DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

March 19, 1985

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Dear Neil:

Thank you for the letter and the fine Task Force document. As usual, your sentiments and your actions parallel mine. Let me now continue on with my thoughts about the future - especially the use of serologic testing for control of transmission. I have tried to further record some of my thoughts regarding control and trace out the reasoning which, I personally, believe will best set us up to minimize future virus transmission.

As I have stated, the overall concept is to identify "all" susceptible and infected people in AIDS risk groups by using the best test available (currently ELISA antibody testing). The major purpose of this would be to organize a currently disorganized situation. Specifically, the identification of susceptible and infected people would allow currently dispersed people and resources to be united to maximize both medical care and disease control. As you so well know, the resources for AIDS have always lagged far behind the need. My hope is that infection-specific identification will both allow these thin resources to be better used and allow speedier allocations of additional resources.

The major premise for identification of susceptible and infected individuals is that it makes both medical and public health sense. In addition, it should add substantial order to the political process of resource allocation.

Let me explain my logic. Medically, the knowledge of a patient's infection status will allow counselling regarding health status and risk reduction to be much more accurate and specific. Although your "assume positive" counselling is logical in the absence of knowledge, I believe that counselling with actual knowledge will have a more real, and thus more effective, impact. I, like you, am concerned about the psychologic impact of this knowledge. Yet, even with this concern, I think testing is justified and, indeed, preferable. My reasoning for this goes like this: first, I believe that humans do better with knowledge than without it, and second, I have great faith in peoples' responses to adversity. Furthermore, in the absense of infection status the individual's or doctor's assumption will often be wrong resulting in poorly founded behavioral or psychologic adjustments being adapted. Besides counselling, I think medical follow-up of infected and non-infected individuals should be differentiated. Infected, and thus "at risk", individuals should be treated differently than uninfected individuals for a variety of medical conditions. Early and aggressive treatment of acute diseases (especially respiratory infections), plus the institution of a variety of prophylactic regimens which will no doubt be developed will, I presume, improve both the quality of life and the longevity of life.

Prevention-wise, identification of infected and susceptible individuals is clearly important. Infectious disease control since the emergence from the miasma theories has been based on separating infectious and susceptible people. In the case of AIDS virus, quarantine in a classic sense is not required because the infectivity of infectious people is low. If individuals are conscientious, voluntary or group-enforced "isolation" from some at-risk practices (eg sexual relations) would, I'm sure have a great effect on decreasing transmission. Furthermore, the identification of susceptible individuals together with subsequent testing will accurately assess control strategies and allow for rapid change should significant continuing transmission be noted.

Serologic testing should also add organization to resource acquisition efforts. First, it will provide accurate sero-prevalence information which will allow accurate disease incidence estimates which will be invaluable in obtaining future funding for research and control. Second, it will automatically establish individual interest groups who will encourage expenditures for specific aspects of AIDS treatment and control. The infected group will encourage anti-viral, prophylaxis, and treatment research and, where appropriate, treatment and counselling programs. The non-infected group will encourage vaccine and other control-oriented research and, where appropriate, control programs.

But can confidentiality be assured, especially for groups at risk of political reprisal? Confidentiality is a relative term, no doubt, but the record of health departments and physicians has been good. Public clinics and private physicians have routinely kept medical records which mention sexual preference and IV drug use. To my knowledge, the confidentiality of these records has never been breached. With AIDS the awareness regarding confidentiality has increased substantially and I see little potential for violation, even considering the current national political climate.

Another question involves anti-homosexual sentiments of the non-homosexual community regarding the spread of the AIDS virus. It is obviously important that the public realize that the homosexual community is doing its utmost to prevent further virus transmission. Everyone, both gay and straight, wants transmission of the AIDS virus to be stopped and nobody wants anyone else to be infected. But it is important that all groups openly express this axiom and that everyone knows what groups are doing to decrease transmission. This expression was well stated (in action) by the gay community's response to transfusion-associated AIDS where, even before many members of the blood collection system universally accepted transmission via transfusion, the leaders of the community asked other gay men not to donate blood. A similar expression, but with an even greater potential effect on the gay community itself, is being made as gay leaders continue to aggressively pursue funding for control programs. Because serologic testing may be an important adjunct to control programs, I ask that you and others not oppose the concept of serologic screeing.

It is important to note, Neil, that I say "not oppose". Why can't individual men decide themselves whether or not they wish to be tested? Certainly they should understand the ramifications, for I agree with you that this test is different from other laboratory tests, but they should decide as individuals what to do. I suggest that the issue we have been discussing in a narrow sense, serologic testing, not be further elevated to a major issue. The issue that we both feel is paramount is how to stop AIDS virus transmission now. Our control tools are very limited at this point, but, despite this, we may still be able to have a profound effect if a national control program is instituted. For the points outlined above, I personally think the foundation of that control program should be infection-specific counselling and medical follow-up. I may be wrong, but if I am right, continued one sided arguments now against testing may limit future options and thus inhibit the control of transmission.

Let me know your opinion. It will be, as it always has been, well thought out and I respect it greatly.

With best wishes.

Sincerely,

Don

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