

File
AIDS in
workplace

University of California

AIDS-Related Policies and Guidelines

Recommendations of the AIDS Policy Steering Committee

Office of the President
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Table of Contents

	<u>Page Number</u>
Introduction and Summary	1
Medical information about AIDS	2
The nature and cause of AIDS; the mode of transmission; control of the spread of the infection.	2
The AIDS antibody test and its use; the meaning of a positive test result.	4
Relevant University Policies	5
Policies and issues of concern to students.	5
Policies and issues of concern to academic and staff employees.	7
Issues pertaining to the safety of the workplace.	9
Unanticipated AIDS-related issues.	10
Guidelines and Recommendations Developed by Public Health Officials and Professional Organizations	11
Responses of the University to the AIDS Epidemic	12
Recommendations	12
Appendix - Pertinent Guidelines Issued by the Centers for Disease Control	
Members - AIDS Policy Steering Committee	

INTRODUCTION AND SUMMARY

The emergence in the past few years of acquired immune deficiency syndrome (AIDS) as a major public health problem that has impact on all segments of society, including the University of California, has generated not only compassion for those who suffer from this disease, but also anxiety about its spread. In order to be able to protect the rights of persons with AIDS and of those who interact with them in the course of their normal University-related activities, the University recognizes the need to examine its policies affecting faculty, students, and staff and to determine whether the existing policies are adequate, insofar as they bear on AIDS-related issues.

To address these issues, the President of the University appointed a committee that is chaired by the Vice President for Health Affairs and consists of administrators responsible for faculty, student, and staff affairs and of additional individuals trained in law, medicine, and ethics. This committee, the AIDS Policy Steering Committee, undertook a detailed analysis of the University's policies, reviewed the medical and epidemiologic information on AIDS available to date, examined relevant guidelines issued by several responsible bodies, and considered the legal and ethical issues involved.

After the review of this information and extensive deliberations, the Steering Committee concluded that existing University policies and practices are adequate for dealing with the AIDS-related situations that can be anticipated to occur, given the available information about AIDS and the evidence that the AIDS virus is not transmitted by casual contact. Consequently, the Steering Committee does not recommend any changes in or additions to University policies at this time. The committee recognizes, however, that the AIDS epidemic places new responsibilities on the University to reduce anxiety about the public health aspects of the disease, to be sensitive to the concerns of both individuals with AIDS and those who come in contact with them in the course of their University activities, and to apply all University policies in a nondiscriminatory manner and in compliance with applicable laws. Moreover, as neither a cure nor a vaccine for AIDS is likely to be available in the near future and therefore education about the mode of transmission of the AIDS virus is the best defense against its widespread dissemination, the University has a moral obligation to make current medical information available on all campuses. Once such information is being provided, the University may have a legal obligation to continue this practice, unless formal notice is given that it will be discontinued.

MEDICAL INFORMATION ABOUT AIDS

The nature and cause of AIDS; the mode of transmission; control of the spread of the infection.

AIDS was first recognized as a clinical entity in 1981. It represents the severe end of a broad clinical spectrum and is characterized by a defect in natural immunity that leaves the patient vulnerable to certain infections and malignancies which are not a threat to individuals whose immune system functions normally. Most of the patients appearing at clinics and doctors' offices present with swollen lymph glands, minor irregularities in the immune response, and generalized complaints of fatigue, night sweats, fevers, weight loss, chills, and diarrhea. To date, about 10-15% of these patients have developed full-blown AIDS, a diagnosis that is made only when a patient has fulfilled certain clinical criteria established by the Centers for Disease Control (CDC) of the United States Department of Health and Human Services. These include the presence of unusual opportunistic infections, such as Pneumocystis carinii pneumonia, and/or unique malignancies, such as Kaposi's sarcoma without the usual predisposing conditions. The mortality rate in patients with the full-blown disease is 100%. In the patients who do not progress to full-blown AIDS, the early symptoms, which have come to be known as AIDS-related complex (ARC), persist for variable lengths of time. Many ARC patients have died from these debilitating conditions. Some patients with AIDS or ARC also suffer from neurological disturbances.

In the United States, the great majority of AIDS patients falls into certain high-risk groups, i.e., sexually active homosexual and bisexual men, intravenous drug abusers, sexual partners of AIDS patients or members of high-risk groups, recipients of blood transfusions and blood products (before the screening of blood), persons with hemophilia and other coagulation disorders, and children born of mothers who have AIDS or are members of high-risk groups.

AIDS is caused by a retrovirus, variously referred to in the technical literature as lymphadenopathy-associated virus (LAV), human T-lymphotropic virus type III (HTLV-III), AIDS-associated retrovirus (ARV), or human immunodeficiency virus (HIV), and in this document as AIDS virus. The AIDS virus infects primarily certain white blood cells, the T-helper/inducer lymphocytes which play a key role in the body's immune response to foreign substances, but also other immune system cells and occasionally brain cells. Thus, infection can lead to profound disturbances in immune function and may account for the neurological symptoms observed in some patients with AIDS or ARC. The virus has been found in blood and semen, to a much lesser extent in other body fluids, such as saliva and tears, and in the cerebrospinal fluid and brain tissue of patients with neurological disturbances. The AIDS

virus is transmitted by sexual contact, by the administration of blood and blood components, by the sharing of hypodermic needles, and from an infected mother to her infant before, during or shortly after birth. No evidence is available pointing to the transmission of the AIDS virus as a result of casual contacts, from sharing a household or an office, through food and water, and by insects. Occupational transmission to health care workers is an extremely uncommon event, despite extensive exposure to AIDS patients and needlestick and other accidents with contaminated patient fluids.

It must be stressed that infection with the AIDS virus is not synonymous with the presence of clinical disease, either ARC or AIDS. The incidence of infection (as detected by the presence of serum antibodies to the AIDS virus) is high in high-risk populations, but most infected individuals have no symptoms and may never develop any. Nevertheless, such individuals rarely become free of the virus and must be considered to be carriers who can transmit the infection to others under appropriate circumstances. The time interval between viral infection and the appearance of symptoms (the incubation period) can vary from several months to five or more years in adults, suggesting that the course of the infection may be influenced by the virulence of the infecting virus strain or by cofactors, such as immunosuppressive drugs, severe malnutrition, infection with other viruses, and development of autoimmune manifestations.

While current knowledge about the epidemiology, pathogenesis, and clinical features of AIDS is still far from complete and changing rapidly, it has provided a basis for instituting measures aimed at controlling the infection. The adoption of stringent procedures to ensure the safety of the blood supply and of clotting factor concentrates has virtually eliminated the risk of infection through administration of these products. Recommendations have been made to high-risk groups to modify sexual practices, to avoid the sharing of needles, and to refrain from donating blood or organs. Infected women are advised to avoid pregnancy. Although the effectiveness of such measures has not been fully demonstrated, adherence to these recommendations can be expected to decrease, and to some extent already has decreased, the dissemination of the virus. As it is unlikely that safe and effective measures that can prevent infection with the virus and eliminate an established infection, i.e., a vaccine and an antiviral therapy, respectively, will be available in the immediate future, reduction of the rapid spread of the AIDS virus can be achieved at this time only by an educational program that emphasizes recognition of the need to change personal behavior patterns.

The AIDS antibody test and its use; the meaning of a positive test.

Shortly after the discovery of the AIDS virus, reagents and procedures for detecting antibodies to the virus were developed. Antibodies are proteins that are made by immune system cells in response to the presence of foreign substances, primarily infectious agents, that can react specifically with the inciting substance, and that can be detected by appropriate laboratory tests. All commercially available and licensed tests to detect antibodies to the AIDS virus employ a method called ELISA and require a blood (serum) specimen. This test is very sensitive and quite specific, but it is subject to a variety of errors which may lead to "false positive" reactions. Consequently, all sera found positive by the ELISA method are retested by a more cumbersome method, either the western blot or the immunofluorescence assay. Both these tests are unlicensed, but they are more specific than the ELISA, and the likelihood is very high that they yield only "true positive" reactions.

The inference to be drawn from a positive antibody test is that the blood specimen was obtained from an individual who, at some time, became infected with the AIDS virus. It is not possible to tell, by the presence of antibodies, when the person was infected. The presence of antibodies does not necessarily signify immunity to the virus. The antibody test does not provide direct information about whether or not a person harbors the virus, but data on the fate of the AIDS virus in infected individuals indicate that a positive antibody test must be considered as presumptive evidence that the individual is a carrier of the virus, i.e., is currently infected and infectious. At this time, any prediction as to the likely clinical consequences of a positive antibody test must be extremely guarded.

Clinicians agree that the AIDS antibody test is helpful in excluding AIDS as a diagnostic possibility in a patient with ambiguous or undefined illnesses that resemble AIDS or ARC. As a screening tool, the AIDS antibody test is very effective in safeguarding the nation's blood supply by identifying potential virus carriers. It is also a valuable research tool for seroepidemiologic studies of the biology of infection with the AIDS virus, providing the nationally endorsed guidelines of voluntary participation, informed consent, and institutional review of human studies are enforced. The test, if taken voluntarily and anonymously, is appropriate also for individuals who wish to use the information as a personal health guide. Legislation recently enacted in the State of California makes it illegal to require an AIDS antibody test or to use the results of such a test as the basis for any employment or insurability decision.

RELEVANT UNIVERSITY POLICIES

Policies and issues of concern to students.

Nondiscrimination

Discrimination based on the disabling effects of AIDS and its related conditions is prohibited by federal and state law, as well as University policy. Sections 20.00 to 21.162 of the Policies Applying to Campus Activities, Organizations and Students, Part B, Revised October 31, 1983, have applicability to essentially all individuals and activities on University property.

Admissions

It is University policy to base admissions on academic criteria, not on medical information. In the light of currently available information about AIDS and the transmission of the AIDS virus, there is no reason to alter existing admissions criteria. Programs which require clinical interaction between students and patients, however, present unique circumstances which will be addressed and may require special University guidelines.

Athletics and Physical Education

Decisions whether students who identify themselves as having AIDS or ARC may participate in organized sports activities should be made on an individual basis, in consultation with the student and his or her physician. There are no reasons, based on current knowledge, to prohibit students with AIDS, ARC, or a positive AIDS antibody test from using the University's recreational facilities, including swimming pools and showers.

Child Care Services and Demonstration Schools

Different philosophies and approaches have developed regarding the advisability of allowing children with AIDS to attend school and child care facilities. Staff of campus child care centers and demonstration schools should be familiar with and follow the CDC's recommendations on the education and foster care of children infected with the AIDS virus, including asymptomatic carriers and children with AIDS and ARC. (Applicable CDC recommendations are listed in the Appendix.)

Class Attendance

Students with AIDS or ARC should attend classes and participate in all aspects of their academic programs. Exceptions to this practice would be made when, in the judgment of the attending physician, a student with AIDS

may be at risk of getting other infections or be too ill to continue his or her studies or activities. Whenever possible, reasonable accommodations should be made for students with AIDS.

Financial Aid

University policies relating to financial aid apply equally to all students attending the University. If the course load of a student with AIDS needs to be modified or reduced for medical reasons, existing guidelines pertaining to reduced courseloads of disabled students should be followed.

Food Services

Decisions regarding the employment in food services of students with AIDS, ARC, or a positive AIDS antibody test should follow established University Environmental Health and Safety Standards and applicable CDC recommendations.

Housing

Decisions about residential housing of students with AIDS, ARC, or a positive AIDS antibody test must be made on a case-by-case basis. Currently available medical information does not support the existence of a risk to those sharing dormitories with individuals infected with the AIDS virus. Living arrangements should be discussed openly with infected students and whenever possible (and agreed to by the student) with roommates, so that the roommates can be fully informed regarding the transmission of the AIDS virus and the perceived risks.

In some circumstances there may be reasonable concern for the health of students with AIDS or ARC who might be exposed to certain contagious diseases, such as measles or chicken pox, in a close living situation. University health officers may wish to recommend that students with AIDS or ARC be assigned to private rooms or alternative housing in the interest of protecting the health of the students with AIDS or ARC.

Student Records

Disclosure of personal information, including medical information, from student records to third parties is governed by federal and California laws. Current University policy (Sections 10.00 to 11.30 of the University's Policies Applying to Campus Activities, Organizations and Students, Part B, Revised October 31, 1983) provides that confidential information from student records can not be disclosed to third parties without first securing the written consent of the student or satisfying

the conditions of third party disclosures set forth in applicable law and University policy. Campus officials and employees may have a right of access to confidential information in student records without the written consent of the student if it has been determined that a request for such information fulfills a "legitimate educational interest." Given that no evidence exists that AIDS is transmitted by casual contact, such as sitting side by side in class, eating in the same dining facility, or using the same bathroom or toilet facilities, the "legitimate educational interest" criterion can generally not be met. Therefore, staff who know that a student has AIDS or ARC or tested positive for antibodies to the AIDS virus should not disclose this information to other campus officials or employees unless written consent is secured from the student.

ROTC Classes

University policies apply to ROTC courses just as they do to other courses. Therefore, ROTC courses are open to all students, regardless of the state of their health. Department of Defense policies with respect to testing for AIDS virus antibodies apply only at the time of commissioning into the Armed Forces and do not affect participation in ROTC classes.

Policies and issues of concern to academic and staff employees.

The University policies described below pertain to academic and staff employees not covered by collective bargaining agreements. For academic and staff employees represented by certified bargaining agents, existing collective bargaining agreements contain provisions which ensure rights and safeguards parallel to the provisions of Executive Program Personnel Policies (EP), Management and Professional Program Personnel Policies (MAP), Staff Personnel Policies (SPP), and the Academic Personnel Manual (APM). It must also be pointed out that this report takes no precedence over established University personnel policies and that some of the policies listed in this section may not apply to all employees, e.g., casual, casual/restricted, or contract employees.

Nondiscrimination

AIDS and ARC are substantially more prevalent at present among homosexual men than any other population subgroup; however, University policy prohibits discrimination in employment based on sexual orientation and provides for resolution of discrimination complaints through the applicable grievance or appeal procedure (EP 2; MAP 12; SPP 200.1; APM 035).

Employee Records

According to policy and law, personal information (which includes medical information) in University employee records cannot be released to the public in the absence of consent or appropriate legal process (EP 20; MAP 60; SPP 605.19; APM 158 and 160). It can be released to other University employees, but only if such information is necessary to the performance of that person's assigned University duties, such as the processing of disability claims filed by the employee (EP 20; MAP 60; SPP 605.16; APM 158, 160 and 165).

Employment

University policy requires that each employment decision is made on the basis of job related criteria (SPP 211.1*). Care should be taken, however, to ensure that assigned duties can be carried out in a manner that safeguards the welfare of the individual and of others (SPP 211.15). It is illegal to require a blood test for antibodies to the AIDS virus or to use the results of such a test as the basis of any employment decision.

Grievances and Appeals

As stated under the section on nondiscrimination, employees can appeal discrimination on the basis of sexual orientation. Employees can also appeal misapplication or discriminatory application of the sick leave, leave of absence, separation, and records policies (EP 22; MAP 70; SPP 280 and 290; APM 140, Academic Senate Bylaws 112 and 113).

Medical Separation

Medical separation may be pursued only if an employee can no longer perform the essential functions of the job even with reasonable accommodation (MAP 78; SPP 765), if the employee has exhausted sick leave and personal leave, and if the separation will not jeopardize the right to apply for disability provided by the employee's retirement system (MAP 78; SPP 765.6). A medical diagnosis is required for processing disability claims.

* When no reference to an EP, MAP or APM policy is made, University practice is to conform to general employee relations practices or to handle the case on an individual basis.

Probationary Period

Employees with AIDS or ARC who are in probationary status are to be treated as any other employee on probation. Time off work, e.g., for illness, extends the probationary period, giving the department head a full evaluation period (SPP 250.1). Probationary status is not applicable to most academic employees or to employees covered under the provisions of EP or MAP.

Rehabilitation

It is University policy to provide information about rehabilitation services and reasonable accommodation to persons with various illnesses, including AIDS and ARC. Such accommodation may include work schedule changes or time for medical treatment (EP 23; MAP 80; SPP 764). Management may request a medical diagnosis before arranging the necessary accommodation.

Sick Leave and Leaves of Absence for Illness

Sick leave (EP 15; MAP 53; SPP 410; APM 710) and leaves of absence for illness (EP 16, 17; MAP 55; SPP 430; APM 758 and 759) should be administered in the case of individuals with AIDS or ARC according to current practice and the appropriate personnel policies. A department head may not request a medical diagnosis, as the nature of an illness is not necessary to administer sick leave (EP 20; MAP 60; SPP 605.1; APM 158 and 160). However, an employee can be asked to provide a physician's certification of ability to work, whether there are any work restrictions, or amount of time needed for medical leave (SPP 410.6c; APM 710). A leave of absence should not be denied for the sole reason that it is not expected that the employee will return to work.

Issues pertaining to the safety of the workplace.

Under ordinary occupational conditions, academic and staff employees are not subjected to health risks by associating with coworkers, students, or clients who are infected with the AIDS virus, as no evidence exists that the virus is transmitted by the casual person-to-person contact that generally occurs in offices, classrooms, dining halls, dormitories, etc. In certain occupational settings, such as hospitals, clinics, blood banks, and laboratories, on the other hand, health care workers may, in the course of their duties, have more than casual exposure to patients infected with the AIDS virus and to their blood or other body fluids. Established hospital procedures appropriate for preventing the transmission of bloodborne infectious diseases should be rigorously enforced in all such instances. Experience has shown that these procedures are effective, except in very rare

cases, in preventing the occupational transmission of the AIDS virus to health care workers. The occupational exposure of health care workers who perform invasive procedures, e.g., surgeons and dentists, should be managed by following the applicable CDC recommendations.

It is the policy of the University to maintain a safe work environment and the right of the University to make appropriate work assignments. If an employee resists working in an environment that involves contact with persons infected with the AIDS virus, the employee should be directed to a person who is knowledgeable about the transmission of the AIDS virus and who can fully address the employee's concerns.

In the case of health care workers who are infected with the AIDS virus, consideration must be given to the fact that they are at increased risk of acquiring other infectious diseases in the work place because of their impaired immune systems.

Such workers should be counseled about the potential risk of caring for patients with transmissible infections and should follow existing recommendations for infection control. Changes in work assignment may be indicated on an individual basis after consulting the worker's personal physician and the institution's employee health service.

A corollary issue concerning health care workers who are infected with the AIDS virus is that a risk of transmitting the virus to patients would exist in situations where blood or serous fluid from the infected health care worker could gain entry to the tissues of the patient, for example, if the health care worker sustains a needlestick or scalpel injury during an invasive procedure. Precautions to prevent transmission of the infection to patients have been promulgated by the CDC and include the recommendation that health care workers who have exudative lesions refrain from all direct patient contact until the condition resolves. Accommodation of work assignments should be made in such instances.

Unanticipated AIDS-related issues.

While the AIDS-related issues that are expected to arise are covered or may be accommodated by existing University policies, unforeseen situations may develop to which specific policies can not be applied and which need to be addressed on a case-by-case basis. Under such circumstances, the following guidelines should be observed:

1. the health and safety of all individuals should be given the highest priority;
2. each person's right to privacy should be protected;

3. University officials should consult medical staff and the most recent information and guidelines available from public health officials and professional organizations to arrive at the most appropriate response to the specific situation; and
4. in the event that additional specialized (medical) expertise is required, questions may be referred to the President's Technical Advisory Committee on AIDS (See RECOMMENDATIONS).

GUIDELINES AND RECOMMENDATIONS DEVELOPED BY PUBLIC HEALTH OFFICIALS AND PROFESSIONAL ORGANIZATIONS

The most widely accepted recommendations for dealing with AIDS-related issues are those developed by the Centers for Disease Control (CDC) of the United States Department of Health and Human Services (see Appendix). These guidelines are based on the most recent medical, scientific, and epidemiologic findings and represent the consensus of experts in the public and private sectors. It is expected that the CDC will up-date the existing recommendations and issue additional recommendations as new knowledge becomes available.

Several relevant professional organizations, e.g., the Association of American Medical Colleges and the American College Health Association, developed and distributed guidelines for dealing with AIDS-related issues on University campuses. In essence, these guidelines recommend adherence to and basing policy decisions on the CDC recommendations. Other professional organizations, such as the Hospital Council of Southern California, provided copies of the CDC guidelines to members without analysis and overview because of the urgency to disseminate this information.

The Hospital Council of Southern California also sent to its members a memorandum entitled "The AIDS Crisis and Employment Issues" prepared by its General Counsel, Musick, Peeler and Garrett. This memorandum addresses several areas of concern to hospitals from the legal perspective and counsels adoption and implementation of an educational program designed to minimize the anxiety of employees. Such a program would provide available information on the transmission of AIDS and affirm management's policy of basing employment decisions on case-by-case considerations of an employee's ability to perform the duties of a given position, making reasonable accommodations to specific situations, and safeguarding the interests of all individuals concerned.

The Association of American Medical Colleges provided its members with a review of the legal questions and implications of AIDS, entitled "AIDS on Campus: Emerging Issues for College and University Administrators," prepared by Sheldon

Elliot Steinbach, General Counsel of the American Council of Education. This document takes the position that institutions may on occasion contemplate more vigorous responses to certain issues than those recommended by the CDC, but counsels careful consideration of qualified medical and legal opinions before taking such actions.

The positions taken by these professional societies reinforce the unanimous opinion of the members of the AIDS Policy Steering Committee that the most responsible approach to the analysis of the adequacy of existing University of California policies for addressing AIDS-related issues must be based on the most recent technical information and the relevant CDC recommendations.

RESPONSES OF THE UNIVERSITY TO THE AIDS EPIDEMIC

The University's campuses have taken a number of steps to educate students, faculty, and staff regarding AIDS. These efforts have included campus-wide symposia and workshops, group discussions in residence halls, distribution of printed materials, individual counseling in student health centers, referrals to community clinics and AIDS antibody testing centers, and establishment of AIDS education telephone lines.

RECOMMENDATIONS

The AIDS Policy Steering Committee makes the following recommendations:

1. that the University's response to the AIDS epidemic focus on the strengthening of efforts to make accurate and up-to-date medical and epidemiologic information, as well as individual counseling, available to all members of the University community;
2. that the President establish a Technical Advisory Committee on AIDS and that each Chancellor appoint a local advisory committee;
3. that no changes in or additions to existing University policies be made at this time; and
4. that these recommendations be reviewed periodically and revised as appropriate.

The University's AIDS-related educational effort should be two-pronged. The University should continue to employ a variety of methods to convey information to faculty, students, and staff for their personal guidance. This is particularly important in the case of students who may be confronting sexual issues for the first time and individuals in identified high-risk groups. More specialized programs should be developed for administrators, supervisory staff, faculty,

counselors, and others who must deal with AIDS-related issues in discharging their responsibilities to the University. With respect to these activities, the University has a duty to ensure that due care is taken to disseminate correct and current information. In order to avoid potential liability based upon the University community's reliance on information given, the University must give formal and public notice that it is disengaging itself from these efforts should it decide to stop providing information.

A specific recommendation of the AIDS Policy Steering Committee is that the President establish a Technical Advisory Committee on AIDS and that its membership be composed of individuals with training in medicine, public health, law, and ethics. This committee would act in an advisory capacity to the President and, on request, to the Chancellors by providing the expertise needed to interpret new findings about AIDS and the AIDS virus that might influence decisions concerning the formulation or amendment of University policies, to address and resolve particularly sensitive or newly emerging issues, and to coordinate relevant policies of individual campuses. A related recommendation is that each Chancellor appoint a technical advisory committee composed of knowledgeable individuals on that campus. Each local committee would act in an advisory capacity to its Chancellor, review and screen all issues intended for referral to the President's Technical Advisory Committee, and ensure that the campus disseminates current and valid information about AIDS and the AIDS virus.

The Steering Committee's position regarding the adequacy of existing University policies for dealing with foreseen AIDS-related situations is based on in-depth examinations of current policies and practices, of available medical and epidemiologic information about AIDS and the AIDS virus, of the recommendations developed by the CDC, and of relevant legal and ethical issues. The evidence that the AIDS virus is not transmitted by casual contact had particular impact on the adoption of the above position. It is the Committee's recommendation that the University should consider each AIDS-related situation on a case-by-case basis and adhere to applicable CDC guidelines (see Appendix) for preventing the transmission of the AIDS virus.

Since new knowledge about AIDS is developing rapidly, the Steering Committee further recommends that the University periodically review its policies, insofar as they may bear on AIDS-related issues, in the light of then available information and implement any revisions or additions that may be indicated.

Appendix

Pertinent guidelines issued by the Centers for Disease Control (CDC), Public Health Service, U.S. Department of Health and Human Services*.

Acquired immune deficiency syndrome (AIDS) precautions for clinical and laboratory staffs. MMWR 31: 577-80 (1982)

Acquired immune deficiency syndrome (AIDS) precautions for health care workers and allied professionals. MMWR 32: 450-451 (1983)

Education and foster care of children infected with human T-lymphotropic virus type III/lymphadenopathy-associated virus. MMWR 34: 517-521 (1985)

ACIP recommendations for protection against viral hepatitis. MMWR 34: 313-335 (1985)

Recommendations for preventing possible transmission of human T-lymphotropic virus type III/lymphadenopathy-associated virus from tears. MMWR 34: 533-534 (1985)

Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus in the workplace. MMWR 34: 681-695 (1985)

Recommendations for preventing transmission of infection with human T-lymphotropic virus type III/lymphadenopathy-associated virus during invasive procedures. MMWR 35: 221-223 (1986)

Recommended infection-control practices for dentistry. MMWR 35: 237-242 (1986)

* All references are to the "Morbidity and Mortality Weekly Report" (MMWR) published by the CDC.

MEMBERS

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October 14, 1986

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA

In keeping with Regent Wada's request at the meeting of The Regents on September 19, 1986 for current information about acquired immune deficiency syndrome (AIDS), I am forwarding to you a paper prepared by the University administration.

I hope this information will be useful to you in developing your individual responses to Proposition 64 (the LaRouche AIDS Initiative) and to other public and private sector measures related to AIDS.


David Pierpont Gardner

Enclosure

FACTS ABOUT AIDS

INTRODUCTION

This paper was prepared by the University administration in response to Regent Wada's request at the meeting of The Regents on September 19, 1986 for current information about acquired immune deficiency syndrome (AIDS). It provides a review of the pertinent medical facts about AIDS and includes more recent information than was presented to The Regents on previous occasions (most recently in November 1985). It is hoped that this updated information will be useful to individual Regents and to others in developing their responses to Proposition 64 (the LaRouche AIDS Initiative) and to other public and private sector measures.

THE NATURE AND CAUSE OF AIDS

AIDS was first recognized as a clinical entity in 1981. It represents the severe end of a broad clinical spectrum and is characterized by a defect in natural immunity that leaves the patient vulnerable to certain infections and malignancies which are not a threat to individuals whose immune system functions normally. Most of the patients appearing at clinics and doctors' offices present with swollen lymph glands, minor irregularities in the immune response, and generalized complaints of fatigue, night sweats, fevers, weight loss, chills, and diarrhea. Each year, about 3-4% of these patients develop full-blown AIDS, a diagnosis that is made only when a patient has fulfilled certain clinical criteria established by the Centers for Disease Control (CDC) of the United States Department of Health and Human Services. These include the presence of unusual opportunistic infections, such as Pneumocystis carinii pneumonia, and/or unique malignancies, such as Kaposi's sarcoma without the usual predisposing conditions. The mortality rate in patients with the full-blown disease is 100%. In the patients who do not progress to full-blown AIDS, the early symptoms, which have come to be known as AIDS-related complex (ARC), persist for variable lengths of time. Many ARC patients have died from these debilitating conditions. Approximately 50% of patients with AIDS or ARC also suffer from neurologic disturbances.

In the United States, the great majority of AIDS patients falls into certain high-risk groups, i.e., sexually active homosexual and bisexual men, intravenous drug abusers, recipients of blood transfusions and blood products (before the screening of blood was

instituted), persons with hemophilia and other coagulation disorders, heterosexual partners of AIDS patients or members of high-risk groups, and children born of mothers who have AIDS or are members of high-risk groups. The disease has remained confined to these groups since recognition of the epidemic; there is no evidence that the disease is spreading to other segments of the population.

AIDS is caused by a retrovirus, variously referred to in the technical literature as human T-lymphotropic virus type III (HTLV-III), lymphadenopathy-associated virus (LAV), AIDS-associated retrovirus (ARV), or human immunodeficiency virus (HIV), and in this document as the AIDS virus. The AIDS virus infects primarily certain white blood cells, the T-helper/inducer lymphocytes which play a key role in the body's immune response to foreign substances, but also macrophages and other immune system cells, and occasionally brain cells. Thus, infection can lead to profound disturbances in immune function and may account for the neurologic symptoms observed in some patients with AIDS or ARC. The virus has been found in blood and semen, to a much lesser extent in other body fluids, such as saliva, tears, vaginal secretions, and mother's milk, and in the cerebrospinal fluid and brain tissue of patients with neurologic disturbances.

It must be stressed that infection with the AIDS virus is not synonymous with the presence of clinical disease, either AIDS or ARC. Most infected individuals have no symptoms and may never develop any. Nevertheless, such individuals rarely become free of the virus and must be considered to be carriers who can transmit the infection to others under appropriate circumstances. The time interval between viral infection and the appearance of symptoms (the incubation period) can vary from several months to five or more years in adults, suggesting that the course of the infection may be influenced by the virulence of the infecting virus strain or by cofactors, such as immunosuppressive drugs, severe malnutrition, infection with other viruses, and development of autoimmune manifestations.

THE AIDS ANTIBODY TEST

The detection of the AIDS virus in blood and other body fluids requires time consuming, expensive and highly specialized laboratory technology. The procedures currently available for culturing and identifying the virus are not suitable for mass screening and are not yet standardized. However, the presence or absence of infection can be assessed by the AIDS antibody test. Antibodies are proteins that are made by immune system cells in response to foreign substances, in this case the AIDS virus, and can be detected by appropriate laboratory tests. All commercially available and licensed tests to detect antibodies to the AIDS virus employ a method called ELISA and require a blood (serum) specimen. This test is very sensitive and quite specific, but it is subject to a variety of errors which may lead to "false

positive" reactions. Consequently, all sera found positive by the ELISA method are retested by a more cumbersome and expensive method, either the western blot or the immunofluorescence assay. These test are not licensed, but they are more specific than the ELISA, and the likelihood is very high that they yield only "true positive" reactions.

The inference to be drawn from a positive antibody test is that the blood specimen was obtained from an individual who, at some time, became infected with the AIDS virus. The presence of antibodies does not reveal when the person was infected, nor does it necessarily signify immunity to the virus. The antibody test does not provide direct information about whether or not a person harbors infectious virus, but data on the fate of the AIDS virus in infected individuals indicate that a positive antibody test must be considered as presumptive evidence that the individual is a carrier of the virus, i.e., is currently infected and infectious.

The inference to be drawn from a negative antibody test is that the blood specimen was obtained from an individual who does not have detectable serum antibodies to the AIDS virus. In almost all instances, this implies that the individual has not become infected with the virus; nevertheless, the possibility of a "false negative" result (an infected individual who lacks detectable antibodies) cannot be ignored. "False negative" results are expected to occur primarily in newly infected individuals who have not yet mounted an antibody response. Few data concerning the incidence of "false negatives" are available, but the rate is thought to be very low.

Clinicians agree that the AIDS virus antibody test is helpful in excluding AIDS as a diagnostic possibility in a patient with undefined illnesses that resemble AIDS or ARC and in perinatal screening of high-risk mothers. If taken voluntarily and anonymously, the test is appropriate also for individuals who wish to use the information as a personal health guide. As a screening tool, the AIDS antibody test is very effective in safeguarding the nation's blood supply and organ donor programs by identifying potential virus carriers. The test is also an invaluable tool in seroepidemiologic studies of the natural history of infection with the AIDS virus, provided that national guidelines of voluntary participation, informed consent, and institutional review of all human studies are enforced. The Centers for Disease Control of the United States Public Health service recommend that the AIDS antibody test be confined to the settings identified above; thus, the test is not appropriate as a screening tool for populations not at risk for AIDS.

TRANSMISSION OF THE AIDS VIRUS

All available evidence supports the premise that AIDS is not a highly contagious disease and that the AIDS virus is not readily

disseminated. Rather, the AIDS virus is transmitted by certain recognized activities, i.e., sexual contact, administration of blood and blood components, and sharing of hypodermic needles, as well as from an infected mother to her unborn or newborn infant. Abundant data are available to support the contention that the AIDS virus is not transmitted as a result of casual contact, from sharing a household or an office, through food and water, or by insects. At least three independent recently published studies document that the AIDS virus is not transmitted among school children nor from an infected individual to other members of the family unit (except for sexual partners). Occupational transmission of the AIDS virus to health care workers is an extremely uncommon event, despite extensive exposure to AIDS patients that includes needlestick and other accidents with contaminated patient fluids. Only two, possibly three, cases of occupational infection with the AIDS virus in health care workers who sustained highly unusual needlestick exposures to blood or fluids from AIDS patients have been documented. Several thousand health care workers who have frequent and close contact with AIDS patients are enrolled in separate prospective studies and have remained free of infection during several years of observation.

Heterosexual transmission of the AIDS virus, probably the most important route of its dissemination in Africa and Haiti, has been documented to occur also in Europe and the United States. It must be stressed, however, that in this country, essentially every instance of such transmission could be traced to sexual contact with an AIDS patient or an individual in a high-risk group.

PREVENTION OF THE SPREAD OF AIDS

While current knowledge about the mode of transmission, the disease mechanisms, and the clinical features of AIDS is far from complete and still changing rapidly, it has provided the basis for instituting measures aimed at controlling the infection. The adoption of stringent procedures to ensure the safety of the blood supply and of clotting factor concentrates has virtually eliminated the risk of infection through administration of these products. Recommendations have been made to high-risk groups to modify sexual practices, to avoid the sharing of needles, and to refrain from donating blood or organs. Infected women are advised to avoid pregnancy. Adherence to safer sex recommendations has resulted in a documented decrease in the dissemination of the virus among homosexual men. As safe and effective measures that can prevent infection with the virus, namely a vaccine, are not likely to be available in the immediate future, the rapid spread of the AIDS virus can be reduced at this time only by an innovative and far reaching educational program that emphasizes recognition of the need to change personal behavior patterns.

TREATMENT

The clinical care of AIDS patients, until most recently, involved nonspecific support therapy and management of the life-threatening opportunistic infections and malignancies that accompany AIDS. Intervention in the underlying disease process, however, requires a more fundamental approach. To this end, clinicians have identified three specific goals: elimination of the AIDS virus infection with antiretroviral drugs, restoration of immune function with immunomodulatory agents, and reduction of the effects of putative cofactors. These objectives are not mutually exclusive; on the contrary, the eventual goal is the development of effective combination therapy. Ongoing research programs in California, elsewhere in the United States, and in other countries address each of these aspects. Clinical tests of potential therapeutic agents were disappointing until very promising results with the antiretroviral drug azidothymidine (AZT) were reported from several medical centers. Although the long-term efficacy and side reactions of AZT remain to be determined, this is the first drug to offer hope for an effective antiviral therapy.

RESEARCH TRENDS

The search for new treatment modalities for AIDS patients, along the lines outlined in the preceding section, and for drugs capable of eliminating AIDS virus infections in asymptomatic persons and in patients with ARC continues to be of the highest priority. Equally urgent is the development of an effective and safe vaccine to prevent the spread of AIDS virus infections. Progress in these areas depends on basic research leading to a better understanding of the properties of the AIDS virus, the nature of the damage to the immune system, the identity and role of the cofactors, etc. Behavioral studies dealing with the coping responses of AIDS patients and persons infected with the AIDS virus are also of importance in meeting the special needs of these individuals. Research programs addressing these and additional issues are being actively pursued by clinicians and scientists within and without the University of California system. Financial support for these investigations is being provided by numerous public and private agencies.

SUMMARY

Despite the rapid advances that have been made in the understanding of the nature and mode of action of the AIDS virus and the accumulation of a large body of clinical and epidemiologic data, the public health information provided in this paper does not differ substantially from that presented to The Regents orally in November 1985. Infection with the AIDS virus remains largely limited to certain high-risk groups of the population and the only recommended measure for preventing the spread of the infection is

avoidance of high-risk activities. The one development of considerable promise is the availability of an antiretroviral drug that has demonstrated, as yet only in short-term tests, effectiveness in the treatment of AIDS patients.

AIDS: WORKERS' COMPENSATION AND HOSPITAL LIABILITY CONFERENCE

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