking cups, toothbrushes, towels, beds, items of clothing, etc., often occurred, yet no case of either AIDS or of infection with the HTLV-III virus was found. Because no single case of AIDS has been attributable to casual contact with a person who has AIDS or HTLV-III infection, and in view of the data above, it becomes clearer that recent episodes of undue alarm concerning AIDS in the school or work setting are completely unwarranted.

Attached for the information of treatment center staff is the December 6, 1985, issue of the Morbidity and Mortality Weekly Report (MMWR), published by the Centers for Disease Control (CDC), which provides "Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome".

For questions concerning these issues, we urge you consult your hemophilia treatment center staff. You may also wish to request a copy of NHF's recent publication "Hemophilia and AIDS: Intimacy and Sexual Behavior" from your treatment center, NHF chapter, or the NHF.

Chapters: Please distribute this information to all chapter members.

Physicians: Please distribute this information to all physicians who treat patients with hemophilia in your area, and to appropriate hemophilia center staff.

Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome

The information and recommendations in this document are intended to assist health-care providers and state and local health departments in developing procedures to prevent perinatal transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus (HTLV-III/LAV), the virus that causes acquired immunodeficiency syndrome (AIDS).

This document contains recommendations for providing counselling and, when indicated, testing for antibody to HTLV-III/LAV for women who are at increased risk of acquiring the virus and who are either pregnant or may become pregnant. It is important that these women know they are at risk, as well as know and understand their HTLV-III/LAV-antibody status, so they can make informed decisions to help prevent perinatally acquired HTLV-III/LAV.

Through counselling, uninfected women can learn how to avoid becoming infected, and infected women can choose to delay pregnancy until more is known about perinatal transmission of the virus. If already pregnant, infected women can be provided information for managing the pregnancy and caring for the child.

Currently available data indicate that most pediatric HTLV-III/LAV infections and AIDS are acquired perinatally from infected women, but additional studies are needed to better quantify the risk of transmission from an infected pregnant woman to the fetus or newborn.

The recommendations below pertain to women. However, men who are HTLV-III/LAV-antibody positive should also be counselled regarding the risks of sexual and perinatal transmission, so they can refer for counselling and testing their sex partners who may be pregnant or considering pregnancy.

BACKGROUND

Pediatric AIDS Cases due to Perinatal Transmission. As of December 1, 1985, 217 (1%) of the 15,172 AIDS cases reported to CDC occurred among children under 13 years of age. Sixty percent of these children are known to have died. These 217 cases represent only the more severe manifestations of HTLV-III/LAV infection. Less severe manifestations, often described as AIDS-related complex (ARC), are not reported to CDC, so the number of children with clinically significant illness attributable to HTLV-III/LAV infection is greater than the reported cases of pediatric AIDS. In addition, a number of infected children are probably asymptomatic.

Of the 217 reported pediatric AIDS patients, 165 (76%) have as their only known risk factor a mother belonging to a group with increased prevalence of HTLV-III/LAV infection. An additional 18% of the pediatric cases are attributable to transfusions of blood or blood products, while risk factor information is missing or incomplete on the remaining 6%. Of the 217 children with AIDS, 48% had mothers who were intravenous (IV) drug abusers; 17% had mothers who were born in Haiti; and 10% had mothers who were sex partners of either IV drug abusers or bisexual men.

Of the patients with perinatally acquired AIDS, 45% resided in New York City, while Florida and New Jersey accounted for an additional 32%.

Mechanisms of Perinatal Transmission. It is believed that HTLV-III/LAV is transmitted from infected women to their fetuses or offspring during pregnancy, during labor and delivery, or perhaps shortly after birth. Transmission of the virus during pregnancy or labor and delivery is demonstrated by two reported AIDS cases occurring in children who had no contact with their infected mothers after birth. One was delivered by Cesarean section (1,2).

Transmission of the virus after birth has been implicated in one case of HTLV-III/LAV infection in a child born to a mother reported to have acquired the infection from a postpartum blood transfusion. Since she breastfed the child for 6 weeks, the authors suggested breastfeeding as the possible mode of transmission (3). Recently, HTLV-III/LAV has been isolated from the breast milk of infected women (4).

Risk of Perinatal Transmission from Infected Mothers. The rate of perinatal transmission of HTLV-III/LAV from infected pregnant women is unknown; however, available data suggest a high rate. In one study of 20 infants born to infected mothers who had already delivered one infant with AIDS, 13 (65%) had serologic and/or clinical evidence of infection with HTLV-III/LAV several months after birth (5,6). Since these women were selected on the basis of having previously transmitted HTLV-III/LAV perinatally, this study may overestimate the average risk of transmission for all infected pregnant women.

Perinatal transmission from an infected mother to her newborn is not inevitable. Of three children born to women who became infected with HTLV-III/LAV by artificial insemination from an infected donor, all were in good health and negative for antibody to the virus more than 1 year after birth (7). Another child, born to a woman who was already pregnant at the time of AIDS diagnosis and was demonstrated to be viremic, was seronegative, culture negative, and healthy at birth and at 4 months of age (8). In a retrospective study evaluating nine children under 5 years of age whose mothers were later diagnosed with AIDS, two (22%) had antibody to HTLV-III/LAV (9). The infection status of these women during pregnancy was unknown.

In these studies, the rate of transmission ranged from 0% (0/3) to 65% (13/20). Additional studies are needed to better define the rate of transmission and variables associated with it.

Risk of Illness among Infected Pregnant Women. Pregnancy is associated with suppression of cell-mediated immunity and increased susceptibility to some infections (10). The T-helper to T-suppressor ratio is decreased during normal pregnancy, being lowest in the third trimester, and returns to normal approximately 3 months postpartum (10). It is not known whether pregnancy increases an infected woman's risk of developing AIDS or ARC, but one study suggests it does (6). Fifteen infected women who were well at time of delivery were followed an average of 30 months after the births of their children. Five (33%) subsequently developed AIDS; seven (47%) developed AIDS-related conditions; and only three (20%) remained asymptomatic. These results may not apply to all infected pregnant women, but they do suggest an increased likelihood of developing disease when an HTLV-III/LAV infection occurs in association with pregnancy.

Prevalence of HTLV-III/LAV infection. Counselling and testing for antibody to HTLV-III/LAV, when indicated, to reduce perinatal transmission of AIDS will be most beneficial in populations of women with increased prevalence of the virus (Table 1). These include: women who have used drugs intravenously for nonmedical purposes; women who were born in countries where heterosexual transmission is thought to play a major role (11,12); women who have engaged in prostitution; and women who are or have been sex partners of men who abuse IV drugs, are bisexual, have hemophilia, were born in countries where heterosexual transmission is thought to play a major role (11,12), or have evidence of HTLV-III/LAV infection.

The prevalence of antibody to HTLV-III/LAV in U.S. populations of men and women ranges from less than 0.01% in female blood donors to as high as 74% in men with hemophilia (13-15). Among heterosexual IV drug abusers, the prevalence of HTLV-III/LAV infection ranges from 2% to 59% in various geographic areas (16,17). Seroprevalence among the heterosexual partners of persons at increased risk for AIDS varies from 10% in female partners of asymptomatic, seropositive hemophilia patients to 71% in the female partners of men with AIDS or ARC (18-20). Among prostitutes, the HTLV-III/LAV antibody prevalence varies from 5% to 40%, depending on geographic area, with most of the women with positive tests relating histories of IV drug abuse (21). Among female blood donors in Atlanta, Georgia, who denied belonging to high-risk groups, 0.01% had repeatedly reactive enzyme-linked immunosorbent assays (ELISAs) followed by reactive Western blot tests (15).

TABLE 1. Prevalence of HTLV-III/LAV antibody in heterosexual populations — United States

Populations	Location	No. tested	Prevalence (%)
Intravenous drug abusers (16,17)	New York City	274	59
	NJ* < 5 miles from NYC†	204	56
	NJ 5-10 miles from NYC	124	43
	NJ > 100 miles from NYC	55	2
	San Francisco	53	9
Persons with hemophilia (13,14)			
Factor VIII concentrate recipients		234	74
Factor IX concentrate recipients		36	39
Cryoprecipitate only recipients		15	40
Female prostitutes (21)	Seattle, Washington	92	5
	Miami, Florida	25	40
Female sex partners of men with AIDS or ARC (two separate studies) (19,20)		7	71
		42	47
Female sex partners of men with asymptomatic HTLV-III/LAV infection (18)		21	10
Haitians (12)	New York City	97	4
	Miami, Florida	129	8
Female blood donors (15)	Atlanta, Georgia	28,354	0.01

*New Jersey.

†New York City.

Commercially available tests to detect antibody to HTLV-III/LAV are ELISAs using antigens derived from whole disrupted HTLV-III/LAV. When the ELISA is reactive on initial testing, it is standard procedure to repeat the test on the same specimen. Repeatedly reactive tests are highly sensitive and specific for antibody to HTLV-III/LAV. However, when the ELISA is used to screen populations in which the prevalence of infection is very low (such as blood donors or women not in high-risk groups), the proportion of repeatedly reactive results that are falsely positive will be higher. For that reason, an additional test, such as a Western blot, is recommended following repeatedly reactive ELISA results, especially in low-prevalence populations. In populations with high prevalence of infection (e.g. homosexual men or IV drug abusers), most repeatedly reactive ELISAs are reactive by Western blot or another test. For example, among 109 IV drug abusers whose sera were repeatedly reactive by ELISA, over 85% were reactive by Western blot (22). In contrast, in a low-prevalence population of 69 female blood donors whose sera were repeatedly reactive by ELISA, only 5% were reactive by Western blot (15).

Due to the seriousness of the implications of HTLV-III/LAV-antibody reactivity, it is recommended that repeatedly reactive ELISAs be followed by an additional test, such as the Western blot. Women with sera repeatedly reactive by ELISA and reactive by Western blot should have a thorough medical evaluation. HTLV-III/LAV has been isolated from a single specimen in 67%-95% of persons with specific antibody (23,24). Because infection has been demonstrated in asymptomatic persons, the presence of specific antibody should be considered presumptive evidence of current infection and infectiousness.

RECOMMENDATIONS

Women Who Should be Offered Counselling and Testing. *Counselling services and testing for antibody to HTLV-III/LAV should be offered to pregnant women and women who may become pregnant in the following groups:* (1) those who have evidence of HTLV-III/LAV infection; (2) those who have used drugs intravenously for nonmedical purposes; (3) those who were born in countries where heterosexual transmission is thought to play a major role (11,12); (4) those who have engaged in prostitution; (5) those who are or have been sex partners of: IV drug abusers, bisexual men, men with hemophilia, men who were born in countries where heterosexual transmission is thought to play a major role (11,12), or men who otherwise have evidence of HTLV-III/LAV infection. If data become available to show that HTLV-III/LAV-antibody prevalence is increased in other groups or settings, counselling and testing programs should be extended to include them. Routine counselling and testing of women who are not included in the above-mentioned groups is not recommended due to low prevalence of infection and concern about interpretation of test results in a low-prevalence population. However if a woman requests it, the service should be provided in accordance with these recommendations.

Settings for Offering Counselling and Testing. Counselling and testing for antibody to HTLV-III/LAV to prevent perinatal transmission is recommended in the setting of any medical service in which women at increased risk are commonly encountered. These include services for treating IV drug abuse (i.e., detoxification and methadone maintenance), comprehensive hemophilia treatment centers, sexually transmitted disease clinics, and clinics that serve female prostitutes. In addition, services related to reproduction, such as family planning and infertility services, gynecologic, premarital, or preconceptional examinations, and prenatal and

obstetric services should also consider offering counselling and testing if high-risk women are seen at these facilities. Testing for antibody to HTLV-III/LAV should be performed with the woman's consent after counselling is provided regarding risk factors for infection, the interpretation of test results, the risks of transmission, and the possible increased likelihood of disease among women infected with HTLV-III/LAV in association with pregnancy. The counselling and testing must be conducted in an environment in which confidentiality can be assured. In settings where confidential counselling and testing cannot be assured, information should be provided and referrals made to appropriate facilities.

Frequency of Testing. Detectable antibodies to HTLV-III/LAV may not develop until 2-4 months after exposure. This, and whether the woman is continuously exposed, should be taken into account when considering the need for, and frequency of, repeat testing. High-risk women should be offered counselling and testing before they become pregnant. During pregnancy, counselling and testing should be offered as soon as the woman is known to be pregnant. If the initial test is negative, repeat testing may be indicated near delivery to aid in the clinical management of the pregnant woman and newborn. If this final test is negative and the mother's risk of exposure no longer exists, she may safely consider breastfeeding the child, and management of the child need not include the same concerns that would be appropriate if the woman had had a positive test or if she were at high risk and had not been tested at all.

Counselling Women with Positive Results. Women with virologic or serologic evidence of HTLV-III/LAV infection should be counselled regarding their own risk of AIDS and the risk of perinatal and sexual transmission of HTLV-III/LAV. Infected women should be counselled to refer their sex partners for counselling and testing. If the partners of these women are not infected, both members of the couple should be counselled on how they may modify their sexual practices to reduce the risk of HTLV-III/LAV transmission to the uninfected partner. In addition, the couple should be told not to donate blood, organs, or sperm and should be discouraged from using IV drugs and advised against sharing needles and syringes. When seeking medical or dental care for intercurrent illness, they should inform those responsible for their care of their positive antibody status so appropriate evaluation can be undertaken. Recommendations for providing information and advice to individuals infected with HTLV-III/LAV have been published (25).

Infected women should be advised to consider delaying pregnancy until more is known about perinatal transmission of the virus. Pregnant infected women may require additional medical and social support services due to an enhanced risk of opportunistic infections and psychosocial difficulties during and after pregnancy. Obstetric-care providers should be alert to signs and symptoms of HTLV-III/LAV and related opportunistic infections in these pregnant women and to the need for specialized medical care.

HTLV-III/LAV-infected women should be advised against breastfeeding to avoid postnatal transmission to a child who may not yet be infected. The child should receive follow-up pediatric evaluations to determine whether he/she has HTLV-III/LAV infection, and to diagnose and treat promptly any diseases that may be secondary to HTLV-III/LAV infection. Recommendations for educating and providing foster care for infected children have been published (26).

Counselling Women with Negative Test Results. A negative ELISA for HTLV-III/LAV antibody in women who have no clinical or laboratory evidence of HTLV-III/LAV infection is evidence that they have probably not been infected. However, uninfected women who have sex

partners with evidence of HTLV-III/LAV infection or with an increased risk of becoming infected should be informed that sexual intercourse increases their risk of infection. These women should be informed of the risks associated with pregnancy if they become infected and advised to consider delaying pregnancy until more is known about perinatal transmission of the virus or until they are no longer considered to be at risk for acquiring the virus. In addition to preventing pregnancy, the consistent and proper use of condoms can offer some protection against HTLV-III/LAV infection.

High-risk women, even if seronegative, should be told not to donate blood or organs. To decrease their risk of becoming infected, IV drug abusers should be encouraged to seek treatment for their drug abuse. Persons counselling IV drug abusers should know that IV drug abuse is often strongly ingrained and compulsive. Despite educational efforts and encouragement for treatment, some addicts will continue to abuse drugs or relapse after treatment. If drug abuse continues, they should be advised not to share needles or syringes and to use only sterile equipment.

Additional Considerations. These recommendations will be revised as additional information becomes available. It is recognized that provision of the recommended professional counselling, HTLV-III/LAV-antibody testing and associated specialized medical services will take time to implement and may stress available resources, particularly in public facilities, which are most greatly affected. Health-care providers, social-service personnel, and others involved in educating and caring for HTLV-III/LAV-infected persons should be aware of the potential for social isolation and should be sensitive to the need for confidentiality. They should be familiar with federal and state laws, regulations, and policies that protect the confidentiality of clinical data and test results. Each institution should assure that specific mechanisms are in place to protect the confidentiality of all records and to prevent the misuse of information. Anonymous testing would not be appropriate if it prevents adequate counselling and medical follow-up evaluation.

Hospital precautions for managing infected women and infants should be patterned after those for caring for patients with HTLV-III/LAV infection (27,28). Additional recommendations will follow.

DEVELOPMENT OF THESE RECOMMENDATIONS

The information and recommendations contained in this document were developed and compiled by CDC and the U.S. Public Health Service in consultation with individuals representing: the Conference of State and Territorial Epidemiologists, the Association of State and Territorial Health Officials, the American Public Health Association, the United States Conference of Local Health Officers, the American Medical Association, the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the Planned Parenthood Federation of America, the American Venereal Disease Association, the Division of Maternal and Child Health of the Health Resources and Services Administration, the National Institute on Drug Abuse of the Alcohol, Drug Abuse, and Mental Health Administration, the National Hemophilia Foundation, the Haitian Medical Association, the American Bar Foundation, and the Kennedy Institute of Ethics at Georgetown University. The consultants also included representatives of the departments of health of the areas with the largest number of perinatally transmitted pediatric AIDS cases: New York City, Florida, and New Jersey. These recommendations may not reflect the views of all individual consultants or the organizations they represented.

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24. Jaffe HW, Feorino PM, Darrow WW, et al. Persistent infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in apparently healthy homosexual men. *Ann Intern Med* 1985;102:627-30.
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27. CDC. Acquired immunodeficiency syndrome (AIDS): precautions for clinical and laboratory staffs. *MMWR* 1982;31:677-80.
28. CDC. Recommendations for preventing transmission of infection with human T-lymphotropic virus

POLICY ON AVAILABILITY OF
HYPODERMIC NEEDLES AND SYRINGES

In December the California State Board of Pharmacy wrote CMA of its concern over the spread of AIDS by IV drug abusers through the use of hypodermic needles and syringes. CMA's response stated:

The CMA shares your view that the risk of AIDS to intravenous drug users and the role of sterile needles as a possible preventive health step are public health issues that deserve serious attention. Our committees are still considering these issues and developing a policy position on them. We recommend that the Board of Pharmacy evaluate the current restrictions on sale of needles and syringes from the perspective of easier availability of sterile needles as as a prophylactic measure against the spread of AIDS. We fully support a study and re-examination of the issues and we offer the Board the clinical expertise of our committees in this effort.

Attached for your use are:

1. Letter to Board of Pharmacy, January 13, 1986
2. Letter from Board of Pharmacy, December 17, 1985
3. Background material on work of CMA Committee on Alcoholism and Other Drug Dependence
4. Background material on position of American Medical Society on Alcoholism and Other Drug Dependencies



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

January 13, 1986

Lorie G. Rice
Executive Officer
California State Board of Pharmacy
1020 N Street
Sacramento, CA 95814

Dear Ms. Rice:

Thank you for the opportunity to submit comments to the Board of Pharmacy on the question of the availability of hypodermic needles and syringes. Several committees of the CMA have an interest in the clinical matters which touch upon the use of needles and syringes. They are the ad hoc AIDS Task Force and the Committee on Alcoholism and Other Drug Dependence. In preparing these comments, we have contacted the chairpersons of these groups to learn their viewpoints and recommendations.

The consensus favors the increased availability of needles and syringes as a means of reducing the practice of sharing needles by intravenous drug users, which has been clearly identified as a major mode of transmission of the AIDS virus. We recognize that there are experts in the drug treatment field who feel that greater availability of needles and syringes has the potential to increase illegal intravenous drug use and that the current restrictions on availability of needles and syringes should be maintained. However, the weight of opinion of our experts favors a lessening of these restrictions in order to reduce as much as possible the sharing of needles.

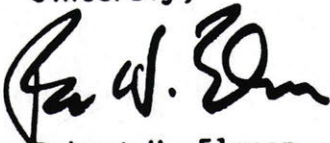
There is ample literature reporting on the alarming incidence of HTLV III/LAV antibodies and AIDS itself in the intravenous drug user population. The November, 1985 Harvard Medical School Health Letter reports that in the United States 26% of AIDS patients have been intravenous drug users. In New York, like California one of 11 states which require prescriptions for the purchase of hypodermic needles, this percentage is almost double. In Canada, where needles are sold over the counter, the figure is 0.5%, and in Great Britain it is 1.5%. A 1984 study of intravenous drug users entering a drug detoxification program in New York City reported that 58% had already been exposed to HTLV III/LAV. The rate of exposure of intravenous drug users in California appears to be much lower, apparently because the incidence of needle-sharing is lower in this state than in New York. If this is true, then efforts to encourage the use of sterile needles may make a significant contribution to efforts to forestall the spread of the disease here.

Lorie G. Rice
January 13, 1986
Page 2

In addition, there is evidence to suggest that intravenous drug users are concerned about their risk of contracting AIDS. A recent survey by the New York State Division of Substance Abuse Services found that approximately 60% of the subjects studied were making efforts to reduce their chances of exposure, primarily through increased use of sterile needles. This self-report was confirmed by the Division's interviews with people selling needles, who reported increased demand for sterile needles.

The CMA shares your view that the risk of AIDS to intravenous drug users and the role of sterile needles as a possible preventive health step are public health issues that deserve serious attention. Our committees are still considering these issues and developing a policy position on them. We recommend that the Board of Pharmacy evaluate the current restrictions on sale of needles and syringes from the perspective of easier availability of sterile needles as a prophylactic measure against the spread of AIDS. We fully support a study and re-examination of the issues and we offer the Board the clinical expertise of our committees in this effort.

Sincerely,



Robert H. Elsner
Executive Vice President

RHE:sw

cc: CMA Executive Committee

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Linda Ramsey

Laurie A. Simon

Bill Cleveland

Alan Silverman, MD

Allen W. Mathias, Jr., MD

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Pierre Dreyfus, MD

DEPARTMENT OF

Consumer Affairs

CALIFORNIA STATE BOARD OF PHARMACY

1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE: (916) 445-5014

December 17, 1985

RECEIVED

DEC 24 1985

EXECUTIVE OFFICE

Robert Elsner
Executive Vice-President
California Medical Association
925 L Street
Sacramento, CA 95814

Dear Mr. Elsner:

The California State Board of Pharmacy is responsible for regulating the sale and dispensing of the hypodermic needles and syringes. At its last meeting, the Board became aware of the growing concern regarding the spread of Acquired Immune Deficiency Syndrome (AIDS) by addicts through the use of hypodermic needles and syringes contaminated with the disease.

Board member Jay Cavanaugh explained that an addict who acquires AIDS and has a long incubation period is going to be unaware that he/she has acquired the disease. Many addicts engage in prostitution to support their habit; thus, creating the vehicle to move AIDS into the population mainstream." Mr. Cavanaugh further stated that current state law forces anyone who is illegally using drugs intravenously, to share needles.

The Board of Pharmacy is aware that this is a very sensitive issue, and is not advocating the deregulation of hypodermics, but perceives it as a public health issue which needs to be addressed. Therefore, the Board is holding an informational hearing and is inviting various health professional associations, members in the public health field and law enforcement agencies to discuss possible approaches to the growing problem.

The hearing is scheduled for Tuesday, January 21, 1986, at the University of Pacific, Regents Dining Hall, 325 Campus Way, Stockton, from 9:30 A.M. 11:00 A.M. Please let me know in advance, if you plan on presenting oral testimony before the Board. If so, please limit your presentation to ten minutes as well as provide a written copy for our records. However, if you plan on submitting written testimony, please do so at the hearing or mail it to my attention no later than January 10, 1986.

Robert Elsner
Page -2-
December 17, 1985

The Board of Pharmacy appreciates your interest in this matter and thanks you in advance for your valuable input.

Truly,


LORIE G. RICE
EXECUTIVE OFFICER

LGR/mcv

CALIFORNIA MEDICAL ASSOCIATION

INTER-OFFICE MEMORANDUM

DEC 10 1985

To: Bob Elsner

Date: 12/10/85

From: Laurie A. Soman *las*

cc: Mike Goldman
Linda Ramsey
Gail Jara
Mark Madsen —

Subject: Committee on Alcoholism and
Other Drug Dependence

The Committee on Alcoholism and Other Drug Dependence met on December 6 and considered the following matters:

AIDS and Drug Use

The Committee is collecting information on the incidence of AIDS in drug users and its implications for both patients and staff in treatment programs. The Committee plans to draft a policy statement for CMA on the treatment of patients with alcoholism or other drug dependencies who have or are at risk for AIDS.

Next Meeting

The Committee will meet next on April 18, 1986.



DEC 9 1985 *Info
Oman*

American Medical Society on Alcoholism & Other Drug Dependencies, inc.

12 West 21st Street, New York, New York 10010 (212) 206-6770

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December 5, 1985

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Editor

Dear Ms. Soman:

Attached is a copy of the POSITION OF AMSAODD
ON THE TREATMENT OF PATIENTS WITH ALCOHOLISM OR
OTHER DRUG DEPENDENCIES AND WHO HAVE OR ARE AT RISK
FOR ACQUIRED IMMUNO DEFICIENCY SYNDROME (AIDS), which
was adopted at its Board of Directors meeting on
October 21, 1985.

Sincerely,

Claire Osman
Claire Osman
Administrative Director

• Executive Committee

enc.

POSITION OF
AMERICAN MEDICAL SOCIETY ON ALCOHOLISM AND OTHER DRUG DEPENDENCIES, INC.
ON THE TREATMENT OF PATIENTS WITH ALCOHOLISM OR OTHER DRUG DEPENDENCIES
AND WHO HAVE OR ARE AT RISK FOR ACQUIRED IMMUNO DEFICIENCY SYNDROME (AIDS)

The American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) recognizes that some patients in need of treatment for alcoholism and/or other drug dependencies may have Acquired Immuno Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or may have a positive test for HTLV-III antibodies. Intravenous drug users are a high-risk group for AIDS. The use of mood altering drugs (i.e., alcohol, marijuana and perhaps others) may depress the immune system and effect prevention and treatment of AIDS.

- AMSAODD strongly recommends that physicians, other health professionals, and programs for the treatment of alcoholism and other drug dependencies provide treatment for these patients.
- Case by case assessment of the medical status of each patient should be made to determine physical capacity to undergo treatment for alcoholism and other drug dependencies. Continuing medical followup by a physician familiar with AIDS is recommended.
- Currently there is anxiety amongst staffs and other patients about associating with AIDS patients. All personnel, including clinical, dietary, maintenance and housekeeping, should be educated with the latest medical data.
- Patients with AIDS do not require isolation techniques any different from patients with active Hepatitis B. Guidelines for the protection of staff and other patients from Hepatitis B should be followed. Caps, masks, gloves and other kinds of protective wear are not necessary in routine contact, e.g., blood pressure checks and group therapy.
- Continued medical monitoring after detoxification period is recommended for these patients.
- The principle of confidentiality, critical to all aspects of alcoholism and other drug dependencies treatment is particularly important with these patients.



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

January 13, 1986

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Executive Officer
California State Board of Pharmacy
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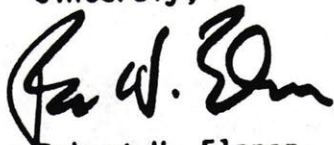
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Lorie G. Rice
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cc: CMA Executive Committee

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CALIFORNIA STATE BOARD OF PHARMACY

1020 N STREET, SACRAMENTO, CALIFORNIA 95814
TELEPHONE: (916) 445-5014



December 17, 1985

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DEC 24 1985
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Robert Elsner
Executive Vice-President
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LORIE G. RICE
EXECUTIVE OFFICER

LGR/mcv

CALIFORNIA MEDICAL ASSOCIATION

INTER-OFFICE MEMORANDUM

DEC 10 1985

To: Bob Elsner

Date: 12/10/85

From: Laurie A. Soman *las*

cc: Mike Goldman
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Mark Madsen —

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DEC 9 1985 *Info*
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American Medical Society on Alcoholism & Other Drug Dependencies, inc.

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December 5, 1985

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AIDS MANAGEMENT PROTOCOLS FOR INMATES

CMA's Corrections and Detentions Health Care Committee has forwarded to this Committee a set of protocols developed by the state Department of Corrections for review and comment. The Committee is also being asked to comment on a variety of questions raised by law enforcement personnel about the risk of transmission during contact with prisoners. These materials are attached.



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

October 28, 1985

TO: Mark Madsen

FR: Rebecca Craig

RE: AIDS Management Protocols for Inmates

Attached is a set of protocols originally developed by the California Department of Corrections. The Corrections and Detentions Health Care Committee recently reviewed these infection control protocols and believe they could easily be rewritten into a generic format and provided to jails statewide.

Could the AIDS Task Force review this material for its efficacy based upon their expertise in the management of AIDS? If the task force concurs with the general principles, the Committee will revise these protocols to facilitate their adoption by jail medical staffs. For your information, an addendum is forthcoming regarding the legal issues surrounding HTLV-III testing and its implications for jails and prisons.

Finally, the Committee would like the Task Force to specifically address the following questions, which are continually brought up by law enforcement personnel. These questions focus upon areas of "casual contact" rather unique to this special environment and are as follows:

If an individual is infectious with AIDS, can the virus be transmitted by any of the following means/vectors:

- being spat upon directly into the face?
- being vomited upon?
- handling clothes covered with emesis, feces or blood?
- conducting a "pat down" search?
- conducting a strip search?
- conducting a body cavity search, while wearing gloves?

Mark Madsen, Staff

RE: AIDS Management Protocols for Inmates

Page 2

- being cut by a used razor?
- performing CPR?
- collecting urine specimens for drug screens?

An additional question, specifically focused at the inmates, is whether the sharing of tattoo needles can spread the disease.

Your attention in this matter is greatly appreciated.

TITLE AIDS, CIGARETTES AND MARIJUANAIntroduced by: Albert Fields, MD

Endorsed by (optional): _____

Author: Albert Fields, MD

RESOLUTIONS

RES. # 106-86

Reference Committee

AMarch 1-5, 1986

1. WHEREAS, as of the end of 1985, of 16,000 reported
2. patients with Acquired Immune Deficiency Syndrome
3. (AIDS) 8,000 had died, after an average hospitalization
4. of 1968 days, and an average medical-hospitalization cost of \$147,000; and
- 5.
6. WHEREAS, in the absence of a protective vaccine, effective anti-viral medication
7. and/or immune enhancement, it is expected that by 1990, 40 per cent of acute
8. hospital beds will be occupied by AIDS patients; and
- 9.
10. WHEREAS, in persons with homosexual and bisexual life styles there is a 50
11. per cent higher incidence of AIDS in those who smoke cigarettes and/or
12. marijuana; now, therefore, be it
- 13.
14. RESOLVED: That the CMA inform the public and the news media that persons
15. with homosexual and bisexual life styles who smoke cigarettes
16. and/or marijuana have a 50 per cent higher probability of
17. developing AIDS.
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29. Current CMA Policy: In response to Resolution 719a-85 CMA currently makes

30. available information regarding diagnostic guidelines, treatment protocols,

31. patient services, epidemiological data and research on therapy regimens.

32. The ad hoc Committ on AIDS continuously reviews information for

33. dissemination.

34.

35. Estimated Cost to CMA: Minimal.

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TITLE PRE-MARITAL BLOOD TESTS FOR AIDS

Introduced by: Stanley K. Monteith, MD

Endorsed by (optional): _____

Author: Stanley K. Monteith, MD

FOR CMA USE ONLY

RESOLUTIONS

RES. # 107-86

Reference Committee

A

March 1-5, 1986

1. WHEREAS, AIDS has become a public health hazard in
2. the United States; and
3.

4. WHEREAS, AIDS can be sexually transmitted both by homosexual and by
5. heterosexual acts; and
6.

7. WHEREAS, organized medicine has traditionally supported public health measures
8. to prevent transmission of communicable diseases; now, therefore, be it
9.

10. RESOLVED: That the CMA urge the Legislature of the State of California to
11. require pre-marital blood tests for HTLV-III Antibodies.
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35. Current CMA Policy: The issue is on the agenda of a future meeting of
36. CMA's Task Force on AIDS. A similar Resolution was introduced into
37. the December, 1985 AMA House and failed to pass; AMA rejected the measure
38. because such tests could be ineffectual and "would unnecessarily
39. increase public anxiety about AIDS."
40.

41. Estimated Cost to CMA: See Resolution 101-86.
42.
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CALIFORNIA REHABILITATION CENTER

MEDICAL STAFF PROTOCOLS FOR INFECTION CONTROL WHILE CARING FOR AIDS PATIENTS

AIDS is a transmissible condition that causes immunosuppression and consequent susceptibility to serious, often lethal, cancers and opportunistic infections. It is contracted by intimate exposure to blood or secretions of AIDS patients (e.g., sexual intercourse, sharing of needles, infusion of contaminated blood products).

OBJECTIVE: Precautions will be taken by medical staff caring for AIDS and AIDS-related-complex patients to protect against transmission of AIDS to susceptible individuals and to protect AIDS patients from contracting serious infections.

POLICY: Patients from CRC who are diagnosed with AIDS or AIDS-related-complex will be transferred to CMF for care and permanent housing. N numbers will be excluded. While the patients are awaiting transfer, care will be taken to prevent possible transmission of AIDS. Patients with AIDS, AIDS-related-complex or suspected AIDS will be housed in the infirmary (women at CIW) pending transfer.

PROCEDURES:

- 1) When AIDS is suspected in a patient, the physician will obtain the following tests: helper/suppressor T cell ratios; CBC, including platelets; serum protein levels.
- 2) When AIDS is confirmed or if the lab tests results are compatible with AIDS, the physician will contact the Chief Medical Officer who will arrange transfer of the patient to CMF. Procedures for exclusion of N numbers will be immediately initiated by the Chief Medical Officer.
- 3) Any patient with AIDS, AIDS-related-complex or suspected AIDS will be admitted to the infirmary pending transfer.
- 4) A single room for an AIDS, AIDS-related-complex or AIDS-suspect patient is not necessary unless the patient needs reverse isolation. Do not house the patients with others who have infections.
- 5) Gloves are to be worn by staff who will handle blood or other body secretions from AIDS, AIDS-related-complex or AIDS-suspect patients.
- 6) Staff caring for AIDS, AIDS-related-complex or AIDS-suspect patients will wash hands before and after direct patient care.
- 7) Gowns will be worn by staff caring for AIDS, AIDS-related-complex or AIDS-suspect patient only if staff is involved in a procedure that might involve gross contamination with blood or body secretions, such as treatment of a draining wound.
- 8) Pregnant staff will not be assigned to care for AIDS, AIDS-related-complex or AIDS-suspect patients.
- 9) Masks will be worn by staff caring for AIDS, AIDS-related-complex or AIDS-suspect patients only if the patients have a contagious respiratory infection, such as tuberculosis.

CALIFORNIA REHABILITATION CENTER

MEDICAL STAFF PROTOCOLS FOR INFECTION CONTROL
WHILE CARING FOR AIDS PATIENTS

PROCEDURES: (continued)

- 10) Laboratory specimens collected from AIDS, AIDS-related-complex or AIDS-suspect patients will be marked with "H/A Precautions" and placed in impervious bags for transport. Lab slips will also be marked "H/A Precautions" and attached outside the bags.
- 11) Needles used on AIDS, AIDS-related-complex or AIDS-suspect patients will not be bent or recapped. Needles will be disposed in puncture-resistant containers.
- 12) No mouth pipetting shall be performed on specimens from AIDS, AIDS-related-complex or AIDS-suspect patients.
- 13) Centrifuge safety caps will be placed on specimens from AIDS, AIDS-related-complex or AIDS-suspect patients during centrifuging.
- 14) AIDS, AIDS-related-complex or AIDS-suspect patients may use showers and bathtubs. After use showers and tubs will be cleaned by infirmary porters and then decontaminated with 1:10 dilution of 5.25% sodium hypochlorite.
- 15) Infirmary porters will clean the rooms of AIDS, AIDS-related-complex or AIDS-suspect patients except when there is a large spill of blood, urine or other body secretions. Large spills will be cleaned by staff who will immediately wipe up the spill with paper towels using gloved hands. The paper towels will be disposed in an infectious waste container. The area will then be decontaminated with 1:10 dilution of 5.25% sodium hypochlorite.
- 16) Linen contaminated with blood, urine or other secretions from AIDS, AIDS-related-complex or AIDS-suspect patients must be placed in hot-water-soluble laundry bags. Noncontaminated laundry does not require special handling.
- 17) No special dietary trays or utensils are required for AIDS, AIDS-related-complex or AIDS-suspect patients.
- 18) Reusable instruments must be sterilized or pasteurized.
- 19) Staff sustaining needlesticks or conjunctival or mucus membrane exposures to blood or secretions from AIDS, AIDS-related-complex or AIDS-suspect patients must thoroughly wash the area immediately, then report the injury to his/her supervisor and fill out an incident report.

Kim M. Thorburn
Kim M. Thorburn, M.D.
Chief Medical Officer

CUSTODY STAFF PROTOCOLS FOR
DEALING WITH AIDS PATIENTS

AIDS is a transmissible condition that suppresses the body's immune system and makes the AIDS patient susceptible to serious, often lethal, cancers and infections. Many of the infections seen in AIDS patients do not occur in normal, healthy people. AIDS is contracted by intimate exposure to blood or secretions of AIDS patients (e.g., sexual intercourse, sharing of needles, infusion of contaminated blood products). AIDS is not spread by casual contacts.

POLICY: Patients from CRC who are diagnosed with AIDS or who are suspected of having AIDS will be transferred to CMF. N numbers will be excluded. While patients are awaiting transfer, care will be taken to prevent possible transmission of AIDS. Patients with AIDS or AIDS suspects will be housed in the infirmary while awaiting transfer.

PROCEDURES:

- 1) Any patient with or suspected of having AIDS will be housed in the infirmary pending transfer to CMF.
- 2) No protective clothing is needed while escorting or transporting AIDS patients. The only exception occurs when the AIDS patient has a contagious respiratory infection, such as tuberculosis, when the patient will wear a mask.
- 3) No special dietary trays are needed for AIDS patients.
- 4) Laundry from AIDS patients may be handled in a routine fashion unless it is contaminated by blood or body secretions. Contact CRC medical staff to handle contaminated laundry.
- 5) Pregnant staff should not work around AIDS patients.
- 6) Handwashing is one of the most effective means to prevent spread of all infective conditions. Custody staff should wash hands frequently with soap and water, especially after tactile contact with inmates such as pat-down lines.
- 7) Cover open sores on hands with bandaids or dressings when working pat-down lines.
- 8) If the skin is cut while searching inmates, immediately wash the injury thoroughly, report to the supervisor and fill out an incident report.

Kim M Thorburn
Kim M. Thorburn, M.D.
Chief Medical Officer

Article 1 - Medical Services

Section 6107. AIDS and the AIDS Related Complex (ARC)

(a) Definitions:

(1) AIDS: A disease at least moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause of demonstrated resistance to that disease. Such diseases include Pneumocystis Carinii pneumonia, Kaposi's Sarcoma and other serious opportunistic infections.

(2) AIDS Related Complex (ARC): AIDS Related Complex or ARC is a recently created definition to include those patients with less severe disease (prodromal period). ARC criteria are any two clinical and two laboratory abnormalities from the following lists:

CLINICAL (3 months or more in the absence of other identifiable cause.)

Fever 100°
Lymphadenopathy
Diarrhea
Nightsweats
Fatigue
Weight loss - 10% or more than 15 pounds

LABORATORY

- (A) Depressed helper T cell
- (B) Depressed helper/suppressor ratio
- (C) One of the following; leukopenia, thrombocytopenia, absolute lymphopenia, or anemia
- (D) Elevated serum globulin
- (E) Depressed blastogenesis (pokeweed and PRA)
- (F) Abnormal skin tests (using multitest or the equivalent)

(3) Infection Control: Patients meeting the Center for Disease Control definition of AIDS or AIDS Related Complex (ARC) definition, or any patient being evaluated for possible AIDS should be handled according to the "Guidelines of Infection Control for AIDS."

The patient should be admitted to the infirmary for evaluation of his having a possible communicable disease.

The local institutional physician must perform laboratory procedures B, C, and D listed above, including a platelet count, before contacting CMF or any other consulting source.

Once the patient has satisfied the criteria in the above definition of AIDS, or has satisfied the above criteria for the diagnosis of AIDS Related Complex, arrangements are to be made for the immediate transfer of the inmate to the California Medical Facility at Vacaville. The institution is designated as the California Department of Corrections' center for the treatment of AIDS and/or the AIDS Related Complex patients.

(b) Reporting. AIDS is reportable to the California Health Department and the Center for Disease Control.

(c) Transmission. AIDS is spread only by very intimate (sexual) contact or by blood or blood product transfusion. There has been no evidence of person-to-person transmission through ordinary social or occupational contact or by airborne or foodborne methods or transmission to medical personnel.

(d) Isolation Technique. In accordance with American Hospital Association and Center for Disease Control guidelines.

(1) All suspected or known AIDS or ARC patients require blood/body fluid precautions (a single room is preferred).

(2) AIDS or ARC patients with suspect tuberculosis or other airborne disease should be placed on respiratory isolation until ruled out. Those with diarrheal disease should be placed on enteric precautions as well as blood and body fluid precautions.

(3) In the ambulatory care setting, suspect or known AIDS or ARC patients may use the same waiting areas and bathrooms as other patients unless the presence of other infections require special precautions.

(e) Laboratory Specimens. All specimens from known or suspect AIDS or ARC patients should be labelled to alert for blood precautions and placed in an impervious bag. In handling specimens, use gloves and good handwashing technique and take care to prevent needle-sticks and cuts.

(f) Guidelines for Patient Care. The following guidelines have been adopted by the Infection Control Committee of the University of California, San Francisco, and are consistent with the recommendation of the U.C. Task Force on AIDS, dated June 2, 1983. These guidelines have been adopted by the Department of Corrections, State of California.

(1) The definition of an AIDS patient is as outlined by the Center for Disease Control in their category A designation, that is, "a disease at least moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause of diminished resistance to that disease. Such diseases included Pneumocystis Carinii pneumonia, Kaposi's Sarcoma and other serious opportunistic infections." It is recommended that patients with the AIDS Related Complex or those being evaluated for the possibility of AIDS should be included for infection control purposes.

(2) The responsibility for identification of the patient in the above categories should rest with the attending physician. It is also the responsibility of the physician to report the diagnosis to the Public Health Department since Category A AIDS is now a reportable disease. The attending physician should also have the responsibility in consultation with the Infection Control Unit, of determining when appropriate precautions and/or isolation measures can be discontinued.

(3) Evidence to date indicates that the transmission of the AIDS virus is similar to that of the hepatitis B virus; that is, it requires direct contact with blood or body secretions. There is no evidence of airborne transmissions, and therefore infection control policies and procedures appropriate for patients with hepatitis B should be applied to patients with AIDS.

(4) The patients conforming to the definitions above should be placed on Blood and Excretion precautions. Specimens from the patients should be labelled "H/A Precautions" and placed in an impervious bag or container for transport.

(5) Since there is no evidence of airborne transmission of an AIDS virus, mask precautions should only be applied as appropriate for patients with possible respiratory infections. Masks are necessary for visitors and personnel if the patient is suspected to have or has confirmed tuberculosis. Personnel and visitors may wear masks for direct sustained contact with AIDS patients who are actively coughing and in whom the diagnosis of tuberculosis has been ruled out; however, there is no data to support respiratory transmission of Pneumocystis Carinii or cytomegalovirus to visitors or staff. These same guidelines apply for the wearing of masks by AIDS patients when they are outside their rooms; it is not recommended that patients wear masks when inside their rooms.

(6) For the purposes of infection control, a single room is not necessary for the care of a patient with AIDS unless he has additional illnesses which would customarily require a single room. However, a patient with AIDS must not be placed, under any circumstances, in a room with another immunocompromised or infected patient. Individuals may want or need a single room for reasons other than infection control and those other factors may be considered during patient placement.

(7) Procedures for cleaning and waste disposal:

(A) All contaminated (visibly soiled with potentially infectious material) disposable items are to be considered infectious waste and must be red-bagged.

(B) Contaminated linen is to be double-bagged and identified and tagged as "infectious".

(C) Needles and syringes should be disposed of in rigid wall, puncture resistant containers and red-bagged.

(D) Environmental surfaces contaminated with blood or other body fluid should be immediately cleansed with a disinfectant. Sodium hypochlorite (Clorox bleach diluted 1:10) is recommended if available.

(E) Patients' rooms do not routinely need to be high-cleaned unless grossly contaminated with blood or excretions. Questions concerning exceptions should be directed to the nearest infection control committee for the region.

(8) Procedures for equipment used for AIDS patients should be as follows:

(A) Lensed instruments should be sterilized as recommended by the Center for Disease Control.

(B) Central Supply should continue to pasteurize respiratory therapy tubing as it is presently doing.

(C) Any instrument which comes in contact with blood, secretions or excretions must be sterilized before reuse. This includes anesthesia instruments, such as a laryngoscope and endotracheal tubes.

(9) Isolation dietary trays are not necessary. Utensils will be cleaned in the regular way.

(10) The general guidelines for hospitalized patients, based on hepatitis B, should also be applied to the outpatient and emergency settings. Efforts should be made, however, to minimize direct contact to other severely immunocompromised patients. Specimen labelling, equipment sterilization, and disposition of equipment will be handled as for hospitalized patients. An outpatient with AIDS may use common waiting areas and bathroom facilities unless he has a symptomatic infection which would otherwise require isolation.

(11) Employees who have needle-stick injuries associated with a case of AIDS should be reported and ongoing records maintained. The injured employee should then be treated according to the protocol for needle-stick exposure for potential hepatitis. At the present time the task force does not recommend follow-up lymphocyte studies since numerous intercurrent illnesses have been shown to reverse the helper/suppressor ratio. Thus, information so devised has a potential for producing untoward anxiety, while not accurately predicting or identifying the disease.

(12) It is a recommendation of the task force that personnel should not be excused on their own request from working with or delivering care to AIDS patients. Employees who believe they are high risks for infection because of their own immune status should be encouraged to discuss their work responsibilities with their personal physician. If the physician determines that there are certain assignments the employee should not accept, this should be communicated in writing to the employing department for appropriate action, according to the institution's policies and procedures. Pregnant employees should not engage in the direct care of patients with AIDS because of the possible risks for acquiring cytomegalovirus.

AIDS IN JAILS

by James E. Lessenger, M.D., F.A.A.F.P.

Committee on Corrections & Detentions Health Care
California Medical Association

A. Target population:

- jail custody officers and administrators
- jail medical staff
- inmates

B. Definitions: see Appendix H

C. Peculiarities of the correctional environment:

● facilities:

- crowding
- extremely close surroundings
- multiple barriers to movement
- lack of air circulation
- communal facilities
 - dining and kitchens
 - laundry
 - laboratories and showers

● high incidence of violence

- assaults on prisoners and guards
- rapes

● secondary gain (the "con")

- prisoners are constantly trying to manipulate "the system" for secondary gain, and might claim having AIDS to gain special quarters and attention.

● Volatile emotions

- anger: may cause prisoner to use AIDS as a manipulative tool, i.e., if another prisoner has AIDS, the prisoner may try to drum up anger towards the guards by using this as a tool, charging indifference to medical care.

AIDS IN JAILS

James E. Lessenger, M.D.

Page 2

-fear: may lead to a prisoner assault on an AIDS victim if the prisoner mistakenly believes he is at risk of contracting the disease through casual contact. This could also result in riots.

- litigious environment

- reason tht jails exist

- attorneys may use AIDS for secondary gain - especially to obtain early release or special treatment for clients due to fear of the disease

- possibility of civil suits over AIDS exposures, discrimination, etc.

- involvement of judges and attorneys in the management and treatment process through court orders

- Insecurity regarding the length of jail stay - may be released momentarily or not for months to years.

D. Historical Perspective

- discovery

- AIDS is a new disease and the research has frequently been distorted due to homophobia masked as "morality" or "Christianity" as well as plague hysteria.

- In 1981 an association of kaposi's sarcoma and pneumocystis carinii pneumonia found in young homosexual or bisexual males, groups not previously at risk for such infections.

- Description of the syndrome (see Appendix H):

- description of the opportunistic infections

- Description of the population and spread (epidemiology)

- statistics and investigation (first American case was a heterosexual female IV drug user):

- homosexual/bisexual males, especially 25-40 years old

- IV drug users

- homophiliacs

- transfusion recipients (before ELISA screening)

- women with multiple sexual partners, especially if partners have direct or indirect contact with IV drugs or bisexuals.

- children of the above population groups

- vectors related to blood exchange:

- unprotected sexual intercourse
- IV drug use with shared needles
- pregnancy to fetus
- receiving contaminated blood products

-studies of medical personnel and family members show no HTLV-III/LAV antibody conversion unless the individual is a sexual partner of an antibody positive individual.

-"Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants or infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV." - MMWR, November 15, 1985, Centers for Disease Control.

- Causal agent

- virus, perhaps with co-factors or passenger virus
- thought to be Human T-Cell Leukemia Virus, otherwise known as Leukemia Associated Virus (HTLV-III/LAV virus)

- pathophysiology (how virus damages)

- takes over T-4 helper lymphocytes for viral reproduction utilizing reverse transcriptase enzyme; destroys T-4 helper cells in the process, leaving the body open to opportunistic infections.

- screening

- blood (ELISA, follow-up with Western Blot if positive)
 - ELISA, which stands for Enzyme Linked ImmunoSorbent Assay, detects the presence of HTLV-III/LAV antibody in a given sample of blood. The test contains a highly specific dye which will bond to the protein coat of the HTLV-III/LAV virus, changing the virus's color to a dark blue. ELISA is a sensitive test, meaning it may detect other viruses in the blood (called false positives), but will not fail to detect the presence of HTLV-III virus.

- no effective test yet devised for people (complicated by virus's long incubation period)

- treatment

AIDS IN JAILS

James E. Lessenger, M.D.

Page 4

- no effective treatment at this time
- most likely course would be drug treatment involving an anti-viral agent combined with an immune augmentor.

● cure

- complicated by AIDS being caused by a retrovirus; vaccines have only been developed for DNA composed viruses
- previous attempts at developing vaccines for other viruses have failed.

● clinical course of disease

- exposure, infection, syndrome link

● prevention and eradiction

- AIDS is a highly preventable disease
- prevention through education about safe sex (condoms, activities without fluid exchange)
- prevention through legalizing purchase of needles
- many barriers to education
 - fiscal restraints on health programs
 - a "let them die and good riddance" attitude held by a very vocal minority.

● Recap

- virus (usually requires a "load" for exposure)
- spread by blood and intercourse
 - similar to hepatitis B
- long incubation period (6 months to 2 years)
- venereal disease
- as yet incurable and untreatable
- positive antibody test may or may not preceed AIDS

E. Custody circumstances and recommendations:

- problem is determining which class the prisoner falls into
 - exposed
 - incubation period (infectious)
 - active AIDS (and infectious)
 - risk group (may or may not be exposed or infected)
- the answer is, you don't know
 - unless the prisoner tells you and he or she may be misinformed or lying.

-prisoner may have been exposed years ago without developing the disease

-MERELY ARRESTING OR BEING IN THE SAME ENVIRONMENT WITH A PERSON WITH AIDS WILL NOT RESULT IN EXPOSURE. DISEASE CAN ONLY BE CONTRACTED BY SEXUAL OR BLOOD CONTACT.

-A PERSON'S SEXUALITY IS NOT TO BE EQUATED WITH EXPOSURE OR INFECTION TO AIDS.

● For Officers: what do you do if:

-dealing with a member of a risk group?

- use the same precautions you should use with all prisoners
- avoid sexual and blood contact.

-prisoner states he or she has AIDS

- immediate protective custody and immediate medical referral

-prisoners states he or she has been exposed

- immediate protective custody and routine medical referral

-special circumstances

- arrest - none
- resisted arrest - avoid blood contact (if officer has lacerations and arrestee is bleeding profusely)
- booking - none (if prisoner is known AIDS patient, keep in protective custody)
- pat search - none
- body cavity search - gloves
- fights - avoid blood
- trustee - none
- CPR - AIDS is not usually present in saliva; gut enzymes kill the virus; and no case has been documented where saliva was the suspected vector. However, a real danger exists for hepatitis B and TB, so using a mask may be beneficial.

● Measures for AIDS prevention in correctional facilities

-use Appendix A

● Officers jail protocol for receiving/screening for AIDS

-use Appendix B

● Nurses protocol screening for AIDS

-use Appendix C

● Supplemental receiving/screening for AIDS

-Use Appendix D

AIDS IN JAILS

James E. Lessenger, M.D.

Page 6

- Protocol for likely or confirmed AIDS prisoners (with symptoms)
-include Appendix E
- Custody staff protocols for dealing with AIDS patients
-include Appendix F
- Medical staff protocols for infection control while caring for AIDS patients
-include Appendix G

APPENDIX A
MEASURES FOR AIDS PREVENTION IN CORRECTIONAL FACILITIES

1. Wash hands with soap and water before and after contact with inmate.
2. Wear gloves when:
 - a. performing cavity search
 - b. contact with blood or semen may occur
 - c. drawing blood
 - d. performing first aid
3. Wash hands with soap and water after contact with body fluids.
Handwashing is one of the most effective preventive measures for all infectious diseases, and cannot be stressed enough in both correctional and medical environments.
4. Avoid puncture wounds:
 - a. Care should be taken with searching suspects or handling personal property of inmates (e.g., needle in purse or pants' pockets).
 - b. If wound occurs, wash immediately with soap and water, then notify supervisor (includes bites).
5. Clean body fluid spills (e.g., blood):
 - a. Wear gloves.
 - b. Use paper towels to clean up spills (dispose in contamination bag).
 - c. Wipe area with 0.5% solution of bleach or Comet liquid cleaner (any common household disinfectant, used according to directions, will perform adequately).
 - d. Wash hands with soap and water.
6. Safety razors and toothbrushes should not be shared. If an electric razor is used, the heads should be cleaned with a .5% solution of bleach between inmate use.
7. Due to potential transmission of cytomegalovirus, pregnant females should not give direct care to AIDS inmates.

Special Precautions for Blood Drawing of High Risk Prisoners:

- A. Blood specimen should be placed in evidence envelope (sobriety) by nurse.
- B. Clean spills on outside of specimen container with 0.5% solution of bleach.

AIDS IN JAILS

James E. Lessenger, M.D.

Page 8

Special Precaution for CPR:

- A. Use ambubag for artificial respirations.

APPENDIX B
PROTOCOL
RECEIVING/SCREENING
FOR AIDS

All arresting officers are to refer arrestees and new prisoners to the nurse when the following is suspected or apparent:

1. IV drug abuse
2. Prostitution
3. Those who state they have AIDS or have been exposed to the disease.

The nurse will complete a Supplemental Receiving/Screening form.

APPENDIX C
PROTOCOL
NURSES SCREENING FOR AIDS

Procedure:

1. Complete the Supplemental Receiving/Screening form.
2. Prisoner with significant history or physical findings (example, several "yes" answers to Part II of the Supplemental Receiving/Screening form) will be:
 - a. Housed in a single cell in the Infirmary;
 - b. Handled as per "hepatitis precautions";
 - c. Respiratory precautions (mask) will be taken if inmate has a productive or chronic cough;
3. Prisoner will be seen at next MD sick call.

APPENDIX D
SUPPLEMENTAL RECEIVING/SCREENING
FOR AIDS

PART I:

	Yes	No
IV Drug Abuse	—	—
Homosexuality	—	—
Prostitution	—	—

PART II:

	Yes	No
Unexplained weight loss		
(Amount) _____ pounds in		
_____ (months/weeks)	—	—
Enlarged lymph nodes	—	—
Fever (nightsweats), achy, malaise	—	—
Diarrhea (periodic episodes)	—	—
Chronic fatigue	—	—
Anorexia	—	—
Lesions, sores or white spots in mouth (current, or history)	—	—

APPENDIX E
LIKELY OR CONFIRMED
AIDS PRISONERS (WITH SYMPTOMS)

1. Isolation with "hepatitis precautions" shall be implemented on all potential or confirmed AIDS inmates - single cell.
2. Respiratory precautions (mask) will be taken if inmate has productive cough.
3. Wash hands with soap and water before and after patient contact.
4. Wear gloves when contact with blood or semen is likely to occur.
5. Dispose of needles properly:
 - a. Place in a puncture-resistant container;
 - b. Do not recap needle;
 - c. Do not break or cut the needle!
6. Keep ambubag outside cell.
7. Place linen in disposal bag. Place disposal bag in red bag; label "infectious material."
8. Place used gloves, masks, etc. in doubled, red bag. Dispose in infectious waste container.
9. No dietary precautions are necessary.
10. Pregnant females should not care for AIDS inmates.

APPENDIX F
CUSTODY STAFF PROTOCOLS FOR
DEALING WITH AIDS PATIENTS

AIDS is a viral disease which destroys part of the body's immune system and makes the AIDS patient susceptible to serious cancers and infections. Many of the infections seen in AIDS patients also occur in patients who have undergone chemotherapy (PCP), or in elderly patients (kaposi's sarcoma). AIDS is contracted by intimate exposure to blood or sexual secretions of people infected (e.g., sexual intercourse, sharing of needles, infusion of contaminated blood products). AIDS is not spread by casual contact, nor is the virus significantly present in saliva, rendering this mode of potential transmission highly unlikely.

POLICY: Patients who are diagnosed or suspected of having with AIDS will be transferred to a medical unit. While patients are awaiting transfer, care will be taken to protect both the patient as well as the other inmates. Patients with AIDS or suspected of having AIDS will be housed in the infirmary while awaiting transfer.

PROCEDURES:

1. Any patient with or suspected of having AIDS will be housed in the infirmary pending transfer to medical unit.
2. No protective clothing is needed while escorting or transporting AIDS patients. The only exception occurs when the AIDS patient has a contagious respiratory infection, such a tuberculosis, when the patient will wear a mask.
3. No special dietary trays or utensils are needed for AIDS patients.
4. Laundry from AIDS patients will be handled in a routine fashion unless it is obviously contaminated by blood or body secretions. Contact medical staff to handle contaminated laundry.
5. Due to possible transmission of cytomegalovirus, pregnant staff should not work with AIDS patients.
6. Handwashing is one of the most effective means to prevent spread of all infective conditions. Custody staff should wash hands frequently with soap and water, especially after tactile contact with inmates, such as pat-down lines.
7. Cover open sores on hands with bandages or dressings when working pat-down lines.

AIDS IN JAILS

James E. Lessenger, M.D.

Page 14

8. If the skin is cut while searching inmates, immediately wash the injury thoroughly, report to the supervisor and fill out an incident report.

APPENDIX G
MEDICAL STAFF PROTOCOLS FOR INFECTION CONTROL
WHILE CARING FOR AIDS PATIENTS

AIDS is a blood-borne, viral infection that causes immunosuppression and consequent susceptibility to serious, ultimately lethal cancers and opportunistic infections. It is contracted by intimate exposure to blood or semen of AIDS patients (sexual intercourse, sharing of needles, infusion of contaminated blood products).

OBJECTIVE: Precautions will be taken by medical staff caring for AIDS and AIDS-Related Complex (ARC) patients to protect against transmission of AIDS to susceptible individuals and to protect AIDS patients from contracting serious infections.

POLICY: Patients who are diagnosed with AIDS or ARC will be transferred to a medical unit for care and permanent housing. There will be no exceptions. While the patients are awaiting transfer, care will be taken to prevent possible transmission of AIDS. Patients with or suspected of having AIDS or ARC will be housed in the infirmary pending transfer.

PROCEDURES

1. When AIDS is suspected in a patient, the physician will obtain the following tests: helper/suppressor T-cell ratios; CBC, including platelets; serum protein levels.
2. When AIDS is confirmed or if the lab test results are compatible with AIDS, the physician will contact the Chief Medical Officer, who will arrange transfer of the patient to a medical unit.
3. Any patient with AIDS, AIDS-related complex (ARC) or suspected AIDS will be admitted to the infirmary pending transfer.
4. A single room for an AIDS or ARC patient, or a patient suspected of having AIDS or ARC, is not necessary unless the patient requires reverse isolation. Do not house the patients with others who have infections.
5. Gloves are to be worn by staff when they handle blood or other body secretions from AIDS, ARC, or AIDS/ARC suspected patients.
6. Staff caring for AIDS, ARC, or AIDS/ARC suspected patients will wash hands before and after direct patient care.
7. Gowns will be worn by staff caring for suspected or actual AIDS/ARC patients only if staff is involved in a procedure that might involve

AIDS IN JAILS

James E. Lessenger, M.D.

Page 16

gross contamination with blood or body secretions, such as treatment of a draining wound.

8. Pregnant staff will not be assigned to care for AIDS or ARC patients.
9. Masks will be worn by staff caring for AIDS, ARC or AIDS/ARC suspect patients only if the patients have a contagious respiratory infection, such as tuberculosis.
10. Laboratory specimens collected from AIDS, ARC or AIDS/ARC suspect patients will be marked with "H/A Precaution" and placed in impervious bags for transport. Lab slips will also be marked "H/A Precautions" and attached outside the bags.
11. Needles used on AIDS, ARC, or AIDS/ARC suspect patients will not be bent or recapped. Needles will be disposed of in puncture-resistant containers.
12. No mouth pipetting shall be performed on specimens from AIDS, ARC or AIDS/ARC suspect patients.
13. Centrifuge safety caps will be placed on specimens from AIDS, ARC, or AIDS/ARC suspect patients during centrifuging.
14. AIDS/ARC, (or suspected) patients may use showers and bathtubs. Showers and tubs will be cleaned by infirmary porters and then decontaminated with 1:10 dilution of household bleach or another disinfectant.
15. Infirmary porters will clean the rooms of AIDS, ARC or AIDS/ARC suspect patients except when there is a large spill of blood or other body secretion(s). Large spills will be cleaned by staff who will immediately wipe up the spill with paper towels using gloved hands. The paper towels will be disposed of in an infectious waste container. This procedure is appropriate to all infectious diseases and should in no way be misconstrued as inferring that the secretions of AIDS patients are of particular "risk" or that casual contact is a factor (it is not) in AIDS transmission. The area will then be decontaminated with 1:10 dilution of 5.25% sodium hypochlorite (bleach).
16. Linen contaminated with blood or other secretions from suspected or actual AIDS/ARC patients must be placed in hot water soluble laundry bags. Non-contaminated laundry does not require special handling.
17. No special dietary trays or utensils are required for AIDS, ARC or AIDS/ARC suspect patients.
18. Reusable instruments must be sterilized or pasteurized.

AIDS IN JAILS

James E. Lessenger, M.D.

Page 17

19. Staff sustaining needlesticks or conjunctival or mucus membrane exposures to blood or secretions from AIDS/ARC patients must thoroughly wash the area immediately, then report the injury to his/her supervisor and fill out an incident report.

APPENDIX H
AIDS DEFINITIONS AND RECOMMENDATIONS

A. Definitions:

1. AIDS: A disease at least moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause of demonstrated resistance to that disease. Such diseases include pneumocystis carini pneumonia, kaposi's sarcoma and other serious opportunistic infections such as toxoplasmosis, CMV or TB.
2. AIDS Related Complex (ARC): AIDS Related Complex, or ARC, is a recently created definition to include those patients with less severe disease (prodromal period). ARC is actually the same disease as AIDS, the difference being that AIDS patients qualify for medical assistance while many ARC patients do not. ARC is defined by the Centers for Disease Control as exhibiting any two clinical and two laboratory abnormalities from the following lists:

CLINICAL (3 months or more in the absence of other identifiable cause):

- Fever (100 degrees F or greater)
- Lymphadenopathy
- Diarrhea
- Nightsweats
- Fatigue (chronic)
- Weight loss (10 percent of body weight or more than 15 pounds)

LABORATORY

- Depressed helper T-cell ratio
- Increased suppressor T-cell ratio
- One of the following: leukopenia, thrombocytopenia, absolute lymphopenia, or anemia;
- Elevated serum globulin
- Depressed blastogenesis (pokeweed and PRA)
- Abnormal skin tests (using multitest or equivalent)

- B. Infection Control: Patients meeting the Centers for Disease Control definition of AIDS or ARC definition, or any patient being evaluated for possible AIDS, should be handled according to the "Guidelines for Infection Control for AIDS." The patient should be admitted to the infirmary for evaluation of his having a possible communicable disease.
- C. Reporting: AIDS is reportable to the California Health Department and the Centers for Disease Control.

AIDS IN JAILS

James E. Lessenger, M.D.

Page 19

- D. **Transmission.** AIDS is spread only by very intimate (sexual) contact involving the exchange of body fluids, the sharing of needles in IV drug usage, or by blood or blood product transfusion. **THE FOLLOWING MODES OF TRANSMISSION ARE NOT APPLICABLE TO CONTRACTING AIDS: AIRBORNE, FOODBORNE, SOCIAL, OCCUPATIONAL OR ENVIRONMENTAL.**
- E. **Isolation Technique.** In accordance with American Hospital Association and Centers for Disease Control guidelines.
- (1) All suspected or known AIDS or ARC patients require blood/body fluid precautions (a single room is preferred).
 - (2) AIDS or ARC patients with suspect tuberculosis or other airborne disease should be placed on respiratory isolation until ruled out. Those with diarrheal disease should be placed on enteric precautions as well as blood and body fluid precautions.
 - (3) In the ambulatory care setting, suspected or known AIDS or ARC patients may use the same waiting areas and bathrooms as other patients unless the presence of other infections require special precautions, especially for the patients who are particularly vulnerable to opportunistic infections.
- F. **Laboratory Specimens.** All specimens from known or suspected AIDS or ARC patients should be labeled to alert for blood precautions and placed in an impervious bag. In handling specimens, use gloves and good handwashing technique and take care to prevent needlesticks and cuts.
- G. **Guidelines for Patient Care.** The following guidelines have been adopted by the Infection Control Committee of the University of California, San Francisco, and are consistent with the recommendations of the U.C. Task Force on AIDS, dated June 2, 1983. These guidelines have been adopted by the Department of Corrections, State of California.
- (1) The definition of an AIDS patient is as outlined by the Centers for Disease Control in their category A designation, that is, "a disease at least moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause of diminished resistance to that disease. Such diseases include Pneumocystis Carinii pneumonia, Kaposi's Sarcoma and other serious opportunistic infections." It is recommended that patients with the AIDS related Complex or those being evaluated for the possibility of AIDS should be included for infection control purposes.
 - (2) The responsibility for identification of the patient in the above categories should rest with the attending physician. It is also

the responsibility of the physician to report the diagnosis to the Public Health Department since Category A AIDS is now a reportable disease. The attending physician should also assume responsibility for consulting with the Infection Control Unit, of determining when appropriate precautions and/or isolation measures can be discontinued.

- (3) Evidence to date indicates that the transmission of the AIDS virus is similar to that of the hepatitis B virus; that is, it requires direct contact with blood or body secretions. There is no evidence of airborne transmission, and not a single health care provider has ever developed AIDS or ARC, and therefore infection control policies and procedures appropriate for patients with hepatitis B should be applied to patients with AIDS.
- (4) The patients conforming to the definitions above should be placed on Blood and Excretion precautions. Specimens from the patients should be labeled "H/A Precautions" and placed in an impervious bag or container for transport.
- (5) Since there is no evidence of airborne transmission of an AIDS virus, mask precautions should only be applied as appropriate for patients with possible respiratory infections. Masks are necessary for visitors and personnel if the patient is suspected to have, or is confirmed to have, tuberculosis. Personnel and visitors may wear masks for direct sustained contact with AIDS patients who are actively coughing and in whom the diagnosis of tuberculosis has been ruled out; however, pneumocystis carinii or cytomegalovirus are infections not transmitted through the air or through the unbroken skin. These same guidelines apply for the wearing of masks by AIDS patients when they are outside their rooms; it is not recommended that patients wear masks when inside their rooms.
- (6) For the purposes of infection control, a single room is not necessary for the care of a patient with AIDS unless he has additional illnesses which would customarily require a single room. However, a patient with AIDS must not be placed, under any circumstances, in a room with another immunocompromised or infected patient. Individuals may want or need a single room for reasons other than infection control and those other factors may be considered during patient placement.
- (7) Procedures for cleaning and waste disposal:
 - (a) all contaminated (visibly soiled with potentially infectious material) disposable items are to be considered infectious waste and must be red bagged.

(b) Contaminated linen is to be double-bagged and identified and tagged as "infectious."

(c) Needles and syringes should be disposed in rigid wall, puncture-resistant containers and red bagged.

(d) Environmental surfaces contaminated with blood or other body fluid should be immediately cleansed with a disinfectant. Sodium hypochlorite (clorox bleach diluted 1:10) is recommended if available.

(e) Patients' rooms do not routinely need to be high-cleaned unless grossly contaminated with blood or excretions. Questions concerning exceptions should be directed to the nearest infection control committee for the region.

8. Procedures for equipment used for AIDS patients should be as follows:

(a) lensed instruments should be sterilized as recommended by the Centers for Disease Control.

(b) Central supply should continue to pasteurize respiratory therapy tubing as it is presently doing.

(c) Any instrument which comes in contact with blood, secretions or excretions must be sterilized before reuse. This includes anesthesia instruments, such as a laryngoscope and endotracheal tubes.

9. Isolation dietary trays are not necessary. Utensils will be cleaned in the regular way.

10. The general guidelines for hospitalized patients, based on hepatitis B, should also be applied to the outpatient and emergency settings. Efforts should be made, however, to minimize direct contact to other severely immunocompromised patients. Specimen labeling, equipment sterilization, and disposition of equipment will be handled as for hospitalized patients. An outpatient with AIDS may use common waiting areas and bathroom facilities unless he has a symptomatic infection which would otherwise require isolation.

11. Employees who have needle-stick injuries associated with a case of AIDS should be reported and ongoing records maintained. The injured employee should then be treated according to the protocol for needle-stick exposure for potential hepatitis. At the present time, the task force does not recommend follow-up lymphocyte studies such numerous intercurrent illnesses have been shown to reverse the helper/suppressor ratio. Thus, information so devised has a potential for producing

AIDS IN JAILS

James E. Lessenger, M.D.

Page 22

untoward anxiety, while not accurately predicting or identifying the disease.

AIDS HEALTH EDUCATION PACKAGE

Staff has asked for assistance in the development of three new Health Tips on AIDS:

1. AIDS Contagibility
2. HTLV-III Antibody Testing: Questions and Answers
3. Children and AIDS

CALIFORNIA MEDICAL ASSOCIATION

Interoffice Memorandum

To Mark Madsen
From Jill Tyler *MT*
Subject AIDS Health Education Package

Date 17 January 1986

Below is a proposed timeline for the Health Tips series on AIDS. Along with the two present Tips, #426 and #439, we plan to prepare and distribute three more topics: "AIDS Contagibility," "HTLV-III Antibody Testing: Questions and Answers," and "Children and AIDS." If these titles are inappropriate, or if others should be considered, please let me know.

January 17 - February 12	Tips written
February 12 - March 5	Physician approvals and suggestions obtained for all five Tips and Resource Directory
March 5 - March 19	Printing and distribution

In addition to the Tips, I would like to update our AIDS resource directory - a listing of referral and resource facilities throughout the state. If you or members of the Committee have any suggestions for other materials that should be included in the Health Education package, please let me know.

This package will be distributed to the regular Health Tips mailing list of 4,000 persons throughout the country. Please advise of suggestions for other distribution possibilities.

Pending comment and information from you, I will try to have rough outlines of these Tips to you by January 30. I would also appreciate your suggestions for physicians and other professionals, in addition to the Task Force, qualified to review these articles.

Thanks for your help.

CALIFORNIA MEDICAL ASSOCIATION

Interoffice Memorandum

To Mark Madsen
From Charlotte Newhart
Subject AIDS, Pregnant Women and Newborns

Date November 26, 1985

At a meeting last week at the California Conference of Local Directors of Maternal, Child and Adolescent Health, a great deal of discussion centered on infants who are born to mothers infected with the AIDS virus. Enclosed for information is a memo to California Health Officers from James Chin, MD of the State Department of Health Services Infectious Disease Branch.

The MCAH directors have a number of concerns. First, how to test high risk women so that if they are infected special precautions can be taken by staff in the delivery room. Second, the fetus and newborn seem to be at extremely high risk for contracting the disease and it tends to reveal itself at 4 months with symptoms of failure to thrive, thrush, and GI problems. In addition, the child should not be immunized with live viruses.

In addition, there are the obvious social issues regarding adoption, foster care and sterilization issues which I know concern you.

#

CN:jr
Attachment

DEPARTMENT OF HEALTH SERVICES

2151 Berkeley Way, Rm. 708
Berkeley, CA 94704
(415) 540-2566

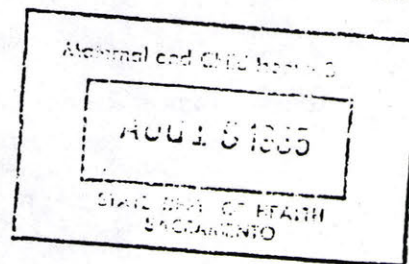
*Cite
AIDS*

August 14, 1985



To: California Health Officers

California AIDS Surveillance
and Epidemiology Personnel



A very important AIDS risk group which has been documented is that of infants who are born to mothers who are infected with the AIDS virus (HTLV-III). Epidemiologic and laboratory data have shown the transmissions of this virus from an HTLV-III infected mother to her child, before, at, or shortly after the time of birth. Although cofactors contributing to AIDS in adults are not known with certainty, it is believed that the undeveloped immune system of a newborn contributes importantly to the development of disease in infants who are infected with the HTLV-III virus. Although not universal, the risk of infection to a baby born to an infected mother appears high and the prognosis for the infant once infected, appears poor.

Because of the potentially disastrous result for the fetus when an expectant mother is infected with the AIDS virus, the Infectious Disease Branch of the State Department of Health Services advises that special health information be given to women of child bearing age who are at increased risk for infection with the AIDS virus. Such information is essential for women who are found to be HTLV-III antibody positive.

It has been well documented that infection with the AIDS virus may be sexually transmitted. One study (military) indicates that a majority (70%) of females (wives) steadily exposed to males with AIDS over a period of months will develop antibodies to the HTLV-III virus.

Groups of women at increased risk to conceive an infant who might develop AIDS include:

1. Female AIDS patients.
2. IV drug abusing females with or without positive antibody tests for HTLV-III.
3. Females receiving a blood transfusion from a donor who is subsequently found to be HTLV-III antibody positive.

4. Females with sexual exposure to men at increased risk of infection, ie:
 - a. male hemophiliacs
 - b. men with multiple transfusions
 - c. IV drug abusing men
 - d. bisexual men
5. Females with multiple episodes of STD's.

Such females should be identified and followed by serologic examination and educated about AIDS. We believe that this difficult and sensitive task is medically and legally appropriate. Education is equally important for women in the above groups who test negative as well as for those who are positive for HTLV-III antibodies.

Suggested protocol for implementation:

1. Male AIDS patients or any male who is found to be HTLV-III antibody positive should be interviewed for steady "female sexual partners over the previous five year period." Steady is defined as an identifiable and locatable female sex partner who was exposed on more than one occasion.
2. Identified sexual consorts should be confirmed by matching with detailed physical description and dates of sexual exposure.
3. The woman should be given HTLV-III antibody test information and encouraged to obtain the HTLV-III antibody test.
 - a. through her private physician (with or without insurance)
 - b. a local county health department clinic if they offer the test
 - c. at an alternate test site
4. A consent and release form should be signed by the woman and a public health worker should be available to discuss the significance of the test results with her and her physician if needed.
 - a. If a woman is found to be positive for HTLV-III antibodies she should be advised to defer pregnancy. Intensive education should be directed at such women on how to prevent transmission of HTLV-III to sex and drug using partners.

- b. If a woman is found negative, she should be advised to consider a repeat test in 6-12 months. Intensive education should be directed at these seronegative women as to how they can keep from being infected with the AIDS virus.
 - c. If the test remains negative, pregnancy may be considered if exposure to high risk sexual partners has not continued.
- 5. Referral for psychological support is imperative because of the emotional distress or anxiety that may accompany notification of women about their potential risks.
 - 6. Referral for clinical evaluation may also be necessary.

State AIDS Field Representatives are available to assist you in providing the services outlined above.

Sincerely,

James Chin, M.D.

James Chin, M.D., Chief
Infectious Disease Branch

cc: James W. Curran, M.D., Director
Harold Van Patten
Infectious Disease Branch
Aids Branch
Centers for Disease Control
Atlanta, GA 30333

Dr. Tom Peterman
AIDS Activity
Bldg. 6, Rm. 285
1600 Clifton Road
Atlanta, GA 30333

Robert Cole, Acting Chief
Maternal and Child Health Branch
714 P Street, Room 740
Sacramento, CA 95814

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
SACRAMENTO, CA 95814



October 10, 1985

The Honorable Bill Honig
Superintendent of Public Instruction and
Director of Education
Department of Education
721 Capitol Mall, Room 524
Sacramento, CA 95814

Dear Superintendent Honig:

In response to your request of September 13, 1985, for advice on whether children with Acquired Immune Deficiency Syndrome (AIDS) present a public health hazard if they are allowed to attend public school, please be advised that our expert scientific AIDS Task Force has completed its review of this matter. Based on their recommendations, input from a variety of other sources, and my own review of relevant medical literature, I would like to now report to you on this Department's assessment of the public health evidence regarding transmission of AIDS.

Since its initial recognition in 1981, a tremendous amount of information has accumulated on AIDS. The data compiled on the over 13,000 AIDS cases that have occurred to date, along with other clinical, laboratory and epidemiologic studies, have confirmed that the HTLV-III/LAV virus is transmitted primarily through sexual contact and/or parenteral exposure to infected blood or blood products. The modes of transmission are essentially identical to that of hepatitis B, and, indeed, the identified risk groups in this country for AIDS are virtually the same as for hepatitis B - i.e., homosexual and bisexual men, intravenous drug abusers, persons who have received contaminated blood or blood products, persons from endemic areas, sexual contacts of all of the above, and infants born to infected mothers.

The major difference between hepatitis B virus and HTLV-III/LAV virus transmission is that an infection with the AIDS virus is much more difficult to acquire. The evidence for this includes the fact that there has been no documented transmission of AIDS to any of the household contacts (other than sexual contacts) of AIDS patients that have been followed-up; there has been no transmission of the disease to foster mothers who have cared for infected infants; and there has been no transmission of the disease to the thousands of health care workers who have taken care of AIDS patients (other than those who are in identified high risk groups), including, except for the two recently identified suspect cases, several hundred health care personnel who have had documented needle-stick exposure to AIDS cases. There is no

The Honorable Bill Honig
October 10, 1985
Page 2

evidence that AIDS can be transmitted by the respiratory route, through saliva or tears, fecal-orally, or by insects or casual person to person contact.

Although it is not entirely clear why it is harder to "catch" AIDS than hepatitis B, the evidence from several different lines of investigation seems to verify this. Probable reasons include the much lower virus titers found in the blood of AIDS patients (and, consequently, their lower infectivity) and the apparent need for one or more co-factors (e.g., an altered cellular immune system) to be present for infection to occur. These factors would account for the consistent pattern of AIDS infection in California.

Although the similarities of transmission between hepatitis B and AIDS are useful in understanding the epidemiology of AIDS and, consequently, in devising recommendations regarding the public health control of the disease, the much greater severity of infection from the AIDS virus requires that we be much more cautious in accepting any risk. Indeed, thus far, AIDS has been found to be incurable and invariably fatal, and no likely prophylactic or therapeutic panaceas are imminent. And even though there is overwhelming consensus among public health authorities that the risk of transmission via casual person to person contact, e.g., in the usual school setting, is essentially nonexistent, the risk at this time is not quantifiable (such as we are accustomed to doing with infectious or toxic contaminants in food, drinking water and the workplace), and we cannot say unequivocally that the risk is zero.

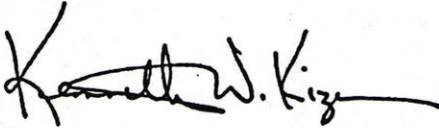
Given the innumerable different and unique scenarios that are possible, the evolving knowledge about this disease, the relative paucity of AIDS cases among school children (only five in California currently), and the number of educational considerations which go beyond medical concerns, your department, the State Board of Education and local elected school boards may wish to address this question on a case-by-case basis where the specific behavior and physical condition of the affected child, the relevant educational, legal and social concerns, and the various educational alternatives can be considered along with existing medical and scientific data to fashion a policy designed to protect the wellbeing of the affected child, the wellbeing of those children attending the public school in question, and the overall educational process in the specific community.

I hope the above is useful to you as you formulate your policy on this issue. It is my understanding that you have also convened a special AIDS advisory group which will be making recommendations directly to you and that members of your staff have been in communication with the federal Centers for Disease Control (which has promulgated national guidelines on this issue) and other state and local health departments for input on this subject. I would strongly encourage you to continue to solicit such broad based input, for, as you know, this is a complex matter which involves many educational and social issues in addition to the medical ones.

The Honorable Bill Honig
October 10, 1985
Page 3

If I can be of further assistance, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Kenneth W. Kizer". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Kenneth W. Kizer, M.D., M.P.H., F.A.C.E.P., F.A.C.P.M.
Director

Attachment



SAN JOSE UNIFIED SCHOOL DISTRICT

1605 PARK AVENUE, SAN JOSE, CA 95126-2196 (408) 998-6057

OFFICE OF THE SUPERINTENDENT

DEC 26 1985

December 19, 1985

Mr. Mark Madsen
Coordinator
Task Force on AIDS
California Medical Assn.
P.O. Box 7690
San Francisco, CA 94120-7690

Dear Mr. Madsen:

Enclosed is a copy of our recently approved policy on AIDS. I will check to see if we can send a copy of our handbook to you as well.

Thank you for your help.

Sincerely,

Aaron Seandel

AS1:123sd



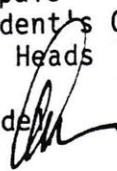
SAN JOSE UNIFIED SCHOOL DISTRICT

1605 PARK AVENUE, SAN JOSE, CA 95126-2196 (408) 998-6057

OFFICE OF THE SUPERINTENDENT

November 12, 1985

Memo To: All Principals
Superintendent's Cabinet
Department Heads

From: Aaron Seander 

Enclosed is a corrected copy of the Board Policy on AIDS adopted at the November 7 meeting. Please discard the copy sent on November 8.

AS/sd
AS1:081



SAN JOSE UNIFIED SCHOOL DISTRICT

1605 PARK AVENUE, SAN JOSE, CA 95126-2196 (408) 998-6057

OFFICE OF THE SUPERINTENDENT

November 12, 1985

Policy on AIDS - Adopted by Board of Education November 7, 1985

- A. Students: Decisions regarding the educational setting for the child who is infected with AIDS virus will be considered on a case by case basis, shall be based on the behavior, neurologic development and physical condition of the child, and the health and safety of others. The Superintendent shall decide the appropriate educational setting after reviewing the recommendation of the school district physician/consultant that is based upon consultation with public health personnel, the child's physician, parents and school officials.

Because there has been no evidence of transmission of AIDS virus by other than sexual contact or blood products, most children with AIDS will be allowed to attend school in an unrestricted setting. For these children, the benefits of an unrestricted educational setting outweigh the risk of acquiring other potential harmful infections in the setting. For other children, whose oral behavior and incontinence could increase the theoretical risk of transmission, an alternative appropriate education setting will be provided.

- B. Employees: Decisions concerning an employee with AIDS will be considered on individual, case by case, basis. The District physician/consultant, in conjunction with the employee's personal physician, and public health personnel shall determine that the employee is free of transmissible infection and does not pose a risk to students or other employees in the course of performing his or her duties.

The Superintendent will consider the recommendation of the District's physician/consultant in making the final determination on the appropriate employee decision.

- C. District Task Force: A District Task Force on AIDS shall be established to serve for one year from its appointment. While in existence, the Task Force will make an annual report of its activities to the Board. Before the conclusion of each term, the Superintendent, or designee, shall recommend whether the Task Force should continue in

existence, its composition, and what its goal should be. The goals of this task force will be:

1. To stimulate educational programs on AIDS for:
 - a. District employees
 - b. Parents
 - c. Students
 - d. Community
 2. To monitor programs, services, and policies developed to deal with AIDS in the schools, and to ensure that they reflect the latest knowledge regarding AIDS.
 3. To maintain liaison with other public and private health/social service agencies and groups whose work relates to AIDS.
- D. Notice: Notice to the school community in which a student or employee has been present will be given if the County Health Department has determined that the infected person presents a risk of transmission of the disease to others and the District has been so notified.

ASID5:cf



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

December 16, 1985

Ronald J. Pion, M.D.
Chairman and Director, Medical Affairs
Hospital Satellite Network
1901 Avenue of the Stars, Suite 1050
Century City
Los Angeles, California 90067

Dear Ron:

Thanks for your letter of December 4 which arrived while I was at the AMA mid-year meeting in Washington.

We, too, have had extremely positive responses to the recent AIDS documentary.

I appreciate your writing, because -- after all the hours and hours of effort expended by the people here, particularly Ron Lopp of our staff -- there was a strong suspicion that HSN was "using" CMA, and was almost totally insensitive to providing us recognition or credits in the show.

Your suggestion for revised credits sounds fine, though it would have been nice to have been included when the show was aired initially -- something which of course is too late. As you know, there also was concern over your pamphlet on the documentary, and the failure to (1) clear copy with those who made the show possible (people at CMA and at S.F. General Hospital), and (2) also include appropriate credits for CMA. This made it impossible for us to use the pamphlet in promoting the screening we held at the AMA meeting for fear that some of our physicians might raise hell over the failure of HSN to adequately acknowledge our involvement.

The demands of my new job here at CMA make it impossible for me to get directly involved in our projects with HSN. But I hope that the long friendship you and I have enjoyed will enable us to help resolve any future differences or problems that may arise -- even though I hope everyone would profit from the experiences over this AIDS documentary and the other difficulties we've had in the past (such as changes without notification in terms of royalties, etc.).

I think we both want our relationship to be mutually-rewarding, Ron. The insensitivity on the part of some of your people has caused us to wonder if it's really worth it. We have many opportunities for public relations

Ronald J. Pion, M.D.

Page 2

December 16, 1985

and communications activities that require far less effort, yet provide considerably higher visibility for CMA. I don't mean we should get undue credit for our efforts, but when we ask our members for dues, they ask why we're not getting more visibility (and recognition) for the things we do, PR-wise.

I didn't mean to ramble on, Ron, but I felt obliged to let you know I hope HSN and CMA can continue to collaborate on a variety of projects for many years to come.

If you ever get up this way, I still hope we might get together for that long-postponed meeting we talked about last summer.

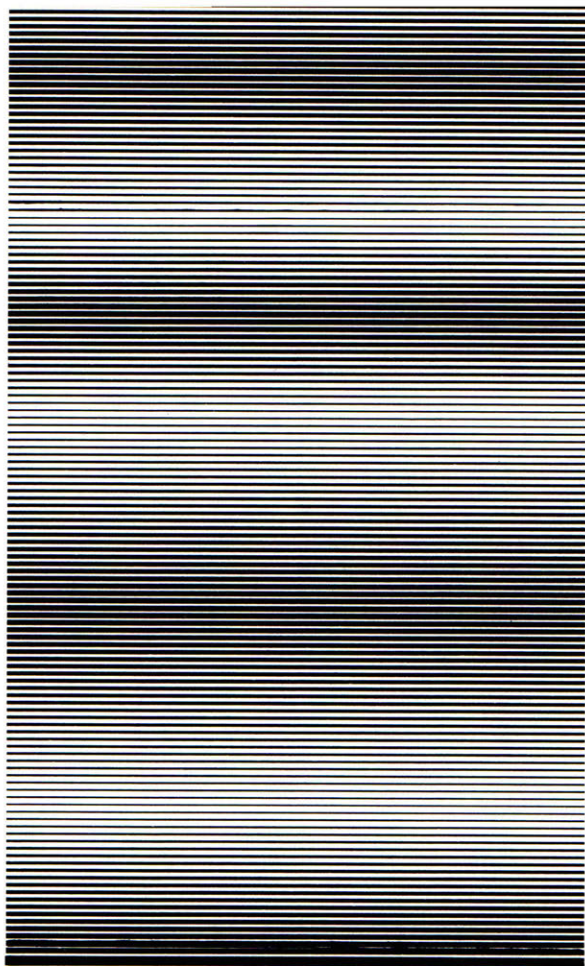
Best wishes for the Holidays.

Sincerely,

Robert H. Elsner
Executive Vice President

RHE:aw

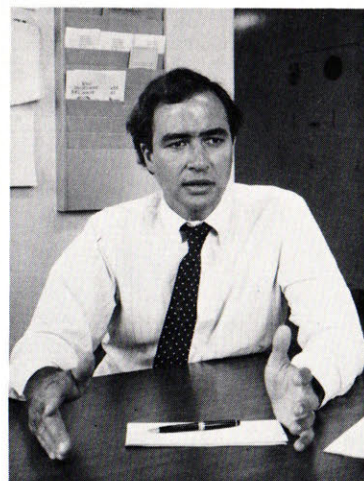
cc: Charles McFadden
Amy Belser
Ron Lopp
Richard Wigod, M.D.



Management of the AIDS Patient:

San Francisco General
Hospital's Experience





It is unlike any other epidemic experienced in this century. No disease has raised more social, moral, and political questions than acquired immunodeficiency syndrome, or AIDS.

Because of its deadly nature, AIDS is being treated as a modern plague. Fear is spreading along with the virus, as ignorance fuels the imagination and a near hysteria grips the public. Those in high-risk groups are not immune to this. Nor are health professionals.

It has been estimated that as many as one-million people have been infected with HTLV-III, the virus that causes AIDS, since the disease was first identified in 1981. It is not certain how many people will go on to develop one or more of the many opportunistic infections associated with AIDS. It is certain that many more health professionals will unexpectedly and suddenly become involved in the diagnosis and care of AIDS patients.

How will you deal with AIDS when it arrives at your hospital? What are the risks in caring for AIDS patients?

"There's no allowance in my mind for physicians who refuse to treat AIDS patients. It's one of the most immoral things I can imagine."

— Paul Volberding, M.D.
Director, AIDS Activities
San Francisco General Hospital

This California Medical Association-Hospital Satellite Network documentary will examine the pioneering efforts of San Francisco General Hospital in responding to this tragic epidemic. Aimed at physicians, nurses, hospital administrators, and ancillary-department managers, this 60-minute program will focus on:

- ☐ disease overview
- ☐ infection control guidelines
- ☐ multidisciplinary approaches to treatment
- ☐ support for the health care team
- ☐ coordination of hospice and outpatient care

The CMA and HSN have produced this videotaped program to educate health care professionals in communities where AIDS is only now gaining a foothold. It is designed to prepare them to deal with the disease when local cases start to mount.

AIDS is everyone's problem. Patients should not be cast from society to receive their care from a dedicated few.

Rental of this videotaped documentary is available through the California Medical Association — contact Ron Lopp at (415) 863-5522. For information regarding purchase, contact Hospital Satellite Network at (213) 277-6710.

California Medical Association
44 Gough Street
San Francisco, CA 94103
(415) 863-5522

There is an epidemic that already is bigger than AIDS--the epidemic of fear and misunderstanding about the disease. Like the disease, it is preventable through education and good health practices.

As AIDS is diagnosed in areas outside of the major metropolitan areas of California (See "AIDS: out of the shadows, November 1985 CALIFORNIA PHYSICIAN), patients who are unfamiliar with disease are prone to believe the worst about AIDS, how it is spread, and how it is caught.

The fact sheet on the following page was developed by the CMA Committee on AIDS for physicians to photocopy and give to their patients. It may be reproduced and distributed without permission.

This material is planned for use in a future issue of California Physician.

AIDS FACT SHEET

Do you know what epidemic is bigger than AIDS? The epidemic of fear and misinformation. Prevention of both is through education and good health practices. The following are some simple facts presented by CMA's Committee on AIDS as the first in a series of ***** UPDATES ON AIDS *****.

What is AIDS?

- * AIDS is shorthand for Acquired Immune Deficiency Sndrome.
- * AIDS is a disease that damages the immune system of otherwise healthy individuals.
- * AIDS is transmitted through sexual contact and blood products.

What causes AIDS?

- * A virus has been discovered, most often called HTLV-III, that is associated with AIDS and is now considered to be the cause. Not everyone who tests positive for HTLV-III antibodies will develop AIDS. Current estimates suggest 5% to 20% of those testing positive will develop AIDS symptoms.

How contagious is AIDS?

- * AIDS is not transmitted by casual everyday contact, by the airborne route, by objects handled by persons with AIDS, by contaminated environmental surfaces or by mosquitoes.

Studies in households of persons with AIDS have shown that infection with HTLV-III (AIDS virus) does not take place through everyday casual contact.

How is AIDS transmitted?

- * The HTLV-III virus and the resultant risk of developing AIDS are transmitted through two main routes:
 - the sharing of bodily fluids through sexual intimacy; and
 - exposure to blood or blood products, most often through the sharing of contaminated needles.

Is it safe to donate blood?

- * Yes. Donating blood in no way puts the donor at risk for AIDS.

Why is there concern about blood transfusions and AIDS?

- * Some people who have received HTLV-III infected blood products have developed AIDS, but many experts believe this should not longer occur as the result of a blood test that indicates infection with the HTLV-III virus. Screening programs have dramatically improved the safety of the nation's blood supply.

How can I learn more about AIDS?

- * In northern California, call the AIDS Hotline at (800) 347-AIDS.
- * In southern California, call the AIDS Hotline at (800) 922-AIDS.
- * Contact your (local) county medical society.
- * **ASK YOUR OWN DOCTOR (bold type).**

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Notes from Conf Call 1-15-86
to begin plans for Stress and Coping workshop for gay phys who treat
AIDS patients
Page 1

Present were:

Hanna Bauer
David McWhirter
Max Schneider
Gail Jara

Target dates for the workshop:

May 30 - June 1 — *first choice*

June 20 - 22

June 27 - 29 *bad choice because it is Gay Pride Week parade in SF)*

Target places:

Stanford Sierra Lodge
Napa Valley place
 e.g., Holiday Inn in Napa Valley
other northern Calif place
UCLA's Idlewild
hotel on Catalina Island
Palm Springs Hilton Hotel

Target audience:

gay and lesbian phys who treat AIDS pts

gay and lesbian phys have the same needs as any phy
treating AIDS patients plus a constant personal
threat felt because they are part of the high risk
population

no registrant would be turned away, but focus of the planning
and the publicity will be to gay and lesbian phys

Early thoughts about topics and faculty:

Shanti Project person

Dave Sheerer, MFCC

I will meet with him before Feb 3

phy who has lots of AIDS pts

mentioned were Bill Owens, SF

Brad Truax, San Diego

Keith Verril, San Diego

others whose names I didn't get

pt advocacy issues, perhaps Drew Mattison

e.g., housing, treatment, employment rights, and
resources for pts besides treatment

Notes from Conf Call 1-15-86

to begin plans for Stress and Coping workshop for gay phys who treat
AIDS patients

Page 2

Publicity:

through PHR groups, including AAPHR

contact Sari ^{Skaver} Shriver to see if news piece can get into
American Medical News

consider budgeting money to give to BAPHR for them to hire
temps to get out this mailing

Planning group:

McWhirter
Schneider
Bauer

Don Clark -- Dave will ask him

Bill Owens, SF, -- Dave will ask him

Doug Carner, or current Exec of BAPHR -- Dave will find out
who is current Pres of BAPHR
and ask that person to ask the Exec to participate
in the planning efforts

Gail will call Carner or current Exec

Planning meeting set for Monday, Feb 3, 1986, from 2:00 pm to 6:00 pm
with dinner afterwards, at SF airport.

gbj

1-15-86

Education concerns parallel epidemic's growth

There's a simple rationale behind the ambitious trio of Annual Session programs on AIDS, sexually transmissible diseases, and topics in transfusion.

"People need to know," says Sarah Miller, M.D., director of the Ventura County Health Care Agency and coordinator of two of the programs.

As AIDS becomes less a "big city" problem, with cases being reported in the state's most rural areas, Dr. Miller says physicians involved with treating AIDS have asked that the disease be addressed "in the context of public health." She says she "can't stress enough" how important physician education is in furthering that end.

Although programs dealing with AIDS and related topics have become more common—even in areas reporting relatively small AIDS caseloads—Dr. Miller says the hunger for more information within the health care community has not been staved. Physicians, nurses, and ancillary staff are eager for more information about AIDS, which has afflicted approximately 13,000 in the United States since 1981. Dr. Miller notes that her own involvement in planning the Annual Session program stemmed from requests by family practice residents in her area for more AIDS education.

Identifying AIDS, treating the patient, and handling the subsequent counseling for patient and family are all addressed in the Saturday, March 1, morning program titled, "The AIDS patient and the primary care physician." Dr. Miller says one program goal is to bring potential problems out into the open, "so physicians and those close to the patient won't be so afraid."

Dr. Miller says physicians will learn about the disease's clinical idiosyncrasies from AIDS research expert Michael Gottlieb, M.D., of UCLA. His presentation will include a section on laboratory evaluation of HTLV-III infections and AIDS, to educate physicians

about the tests necessary for diagnosis of the disease, and subsequent patient management strategies.

Other program presenters include Thomas Prendergast, M.D., director of the Orange County Department of Public Health, and two Orange County physicians familiar with the treatment of AIDS and unusual manifestations: Thomas Cesario, M.D., and Alexandria Levine, M.D.

Aside from the clinical elements involved with treating an AIDS patient, Dr. Miller says the Annual Session program will help physicians deal with the social aspect as well. The role of emergency service personnel and others who provide care to AIDS patients will be addressed. Helping physicians become resources for health care personnel and others concerned about the transmission of the disease will be stressed by both Drs. Gottlieb and Prendergast.

The afternoon session, titled, "Update on sexually transmitted disease," offers an overview of maternal and neonatal infections by San Diego physician Philip Goscienski, M.D., considered an expert in the field of sexually transmitted diseases, particularly chlamydia. Identifying and treating chlamydia, which Dr. Miller notes was only recently recognized as the catalyst for a host of sexually related diseases in women, will be stressed.

Coinciding with the morning AIDS program, but as part of a separate presentation titled, "New and important topics in transfusion," James Mosley, M.D., will speak on the risks of disease transmission with transfusions. The program will offer current statistics concerning blood donors and disease contractors, discuss the myths and facts behind giving—and receiving—blood, and address practical precautions. Dr. Mosley, an infectious disease specialist, is also principal investigator of UCLA's transfusion safety study.

Saturday March 1

Section on Preventive Medicine and Public Health presents

★ The AIDS Patient and the Primary Care Physician

Cosponsor: Task Force on Sexually Transmissible Diseases

Program planner and moderator: Sarah L. Miller, M.D., Ventura

Overview of HTLV-III infections and AIDS

Thomas Prendergast, M.D., Orange

Clinical presentation and laboratory evaluation

Michael Gottlieb, M.D., Los Angeles

Managing patients with evidence of HTLV-III infections and AIDS

Thomas Cesario, M.D., Orange

Neoplastic manifestations of AIDS

Alexandra Levine, M.D., Los Angeles

Role of primary care physician in counseling patients and families

Dr. Cesario

Emergency medical service personnel and others in care of patients with HTLV-III infections and AIDS

Dr. Gottlieb; Dr. Prendergast

CME credit: 4 hours of CMA, ACEP and BRN Category I credit. The financial assistance of Hoffmann-La Roche is gratefully acknowledged.

D R A F T

January 10, 1986

TO: Presidents, Component Medical Societies

RE: Acquired Immune Deficiency Syndrome (AIDS) -- Follow-up

Dear Doctors:

In mid-September I wrote to you regarding Resolution 719a-85:

Resolution No. 719a-85

Identification of Resources for Patients with AIDS

RESOLVED: That CMA encourage its component societies to identify those physicians who are willing to care for patients with AIDS and make that information available through local referral services and AIDS resource organizations.

ACTION: Substitute resolution adopted as amended.

At that time I requested your help in identifying those physicians in your communities with the expertise and ability to care for patients with AIDS or AIDS Related Conditions.

I am now requesting that you forward a copy of your AIDS provider resource list to CMA's Department of Continuing Medical Education in order to coordinate a statewide referral system.

Sincerely,

Clarence S. Avery, MD
President

CSA/sdc

SEP 19 1985

FYI



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

September 18, 1985

TO: Presidents, Component Medical Societies

RE: Acquired Immune Deficiency Syndrome (AIDS)

During the 1985 Annual Session of the House of Delegates, the following resolution was adopted:

Resolution No. 719a-85 / G

Identification of Resources for Patients with AIDS

RESOLVED: That CMA encourage its component societies to identify those physicians who are willing to care for patients with AIDS and make that information available through local referral services and AIDS resource organizations.

ACTION: Substitute resolution adopted as amended.

Referred to: Commission on Community Health Services.

The Commission on Community Health Services has reviewed recent data regarding the numbers of diagnosed cases of Acquired Immune Deficiency Syndrome (AIDS) statewide. The California Medical Association recognizes that AIDS patients should have access to the best and most current medical care available. The CMA is therefore updating its resource materials to assist you in your endeavors. Information regarding diagnostic guidelines, treatment protocols, patient services, epidemiological data, and research on therapy regimens is available from CMA's Department of Continuing Medical Education to assist your physician members in diagnosing and caring for people with this disease.

Enclosed you will find the most recent data regarding transmission for AIDS reported by county of residency. As this data clearly shows, AIDS is a statewide as well as nationwide epidemic increasing at an exponential rate. While a large number of patients are currently reported in San Francisco and Los Angeles counties, it should be noted that many persons diagnosed with AIDS may have relocated to these areas to receive the most current medical care. In the coming years, however, hospital resources in the major metropolitan areas will be overburdened and patients will require care and treatment in their county of residence.

Presidents, Component Medical Societies
RE: Acquired Immune Deficiency Syndrome (AIDS)

Recently, AIDS patients and persons with AIDS Related Conditions in other parts of the country have been refused medical care and/or referrals to other health providers. As members of the medical profession, we have a responsibility to ensure that AIDS patients have access to the same quality of care as all other patients. The CMA therefore urges you to identify those physicians in your communities with the expertise and ability to care for patients with AIDS or AIDS Related Conditions. We also ask that you develop a list of health providers in your communities qualified and knowledgeable about this disease in order for you to provide referrals for persons requiring medical care.

Sincerely,

A handwritten signature in cursive script that reads "Clarence S. Avery, M.D." The signature is written in dark ink and is positioned above the typed name.

Clarence S. Avery, MD
President

Enclosure

**AIDS CASES BY COUNTY
OF RESIDENCE AT ONSET OF ILLNESS**

January 1981 - July 31, 1985

	CASES	DEATHS
San Francisco	1179	464
Los Angeles	1041	457
Orange	103	46
Alameda (ex. Berkeley)..	99	35
San Diego	90	33
Santa Clara	47	23
Riverside	39	17
Contra Costa	37	12
Sonoma	31	8
San Mateo	29	14
Marin.....	28	11
Sacramento	23	9
Monterey	12	6
San Bernardino	11	4
Santa Barbara	11	3
Out of State	8	3
Santa Cruz	7	4
San Luis Obispo	7	3
Kern	7	1
Fresno	6	5
Mendocino	6	4
San Joaquin	6	2
Ventura	5	2
Berkeley	4	1
Stanislaus	3	3
El Dorado	3	2
Lake	3	2
Sojano	3	1
Yuba	2	1
Imperial	2	1
Placer.....	2	1
Napa	2	0
Merced	1	1
Trinity	1	1
San Benito	1	0
Humboldt/DelNorte.....	1	0
TOTAL	2860	1180



CALIFORNIA MEDICAL ASSOCIATION

44 Gough St. • P.O. Box 7690 • San Francisco, CA 94120-7690 • (415) 863-5522

January 15, 1986

Eleanor Bell
Kansas Medical Society
1300 Topeka Avenue
Topeka, Kansas 66612

Dear Ms. Bell:

Enclosed are the tiems you requested. In addition to the chaptered versions of AB 403 and AB 488, I've included the legislative staff's analysis and our legal counsel's opinion on these laws. Also enclosed is San Francisco Medical Society's interpretation for physicians and hospitals and the California Hospital Association Bulletins regarding the same.

As one would expect, opinions on these two laws vary. Many physicians feel that these laws restrict them in caring for their patients. In reality, I think they feel inconvenienced by having to secure a release from the patient for each referral or consultation. However, since laws are not truely defined until they hit the courts, strict interpretation does create some unusual restrictions on physicians and hospitals alike. I know several groups will be introducing legislation to clarify and perhaps restructure parts of AB 403 and AB 488 which are cumbersome.

Although both AB 403 and AB 488 protect confidentiality, there are concerns that this information will somehow become available to employers and insurance companies. Insurance companies are now developing their own strategies for selection and de-selection of insurees.

Should you have any further questions, please don't hesistate to call or write.

Sincerely yours,

Mark L. Madsen, MPH
Staff to the ad hoc Committee on AIDS

MLM/sdc
Enclosures

TO MARK MADSEN FOR HANDLING

KMS

KANSAS MEDICAL SOCIETY

1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

TO:

Mark
Madsen

can do one year
signature -
A.

December 13, 1985

California Medical Association
44 Gough Street
San Francisco CA 94103

To the Legislative Liaison:

The Kansas Legislature will convene shortly after the first of the year, and it is quite likely that efforts will be made to address potential problems from the growing AIDS crisis. The Kansas Medical Society hopes to provide rational and informed direction for such legislation, and is therefore seeking information from states that have already enacted AIDS-related legislation. According to the American Medical News, yours is among them.

We would appreciate it if you would send us a copy of your state's legislation, any rules or regulations developed for its implementation, and any comments you might make related to the process or your assessment of the strengths or shortcomings of the present law and its mechanisms.

Thank you for your cooperation; I look forward to hearing from you.

Sincerely,

Eleanor Bell

Eleanor Bell

RECEIVED

DEC 18 1985



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

December 5, 1985

Paul U. Strauss, MD
Chief of Staff
Harbor View Medical Center
120 Elm Street
San Diego, California 92101

Dear Doctor Strauss:

CMA President Clarence S. Avery, MD, included your name on CMA's AIDS information update list. Noting that your recent correspondence concerned confidentiality issues, I have enclosed for you some confidentiality guidelines which were developed by the San Francisco Medical Society. Interpretations of AB 403 and AB 488 have varied substantially. I believe these guidelines were developed from the most strict interpretation. I hope they provide you with some further guidance.

If I may be of further help, please don't hesitate to contact me directly.

Sincerely,

Mark L. Madsen, MPH
Staff, Ad Hoc Committee on AIDS

MLM/sdc
Enclosure

cc: Clarence S. Avery, MD



CALIFORNIA MEDICAL ASSOCIATION

44 Gough Street • San Francisco, California 94103-1233 • (415) 863-5522

October 7, 1985

Paul U. Strauss, MD
Chief of Staff
Harbor View Medical Center
120 Elm Street
San Deigo, California 92101

Dear Doctor Strauss:

Recently there has been a great deal of confusion regarding the new California law (Chapter 22, 1985) regarding HTLV-III test results and confidentiality. Your letter of August 8, 1985 expressed concerns voiced by many health care providers throughout California.

AB 403 (which was enacted as Chapter 22) provides for the confidentiality of HTLV-III test results only and is not intended to restrict in any way the physician who treats patients with AIDS or AIDS-related conditions. In California and throughout the nation, AIDS is a reportable disease. Physicians are encouraged to respond to this disorder as one would any communicable disease with respect to reporting, confidentiality and referral.

I have enclosed for your information several articles which may help to clarify the issues you raise. Further information regarding diagnostic guidelines, treatment protocols, patient services, epidemiological data and research on therapy regimens is available from CMA's Department of Continuing Medical Education to assist physicians in diagnosing and caring for people with this disease.

Sincerely,

Clarence S. Avery, MD
President

CSA/sdc
Enclosures

bcc: Robert Elsner
Andrina Walsh
Linda Ramsey



Mark Madsen
for handling

RECEIVED

SEP 8 1985

August 8, 1985

Clarence S. Avery, M.D.
President
California Medical Association
44 Gough Street
San Francisco, CA 94103-1233

Copies to Doctor Avery, Doctor Elliott,
Robert Elsner, Linda Ramsey, Mark
Madsen (to coordinate response over
Doctor Avery's signature), and
Jay Michael.

Dear Dr. Avery:

The Medical Executive Committee of Harbor View Medical Center views with great concern the recent State of California Law (AB 403) now in effect regarding the confidentiality for evaluation of Acquired Immune Deficiency Syndrome (AIDS) as reported in the County of San Diego Physicians Bulletin of June 1985, #296.

The Medical Executive Committee of Harbor View Medical Center acknowledges the sensitivity of the matter and the need for confidentiality to protect persons who are being evaluated for AIDS. The Committee also recognizes the severity of the disease and the potential for spread in the entire population. This disease is viewed as a potential devastating public health problem and all effective measures should be taken to control its dissemination.

The antibody test for the probable causative agent of AIDS (HTLV-III) is a significant breakthrough in this disease and its utilization is the only currently available effective means of gaining some insight into the epidemiology of the disease.

The current law is extremely harsh and one-sided and is not in the best interests of the general public. It does not allow responsible physicians to take appropriate action to help contain the spread of this dreaded disease because of the restraints placed upon the physician by the new law. The threats of punishment may deter physicians from involvement in any AIDS related testing.

The Medical Executive Committee strongly urges all responsible agencies to make every effort to have the law changed so that both the interests and health of the general public, as well as the confidentiality of the individuals being evaluated, are respected and protected. Currently the law protects only those individuals being evaluated for AIDS.

AIDS Resolution
August 8, 1985
Page 2

Your assistance and cooperation are greatly appreciated.

Cordially,

A handwritten signature in cursive script, reading "Paul U. Strauss". The signature is written in dark ink and is positioned above the typed name.

Paul U. Strauss, M.D.
Chief of Staff
Harbor View Medical Center

PUS:dar



CMA AUXILIARY / 44 Gough Street / San Francisco, California 94103 / 415 863-5522

November 8, 1985

TO: County & District Presidents & Presidents-Elect
State Board Members

Dear Auxiliary Members:

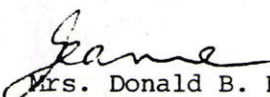
As you know, recently Assemblywoman Doris Allen (Orange County) addressed the Auxiliary's Fall Conference and made several comments regarding AIDS. With the assistance of CMA's Committee on AIDS, I thought it would be helpful to provide you with accurate information on those issues raised by Assemblywoman Allen.

- o As of August 19, 1985, there were 12,444 reported cases of AIDS nationwide, of these 816 were women. Clearly, AIDS is not a "gay disease." Nor is it confined to metropolitan areas, as cases have been reported all across California.
- o "No evidence supports AIDS transmission by casual contact, by the airborne route, by objects handled by people with AIDS, or by contaminated environmental surfaces." (James W. Curran, MD, MPH, Director AIDS Activity, Centers for Disease Control, Atlanta). The medical profession uniformly agrees that you can engage in your usual daily activities, such as working in a group setting, shaking hands, attending public events, eating in restaurants, attending school, and swimming in public pools, without any risk of getting AIDS. Obviously, quarantine measures are unnecessary.
- o San Francisco General Hospital does not provide "rooms for sex" for any patients. This rumor started as a result of a nurse asking for policy guidelines as one of her patients (not an AIDS patient) was being visited by his girlfriend in the late evening.
- o Children who are up for adoption and are from parents who are members of high-risk groups are routinely tested for HTLV-III antibodies. As these children are wards of the court, there is no obstacle to full and complete medical evaluation prior to placement.

I would also like to refer you to the November issue of California Physician and the October issue of The Atlantic. Both publications have excellent articles which give accurate and reasonable information on AIDS. Fear and hysteria about AIDS is spreading. The best protection against both AIDS and the fear is accurate scientific information.

For additional information, the AIDS Hotline is an excellent resource. In northern California the toll free number is 800-367-AIDS, in southern California 800-922-AIDS.

Sincerely,


Mrs. Donald B. Hull
President

LACMA LEADER LETTER

THE NEWSLETTER FOR THE LEADERS OF THE LOS ANGELES COUNTY MEDICAL ASSOCIATION

At their first formal meeting on November 12 (the second will be Monday evening, December 9), members of the Committee on AIDS decided that their initial and primary purpose will be to serve fellow physicians as an information and education resource on AIDS and AIDS-related conditions.

To that end they voted to develop a three-pronged program. They will submit a series of timely and meaningful articles on AIDS to Managing Editor Howard Bender for publication in LACMA Physician. Bender has indicated that he will be receptive to such material. The Committee will establish a "WARMLINE" physicians will be able to call when they need to ask questions or discuss an AIDS matter with an expert. Thirdly, the Committee decided to establish a Speakers Bureau to provide individuals with special expertise in and experience with AIDS to speak at LACMA District, Specialty Society and Hospital Medical Staff meetings.

Thanks to Steven Kleinman, MD, Committee member and Associate Medical Director of the American Red Cross Los Angeles and Orange County Blood Services, the Committee has a list of 18 infectious disease specialists (all LACMA members) who have agreed to allow their names to be used as referrals.

But the call is out right now for additional physicians who are ready, willing and able to speak to physician audiences or to respond to phone calls from fellow physicians seeking information on AIDS-related matters. All physicians who are interested are invited to phone the LACMA Communications Department at 483-1581 ext. 312 or 338.

LACMA's AIDS Committee Sets Agenda

LACMA's Committee on AIDS met for the first time recently. As a result of that meeting, the committee has formulated a three-point agenda toward which it will direct its activities.

The first project will be the development and implementation of an information service for physicians. The idea of a "warmline," wherein physicians could call LACMA and get up-to-date information during regular business hours was favored over a more expensive, and largely unnecessary, 24-hour "hotline" service. Physician callers to this number would be given the name and number of an expert in the area of concern to the caller. The committee is currently assembling a list of physicians who are qualified and willing to participate in the service.

The second point on the committee's agenda is the development of a speaker's bureau. The physicians who participate in this project would speak before physician groups only, such as LACMA Districts, specialty societies, etc. Again, the committee is seeking participants who are both qualified and willing to speak.

The final point of the agenda is preparation of articles to appear in LACMA Physician. Suggested ideas would be an AIDS primer for physicians, and an article on the problem of insurance companies and coverage for AIDS patients.

For additional information on the activities of the AIDS Committee, or to volunteer for either the "warmline" or speaker's bureau, contact David Zeitlin, LACMA's Director of Communications, at (213) 483-1581, ext. 312.

CALIFORNIA MEDICAL ASSOCIATION

SEP 19 1985

INTER-OFFICE MEMORANDUM

To: Bob Elsner

Date: 17 September 85

From: Paul K. Strobel

Paul

Subject: Monterey County Medical Society Board Meeting
September 16, 1985

AIDS CONTROVERSY

Reacting to the third grade, eight-year-old hemophiliac in Carmel who contracted AIDS, the Board voted to refer media, school district, parent, physician and other inquiries to the existing society Task Force on AIDS.

It was strongly emphasized, however, that the Task Force will dispense only the latest information. Strategies or advice on specific courses of action, it was noted, are political and not medical decisions.

County Health Officer Bob Melton, who will be meeting with school district officials in a town meeting Tuesday, reported that the New York Times recently carried an excellent article on the fifteen most often asked AIDS questions with answers. He intends to pass copies of that article out at the meeting.

sc
Do we have this.

In a related item, Doctor Melton reported that the alternate testing site for HTLV-III screening opened in Seaside (near Fort Ord) on August 1 and screened 29 persons without a positive result. The bad news is that two positives have been found among only 12 screened so far in September.

NICORETTE STUDY

Endorsed the Stanford Heart Disease Prevention Program's nicorette study to determine if a supplemental education program, when combined with the physician's prescription for the nicotine chewing gum, is more effective in smoking cessation. Materials have been forwarded to Cathy Maley. They include 16, slick 8 1/2 x 11 pamphlets with titles like "How to Have a Drink Without Smoking", "How to Cope With Stress Without Smoking" and "How to Drink Coffee or Tea Without Smoking."

CORONER AND "NO CPR"

Asked Doctor Melton to clarify the legal aspects of a letter from his department which advises convalescent facilities to contact the coroner's office "if a patient expires. . .and 'do not resuscitate' orders have been given." It was Doctor Melton's offhand opinion "that the essence of the letter is don't call 911 and use valuable and well-trained paramedics for terminal situations."

CALIFORNIA MEDICAL ASSOCIATION

Interoffice Memorandum

TO: BOB ELSNER
FROM: PAUL K. STROBEL

Date: 19 NOVEMBER 85

(DICTATED BUT NOT READ)

RE: Monterey County Medical Society
Board Meeting, November 18, 1985

JOHN HAYS TRANSFERS TO INYO-MONO

Learned that CMA Delegate and CALPac Board member John Hays, an orthoped, is going to where the action is: Mammoth Lakes on November 25. His address will be P.O. Box 1849, ZIP 93546.

His replacement as delegate is Warren D. "Duke" Turner who moves up from alternate delegate. The president was authorized to appoint an alternate delegate to fill Dr. Turner's unexpired one-year term.

Also named Salinas OB/GYN Norman D. Nelson to replace John on the CALPac Board.

AIDS PROJECT

Supported, in concept, the non-profit Monterey County AIDS Project. The two-page fact sheet describing the project has been sent to Mark Madsen and Cathy Maley.

CMA REPORT

Heard Dave Holley report on: 1) the Supreme Court's decision in Roa; 2) the fact that the Sabih initiative is dead, 3) the importance of passage of the joint and several liability initiative and 4) the outstanding track record that CMA compiled in Sacramento this year.

HEALTH INITIATIVE

Received an update that the county, along with the Health Initiative's ten largest creditors (probably all the hospitals plus some heavy hitters), will file a letter of intent to sue the State. This is the Medi-Cal pilot project that went way over budget and left providers holding an empty bag.



San Francisco Medical Society

NEWS RELEASE

250 Masonic Avenue • San Francisco, CA 94118 • (415) 567-6230

FOR RELEASE: Friday, December 20, 1985
CONTACT: **STEVE L HEILIG**
PHONE: (415) 567-6230

SAN FRANCISCO MEDICAL SOCIETY ADVOCATES VOLUNTARY AIDS ANTIBODY TESTING FOR ALL HIGH-RISK INDIVIDUALS

SAN FRANCISCO — The San Francisco Medical Society has issued a statement encouraging all high-risk individuals to volunteer for HTLV-III testing. The HTLV-III test is an indication of the exposure to the virus that has been found to cause Acquired Immune Deficiency Syndrome (AIDS).

Edward A Chow, MD, SFMS President, noted the policy provisions are applicable only as advisory guidelines in San Francisco, and were developed by the AIDS Task Force of the SFMS in consultation with representatives from a broad spectrum of private and governmental medical organizations.

"SFMS strongly supports the provision of all needed resources for the care of people with AIDS and AIDS-related conditions, and for research and treatment of this disease," said Dr Chow. "Education of the at-risk population groups has been effective, but we are concerned that even more can and should be done. Voluntary testing will offer concerned, at-risk individuals greater impetus to live healthy lifestyles and to limit unsafe sexual contacts and practices."

"While we are all aware the HTLV-III test is not a test for AIDS itself," Dr Chow noted, "and fortunately only a minority of those infected with the virus (and thus testing positive) will develop AIDS, we believe it extremely important that those

(more)

SAN FRANCISCO MEDICAL SOCIETY ADVOCATES VOLUNTARY AIDS ANTIBODY
TESTING FOR ALL HIGH-RISK INDIVIDUALS - Press Release Page 2

at risk of becoming infected and those already exposed to the virus make every effort to avoid behaviors, conditions, and potentially infectious agents which might place unnecessary stress upon their health."

The test now appears to be much more accurate than was initially indicated, so the fears about false results are less important than earlier in the year. Also, San Francisco's model anonymous testing program and state legislation regarding confidentiality and discrimination further support those deciding to take the test.

"Even though new AIDS cases appear to have reached a plateau of 60-70 cases per month in San Francisco," Dr Chow said, "this is still an unacceptably high incidence of a disease with a mortality rate of near 100%. One death per day is too many for a disease that strikes young, vigorous, and previously healthy individuals in their prime."

#####



San Francisco Medical Society

**SAN FRANCISCO MEDICAL SOCIETY
ADVISORY STATEMENT REGARDING
AIDS AND HTLV-III TESTING
December 1985**

250 Masonic Avenue
PO Box 18719
San Francisco, CA 94118
415 567-6230

The following statement is the product of intensive review by the San Francisco Medical Society Bioethics Committee and AIDS Task Force and was approved by the SFMS Board of Directors in December of 1985. Representatives from a broad spectrum of private and governmental medical organizations participated in the development of the statement. The recommendations contained herein are intended as advisory guidelines to San Francisco for the continuation of the difficult battle against the spread of AIDS. They are in no way intended for use as coercive measures or by parties other than concerned individuals, their physicians, and recognized organizations serving the interests of public health.

WHEREAS the AIDS epidemic poses an extremely serious threat to the health of all individuals, and

WHEREAS the San Francisco Medical Society is deeply concerned about the health of all members of society, including those in groups at high risk for AIDS:

1. The SFMS fully supports the provision of all needed resources for the care of people with AIDS and AIDS-related conditions, and for research and treatment of this disease.
2. The SFMS strongly encourages all individuals in groups at risk for AIDS and anyone having sexual contact with those in high risk groups to be voluntarily tested for HTLV-III antibodies.
3. The SFMS strongly supports the continued confidentiality of the HTLV-III test and the continuance of the anonymous testing site program.
4. All persons at risk for AIDS are urged to practice safe sex (sexual practices that do not involve the transmission of bodily fluids) at all times. Sharing of needles and syringes among drug users is also an unsafe practice that should be avoided at all cost.
5. As AIDS is primarily a sexually-transmitted disease, all individuals, regardless of sexual orientation, who have had or currently have multiple sexual partners should consider themselves at risk for the disease. Anyone at risk for AIDS should eliminate those sexual activities that put him or her at risk.

The SFMS wishes to remind all interested persons that the HTLV-III test is NOT a test for AIDS itself, but is a test for the virus which can cause AIDS. Medical research indicates that only a minority of those infected with the virus (and thus testing positive) will subsequently develop AIDS. Thus it is extremely important that those at risk of becoming infected and those already exposed to the virus make every effort to avoid behaviors, conditions, and potentially infectious agents which might place unnecessary stress upon their health. People choosing to be tested are strongly advised to avail themselves of the educational resources provided by AIDS-aware community organizations such as the San Francisco AIDS Foundation and the Department of Public Health and to seek appropriate medical advice and care when indicated.



San Francisco Medical Society

250 Masonic Avenue
PO Box 18719
San Francisco, CA 94118
415 567-6230

RECOMMENDED GUIDELINES FOR NOTIFICATION OF PATIENTS OF THE RECEIPT OF BLOOD OR BLOOD PRODUCTS FROM DONORS WHO TEST POSITIVE TO THE HTLV-III ANTIBODY

(May also be used with appropriate modifications for Notification when Donors have Frank AIDS)

November 1985

1. The overall hospital policy should be that, for the well being of the patients, their family and friends, and the general public, notification be given to recipients of blood products from donors who subsequently develop AIDS and from donors who subsequently test positive to the HTLV-III antibody.
2. The notification policies and procedures should respect the patient-physician relationship and to the extent possible the notification decisions should be made by the patient's personal physician.
3. Hospitals should identify the appropriate existing medical staff committee (eg, one which relates to the transfusion service, Infectious Disease or Quality Assurance) or, if necessary, establish a new one and charge it with the overall responsibility of handling the notification from the blood bank in the manner most supportive of the recipient, his family and friends, and his physician relationships.
4. The medical staff structure identified should be responsible to monitor and keep records of the attending physician's action with respect to the notification. A model letter for notification of the physician and documentation of his responses is attached. In the event that the attending physician cannot be identified or located, or cannot for some reason be expected to act upon the information, it is that structure's responsibility to assign the task to another appropriate physician.
5. If the patient's attending physician at the time of the transfusion is not currently the patient's primary physician, the attending physician should be encouraged to consult with the primary physician with a decision being made jointly regarding notification of the patient.
6. If the attending physician does not ^{elect} to notify the patient, he/she should be advised to document his/her decision and the reasons for that decision. This action should be reviewed by the responsible medical staff structure.
7. Procedures should be established to assist the attending physician and the patient with up-to-date information regarding the meaning of the test results, the risk of transfusion-related transmission, and the state of the art in diagnosis and treatment of AIDS. The material developed and maintained by the Irwin Memorial Blood Bank should be put to full use in this regard.
8. As with any patient record, confidentiality should be fully protected. Hospitals should be prepared, however, for public disclosure of the occurrence and for requests for information regarding the notification policy and practice.

Marle Madsen

CALIFORNIA MEDICAL ASSOCIATION

Interoffice Memorandum

To Bob Elsner
From Paul K. Strobel *Paul*
Subject Santa Clara County Medical Society
Council Meeting, December 3, 1985

Date DEC 5 1985

MANDATED PROFESSIONAL LIABILITY INSURANCE

Reported that several dissident physicians from San Jose Hospital bypassed the local medical society and went directly to Clarence Avery and Phil Lippe for help in the battle against Hospital Board mandated professional liability insurance. Phil maintains that the perception of many local physicians, rightly or wrongly, is that Society sidesteps controversial issues.

I was directed to obtain as much information as possible from CMA staff and AMA on this question and send it to Howie Pearce. By copy of this memo to Richard Robinson, Libby Snelson, Jack Light, Dick Pronovost, Ralph Thomas, and Carla WycKoff, I am asking that you forward any information on the subject to me at your early convenience.

A motion to strongly endorse the principle that Organized Medical Staffs, and not Hospital Boards, should decide the question of professional liability coverage for physicians was deferred to the next Council meeting.

LEGAL COUNSEL

Allocated up to \$2,000 to retain the services of Bob Singer to "assist in systematizing the Society's peer review guidelines."

INSURANCE REVIEW COMMITTEE

Approved the form letter (attached) to be sent to patients' insurance companies with copies to patients to counter the impression, when appropriate, that physicians' fees are exorbitant. It was also decided to inform the Insurance Commissioner of companies who habitually underpay claims.

AIDS TASK FORCE

Authorized formation of an AIDS Task Force to address the questions raised in Wally Sampson's memo of November 22 (attached). I suggested that the leadership may want to check with the San Francisco Medical Society which has a similar Task Force.

County Health Doctor Bernadette De Armond reported that the County, with a population of 1.4 million, has had only 90 cases of AIDS since April of 1983. She expects, however, that the case finding will increase as victims begin to seek medical help locally rather than travelling to San Francisco and San Mateo counties for care.



Santa Clara County Medical Society

700 Empey Way
San Jose, CA 95128
(408) 998-8850

November 22, 1985

TO: Executive Committee and Council
FROM: Wallace Sampson, M.D., President-Elect
RE: Proposal for Establishment of a County-Wide AIDS Task Force

There is an urgent need for a coordinated informational and action oriented task force of physicians for the present and forthcoming problems of the AIDS epidemic. It is not likely that a coherent and balanced system of care can be developed by staffs of individual hospitals, nor is it likely that a statewide or nationwide system can be developed because of the problems of geography and distance. The county-based orientation would seem to be the ideal size for such a project.

The project would have several aims.

1. The project task force will attempt to ensure adequately trained medical personal to be available at each hospital, where possible, to assure maximum quality of medical care for people with AIDS, or ARC (Aids Related Complex) when hospitalization is necessary.
2. It would ensure standardization for acceptable communicable disease principles and for public education programs to relieve community anxiety about the communicability of AIDS.
3. The project task force would attempt to assure adequate home care for all patients in need of such, including ambulatory and intravenous therapy where necessary, to avoid unnecessary and prolonged hospitalization.
4. The project Task Force, by adopting sound communicable disease and

Richard Mercer, M.D., President
Wallace Sampson, M.D., President-Elect
Don Gurtman, M.D., Past President
Myron Weisbart, M.D., Secretary

Melvin Russi, M.D., Treasurer
Martin Inkelas, M.D., Editor
John Shinn, M.D., VP Member Services
Hugh Walsh, M.D., VP Prof Conduct

Robert Naughten, M.D., VP Community Health
Elliot Morrison, M.D., VP External Affairs
Marc Wakefield, M.D., House Officer
Mr. Sean Tunis, Medical Student

Councillors: Emiro Burbano, M.D. • David Discher, M.D. • Theodore Fainstat, M.D. • i
• Richard Sieve, M.D. • Sherman Souther, M.D. • Martin Vancil, M.D. • William Wate

29

A.D. • Jerry Hanson, M.D. • Roger Kennedy, M.D. • Robert Leasure, M.D.
Norman Woods, M.D. • Delegation Chairman: Robert Reid, M.D.

medical principles, combined with sensitive and humane principles of care, could assure the community, insurance underwriters, and government agencies, that care can be provided with maximal benefit at the most reasonable output of funds.

5. The task force would be organized by the Santa Clara County Medical Society, jointly with the Santa Clara County Health Department, with a nucleus of physician members, and perhaps subcommittees, to retain non-physician members as well. Representative physicians from each of the major community hospitals and teaching hospitals in the County (at least two from each) could form this physician nucleus, with one or two M.D. public health officers. One or more primary care physicians could be selected at large from the physician community, as could one or more physicians from the gay community.
6. The task force would seek ways to discourage use of unproven and disproven methods by helping to implement standards of effectiveness, and to help to discourage use of investigational drugs outside of approved research protocols.

Because of the predicted immensity of the AIDS problem, it is urgent that we begin such a project now, so that the task force can be available to undertake study and solution of future and unpredicted problems, as well as the present ones. The existence of such a task force may be reassuring to the community, and will increase the effectiveness and relevance of the Medical Society. The concentration of effort being on local and community based care, will be a major asset to the County of Santa Clara.

REPORT OF THE BOARD OF TRUSTEES

Report: PP
(I-85)

Subject: AIDS and HTLV-III Antibody Testing
(Resolution 9, A-85)

Presented by: William S. Hotchkiss, M.D., Chairman

Referred to: Reference Committee E
(John A. Martin, M.D., Chairman)

1 Resolution 9, (A-85), which was referred to the Board of
2 Trustees with a suggested amendment, reads as follows:
3

4 RESOLVED, That the American Medical
5 Association immediately request the U.S.
6 Department of Health and Human Services not
7 to proceed further on publishing the
8 information on AIDS and HTLV-III Antibody
9 Blood Testing found in the January 11, 1985
10 edition of "Morbidity and Mortality Weekly
11 Report" until the government has time to
12 consider valid objections to the language
13 therein; and be it further;
14

15 RESOLVED, That the AMA also urge the
16 Department of Health and Human Services to
17 permit blood collection centers to perform
18 HTLV-III antibody testing for their own use,
19 but to relieve the centers of any
20 responsibility for supplying test results to
21 test subjects until appropriate scientific
22 knowledge is available; and be it further;
23

24 The House of Delegates considered amending the resolution by
25 adding a resolve urging the government to "support studies to
26 determine the meaning, if anything, of HTLV-III positivity in
27 otherwise healthy people in non-high risk categories and to
28 determine what medical evaluation and recommendations should be
29 made."

Past House Action: A-85:254; A-84:343,345,349; I-83:121; A-83:240

1 Introduction

2
3 Acquired Immunodeficiency Syndrome (AIDS) presents a
4 significant challenge to the American medical community. This
5 challenge is being answered by intense research efforts seeking
6 improvement in medicine's capacity to prevent, diagnose, and treat
7 this syndrome. The nation's biomedical research community
8 identified the causal agent, the human T-lymphotropic virus type
9 III (HTLV-III) for AIDS and quickly developed a diagnostic
10 procedure to identify those who have been exposed to the virus.

11
12 The presence of antibodies to HTLV-III indicates exposure to
13 the virus and these antibodies constitute the basis for detection
14 by the diagnostic HTLV-III ELISA test. As presently performed,
15 the HTLV-III ELISA test does not discriminate between the presence
16 of antiviral antibodies and anticellular antibodies. Thus, the
17 specificity of this diagnostic tool has been questioned.

18
19 Notwithstanding the fact that a true positive ELISA test
20 indicates some exposure to the HTLV-III virus and not the presence
21 of AIDS, the severity of the disease coupled with the uncertain
22 implications of the HTLV-III ELISA test poses a difficult dilemma
23 for the practicing medical community with respect to interpreting
24 and acting upon positive test results. A confirmatory procedure,
25 the Western Blot Test, is available for individuals who initially
26 test positive with the HTLV-III ELISA test. However, the
27 availability of the confirmatory test to the practicing medical
28 community is limited and this situation is compounded by delays in
29 both the processing of test specimens and the communication of
30 test results.

31
32 The following is a brief exposition of the scientific evidence
33 that underlies uncertainty regarding interpretation of the results
34 of the HTLV-III ELISA test. The diagnosis of AIDS is discussed at
35 length in two recent reports of the Council on Scientific
36 Affairs.^{1,2}

37
38 Discussion of Scientific Evidence

39
40 Virus antigens used in the ELISA test are prepared from whole
41 virus grown in the leukemic cell line H9. Viral harvests from the
42 infected cells are "purified" by density gradient centrifugation
43 and are then disrupted prior to coating beads or microtiter
44 wells. If host cell antigen is incorporated into the virus
45 particle, "purification" by density gradient cannot be expected to
46 separate host cell and viral antigens. Even if host cell antigens
47 are not incorporated, density gradient centrifugation does not
48 assure the separation of these two groups of antigens. Thus, in
49 order to distinguish between antiviral and anticellular antibodies
50 in the ELISA test an uninfected cell control (H9 cells) is
51 necessary. None of the presently licensed HTLV-III test kits
52 contain an uninfected cell control.

1 At a recent Public Health Service workshop (31 July 1985),
2 "Experience with HTLV-III, Antibody Testing - Update on:
3 Screening, Laboratory and Epidemiologic Correlations," several
4 papers were presented that reported very high false-positive rates
5 (70% or higher) between initial and repeat ELISA test results, as
6 well as between repeatedly reactive ELISA test results and Western
7 Blot Test results. A number of ELISA positive sera were found to
8 be reactive with uninfected H9 cell antigens. The HLA antigens
9 H1, Bw62, Bw6, Cw3, DR4 and DQW3 have been identified in H9 cell
10 cultures (Weiss et al, Lancet 2:157, 1985). Using two commercial
11 screening assays, Kuhn1 et al (Lancet 1:1222, 1985) reported that
12 27% of DR4 typing sera scored as positive for HTLV-III antibody.
13 At the PHS workshop on HTLV-III antibody testing, Dr. J. Menitove
14 of the Council of Community Blood Centers reported finding not
15 only anti-DR4 antibodies in repeatedly positive ELISA test sera,
16 but also found anti-HLA DQ3 antibodies in some of the same sera.
17 At this same meeting a subset of the normal population having no
18 known risk factors for AIDS, multiparous females, was reported by
19 Dr. S.C. Lloyd of Serologics, Inc. to give equivocal ("biological
20 false positives") ELISA results using licensed HTLV-III antibody
21 test kits. These females gave negative Western Blot Tests and
22 were shown to possess antibodies to both leukocyte and
23 erythrocyte antigens.

24

25 Conclusion

26

27 The first resolve of Resolution 9 (A-85) deals with
28 information contained in the January 11, 1985 issue of Morbidity
29 and Mortality Weekly Report. It should be noted that the
30 recommendations made in this issue are provisional and it is
31 stated at the end of the article that, "Revised recommendations
32 will be published as additional information becomes available and
33 additional experience is gained with this test." The Board notes
34 that the Public Health Service is presently considering revising
35 these recommendations and a new set can be expected before the
36 next meeting of the House of Delegates.

37

38 The second resolve of the resolution seems to imply that blood
39 collecting centers are required by Food and Drug Administration
40 regulations to supply test results to test subjects. There is not
41 now, nor has there ever been, any FDA regulation requiring
42 notification of positive test results to donors. What is in
43 effect is a recommendation that they be notified. At a meeting
44 following the workshop on HTLV-III antibody testing, Dr. Harry M.
45 Meyer, Jr, Director, Center for Drugs and Biologics, Food and Drug
46 Administration stated that the FDA does not have any immediate
47 plans to require donor notification and would not consider doing
48 so until more is known about current tests.

1 The Council on Scientific Affairs, from whom the Board sought
2 guidance on this matter, believes that at present two important issues
3 among the many important issues surrounding HTLV-III antibody testing
4 are:

- 5
6 1. The number of positive results with the
7 HTLV-III ELISA test that have been reported
8 for individuals in non-high risk categories.
9
- 10 2. The number of false-positive results that
11 appear to be due to anticellular antibodies
12 (which may or may not occur together with
13 antiviral antibodies).
14

15 These issues increasingly are confronting the practicing
16 medical community which is faced with interpreting HTLV-III test
17 results and acting upon such results in the best interests of
18 individual patients. Therefore, the Board of Trustees recommends
19 that:

- 20
21 1. The AMA urge the government to continue to support
22 studies to determine the meaning of HTLV-III
23 positive antibody test results in otherwise
24 healthy people in non-high risk categories to
25 determine what medical evaluations and recom-
26 mendations should be made.
27
- 28 2. This report be adopted in lieu of Resolution 9,
29 (A-85).

REFERENCES

1. The Acquired Immunodeficiency Syndrome. JAMA 252:2037-2043
 Oct. 19, 1984.
2. Status Report on the Acquired Immunodeficiency Syndrome. Human
 T-Cell Lymphotropic Virus Type III Testing. JAMA 254:1342-1345,
 Sept. 13, 1985.

REPORT OF THE BOARD OF TRUSTEES

Report: SS
(I-85)

Subject: AMA Action Plan for AIDS
Presented by: William S. Hotchkiss, M.D., Chairman
Referred to: Reference Committee E
(John A. Martin, M.D., Chairman)

1 As of October, 1985, over 14,000 cases of acquired immunodeficiency
2 syndrome (AIDS) had been reported in the United States, and over
3 1,000,000 persons are estimated to be infected with the AIDS retro-
4 virus. Unless current trends of infection are slowed, AIDS has the
5 potential of becoming the major lethal pandemic of the century. In
6 at least the near future, vaccines and specific therapies will not be
7 available to control the AIDS retrovirus; the only effective counter-
8 measure is education leading to behavior modification.

9
10 Physicians are uniquely qualified to educate patients, their
11 families, and the general public about AIDS. The American Medical
12 Association (AMA) is the logical source of information for physicians
13 about AIDS. The AMA's role, therefore, is to disseminate information
14 about AIDS to physicians and to establish physicians as the most
15 credible accessible source of AIDS information in the eyes of the
16 public. To fulfill this role, the AMA has developed an Action Plan
17 for AIDS that is focused primarily through physicians serving as
18 resources for education and guidance in their communities.

19
20 The AMA Action Plan for AIDS will provide physicians with current
21 information about AIDS through various mechanisms including written
22 and electronic media, conferences, liaison with other organizations,
23 and interfaces with all sources of accessible information. Education
24 of the public will occur principally through identification of
25 physicians, medical societies and the Auxilliary as educational and
26 informational resources within the community. In addition, the AMA
27 will interface with various governmental agencies to facilitate
28 adequate allocation of funding resources to AIDS research.

1 (10) RESOLUTION 70 - CONTROL STUDY
2 OF HEROIN
3

4 RECOMMENDATION:
5

6 Mr. Speaker, your Reference Committee recommends
7 that Resolution 70 be referred to the Board of
8 Trustees. *rept back A86.*
9

10 Resolution 70 asks that the AMA encourage the National Institutes
11 of Health to conduct a controlled study to evaluate heroin as compared
12 to other available narcotics in the treatment of patients suffering
13 intractable pain due to cancer.
14

15 All in attendance were sympathetic to the goal of providing optimal
16 pain relief to cancer patients. However, because a controlled study of
17 pain relief with heroin is now underway, referral is suggested.
18

19 (11) REPORT SS OF BOARD OF TRUSTEES
20 AMA ACTION PLAN FOR AIDS AND
21 RELATED CONDITIONS
22 RESOLUTION 108
23 TASK FORCE ON AIDS
24 RESOLUTION 113
25 SOCIETAL CONSEQUENCES OF AIDS
26

27 RECOMMENDATION:
28

29 Mr. Speaker, your Reference Committee recommends that
30 Report SS of the Board of Trustees be adopted in lieu
31 of Resolutions 108 and 113.
32

33 Report SS of the Board of Trustees describes an AMA action plan
34 to disseminate information about AIDS to physicians and to establish
35 physicians as the most credible accessible source of AIDS information
36 for the public.
37

38 Resolution 108 calls for the AMA to establish a task force to
39 review and support the Centers for Disease Control guidelines concerning
40 protection of health care workers from AIDS and to enhance understanding
41 of the disease and appropriate precautions required to prevent infection
42 of health care workers.
43

44 Resolution 113 asks that AMA (1) include the concerns of the
45 general public in its task force on AIDS, (2) work with the Centers
46 for Disease Control in a public education program about AIDS, and
47 (3) investigate the financial problems of patients in high risk groups
48 in obtaining health insurance as well as the financial difficulties of
49 institutions that treat a disproportionate number of AIDS patients.
50

51 Resolutions 108 and 113 are encompassed in activities proposed
52 by Report SS of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 76
(I-85)

Introduced by: Oklahoma Delegation

Subject: Acquired Immune Deficiency Syndrome (AIDS)

Referred to: Reference Committee E
(John A. Martin, M. D., Chairman)

-
- 1 Whereas, Acquired Immune Deficiency Syndrome (AIDS) has in the last few years
2 become a hazard to our American society; and
3
4 Whereas, The American public has become very aware of this hazardous physical
5 illness; and
6
7 Whereas, The disease is spreading rapidly over all parts of this country; and
8
9 Whereas, The disease of AIDS is rapidly becoming a threat to the health of all of the
10 American people; and
11
12 Whereas, Most states have required premarital tests before a marriage license is issued;
13 therefore be it
14
15 RESOLVED, That the American Medical Association encourage continuing research
16 and studies concerning Acquired Immune Deficiency Syndrome (AIDS) and AIDS-related
17 complexes; and be it further
18
19 RESOLVED, That the AMA recommend that each of our fifty states encourage intro-
20 duction of legislation to require an HTLV-III test for AIDS for each person before a
21 marriage license can be issued.

Fiscal Note: \$2,500

1 (12) RESOLUTION 76 - ACQUIRED IMMUNE
2 DEFICIENCY SYNDROME (AIDS)

3
4 RECOMMENDATIONS:

5
6 Mr. Speaker, your Reference Committee recommends:

7
8 Recommendation 1:

9
10 That the second resolve of Resolution 76 be deleted.

11
12 Recommendation 2:

13
14 Mr. Speaker, your Reference Committee recommends that
15 Resolution 76 be adopted as amended.

16
17 Resolution 76 recommends that 1) the American Medical Association
18 encourage continuing research and studies on Acquired Immune Deficiency
19 Syndrome (AIDS) and AIDS-related complexes; and 2) that each of our
20 fifty states encourage introduction of legislation to require an HTLV-III
21 test for AIDS, for each person, before a marriage license can be issued.

22
23 The first Resolve of Resolution 76 is an affirmation of existing
24 AMA policy.

25
26 The second Resolve of Resolution 76 is not recommended for
27 adoption for the following reasons:

- 28
29 (a) the significance of a positive test for HTLV-III
30 antibodies in non-high risk groups is not thoroughly
31 understood;
32 (b) pre-marital screening tests are considered ineffective
33 as a public health measure;
34 (c) the resolve does not address what is to be done with the
35 results of the test;
36 (d) pre-marital screening for HTLV-III antibodies would
37 unnecessarily increase public anxiety about AIDS.

38
39 (13) RESOLUTION 96 - AIDS AND SCHOOL CHILDREN

40
41 RECOMMENDATION:

42
43 Mr. Speaker, your Reference Committee recommends that
44 Resolution 96 be referred to the Board of Trustees.

45
46 Resolution 96 asks that the AMA study the public health consequences
47 of allowing children with AIDS and AIDS Related Complex to attend school,
48 and to report back at the 1986 Annual Meeting.

1 (12) RESOLUTION 76 - ACQUIRED IMMUNE
2 DEFICIENCY SYNDROME (AIDS)

3
4 RECOMMENDATIONS:

5
6 Mr. Speaker, your Reference Committee recommends:

7
8 Recommendation 1:

9
10 That the second resolve of Resolution 76 be deleted.

11
12 Recommendation 2:

13
14 Mr. Speaker, your Reference Committee recommends that
15 Resolution 76 be adopted as amended.

16
17 Resolution 76 recommends that 1) the American Medical Association
18 encourage continuing research and studies on Acquired Immune Deficiency
19 Syndrome (AIDS) and AIDS-related complexes; and 2) that each of our
20 fifty states encourage introduction of legislation to require an HTLV-III
21 test for AIDS, for each person, before a marriage license can be issued.

22
23 The first Resolve of Resolution 76 is an affirmation of existing
24 AMA policy.

25
26 The second Resolve of Resolution 76 is not recommended for
27 adoption for the following reasons:

- 28
29 (a) the significance of a positive test for HTLV-III
30 antibodies in non-high risk groups is not thoroughly
31 understood;
32 (b) pre-marital screening tests are considered ineffective
33 as a public health measure;
34 (c) the resolve does not address what is to be done with the
35 results of the test;
36 (d) pre-marital screening for HTLV-III antibodies would
37 unnecessarily increase public anxiety about AIDS.

38
39 (13) RESOLUTION 96 - AIDS AND SCHOOL CHILDREN

40
41 RECOMMENDATION:

42
43 Mr. Speaker, your Reference Committee recommends that
44 Resolution 96 be referred to the Board of Trustees.

45
46 Resolution 96 asks that the AMA study the public health consequences
47 of allowing children with AIDS and AIDS Related Complex to attend school,
48 and to report back at the 1986 Annual Meeting.

OK

OK

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 96
(I-85)

Introduced by: Resident Physicians Section
Subject: AIDS and School Children
Referred to: Reference Committee E
(John A. Martin, M.D., Chairman)

1 Whereas, Acquired Immune Deficiency Syndrome can be transmitted
2 only via intimate contact or parentally; and

3
4 Whereas, School-age children have a right to quality education;
5 and

6
7 Whereas, Children may be stigmatized and psychologically damaged
8 by exclusion solely because of a diagnosis of "AIDS" or "Pre-AIDS";
9 and

10
11 Whereas, Many individuals have abnormal T4/T8 ratios who have
12 no signs or symptoms of AIDS; therefore be it

13
14 RESOLVED, That the American Medical Association study the public
15 health implications of allowing children with Acquired Immune Defi-
16 ciency Syndrome and AIDS Related Complex to attend classes and report
17 back at the 1986 Annual Meeting.

Fiscal Note: \$160,000

1 (12) RESOLUTION 76 - ACQUIRED IMMUNE
2 DEFICIENCY SYNDROME (AIDS)

3
4 RECOMMENDATIONS:

5
6 Mr. Speaker, your Reference Committee recommends:

7
8 Recommendation 1:

9
10 That the second resolve of Resolution 76 be deleted.

11
12 Recommendation 2:

13
14 Mr. Speaker, your Reference Committee recommends that
15 Resolution 76 be adopted as amended.

16
17 Resolution 76 recommends that 1) the American Medical Association
18 encourage continuing research and studies on Acquired Immune Deficiency
19 Syndrome (AIDS) and AIDS-related complexes; and 2) that each of our
20 fifty states encourage introduction of legislation to require an HTLV-III
21 test for AIDS, for each person, before a marriage license can be issued.

22
23 The first Resolve of Resolution 76 is an affirmation of existing
24 AMA policy.

25
26 The second Resolve of Resolution 76 is not recommended for
27 adoption for the following reasons:

- 28
29 (a) the significance of a positive test for HTLV-III
30 antibodies in non-high risk groups is not thoroughly
31 understood;
32 (b) pre-marital screening tests are considered ineffective
33 as a public health measure;
34 (c) the resolve does not address what is to be done with the
35 results of the test;
36 (d) pre-marital screening for HTLV-III antibodies would
37 unnecessarily increase public anxiety about AIDS.

38
39 (13) RESOLUTION 96 - AIDS AND SCHOOL CHILDREN

40
41 RECOMMENDATION:

42
43 Mr. Speaker, your Reference Committee recommends that
44 Resolution 96 be referred to the Board of Trustees.

45
46 Resolution 96 asks that the AMA study the public health consequences
47 of allowing children with AIDS and AIDS Related Complex to attend school,
48 and to report back at the 1986 Annual Meeting.

OK

OK

1 Referral is recommended because the Resolution addresses
2 a complex issue that requires careful investigation and thought.
3 Investigation of this issue is consistent with Report SS of the
4 Board of Trustees. Referral will permit adequate time to consider
5 the issue on an individual and community, as well as a national,
6 level. A report on the issue raised in Resolution 96 is anticipated
7 for the 1986 Annual Meeting.

8
9 (14) RESOLUTION 99 - HERPES SIMPLEX AND
10 SCHOOL CHILDREN
11

12 RECOMMENDATION:

13
14 Mr. Speaker, your Reference Committee recommends
15 that Resolution 99 be referred to the Board of
16 Trustees.

17
18 Resolution 99 asks that AMA support the rights of children
19 with herpes infections to attend school and to develop model legisla-
20 tion which would guarantee such rights.

21
22 This Resolution is unclear as to whether herpes simplex only
23 should be included or whether all herpes viruses are included. Referral
24 is recommended with a report to be prepared for the 1986 Annual Meeting.

25
26 (15) REPORT A OF COUNCIL ON SCIENTIFIC
27 AFFAIRS - EFFECTS OF PESTICIDE
28 EXPOSURE (RESOLUTION 42, I-84)
29

30 RECOMMENDATIONS:

31
32 Mr. Speaker, your Reference Committee recommends:

33
34 Recommendation 1:

35
36 That Report A of the Council on Scientific Affairs be
37 amended by substitution of the following paragraph
38 beginning on line 39, page 3 as approved by the Council
39 so that it reads: "The Council on Scientific Affairs
40 recognizes the need for better regulations, standards
41 and surveillance for pesticide application to assure
42 worker safety and environmental quality. The Council
43 believes that the AMA should strongly encourage the
44 appropriate governmental agencies and private organi-
45 zations to monitor closely the long-term effects of
46 pesticides upon exposed individuals, especially farm-
47 workers. The Council believes, however, that a thorough
48 evaluation of pesticide safety as proposed by Resolution
49 42 would not represent reasonable use of AMA resources."

50
51 Recommendation 2:

52
53 Mr. Speaker, your Reference Committee recommends that
54 Report A of the Council on Scientific Affairs be
55 adopted as amended in lieu of Resolution 42 (I-84).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 97
(I-85)

Introduced by: Resident Physicians Section
Subject: Discrimination of AIDS Patients
Referred to: Reference Committee E
(John A. Martin, M.D., Chairman)

1 Whereas, The HTLV III virus has never been shown to be transmitted
2 by casual contact; and

3
4 Whereas, AIDS patients have been the victims of discrimination;
5 and

6
7 Whereas, Legislation has been passed requiring that HTLV III
8 positive patients be reported to state health authorities; therefore
9 be it

10
11 RESOLVED, That the American Medical oppose discrimination against
12 AIDS patients or individuals with HTLV III positive serum and individuals
13 at increased risk in developing AIDS; and be it further

14
15 RESOLVED, That the AMA oppose any local, state or federal legisla-
16 tion that would lead to such discrimination, or that would invade
17 patient/doctor confidentiality.

Fiscal Note: \$50,000 - \$100,000

CONSENT CALENDAR ---REFERENCE COMMITTEE E

OK 1 RECOMMENDED FOR ADOPTION:

2
3 (18) RESOLUTION 90
4 SMOKELESS TOBACCO

5
6 (19) RESOLUTION 109
7 TOBACCO PRODUCT SALES

8
9 (20) RESOLUTION 60
10 TOBACCO-FREE SOCIETY BY 2,000

11
12 (21) REPORT T OF BOARD OF TRUSTEES
13 ALCOHOL-RELATED INJURIES REQUIRING MEDICAL CARE
14 (IN LIEU OF RESOLUTION 168, A-84)

15
16 (22) REPORT J OF BOARD OF TRUSTEES
17 REPORTS OF THE COUNCIL ON SCIENTIFIC AFFAIRS

18
19 (23) RESOLUTION 15
20 DISSEMINATION OF CSA INFORMATION

21
22 (24) RESOLUTION 89
23 THERAPEUTIC AND PHARMACEUTICAL ALTERNATIVES BY PHARMACISTS

24
25 (25) RESOLUTION 66
26 ADVERTISING OF PRESCRIPTION DRUGS

27
28 (26) REPORT M OF BOARD OF TRUSTEES
29 JOINT VENTURE WITH USPC, INC.
30 (IN LIEU OF RESOLUTION 91, A-85)

31
32 (27) REPORT C OF COUNCIL ON SCIENTIFIC AFFAIRS
33 ANTIBIOTICS IN ANIMAL FEEDS
34 (IN LIEU OF RESOLUTION 54, A-84)

35
36 (28) RESOLUTION 106
37 SUBSTANCE ABUSE

38
39 (29) RESOLUTION 9
40 PHARMACEUTICAL COSTS

41
42 (30) REPORT PP OF BOARD OF TRUSTEES
43 AIDS AND HTLV-III ANTIBODY TESTING
44 (IN LIEU OF RESOLUTION 9, A-85)

45
46 [(31) RESOLUTION 97
47 DISCRIMINATION OF AIDS PATIENTS

48
49 (32) REPORT I OF BOARD OF TRUSTEES
50 CLINICAL LABORATORY TESTS AND STANDARDS
51 (IN LIEU OF RESOLUTION 3, I-84; RESOLUTION 48, A-89)

withdrawn

referred

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(I-85)

Introduced by: Section on Medical Schools

Subject: Task Force on AIDS

Referred to: Reference Committee E
(John A. Martin, M.D., Chairman)

-
- 1 Whereas, Reports on Acquired Immune Deficiency Syndrome (AIDS) in
2 leading scientific publications and responsible segments of the media
3 have contributed significantly to the medical profession's and the
4 public's understanding of this disease; and
5
6 Whereas, Coverage of AIDS by the media has caused unfounded fear of
7 contagion among some health care workers and the general public; therefore
8 be it
9
10 RESOLVED, That the American Medical Association establish a task
11 force to review and support the Center for Disease Control guidelines
12 for protection of health care workers and to develop ways to enhance
13 understanding of the disease and appropriate precautions recommended
14 for health care workers, including physicians, and for the general public.

Fiscal Note: \$40,000

1 (10) RESOLUTION 70 - CONTROL STUDY
2 OF HEROIN
3

4 RECOMMENDATION:
5

6 Mr. Speaker, your Reference Committee recommends
7 that Resolution 70 be referred to the Board of
8 Trustees *rept back A86.*
9

10 Resolution 70 asks that the AMA encourage the National Institutes
11 of Health to conduct a controlled study to evaluate heroin as compared
12 to other available narcotics in the treatment of patients suffering
13 intractable pain due to cancer.
14

15 All in attendance were sympathetic to the goal of providing optimal
16 pain relief to cancer patients. However, because a controlled study of
17 pain relief with heroin is now underway, referral is suggested.
18

19 (11) REPORT SS OF BOARD OF TRUSTEES
20 AMA ACTION PLAN FOR AIDS AND
21 RELATED CONDITIONS
22 RESOLUTION 108
23 TASK FORCE ON AIDS
24 RESOLUTION 113
25 SOCIETAL CONSEQUENCES OF AIDS
26

27 RECOMMENDATION:
28

29 Mr. Speaker, your Reference Committee recommends that
30 Report SS of the Board of Trustees be adopted in lieu
31 of Resolutions 108 and 113.
32

33 Report SS of the Board of Trustees describes an AMA action plan
34 to disseminate information about AIDS to physicians and to establish
35 physicians as the most credible accessible source of AIDS information
36 for the public.
37

38 Resolution 108 calls for the AMA to establish a task force to
39 review and support the Centers for Disease Control guidelines concerning
40 protection of health care workers from AIDS and to enhance understanding
41 of the disease and appropriate precautions required to prevent infection
42 of health care workers.
43

44 Resolution 113 asks that AMA (1) include the concerns of the
45 general public in its task force on AIDS, (2) work with the Centers
46 for Disease Control in a public education program about AIDS, and
47 (3) investigate the financial problems of patients in high risk groups
48 in obtaining health insurance as well as the financial difficulties of
49 institutions that treat a disproportionate number of AIDS patients.
50

51 Resolutions 108 and 113 are encompassed in activities proposed
52 by Report SS of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(I-85)

Introduced by: Medical Student Section
Subject: Societal Consequences of Aids
Referred to: Reference Committee E
(John A. Martin, M.D., Chairman)

1 Whereas, AIDS (Acquired Immune Deficiency Syndrome) was first
2 described in the summer of 1981 and continues to affect all of our
3 society in epidemic fashion today, the fear of this syndrome's
4 potential capabilities has turned into irrational phobias on the
5 part of many uninformed Americans; and
6

7 Whereas, Public concern over the disease is now approaching
8 hysteria in some instances with children being prohibited from
9 attending school, blood supplies dropping to dangerously low levels
10 and job discrimination against those with the disease continuing to
11 exist; and
12

13 Whereas, Well-defined risk factors are known predisposing
14 individuals to acquisition of the HTLV-III/LAV virus through careful
15 research and epidemiological study as published by the U.S. Centers
16 for Disease Control; and
17

18 Whereas, The fears of certain Americans in the educational
19 system's hierarchy have affected the social and mental well-being of
20 our children by deeming them unfit to attend school for fear of trans-
21 mitting the virus to other children; and
22

23 Whereas, This isolation may only further heighten such unfounded
24 acts and allow for widespread dissemination of misinformation to the
25 people of the United States and the World; and
26

27 Whereas, The number of AIDS cases doubles every ten months,
28 thereby increasing the need for accurate public education; therefore be it
29

30 RESOLVED, That the American Medical Association broaden the scope of
31 its Task Force on Acquired Immune Deficiency Syndrome (AIDS) to address
32 the concerns of the general public; and be it further
33

34 RESOLVED, That the AMA work with the Centers for Disease Control to
35 educate the general public including educators, parents, and the legal
36 profession about AIDS developments in a timely and effective manner; and
37 be it further
38

39 RESOLVED, That the AMA investigate the financial difficulties faced
40 by institutions which treat a disproportionate number of AIDS patients,
41 as well as the difficulty encountered by HTLV-III seropositive individuals,
42 members of high risk groups and AIDS patients in obtaining health insurance.

Fiscal Note: \$40,000 to \$100,000 depending upon the size and scope
of the study

1 (10) RESOLUTION 70 - CONTROL STUDY
2 OF HEROIN
3

4 RECOMMENDATION:
5

6 Mr. Speaker, your Reference Committee recommends
7 that Resolution 70 be referred to the Board of
8 Trustees *rept back A86.*
9

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