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NATIONAL CENTER FOR HEALTH SERVICES RESEARCH
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Selected Bibliography on AIDS for Health Services Research

September 1988

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service

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This bibliography may be obtained from the NCHSR Publications and Information Branch. (See front cover for address).

INTRODUCTORY NOTE

This publication updates the first Selected Bibliography on AIDS for Health Services Research, which was published in September 1987. The current compilation again focuses on issues related to AIDS (acquired immunodeficiency syndrome) and its etiologic agent HIV (human immunodeficiency virus) as they affect the delivery of health services. The content is intentionally selective, including, for example, scientific and biomedical literature to the extent that the articles are relevant to health services research.

Content divisions differ slightly from those in the 1987 bibliography. Special issues of scholarly publications and State medical association journals devoted to AIDS have been included. Provision of care is addressed in separate sections on **community care** (outpatient services, hospice or home care, and other support services) and **inhospital care** (resource utilization, system support, and inpatient management). Issues related to **costs, financing, or insurance** (including Medicare and Medicaid expenditures) are treated in a single section. Guidelines for disease control, risk reduction, and education are included in a **prevention** category. AIDS-related public health iniatives at the Federal, State, and local level make up a general **public policy** section. Finally, a new section on **legal and ethical issues** addresses physician liability, confidentiality questions, treatment dilemmas, conditions of releasing medical records and test results, and considerations for AIDS research.

Articles included in this Selected Bibliography on AIDS for Health Services Research were published in the source cited between August 1987 and August 1988. Significant portions of text that have been reproduced from the original article or its abstract appear in quotation marks in this report.

CONTENTS

BIBLIOGRAPHIES & SPECIAL ISSUES

1. Acquired immunodeficiency syndrome: Focus on the tri-state area. (1988, May). New York State Journal of Medicine 88(5).

This issue is entirely devoted to AIDS in Connecticut, New Jersey, and New York. Included are commentaries, research papers, review articles, case reports, and special articles on epidemiology, health services, and biomedical issues related to AIDS. Titles include: "Acquired immunodeficiency syndrome as a paradigm for medicolegal education" (pp. 221-222); "HIV infection among young adults in the New York City area" (pp. 232-235); "The epidemiology of HIV in New York State" (pp. 242-246); and "AIDS in Connecticut" (pp. 250-252). Some guidelines on ethics and disease control are reprinted from other sources.

2. AIDS. (1988, April). Kansas Medicine 89(4).

Several scientific articles, commentaries, and executive reports in this issue of Kansas Medicine are devoted to AIDS and HIV infection. Titles include: "Recording HIV test results" (pp. 94-95), "Governor's task force on AIDS: Executive summary" (pp. 96-97), "AIDS in Kansas" (pp. 110-111), and "Psychiatric aspects of HIV infection" (pp. 112-113).

3. AIDS. (1988, May). Minnesota Medicine 71(5).

This issue of Minnesota Medicine is devoted to acquired immunodeficiency syndrome in Minnesota. One medicolegal and seven health affairs articles are included. Topics co ered follow: the prevalence of HIV infection and self-perception of risk among heterosexuals (pp. 265-270); results of a physician survey on AIDS (pp. 277-283); HIV infection in children (pp. 284-288); treatment strategies and the Minnesota AIDS clinical trials unit (pp. 289-292); physicians' guide to alternative therapies for AIDS (pp. 297-299); risk reduction and disease prevention (pp. 300-301); AIDS and emergency services (pp. 303, 319); and confidentiality and duty to inform (pp. 307-310).

4. AIDS: Bridging the gap between information and practice. (1988, June). Social Casework [Special Issue] 69(6), pp. 324-408.

This special issue of "The Journal of Contemporary Social Work" includes 11 articles on legal and ethical considerations; counseling, countertransference, and other practice issues; women and children with AIDS; AIDS in the inner city and in rural communities; patient care at various stages of the disease; and AIDS education. The issue focuses on the application of specialized information to clinical populations and offers specific recommendations to social workers on practice, prevention,

education, and methods and models of care. The goal of the publication is to "... provide strategic direction and critical information so that social workers can continue to battle this disease with effective and timely services."

5. AIDS: The responsibility of health professionals [Special supplement]. (1988, April/May). Hastings Center Report 18(2).

This separately numbered insert to the Hastings Center Report is comprised of five articles on the ethical response of health professionals to AIDS patient care and management. Topics examined include: the risk of HIV transmission in the health care setting (pp. 2-5); politics and the physician's responsibility in epidemics (pp. 5-10); the duty to treat (pp. 10-20) and the right of refusal (pp. 20-25); and physicians' legal risks and responsibilities in the AIDS context (pp. 26-32).

6. AIDS and intravenous drug use. (1988). AIDS & Public Policy Journal 3(2).

The purpose of this special issue of AIDS & Public Policy Journal is "to examine a variety of policy issues related to AIDS among persons who inject illicit drugs." An overview (pp. 1-4) is followed by separate articles on the following topics: AIDS and drug abuse in minorities (pp. 5-15), prostitutes (pp. 16-22), and prison inmates (pp. 42-46); AIDS-related drug use in Germany (pp. 23-29), San Francisco (pp. 37-41), and Australia (pp. 47-49); and self-organization among drug users (pp. 30-36).

7. AIDS and public health. (1988, April). American Journal of Public Health 78(4), pp. 364-480.

This special issue includes 17 articles on AIDS and public health. They range in topic from a historical perspective of AIDS and past lessons on venereal disease control to AIDS prevention and the impact of AIDS on State and local health departments. Also addressed are prostitutes and AIDS, State Medicaid coverage of AZT, health insurance and AIDS, hemophilia-associated AIDS, and sexually active adolescents and condoms.

8. Bimonthly issue. (1988, March/April). International Nursing Review 35(2).

This issue of the International Nursing Review examines HIV infection and AIDS from a nursing perspective. "How nurses can influence national policies on AIDS: An American example" (pp. 42-43) and "Guidelines for nursing management of HIV infection" (pp. 53-53) are among the articles included. Current research findings on HIV transmission are also presented in a review article (pp. 44-52, 54).

9. Response to AIDS. (1988, May/June). Public Health Reports 103(3), pp. 209-321.

This special issue includes 19 general articles on the response to AIDS. The topics range from monitoring HIV infection and progress in drug therapies to the development of an AIDS vaccine and the effect of the disease on the safety of the nation's blood supply. Other topics covered are intravenous drug abuse and AIDS prevention, the role of State health agencies and the American Hospital Association, current Centers for Disease Control efforts, pathology of AIDS, and financing care for persons with AIDS. This publication also includes AIDS posters and issue-specific columns.

10. Special issue on AIDS. (1988, May). Journal of the Florida Medical Association 75(5).

Subjects discussed in some of the articles in this special AIDS issue include: pediatric AIDS (pp. 295-296); psychosocial needs of AIDS patients (pp. 299-300); AIDS and drug abuse (pp. 297-298); HIV infection diagnosis (pp. 289-291); and ethics in AIDS patient care (pp. 305-308).

11. Bloom, A. (1988). Acquired immune deficiency syndrome in children. Public Health 102, pp. 97-106.

This article details the many aspects of AIDS in children ranging from the definition of AIDS to school policies. The author reviews the Centers for Disease Control (CDC) definition of AIDS and emphasizes the importance of excluding primary and other secondary immune deficiency syndromes in children. He describes the life cycle of the retrovirus and serological responses to it. The author then focuses on the epidemiological aspects of AIDS in children. He addresses the mechanisms of perinatal AIDS, including precautions during labor and for artificial insemination by donors. The author also details procedures adopted in milk-banks; anti-natal HIV-antibody screening; immunological and clinical features of AIDS in children; HIV infection and childhood immunizations; and guidelines for school policies.

12. Centers for Disease Control. (1987, December 25). Human immunodeficiency virus (HIV) infection codes: Official authorized addendum ICD-9-CM (revision No. 1) effective January 1, 1988. Morbidity and Mortality Weekly Report 36(S-7).

"This addendum replaces the addendum containing codes for human T-cell lymphotropic virus-III/lymphadenopathy-associated virus (HTLV-III/LAV) infection (042-044), which were effective October 1, 1986....This addendum incorporates recent changes in official terminology and minor changes in content of the classification reflecting new scientific knowledge."

13. De Cock, K. and others. (1988, June). Evaluation of the WHO clinical case definition for AIDS in rural Zaire. AIDS 2(3), pp. 219-221.

"The clinical case definition for AIDS proposed by WHO for use in Africa was evaluated against HIV antibody status in 72 patients in rural Zaire. Twenty-one (29%) of the patients were antibody-positive. For diagnosing anti-HIV seropositivity, the case definition had a sensitivity of 52%, a specificity of 78%, a positive predictive value of 50% and a negative predictive value of 80%. Calculation of the positive predictive value at different levels of prevalence of HIV infection suggests that the case definition operates at maximum reliability in selected high-risk groups. Modifications to the case definition should be evaluated to try and improve its sensitivity and positive predictive value."

14. Robinson, M. (1988, February 20). New York state tests DRGs for AIDS patients. Hospitals 62(4), pp. 24, 26.

"On Jan. 1, 1988, hospitals in New York state became the first in the nation to use DRGs to classify and receive payment for patients with AIDS and AIDS-related conditions." Reasons for the development of an AIDS major disease category are given in the article. Also included is a chart listing the 15 AIDS DRGs, a description of each, and the weight assigned to each DRG for payment purposes.

15. Belfer, M. and others. (1988). AIDS in children and adolescents. Journal of the American Academy of Child and Adolescent Psychiatry 27(2), pp. 147-151.

This review article, directed at child psychiatrists, discusses the devastating impact of AIDS on the child and adolescent's psychological development and emphasizes the need for specialized support services. Noting the extensive psychiatric impact of AIDS and the critical role of child psychiatrists, the authors try to provide an understanding of the presentation of HIV infection in children. They note that while clinical presentation in children spans the full range of symptoms, including neurological manifestations, clinical patterns may have different distributions. The authors also address the issues pertinent to appropriate clinical interventions. They warn that, given the long incubation period of the HIV and "continued operation of known risk-transmission vectors, AIDS will spread, especially among the adolescent population so prone to beginning now hazardous sexual activity." They urge child psychiatrists to extend their role beyond patient care to work to combat irrationality and promote social awareness.

16. Droste, T. (1987, August 20). Going home to die; developing home health care services for AIDS patients. Hospitals 61(16), pp. 54-58.

This article focuses on the factors affecting the availability of home health care services provided for AIDS patients. Citing a 1986 Home Care Survey by the American Hospital Association, the authors note that hospitals vary greatly in the extent of their home services based on regional location, bed size, and hospital ownership. The authors also detail the cost factors that affect the availability of home health care services. They describe Federal programs that allow additional home services for AIDS patients and provide funding of demonstration home care models. The authors note that with many persons with AIDS returning to their rural or suburban homes, the latter are often unprepared to provide services. They describe some exemplary programs that have developed in response to this problem. The authors conclude, that despite the funding of home care models nationwide, there remains a need for long-term care facilities to house persons with AIDS.

17. Graham, L. and J. Cates. (1987, December). AIDS: Developing a primary health care task force. Journal of Psychosocial Nursing and Mental Health Services 25(12), pp. 21-25.

"As the number of people with AIDS increases, the number of people impacted by the AIDS crisis will also increase. Larger metropolitan

areas have already responded to the crisis with various services (Deuchar, 1984); but the disease has yet to fully impact on smaller cities and towns. The formation of community service groups to cope with the AIDS crisis is a virtual necessity in health care preparation for persons with AIDS. The experience of the Fort Wayne AIDS Task Force reflects the potential of any community to utilize the existing resources in the gay and lesbian community, health and social service professions, and among family and friends of persons with AIDS.
Consultation and resources are available through local and State boards of health, as well as local social service and health personnel currently dealing with the AIDS crisis."

18. Johnson, J. (1988, February). AIDS-related psychosocial issues for the patient and physician. JAOA 88(2), pp. 234-238.

The author examines four psychosocial issues within an AIDS context: patient fears and concerns, HIV antibody testing, HIV-related suicide, and life-support intervention decisions. Results of a number of studies are cited including some HIV-specific suicide risk factors. Procedures to be followed by physicians during pre- and post-HIV test counseling sessions with HIV-infected patients are also outlined.

19. Joseph, S. (1988, May). Current issues concerning AIDS in New York City. New York State Journal of Medicine 88(5), pp. 253-258.

Several issues are addressed including AIDS among intravenous drug abusers, public health education, outreach, and risk-reduction counseling. The article also presents projections on the incidence of AIDS in New York City through 1991 and discusses the implications for hospital services. The author points out that "...long term resource requirements for clinical care and social, mental health, housing, hospice, and respite services are major concerns."

20. Kenkel, P. (1988, January 8). Health insurers turning to managed care to control growing cost of AIDS care. Modern Healthcare, pp. 38-39.

This article summarizes efforts to reduce inpatient hospitalization for persons with AIDS, thereby reducing costs of care. Home health care is emphasized but hospices and alternative clinics are also mentioned. Other problems cited by the author are the lack of beds in skilled nursing facilities and the potentially high proportion of AIDS patients who may be uninsured, thus relying on public assistance for their care.

21. Lehmann, R. (1988, February). Access to care. Quarterly Review Bulletin 14(2), pp. 55-57.

This general news article summarizes a 1987 Boston conference on the economics of health care and its effect on access. Topics included comparisons between Canada's and the United States' health care systems, socialized medicine, access by the homeless, the AIDS patient, the mentally ill, and children. Other access problems cited were inappropriate patient transfers and discrimination against women in insurance coverage. The author notes that although the problems were presented by various speakers with suggestions for reforms, the suggestions did not appear politically viable at the present time.

22. Lewis, L. (1988, June). Housing people with HIV dementia. AIDS Patient Care 2(3), pp. 35-37.

This feature article describes the specific living arrangements required for the HIV-infected individual with dementia who should not be at home alone, yet who does not need hospital care. The author details the numerous alternatives currently offered to such individuals. These range from group living provisions and agreements with skilled nursing facilities to day care centers. She notes that none of the alternatives are tailored to this group of people, but most of the arrangements have achieved some degree of success. Specifically covered in the article are supervised and unsupervised residences, institutional care, and day care. The author includes brief summaries of the special living needs of patients with HIV dementia and the sources for housing information. She concludes that housing does not appear to be as critical a problem as it was a year ago.

23. McCaffrey, E. (1987, September). Short stays and low costs. AIDS Patient Care 1(2), pp. 22-25.

This article describes the comprehensive array of services available in San Francisco with specific reference to San Francisco General Hospital and the model of care that is provided to persons with AIDS by the AIDS unit. The article includes a listing of clinical, chronic care, and housing support services; psychological and mental health services; and substance abuse services that exist in San Francisco.

24. Newman, K. and others. (1988, July). Nurse management of the HIV-infected employee, AAOHN Journal 36(7), pp. 258-261.

This study focuses on managing the problem of HIV-infected employees by occupational health nurses. It addresses the psychological and emotional aspects of care as well as health education and counseling parameters. It also provides guidelines on taking employee health histories and describes their role in

revealing employees at risk, who might warrant counseling or education. The article also outlines the signs of HIV infection and management of employees suspected of being infected. The role of the occupational health nurse, according to the authors, is to provide emotional care to the asymptomatic worker, and help workers with AIDS or ARC to handle the psychosocial tasks related to their terminal illness. They stress that health education should focus on self-esteem and emotional control, safe sex, stress reduction techniques, and nutritional needs. The authors conclude with four objectives that education and counseling of HIV-infected employees should achieve.

25. Oleske, J. and others. (1988, May). A perspective on AIDS. Pediatric Annals 17(5), pp. 319-321.

This article provides some startling details on the number of pediatric AIDS cases and their prognosis. The authors, who have more than six years of experience in clinical care and research with pediatric AIDS, provide a unique perspective. Based on their experience, they project that by 1991 there will be 10,000 to 20,000 symptomatic HIV-infected infants and children. They detail present care costs for these children and underscore the need for a variety of psychosocial support services such as foster care. They summarize their six recommendations to the Presidential Commission on the HIV epidemic: 1) designation of support centers to provide medical and psychosocial services to HIV-infected children and their mothers; 2) establishment of pediatric AIDS day care or respite care centers; 3) establishment of community-based transitional foster care homes; 4) restructuring of entitlement programs to broaden benefits for outpatient services; 5) expansion of AIDS cooperative treatment groups; and 6) commitment by the Federal government to fund HIV surveillance, biomedical research, and clinical care programs.

26. Shulman, L. and J. Mantell. (1988). The AIDS crisis: A United States healthcare perspective. Social Science and Medicine 26(10), pp. 979-988.

"Some hospitals have faced economic and allocation dilemmas because of high occupancy rates by AIDS patients since there are no specialized reimbursement rates for the intensive resource utilization required for their care. These substantial burdens underscored the need for coordinated long-term planning for a continuum of in-patient, out-patient and community support services. A major response to the epidemic has been a restructuring of the health and social service delivery systems....In the past year, there has been a discernible shift to widening the network of ambulatory medical services and community-based social and health care supports. A major focus of this paper is the social and organizational impact of this epidemic on the hospital and health care system and the system's responses. Alternatives to an acute

care treatment locus for persons with AIDS are explored. Recommendations for future directions for a comprehensive, coordinated health and social services delivery network are presented."

27. Sowell, R. and A. Lowenstein. (1988, May). Comprehensive planning for AIDS-related services. Journal of Nursing Administration 18(5), pp. 40-44.

"Because of the potentially devastating effects AIDS has on both individuals and the health care system, nursing administrators can take a leadership role in developing comprehensive and humane strategies to combat this disease. To develop such strategies, the authors present an AIDS-related services planning model for provision of patient care, human resources management, and community development." The model includes issues relating to access to care, adequacy of care, general employee responsibilities and procedures in the health care setting, guidelines for employees with AIDS/HIV, alternative care arrangements, and education.

28. Sundwall, D. and D. Bailey. (1988, May/June). Meeting the needs of people with AIDS: Local initiatives and Federal support. Public Health Reports 103(3), 293-298.

"The Health Resources and Services Administration (HRSA)...is working to meet some of the resource and patient service needs engendered by the epidemic of acquired immune deficiency syndrome (AIDS)....HRSA is carrying out many of the recommendations of the Intragovernmental Task Force on AIDS Health Care Delivery by enhancing the AIDS training of health care personnel...and encouraging the expansion of facilities outside hospitals to care for AIDS patients. The agency...is working on models for the care of children with HIV infections. The needs of AIDS patients are being addressed through a drug therapy reimbursement program; demonstration grants to 13 projects to promote coordinated, integrated systems of care in the community; and grants for the development of intermediate and long-term care facilities for patients. Ten regional education and training centers, funded in 1987 and 1988, will increase the supply of health care providers prepared to diagnose and treat persons with HIV infections. Programs will be conducted for several thousand providers over the next 3 years."

29. Taravella, S. (1988, April 8). Alternative facilities sheltering patients, hospitals from high costs of AIDS care. Modern Healthcare, p. 46.

Various community efforts to treat AIDS patients outside of acute-care hospitals are briefly summarized. "These facilities, located in different parts of the country, are minimizing AIDS patients' reliance on costly inpatient services and providing shelter and

living assistance for homeless people who have AIDS." Ambulatory shelters for AIDS patients in San Francisco, St. Louis, and Dallas are among those cited.

30. Young, S. (1988, May). The impact of AIDS on the health care system in New Jersey. New York State Journal of Medicine 88(5), pp. 258-262.

The author provides an overview of AIDS in New Jersey and its impact on the delivery of services to persons with AIDS or AIDS-related complex. Also discussed are the financial impact on hospitals and health care providers and interrelationships between the financing of care and the delivery of services. It is maintained that "increased availability of alternative levels of care is essential. In the short term this will increase costs due to start up expenses, but in the long term will be a more cost-effective approach....Politically and clinically, linking a continuum of care with acute care makes sense."

COSTS, FINANCING, AND INSURANCE

31. AIDS and life insurance [News]. (1988, June 4). Lancet 1(8597), p. 1293.

This short presentation highlights the possibility that the AIDS menace may result in increased insurance premiums.

32. Andrulis, D. and others. (1987, Winter). State Medicaid policies and hospital care for AIDS patients. Health Affairs 6(4), pp. 110-118.

This "Datawatch" article reports data from a national survey of AIDS inpatient care in public and private major teaching hospitals during 1985 and data from the Health Care Finance Administration (HCFA) to analyze the characteristics of hospitals treating AIDS patients. The HCFA data analyzed hospitals according to whether they were located in States with liberal or restrictive Medicaid programs. The study results showed that: 1) hospital costs were significantly lower in restrictive States; 2) hospitals in liberal States treated more AIDS patients than those in restrictive states; and 3) private hospitals in liberal States treated 65 percent fewer AIDS patients than public hospitals; whereas in restrictive States they treated 68 percent fewer AIDS patients than public hospitals.

33. Andrulis, D. and others. (1987, September 11). The provision and financing of medical care for AIDS patients in US public and private teaching hospitals. Journal of the American Medical Association 258(10), pp. 1343-1346.

"The National Association of Public Hospitals and the Association of American Medical Colleges' Council of Teaching Hospitals conducted a detailed survey on hospital care to patients with acquired immunodeficiency syndrome (AIDS) in major US public and private teaching institutions in 1985. The 169 hospitals treating patients with AIDS that responded to the survey reported providing inpatient services to 5393 patients with AIDS. These patients accounted for 171,205 inpatient days and 8806 inpatient admissions, with an average length of stay of 19 days. The average costs and revenue for patients with AIDS per day were $635 and $482, respectively, with Medicaid representing the most frequent third-party payer. The average inpatient cost per patient per year was $20,320. Using Centers for Disease Control estimates of 18,720 patients diagnosed as having AIDS and alive during any part of 1985, we estimate that the total cost of inpatient care for patients with AIDS was $380 million for that year. We also found significant regional and ownership differences in source of payment for patients with AIDS and regional differences in revenues received for AIDS treatment. Results indicate that the costs of treating patients with AIDS will profoundly affect major public and

private teaching institutions, but that public teaching hospitals in States with restrictive Medicaid programs will be most adversely affected."

34. Arno, P. (1987, September 11). The economic impact of AIDS [Editorial]. Journal of the American Medical Association 258(10), pp. 1376-1377.

This editorial laments the shift of AIDS health care costs from the Federal to the local level and away from traditional health insurers and businesses to the public sector. It advocates specific changes in current health-care financing mechanisms to distribute the AIDS cost burden in a more equitable and efficient way. The editorial criticizes the Federal government for denying AIDS patients disability benefits under Medicare, chastises the private insurance sector for restricting eligibility, and disapproves of private employers' moves toward self-insurance. The author contends that these shifts have made the cost of indigent care a burden to be borne in large part by cities, counties, and public hospitals. This editorial proposes State risk pools as one solution to providing PWAs or HIV-infected persons with insurance and access to care. The author concludes with the hope that the AIDS epidemic may eventually provide a political basis in the United States for cost sharing instead of cost shifting.

35. Athy, D. (1988, May). In search of the great compromise: The insurance industry and the cost of AIDS. Ohio Medicine 84(5), pp. 361-364.

This article explores the cost issues of AIDS as debated by the Ohio insurance industry and the Ohio State Medical Association. These issues are also at the core of Senate Bill 353, introduced in January 1988 and referred to the Ohio Senate Health, Human Services and Aging Committee. The committee's response to several issues are addressed here: underwriting based on sexual preference and lifestyle; limiting benefits for AIDS-related illnesses; proper screening for AIDS (Insurance companies screen for diabetes but not for sickle cell anemia, for example.); and what insurers can and cannot ask potential policyholders regarding AIDS or HIV-antibody test results. Pre-and post-test counseling is another area of concern. Health agencies stress counseling as a key part of testing procedures, whereas the Ohio insurance companies believe that they are "not in the business of counseling." Also debated between Ohio health groups and insurance companies is the accuracy of HIV-antibody tests, and the cancellation or refused renewal of insurance policies based on a policyholder's AIDS diagnosis.

36. Bloom, D. and G. Carliner. (1988, February). The economic impact of AIDS in the United States. Science 239(4840), pp. 604-610.

"This analysis of several previous studies of the cost of AIDS suggests that the lifetime cost of medical care per patient will not exceed $80,000, an amount similar to the cost of treating other serious illnesses. If current projections of future AIDS cases are accurate, the cumulative lifetime costs of 270,000 cases diagnosed between 1981 and the end of 1991 will not exceed $22 billion. This amount is small compared with total U.S. medical spending. The economic impact of AIDS on San Francisco, New York, and some other cities,however, is likely to be more serious. The AIDS epidemic will also highlight the financial problems of Americans who face large medical bills without adequate insurance."

37. Brunetta, L. (1988, February). Paying the bills: Medicaid and hospitals cover much of the cost. AIDS Patient Care 2(1), pp. 7-10.

The costs of care for AIDS patients are explored. Special attention is paid to regional differences in hospital reimbursement and sources of payment. Regional studies in Massachusetts and California are cited as well but the author points out that..."the area or groups of hospitals a researcher chooses can make a significant difference in what figures will emerge. When examined together with [other] studies, they help to explain why even those in the know--insurance executives, public health officials, and AIDS patient advocates--have very different perceptions of who has been bearing the financial brunt of AIDS...."

38. Buchanan, R. (1988, April). State Medicaid coverage of AZT and AIDS-related policies. American Journal of Public Health 78(4), pp. 432-436.

State Medicaid programs were surveyed in mid 1987 to determine if AZT treatment was covered, if States had AIDS-related policies, and if hospice care was a covered item. "Forty-four states cover AZT (two additional states cover AZT only during inpatient hospital care), with most Medicaid programs placing some limit on coverage or reimbursement. Most states do not have special Medicaid coverage for AIDS care nor are they developing proposals or policies for this care. However, a number of states are developing or implementing AIDS-related policies through their Medicaid programs. These policies can become models for other Medicaid programs to follow if the incidence of AIDS increases in their states."

39. Burda, D. (1987, August 20). Casualty insurers eye AIDS claims. Hospitals 61(16), p. 36.

This article recounts the concerns of casualty insurers about the cost impact of AIDS and describes the adjustments some have made. Like property insurers, casualty carriers may try to exclude from policies all transmittable disease claims. One company reportedly excludes AIDS-related claims from its excess and umbrella liability policies. Others are considering excluding these claims from liability and workers' compensation policies. One hospital association workers' compensation fund does not exclude AIDS-related claims from coverage because they've yet to receive a claim in which AIDS was contracted from work-related activities. To ensure that this happy state continues, the company conducts AIDS prevention seminars for hospital health care workers. A different protective adjustment is being made by a casualty carrier, who is making employee testing for AIDS a requirement for coverage. A distinct concern of casualty insurers who sell liability insurance to hospitals is the AIDS-related lawsuits against hospitals, whose claims are expensive to settle.

40. Chambers, D. (1988). AIDS: Underwriting practices. Transactions of the Association of Life Insurance Medical Directors of America 71, pp. 70-76.

This presentation discusses insurance underwriting and testing considerations in AIDS and describes in detail the association's AIDS Committee that is affiliated with the medical section of the American Council of Life Insurance. The author details a number of tests, including the T-Cell and the DuPont Western Blot. He argues that sexual "orientation" should have no place in the underwriting process. In describing the AIDS Committee, he offers a detailed history of its beginnings and the results of its most recent meeting in September 1987.

41. Coile, R. and R. Grossman. (1987, November-December). Is AIDS a manageable public health problem? Healthcare Forum Journal 30(6), pp. 41-43.

The authors present the results of a Delphi survey of 30 health care executives and industry observers. The panel respondents considered reimbursement for the costs of AIDS treatment to be a major problem and noted that a major influx of funds will be necessary to cover facilities' losses.

42. Cowell, M. (1988). AIDS: Mortality. Transactions of the Association of Life Insurance Medical Directors of America 71, pp. 77-103.

This detailed report attempts to estimate the spread of HIV infection among the insured populations of the United States and

Canada and to predict the mortality of those testing positive for HIV. The author also discusses the ramifications of AIDS for underwriting and pricing in the life insurance industry and projects the long-term impact of AIDS on insurance company solvency. He touches on the nature of the epidemic, epidemiological models, the size of the groups at risk, and then offers a summary of a number of studies completed on the progression from HIV infection to AIDS. The author concludes that the HIV epidemic will not be as serious in Canada as in the United States. Still, premature death claims from its complications will cost the life insurance industry in the two countries tens of billions of dollars. He urges insurance industry executives to assume strong leadership positions in educating the public on the impact of AIDS.

43. Cunningham, D. (1987, October 10). AIDS: Counting the cost [Letter]. British Medical Journal 295, pp. 921-922.

This letter to the editor describes a "theoretical package of care" designed for a hypothetical average adult patient and provides an itemized cost of the package. The patient care model includes 4 weeks of hospital inpatient care and 11 months of treatment at home. The home treatment includes 4 months of day care treatment, including meals, and 7 months of management by the acute district nursing service. Included in the care are blood and zidovudine transfusions, transfusion-associated overnights, 6 outpatient visits, and a home help provision. A total of 12 cost-related care items are included in the package, which will cost a total of 27,055 pounds sterling for a patient receiving zidovudine. Although this care model shifts care from the hospital to the community, it will nevertheless be expensive, concludes the author.

44. Denler, J. (1988, February). Insurance testing for HIV: How States have responded. AIDS Patient Care 2(1), pp. 11-13.

"Since 1985 the issue of insurance companies testing applicants for the presence of HIV has caused considerable controversy among the insurance industry and state legislators and regulators. "This article summarizes the legislative and regulatory responses of California, Maine, Massachusetts, New York, Wisconsin, and the District of Columbia regarding HIV testing for insurance purposes. "According to a study commissioned by the Society of Actuaries in August 1987, people in high-risk groups for AIDS are buying large amounts of health insurance and, even with new policyholders being screened for HIV infection, $30 billion in new AIDS claims could be generated by the turn of the century. Without screening, the study said, that figure would double, threatening the solvency of some companies."

45. Droste, T. (1988, March 5). Corporate CEOs don't want to pay for AIDS. Hospitals 62(5), p. 66.

Results are reported from a survey of employers who were asked about corporate policies towards AIDS victims. Although 45 percent felt that insurance companies should cover medical bills for AIDS patients,..."only 11 percent said that the employer should bear the brunt of health costs for an employee with AIDS." The survey was cosponsored by Allstate Insurance Company and Fortune.

46. Eden, J. and others. (1988). AIDS and health insurance: An OTA survey. AIDS-Related Issues Staff Paper 2, Office of Technology Assessment. Washington, DC: U.S. Congress.

"This survey is...an attempt to provide a view of HIV testing in the context of other routine tests required by health insurers and had a twofold purpose: 1) to collect basic information on underwriting practices and the use of medical screening by health insurers; and 2) to document how health underwriters are responding to the AIDS epidemic....The survey was sent to 88 commercial insurers who comprise 70 percent of the commercial, individual health insurance market; to 15 of the 77 BC/BS plans; and to the 50 largest local and national HMOs in the United States." Survey results are reported separately for the commercial, Blue Cross/Blue Shield, and HMO plans in the following areas: medical and other factors used for risk classification; sources of medical information used for underwriting such as questionnaires, attending physician statements, physical examinations, and blood and urine screening; and AIDS policies and experience. How AIDs compares with other major illnesses is also discussed.

47. Eisenstaedt, R. and T. Getzen. (1988, April). Screening blood donors for human immunodeficiency virus antibody: Cost-benefit analysis. American Journal of Public Health 78(4), pp. 450-454.

The authors look at the costs and benefits of screening blood donors for HIV antibody. Total annual costs, including testing, discarding processed blood, marginal donor recruiting, and notifying and evaluating positive donors are determined for 10 million donors in 1986. The cost benefit ratio of screening donors in terms of prevention of transfusion-transmitted AIDS (TT-AIDS) and the net economic benefits per donor are calculated. The authors point out that many of their projections will alter as changes in costs, test sensitivity, and follow-up procedures occur.

48. Faden, R. and N. Kass. (1988, April). Health insurance and AIDS: The status of State regulatory activity. American Journal of Public Health 78(4), pp. 437-438.

"Information collected by the National Gay Rights Advocates in 1986 and by the authors in the spring of 1987 was used to determine the

extent to which the states currently regulate the practices of the health insurance industry specific to acquired immunodeficiency syndrome (AIDS). Of the 10 states reporting the greatest number of AIDS cases, six prohibit insurers form denying coverage to group policy applicants because of human immunodeficiency virus (HIV) infection. These findings refer only to the status of state regulatory activity specific to AIDS."

49. Fox, D. and E. Thomas. (1987-1988, Winter). AIDS cost analysis and social policy. Law, Medicine and Health Care 15(4), p. 186-211.

This scholarly review article provides a detailed historical perspective on how medical insurers, hospitals, and society as a whole have perceived the costs of treating persons with AIDS and how their perceptions have affected the evolution of payment policies. The authors cite information derived from several published or in-progress studies, which they detail in nine tables in an appendix. Initially health insurers and hospital administrators were aghast at what they felt would be enormous, unprecedented costs; and Federal and State officials were "eager to spend less, not more, on health care." Some initial studies supported their fears. However, the "first systematic study" (Hardy et al, 1986) on AIDS health care costs indicated that AIDS was not an exceptional health care cost. The authors draw out the impact of this and other recent studies on health policy and note the renewed interest in national policy in 1987. In conclusion, they state that future AIDS payment policies will be determined by whether the disease remains in current at-risk groups or spreads rapidly among white heterosexuals.

50. Hamilton, J. and S. Garland. (1988, March 28). Insurers pass the buck on AIDS patients. Business Week, p. 27.

The authors report that "AIDS patients are being denied medical coverage and reimbursement by health insurers and companies that insure their own health plans." They argue that employers and insurers should provide the same financial payment for AIDS treatment as they do for treatment of other diseases.

51. Health and Public Policy Committee, American College of Physicians. (1988, March). Financing the care of patients with the acquired immunodeficiency syndrome (AIDS). Annals of Internal Medicine 108(3), pp. 470-473.

This article presents several recommendations on the financing of AIDS patient care. They are detailed separately for five major components of the healthcare financing system: group coverage provided by employers; individual coverage; Medicaid; Medicare; and public health support at the Federal, State, and local level.

52. Hellinger, F. (1988, May-June). Forecasting the personal medical care costs of AIDS from 1988 through 1991. Public Health Reports 103(3), pp. 309-319.

This is the first study to include the cost of purchasing azidothymidine (AZT) in calculating the personal medical costs of AIDS. These costs are forecast in 1988 to be "$2.2 billion, an amount that will increase to $4.5 billion in 1991." The forecasts of this study are lower than those reported by other researchers, because of more recent data, greater use of outpatient care resulting in shorter hospital stays, and because future projections of the number of AIDS cases diagnosed is lower than that made by the Centers for Disease Control (CDC). "It is also projected that the lifetime cost of treating an AIDS patient will increase from $57,000 in 1988 to $61,800 in 1991 due to the wider use of AZT."

53. Hiatt, R. and others. (1988). The Impact of AIDS on the Kaiser Permanente Medical Care Program (Northern California Region). AIDS-Related Issues Staff Paper 4, Office of Technology Assessment. Washington, DC: U.S. Congress.

This paper examines the resource utilization of AIDS-infected members of Kaiser Permanente (Northern California Region). Hospital utilization data for 913 AIDS patients are presented from the date of their diagnosis through June 1987. Also presented are the results of a cost analysis for 30 of the patients for whom mean and median lifetime utilization and costs were estimated using survival methods. Construction of the data base, data collection procedures, unit cost calculation, and survival methodology are extensively detailed.

54. Hill, D. (1987, November 16). AIDS and insurance [Letter]. Medical Journal of Australia 147, p. 521.

In this letter to the editor, a pediatrician seriously questions the intrusion of insurance companies into doctor-patient confidentiality. The author cites an insurance report sent to him in error. It requested a patient's HIV antibody test results, and asked whether the patient suffered any sexually transmitted diseases such as gonorrhea, syphilis, and genital herpes, or hepatitis B, cytomegalovirus, or chlamydial infection. The pediatrician questions the disclosure of HIV test results to an insurance company, especially since the debate continues about whether this information should be disclosed to medical practitioners. He asserts that most of the sexually transmitted diseases mentioned do not seriously affect life expectancy when the condition is treated and, in some cases, even when it is not treated.

55. Insuring against AIDS [Editorial]. (1988, January 28). Nature 31(6154), p. 288.

This editorial makes the point that, "AIDS is a problem for insurance companies, but there are more awkward ethical problems." The true actuarial cost of life insurance in Britain is estimated to be as much as two to three times previous costs as a result of AIDS. The author notes that it is not surprising, therefore, that insurers will pursue ways to insulate themselves from future risks. The ethical problems discussed include: questions about potential policyholders' sexual tendencies and blood tests; and the results of changed circumstances. For example, what if a policyholder declares himself heterosexual and later in life finds himself drawn to homosexual practices? Another critical question, which cannot be answered by actuaries, according to the author, is whether the emergence of homosexual tendencies or drug dependence should be considered a willful or involuntary development.

56. Jones, P. (1987, October 17). Haemophilia, AIDS, and no fault compensation. British Medical Journal 295, pp. 944-945.

This article urges the British government to take swift action to provide hemophiliacs with some type of no-fault compensation for their suffering HIV infection or AIDS as a result of transfusions of contaminated factors 8 or 9. Approximately 1,200 British hemophiliacs have been infected in this manner. The Haemophilia Society has campaigned to ask that the government ensure protection of the family home; provide dependents of hemophiliacs with a weekly hardship allowance; and replace single payments with a disability premium sufficient to cover the costs of coping with HIV-related problems as well as the underlying hemophilia. Recounted is the rationale of the Royal Commission on Civil Liability and Compensation for Personal Injury, better known as the Pearson Commission, for not introducing a no-fault scheme for medical accidents in Britain. The article proceeds to argue for special-case considerations for hemophiliacs: causation is clear; the patients are already known to hemophilia center directors and other agencies; and they are a small group. The article concludes that there's a consensus in the British Parliament and community to provide special help to hemophiliacs. The author points out that the Pearson Commission and Vaccine Damage Payment Act of 1979 provide a vehicle for this.

57. Kaplowitz, L. and others. (1988, August). Medical care costs of patients with acquired immunodeficiency syndrome in Richmond, Va.: A quantitative analysis. Archives of Internal Medicine 148(8), pp. 1793-1797.

Inpatient charges for 52 adult AIDS patients having 102 admissions to the Medical College of Virginia Hospitals in Richmond from October 1983 through December 1986 are studied. Complete charge

data, average length of stay,total charges per hospitalization, and total lifetime hospital charges were analyzed for 81 hospitalizations. Findings suggest that "inpatient costs of treating individual patients with AIDS are less than initially estimated and are decreasing due to the ability to more effectively manage these patients."

58. Kochanski, M. (1988, April). Insurance and AIDS [Letter]. Nature 332(6167), p. 774.

This letter responds to an article that addresses some of the problems insurers have with the spread of AIDS and suggests that life insurance not be paid to beneficiaries of AIDS victims, likening it to the way suicides are handled by the insurance industry: "If AIDS-related death were considered as a sort of slow suicide--with, say, a five-year rather than a one-year exclusion--then insurers would have at least as much protection as they could hope to gain through blood tests, but at rather less expense; and privacy would not need to be invaded."

59. Lafferty, W. and others. (1988, August). Hospital charges for people with AIDS in Washington State: Utilization of a statewide hospital discharge data base. American Journal of Public Health 78(8), pp. 949-952.

The authors analyzed the inpatient hospital utilization for 165 AIDS cases with 344 hospitalizations from July 1984 through December 1985 in Washington State. Data on mean charges per hospitalization and mean length of stay are presented. "In addition, evaluation of two diagnosis-related groups (DRGs 079 and 398) commonly used for AIDS hospitalizations showed that AIDS hospitalizations were substantially more expensive than non-AIDS hospitalizations within the same diagnosis-related group. AIDS-specific diagnosis-related groups may be necessary to achieve a balance between inpatient charges and reimbursements."

60. Long, D. (1987, September). Fighting the economic epidemic. Nursing Management 18(9), pp. 66-71.

Presented here are issues related to hospital administrators' role in developing a strategy for minimizing AIDS-related costs to hospitals. Pertinent internal issues include: best use of bed space; patient care costs, which average 50-70 percent more for AIDS patients than non-AIDS patients; outpatient clinics; psychological support; education of staff; legislation concerning the handicapped; blood screening; confidentiality; and worker compensation. External issues to be considered include: cost reimbursement by Medicare and Medicaid or personal insurance companies; availability of long-term care facilities; litigation against hospitals; and current research. The author concludes that hospital expenses can be reduced by rapid diagnosis of AIDS,

development of more effective drugs and treatment, increased use of long-term care facilities, and protection against AIDS-related litigation.

61. Mercola, J. (1988, March). Private resources should share AIDS funding responsibility [Letter]. JAOA 88(3), p. 313.

The author maintains that "strong efforts to consclidate private community resources with minimum government intervention should be pursued." The potential impact on the future tax base of large numbers of young and middle-aged workers becoming disabled because of AIDS is considered.

62. Nelson, D. (1987, Summer/Fall). AIDS and life insurance: A look behind the testing issue. AIDS & Pubic Policy Journal 2(3), pp. 26-28.

The author briefly describes "ways in which the [insurance] industry is vulnerable to solvency or profitability difficulties due to AIDS--difficulties that may well exist regardless of whether applicants for insurance are tested or not." Issues addressed include: financial solvency of companies in the event of catastrophic AIDS claims; adequacy of current reserve levels to meet solvency and legal requirements; and the possibility that systems of State insurance guarantee funds may be unable to function as intended if an AIDS epidemic causes numerous insurance company insolvencies.

63. Roper, W. and W. Winkenwerder. (1988). Making fair decisions about financing care for persons with AIDS. Public Health Reports 103(3), pp. 305-308.

This article presents four policy principles proposed for meeting the increased Medicaid cost burden of AIDS "in a way that is fair, responsive, efficient,and in harmony with current joint public-private system of health care financing. The four guidelines are to (a) treat AIDS as any other serious disease,without the creation of a disease-specific entitlement program; (b) bring AIDS treatment financing into the mainstream of the health care financing system, making it a shared responsibility and promoting initiatives such as high-risk insurance pools; (c) give States the flexibility to meet local needs, including Medicaid home care and community-based care services waivers; (d) encourage health care professionals to meet their obligation to care for AIDS patients."

64. Rowe, M. and C. Ryan. (1988, April). Comparing State-only expenditures for AIDS. American Journal of Public Health 78(4), pp. 424-429.

This article presents results of a 50-State survey to determine State AIDS expenditures, excluding Medicaid or Federal funds, for

FYs 1984-88. The authors note that State-only expenditures have increased 15-fold. Between FY86-88, the distribution of State funding for AIDS patient care and support services doubled, and States supplementing Federal funds for testing and counseling went from eight to 20. Also reviewed are the per patient cost appropriations for diagnosis and for testing, counseling, and education. How some States are allocating funds to meet increased demands is discussed.

65. Seage III, G. and others. (1988, August). Medical costs of ambulatory patients with AIDS-related complex (ARC) and/or generalized lymphadenopathy syndrome (GLS) related to HIV infection, 1984-85. American Journal of Public Health 78(8), pp. 969-970.

"A cost-of-illness study July 1, 1984-June 30, 1985 evaluating 28 patients with AIDS-Related Complex (ARC) and/or Generalized Lymphadenopathy Syndrome (GLS) found the average cost to be $489 per patient per year. None of the ARC or GLS patients in [the] study was hospitalized during the one year period, and none progressed to AIDS. No AIDS-specific treatment such as AZT was available at the time this study was completed." The results "suggest that the medical management of ARC and GLS did not require significant financial resources for individual patients at [that] time...."

66. Smillie, J. and F. Ala. (1988, February). Reducing the cost of anti-HIV screening. Journal of Virological Methods 19(2), pp. 181-184.

"In an attempt to reduce the cost of testing for anti-human immunodeficiency virus (HIV) we looked at the possibility of recycling the Wellcozyme (R) HIV antigen bound wells; our findings showed that there was no significant reduction in sensitivity of the test samples or controls when run in parallel with new plates. It was concluded that the use of recycled plates was a cost effective means of performing more tests."

67. Solovy, A. (1988, June 5). The economics of AIDS: One analyst's views. Hospitals 62(11), pp. 38, 40.

Financial issues--which center on costs--as distinguished from economic issues--which center on allocation of scarce resources are discussed in relation to the AIDS epidemic by Sandra Panem, author of The AIDS Bureaucracy: Why Society Failed to Meet the AIDS Crisis and How We Might Improve Our Response.

68. Stoto, M. and others. (1988, March-April). Federal funding for AIDS research: Decision process and results in fiscal year 1986. Reviews of Infectious Diseases 10(2), pp. 406-419.

"With the history of the U.S. federal budget for fiscal year 1986 as a vehicle, the usual processes in the executive branch and the Congress that establish health research priorities and the unusual developments that have shaped priorities for AIDS are described. In the 3 years between the initial formulation of the AIDS budget and its execution, there were numerous revisions and evidence of poor communication between scientists and policy makers. On the basis of this analysis, two recommendations are made: the director of the National Institutes of Health and the heads of other U.S. Public Health Service agencies should have discretionary funds to use for AIDS activities; and better channels of communication between the Congress, the Public Health Service, and outside biomedical researchers should be established for consultation on priorities for AIDS research."

69. Study focuses on AIDS, health insurance industry. (1988, June). AORN Journal 47(6), p. 1496.

This short article discusses the results of a study on AIDS vis-a-vis the health insurance industry and the apparent trend among employers toward self-insuring. The text points out that, because self-insurers are unregulated by State insurance commissions, they can exclude specific conditions, such as AIDS, from coverage. The researchers recommend addressing this movement to self-insurance.

70. Traska, M. (1988, March 5). AIDS cases haven't increased HMO costs--yet. Hospitals 62(5), pp. 45-46.

The author points out that health maintenance organizations that treat AIDS patients in New York and California have not yet experienced substantial increases in costs or utilization. Some reasons for this are summarized and the potential for future risk and loss is explained.

71. Wells, J. (1987, Fall). Foundation funding for AIDS programs. Health Affairs, pp. 113-123.

This essay analyzes funding patterns of private foundations for AIDS programs. Using regular reports of The Foundation Center the essay covers grants made from 1981 to early 1987, during which time a total of $19,604,204 in grants for AIDS programs were awarded. The author details trends in the grants awarded during that period and specifies the categories in which the awards were made. The patient care category has received the bulk of foundation funds, with public health education receiving funds that amount to a "relatively minor commitment," according to the author. The essay identifies the foundations that granted the awards and illustrates

the uses of these grants with three specific examples. It concludes with a discussion of problems in giving to AIDS programs and the prospects for future foundation participation in AIDS giving.

72. Whyte, B. and others. (1987, September 21). The costs of hospital-based medical care for patients with the acquired immunodeficiency syndrome. Medical Journal of Australia 147(6), pp. 269-272.

"The costs which were incurred by patients for hospital-based care during the time from the diagnosis of the acquired immunodeficiency syndrome (AIDS) to death, range from pounds 6838 in London, England, to US$147,000 in Atlanta, USA. In 1986, a study was undertaken in Sydney to calculate the costs of the hospital-based treatment of patients with AIDS. The medical records of 39 patients who had received all their treatment at one institution were analyzed retrospectively, and data were collected on their survival, hospitalizations, investigations and treatments. The mean survival time of the 39 patients was 7.2 months; during this time they had a mean of 4.0 hospital admissions that accounted for an average total stay of 34.6 days. In addition, they made, on average, 9.4 outpatient visits. There was a significant difference in the duration of hospitalization between those who presented with an opportunistic infection and those who presented with a malignancy (38.3 days and 22.4 days, respectively; P = 0.01). The mean cost for hospital-based care was $A22,332 (range, $A4229-$A58,398), of which 95% of costs were incurred for inpatient care. The mean cost of care of those who presented with an opportunistic infection was significantly higher than that of those who presented with a malignancy, but there was no difference according to the age at the time of diagnosis. If the predictions of 3000 cases of AIDS in Australia by 1991 are realized, such cases will represent, conservatively, an additional cost to the community of $A58.5 million. This study emphasizes the need for health authorities to plan for the future financial impact of the hospital-based treatment of patients with AIDS."

73. Allegra, C. and others. (1987, October 15). Trimetrexate for the treatment of pneumocystis carinii pneumonia in patients with the acquired immunodeficiency syndrome. New England Journal of Medicine 317(16), pp. 978-985.

"Preclinical studies have demonstrated that trimetrexate is a potent inhibitor of dihydrofolate reductase from Pneumocystis carinii. On the basis of this evidence, this lipid-soluble antifolate was used as an antipneumocystis agent in 49 patients with the acquired immunodeficiency syndrome (AIDS) and pneumocystis pneumonia. Simultaneous treatment with the reduced folate leucovorin was used as a specific antidote to protect host tissues from the toxic effects of the antifolate without affecting the antipneumocystis action of trimetrexate. Patients were assigned to three groups and treated for 21 days: in Group I, trimetrexate with leucovorin was used as salvage therapy in patients in whom standard treatments (both pentamidine isethionate and trimethoprim-sulfamethoxazole) could not be tolerated or had failed (16 patients); in Group II, trimetrexate with leucovorin was used as initial therapy in patients with a history of sulfonamide inefficacy or intolerance (16 patients); and in Group III, trimetrexate with leucovorin plus sulfadiazine was used as initial therapy (17 patients). The response and survival rates were, respectively, 69 percent and 69 percent in Group I; 63 percent and 88 percent in Group II; and 71 percent and 77 percent in Group III. Trimetrexate therapy had minimal toxicity; transient neutropenia or thrombocytopenia occurred in 12 patients and mild elevation of serum aminotransferases in 4. We conclude that the combination of trimetrexate and leucovorin is safe and effective for the initial treatment of pneumocystis pneumonia in patients with AIDS and for the treatment of patients with intolerance or lack of response to standard therapies."

74. De Clercq, E. (1988). Antiviral chemotherapy today and tomorrow. Annals de Medecine Interne (Paris) 139(2), pp. 84-86.

"Antiviral chemotherapy has come of age. Several compounds, i.e. amantadine, rimantadine, idoxuridine, trifluridine, vidarabine, acyclovir, ribavirin and azidothymidine, have been licensed for clinical use and other promising compounds may follow soon. The search for new antiviral agents has been boosted by the advent of AIDS, but the activity spectrum of the newly developed antivirals not only spans retroviruses but also various other virus infections, i.e. herpes-, adeno-, pox- and rhinovirus infections. Clinical trials have been started with a variety of these new compounds and the prospects for an effective chemotherapy of several viral diseases certainly look bright."

75. Faber, V. and others. (1987, October 10). Inhibition of HIV replication in vitro by fusidic acid. Lancet 2(8563), pp. 827-828.

"A 58-year-old man with AIDS improved clinically after the introduction of fusidic acid, 500 mg three times a day orally, to his therapeutic regimen. Fusidic acid may have had a direct effect against HIV. Fusidic acid has anti-HIV activity in vitro at levels readily attainable in vivo. The drug does not appear to be a reverse transcriptase inhibitor and its mode of action against HIV is unknown. Fusidic acid can be given orally and has few side-effects. These results justify fuller evaluation of fusidic acid as therapy against AIDS and HIV infection."

76. Fischl, M. and others. (1988, February). Safety and efficacy of sulfamethoxazole and trimethoprim chemoprophylaxis for Pneumocystis carinii pneumonia in AIDS. Journal of the American Medical Association 259(8), pp. 1185-1189.

This article evaluates the safety and efficacy of sulfamethoxazole and trimethoprim in the prevention of AIDS-associated P. carinii pneumonia. "Sixty patients with a new diagnosis of Kaposi's sarcoma and no history of opportunistic infections were randomly assigned to receive 800 mg of sulfamethoxazole and 160 mg of trimethoprim twice per day or no therapy. None of the 30 patients receiving sulfamethoxazole and trimethoprim developed P. carinii pneumonia. Sixteen of the 30 patients receiving no suppressive therapy developed P. carinii pneumonia....The proportion of patients surviving and the mean length of survival were significantly greater in the treatment group compared with the control group. Adverse reactions occurred in 15 patients (50%)."

77. Gill, P. and others. (1987, September). AIDS-related malignant lymphoma: Results of prospective treatment trials. Journal of Clinical Oncology 5(9), pp. 1322-1328.

"Twenty-two consecutive patients with high-grade, B-cell lymphomas related to the acquired immunodeficiency syndrome (AIDS) were accrued onto two sequential phase II studies, consisting of a standard regimen (M-BACOD, group no. 1, N = 13), or a novel, intensive regimen (group no. 2, N = 9), which included high-dose cytosine arabinoside (HD-Ara-C), and high-dose methotrexate (HD-MTX), in an attempt to prevent CNS relapse and improve response rates. Stage IV disease was present in 82%. Complete remission (CR) was achieved in seven of 13 patients (54%) in group no. 1, and in three of nine (33%) group no. 2 (P = NS). By multivariate analysis, the most significant factor in predicting response was a Karnofsky performance score (KPS) greater than 60 (P = .04). Three of the ten patients who achieved CR on either regimen have relapsed; in all, five of 13 patients (31%) in group no. 1 have achieved disease-free survival for more than 1 year, compared with one of nine (11%) in group no. 2. CNS progression occurred in six patients in group no.

2, and in two patients in group no. 1. Hematologic toxicity was significantly greater in group no. 2, and these patients had an increased risk of opportunistic infection (one in group no. 1 versus seven in group no. 2; P less than .01). Survival was similar, with a median of 11 months in group no. 1 and 6 months in group no. 2. We conclude that the intensive regimen of combination chemotherapy described here is associated with significant risk of early death due to opportunistic infection in patients with AIDS-related lymphoma, and that progression in the CNS remains a major problem. Trials of combination chemotherapy of a less intensive nature, perhaps in combination with immunomodulators or antiretroviral agents should be explored."

78. Immunization and AIDS. (1988, June). Pediatric Infectious Disease Journal 14(6), p. 12.

This news brief summarizes Centers for Disease Control (CDC) recommendations for immunizing children with HIV infection against measles, mumps, and rubella (MMR). A CDC committee formerly recommended that the MMR vaccine be given to asymptomatic HIV-infected children, but not to those with symptoms. Due to reports of severe and fatal measles in children with AIDS and no reports of "serious or unusual reactions" of HIV-infected infants to the MMR vaccine, the committee now recommends that the MMR vaccine be considered for immunizing all HIV-infected children regardless of symptoms.

79. Jacobsen, P. (1988, Spring). Psychological reactions of individuals at risk for AIDS during an experimental drug trial. Psychosomatics 29(2), pp. 182-187.

The impact of experimental drug testing was examined in 26 homosexual and bisexual men seropositive for HIV. Participants reported significant emotional distress, although this "did not impede adherence [to the treatment regimen], decrease over the period of the study, or relate to subjects' beliefs that they were receiving a placebo"....The authors conclude that "these findings suggest both the feasibility of placebo-controlled studies in this distressed population and provide a focus for psychoeducational counseling."

80. Katzenstein, D. and others. (1988, June). Issues in the evaluation of AIDS vaccines [Editorial review]. AIDS 2(3), pp. 151-155.

This article discusses approaches to HIV vaccine development and the necessity for understanding the types of immune responses induced. Steps in vaccine evaluation are extensively detailed and include both preclinical testing and clinical trials in three distinct phases. One concern mentioned by the authors in the design

of vaccine trials in humans is "the potential for volunteers to engage in high-risk behaviours based on the belief that they have been vaccinated against HIV." Prevention of infection through education as well as vaccination is stressed.

81. Koff, W. and D. Hoth. (1988, July 22). Development and testing of AIDS vaccines. Science 241(4864), pp. 426-432.

"Recent advances in delineating the molecular biology of human immunodeficiency virus type 1 (HIV-1) have led to innovative approaches to development of a vaccine for acquired immunodeficiency syndrome (AIDS). However, the lack of understanding of mechanisms of protective immunity against HIV-1, the magnitude of genetic variation of the virus, and the lack of effective animal models for HIV-1 infection and AIDS have impeded progress. The testing of AIDS vaccines also presents challenges. These include liability concerns over vaccine-related injuries; identification of suitable populations for phase 3 efficacy studies; balancing the ethical obligation to counsel research subjects to avoid high-risk behavior with the necessity to obtain vaccine efficacy data; and the effect of vaccine-induced seroconversion on the recruiting and welfare of trial volunteers. Several candidate AIDS vaccines are nevertheless currently under development, and some are undergoing phase 1 clinical trials."

82. Laukamm-Josten, U. and others. (1987). Active immunization against hepatitis B: Immunogenicity of a recombinant DNA vaccine in females, heterosexual and homosexual males. Postgraduate Medical Journal 63(Suppl. 2), pp. 143-146.

"Three groups of subjects (58 females, 54 heterosexual males, and 50 homosexual males) received three doses of a recombinant DNA yeast-derived hepatitis B vaccine according to a 0, 1, and 6 month vaccination schedule. Local and general side effects were mild. Seroconversion rates after three injections were not significantly different between the groups. Females showed a significantly higher anti-HBs response than both groups of males, and heterosexual males had higher antibody titres than homosexual males. Among the four homosexual non-responders, three were carriers of the human immunodeficiency virus."

83. Morrison, R. and others. (1987, October 22-28). Different H-2 subregions influence immunization against retrovirus and immunosuppression. Nature 329(6141), pp. 729-732.

"Friend murine leukaemia virus complex (FV) causes an immunosuppressive retrovirus-induced disease. In certain mouse strains, FV shows striking similarities to human immunodeficiency virus (HIV) infection in man in that infected mice have severe T-cell immunosuppression but also develop virus-neutralizing antibodies incapable of eliminating infected cells. Previously we

noted the influence of mouse major histocompatibility complex (H-2) genes on both FV-induced immunosuppression and on ability to protect mice against FV by immunizing with a vaccinia-Friend murine leukaemia helper virus (F-MuLV) envelope (env) recombinant virus. Here we show that different subregions of H-2 are involved in susceptibility to virus-induced immunosuppression (H-2D subregion) and protective immunization with a recombinant vaccinia virus (H-2K or I-A subregions). Thus, susceptibility to virus-induced immunosuppression does not preclude protection by vaccinia-Friend immunization. The mechanism of protection seems to involve priming of immune T cells, and not initial induction of neutralizing antibodies or cytotoxic T lymphocytes (CTL) (ref. 2). Subsequent virus challenge generates a secondary response, resulting in appearance of IgG antibodies and CTL. In human HIV infection there could also be host genetic influences on elements of disease pathogenesis, such as immunosuppression, and on the success of T-cell priming by potential protective vaccines."

84. Surbone, A. and others. (1988, April). Treatment of the acquired immunodeficiency syndrome (AIDS) and AIDS-related complex with a regimen of 3'-azido-2',3'-dideoxythymidine (azidothymidine or zidovudine) and acyclovir. A pilot study. Annals of Internal Medicine 108(4), pp. 534-540.

Eight patients either with AIDS or ARC were given acyclovir (800 mg) and AZT (100 mg), orally four times per day, based on observations that acyclovir potentiates AZT activity in vitro. "The pharmacokinetics of the two drugs were independent of each other. Six patients received the drug combination for at least 10 weeks; all had increased numbers of T4+ lymphocytes..., and two of three assessable patients had reversal of anergy. Two patients tested positive for serum HIV p24 antigen at entry, but became negative with treatment. Data for this small group suggest that this drug combination can be tolerated in patients with severe HIV infections; this study can be used as a basis for larger studies of this drug combination."

85. von Reyn, C. and others. (1987, September 19). Human immunodeficiency virus infection and routine childhood immunisation. Lancet 2(8560), pp. 669-672.

"Current experience with the safety and efficacy of vaccines in infected children and adults is reviewed to examine the basis for decisions about routine immunisations of children infected with the human immunodeficiency virus (HIV). No adverse reactions to inactivated vaccines have been noted, but complications with live vaccines have been recorded with both BCG and smallpox. Limited experience with live poliomyelitis and measles vaccines in HIV-infected children has not yet shown any severe complications from these vaccines. Theoretical concerns that immunisation might accelerate the course of HIV infection are not supported by

available data. Serological response to most inactivated and live vaccines is reduced in HIV-infected persons, and is related to the degree of immunosuppression present. Preliminary evidence suggests that the severity of some vaccine-preventable diseases is increased in HIV-infected children. This review finds general support for recommendations on immunisation of HIV-infected children that have been developed by the World Health Organization."

86. Wainberg, M. and others. (1988, May 1). Vaccine and antiviral strategies against infections caused by human immunodeficiency virus. Canadian Medical Association Journal 138(9), pp. 797-807.

The researchers report on several antiviral therapies being investigated which aim "to prevent virus binding and entry, to inhibit reverse transcription, to inhibit the virus's life cycle and to restore immune competence in immunocompromised patients." According to the researchers, an ideal vaccine would ..."prevent adsorption of the virus into the cell, but it is difficult to develop stable resistance because the virus has many antigenic patterns and mutates frequently."

87. Young, F. and S. Nightingale. (1988, July 8). FDA's newly designated treatment INDs. Journal of the American Medical Association 260(2), pp. 224-225.

This technical article describes two investigational drugs that physicians can obtain under treatment protocols for patients with serious or life-threatening AIDS-related conditions. The drugs, approved for early availability under special so-called treatment investigational new drug procedures, are cytomegalovirus immune globulin and trimetrexate glucuronate. The authors offer background on the drugs including sponsors, indications, use, and treatment protocols for eligible patients as well as sources for further information.

EPIDEMIOLOGY

88. AIDS in sub-Saharan Africa. (1988, June 4). Lancet 1(8597), pp. 1260-1261.

This article discusses the level and extent of HIV infection particularly in the heterosexual population of sub-Saharan Africa. In seeking to identify causative factors and cofactors, the sociocultural and biomedical aspects of the disease and its transmission are examined. The possibility that susceptibility to and incidence of HIV infection is greater in individuals with chronic infections, such as sexually transmitted diseases, and that there is a much higher prevalence of such diseases in Africa was suggested as a contributing factor.

89. Allaire, S. (1988, April 1). Trace back of a case of acquired immune deficiency syndrome related to a blood transfusion. Canadian Medical Association Journal 138(7), pp. 630-632.

The author documents two cases of repeated HIV transmission from one blood donor. The difficulties of contact tracing of both affected blood donors and recipients are included in the discussion.

90. Altman, R. (1988, May). The epidemiology of AIDS in New Jersey. New York State Journal of Medicine 88(5), pp. 236-239.

"The epidemiology of acquired immunodeficiency syndrome in New Jersey is presented for the period 1982-1986. Additional data are also presented for 1987. A total of 1,728 nonincarcerated adult AIDS cases were diagnosed in the period 1982-1986. The largest number of cases occurred in the counties that contain sizable urban populations. The proportion of cases among females is very high in New Jersey, with most of them occurring in those areas of the state near New York City. Intravenous drug abuse is the risk factor most directly associated with AIDS in the high incidence metropolitan areas of New Jersey."

91. Anderson, R. and R. May. (1988, June 9). Epidemiological parameters of HIV transmission. Nature 333(6173), pp. 514-518.

This technical article addresses the likely demographic impact of the HIV virus, whether or not it will spread in the heterosexual population in developed countries, and the reasons why heterosexual transmission is so rapid in certain developing countries. The authors review the incubation and infectious periods for AIDS, the probability of transmission, and the issues involved in predictions and levels of uncertainty. They conclude that even though "... many uncertainties still surround the key epidemiological parameters that determine transmission within and between different at risk

groups," this is not surprising when one takes account of the long incubation period of AIDS and its primary mode of transmission. They note that an essential prerequisite for designing trials for promising candidate vaccines or drugs is better epidemiological understanding.

92. Anderson, R. and others. (1988, March 17). Possible demographic consequences of AIDS in developing countries. Nature 332, pp. 228-233.

"Simple mathematical models of the transmission dynamics of HIV that incorporate demographic and epidemiological processes to assess the potential impact of AIDS on human population growth and structure in developing countries suggest that AIDS is capable of changing population growth rates from positive to negative values over timescales of a few decades. The disease is predicted to have little if any impact on the dependency ratio of a population, defined as the number of children below age 15 years and elderly people over 64 years, divided by the number of adults between 15 to 64 years."

93. Bachetti, P. and others. (1988, May). Survival patterns of the first 500 patients with AIDS in San Francisco. The Journal of Infectious Diseases 157(5), pp. 1044-1047.

This study examines the survival patterns of 500 San Francisco residents diagnosed with AIDS through May 31, 1984. The researchers used the national surveillance definition of AIDS as the diagnostic criteria and the Department of Public Health's surveillance system as well as medical records, death certificates, and newspaper obituaries to identify the AIDS victims. They measured survival of these patients, of whom 99 percent were homosexual or bisexual men, from diagnosis to death. They estimated that the overall median survival time was 11 months, with 44 percent one-year survival rates and 11 percent three-year survival rates. Patients with an initial diagnosis that included an opportunistic infection tended to have shorter survival times than those diagnosed with Kaposi's Sarcoma alone. Patients with Pneumocystis carinii pneumonia (PCP) tended to live longer than patients with other opportunistic infections, but the difference was not significant. Moreover, older patients were more likely to have an opportunistic infection at initial diagnosis and, therefore, tended to die sooner than younger patients.

94. Centers for Disease Control. (1988, September 11). HIV infection and pregnancies in sexual partners of HIV-seropositive men--United States. Morbidity and Mortality Weekly Report 36(35), pp. 593-596.

Results are presented from a survey of 246 U.S. hemophilia treatment centers and physicians known to treat hemophilic

patients; 237 (96 percent) responded. It was reported that 34 percent of the spouses/sexual partners of HIV-seropositive patients had been serologically tested for HIV antibody. Ten percent of those tested were reported to be seropositive.

95. Centers for Disease Control. (1987). Human immunodeficiency virus infection in the United States: A review of current knowledge. Morbidity and Mortality Weekly Report 36(Suppl. S-6), pp. 1-48.

This extensive report, replete with tables, figures, charts, maps, and graphs, summarizes published and unpublished information on HIV infection in the United States. At the time of the review, conducted from September to November, the Centers for Disease Control had recorded 46,000 cases of AIDS since 1981. The authors of the report admit that the various studies reviewed differ in design and thus cannot be precisely compared. However, they state that the review gives a description of the approximate patterns and trends of HIV infection in the United States. The report covers infection among groups at recognized risk; infection among groups within the general population; HIV antibody prevalence by geographic location, age, sex and race or ethnicity; and heterosexuals. It also describes HIV infection trends over time and the incidence of new infection. The report concludes that many gaps in knowledge about AIDS remain and that "more precise and more consistently collected data ..." on the prevalence of HIV infection must be gathered.

96. Centers for Disease Control. (1988, July 1). Partner notification for preventing human immunodeficiency virus (HIV) infections - Colorado, Idaho, South Carolina, Virginia. Morbidity and Mortality Weekly Report 37(25), pp. 393-396, 401-402.

This report summarizes Centers for Disease Control (CDC) recommendations regarding partner notification to prevent HIV infection. Persons testing HIV-antibody positive should be counseled on how to notify their partners and refer them for counseling and testing. If they will not notify their partners or if it is not certain that their partners will seek counseling, the CDC recommends that "physicians or health department personnel should use confidential procedures to assure that the partners are notified." The report suggests specific notification procedures, including those that protect the anonymity of patients. CDC-supported, State AIDS prevention and surveillance projects require the States to confidentially notify sex and needle-sharing partners of AIDS patients and HIV-seropositive individuals. The report includes a table of partner-notification activities by State and describes some of these State programs. It concludes with some thoughts on the limitations of the partner-notification model.

97. Centers for Disease Control. (1988, June 24). Update: Universal precautions for prevention of transmission of human immunodeficiency virus, hepatitis B virus, and other bloodborne pathogens in health-care settings. Morbidity and Mortality Weekly Report 37(24), pp. 377-382, 387-388.

This report clarifies and supplements the Centers for Disease Control (CDC) publication, "Recommendations for Prevention of HIV Transmission in Health-Care Settings," which was published in August 1987. The CDC's 1987 document recommended blood and body fluid precautions be used for all patients "regardless of their bloodborne infection status." Since these "universal precautions" were published, the CDC and Food and Drug Administration have been asked to clarify several issues. These issues are clarified in this report: 1) body fluids to which universal precautions apply; 2) use of protective barriers; 3) use of gloves for phlebotomy; 4) glove selection for various procedures; and 5) waste management programs as a consequence of adopting universal precautions.

98. Cleary, P. and others. (1988, August). Sociodemographic and behavioral characteristics of HIV antibody-positive blood donors. American Journal of Public Health 78(8), pp. 953-957.

"This paper describes the sociodemographic and behavioral characteristics of 173 blood donors who were confirmed by Western blot tests to have antibodies to human immunodeficiency virus (HIV), the etiologic agent for acquired immunodeficiency syndrome (AIDS). Seropositive donors were predominately young, unmarried, and male, and major risk factors could be identified for almost all donors. However, more than 20 percent of the study participants were women,and many participants were not aware that they were at risk of infection. The heterogeneity of the study population, the lack of awareness among many subjects of risk factors and self-exclusion procedures, and the high level of distress among many subjects after notification, emphasize the need for intensive, well-designed education and support programs."

99. Hopkins, D. (1987, November-December). AIDS in minority populations in the United States. Public Health Reports 102(6), pp. 677-681.

"Among ethnic minorities in the United States, blacks and Hispanics, who compose 12 percent and 7 percent of the U.S. population, respectively, constitute 24 percent and 14 percent of the cases of AIDS. Seventy-eight percent of all children with AIDS are black or Hispanic, as are 71 percent of all women with AIDS. In the black and Hispanic communities, intravenous (IV) drug abuse is associated with much of the AIDS transmission, and parenterally acquired infections are spread secondarily by sexual and perinatal transmission. Almost two-thirds of black and Hispanic persons with AIDS in the United States reside in New York, New Jersey, or

Florida. Important differences in the understanding of AIDS and human immunodeficiency virus infection and control measures in minority communities must be considered in devising information and intervention programs for those communities. Programs intended specifically for minorities, especially greatly intensified prevention and treatment of IV drug abuse, are needed to supplement programs aimed at the U.S. population in general. Combatting AIDS offers black and Hispanic populations an opportunity to greatly reduce IV drug abuse, other sexually transmitted diseases, and teenage pregnancy."

100. Layne, S. and others. (1988, June 9). The need for national HIV databases. Nature 333(6173), pp. 511-512.

This article proposes that national HIV databases be created to coordinate the sharing of raw data among researchers in such areas as epidemiology, sociology, and mathematical modelling. The authors argue that because information on HIV is surrounded by sensitive social, legal, and ethical issues, researchers do not have access to many elements of raw data. They claim that "finding sources of such data and entering into collaborative relationships happens haphazardly, ..." The authors, citing deficiencies in currently available databases, call for the creation of such a database in the United States. They offer both design options for a national HIV database and an example of a database questionnaire for requesting data.

101. Lieb, S. and others. (1988, May). Human immunodeficiency virus infection in a rural community. Journal of the Florida Medical Association 75(5), pp. 301-304.

A community-based study and a clinic-based study were conducted in Belle Glade, Florida, a rural community with a high incidence of AIDS. The most commonly reported risk factor was found to be heterosexual contact with a person with AIDS or at increased risk for AIDS. The authors also reported high rates of participation for both the community study (17 of 20 adults, 85 percent) and the clinic study (275 of 284 eligible persons, 97 percent) which they felt..."indicated that further study of the problem was feasible."

102. Lifson, A. (1988, March 4). Do alternate modes for transmission of human immunodeficiency virus exist? Journal of the American Medical Association 259(9), pp. 1353-1356.

"Transmission of human immunodeficiency virus (HIV) is known to occur perinatally, through sexual contact, and after exposure to infected blood or blood products. The possibility that breast milk may transmit HIV continues to be evaluated. There is no epidemiologic evidence that contact with saliva, tears, or urine has resulted in HIV infection. However, because HIV has (in some cases rarely) been isolated from these body fluids, guidelines have

been developed to reduce more extensive exposures to such secretions. Laboratory and epidemiologic data strongly indicate that HIV is not transmitted through immune globulin preparations, the hepatitis B vaccine, or contact with insects. Increasingly evidence from many studies also indicates that HIV is not transmitted through casual contact. All individuals need to be aware of how HIV is and is not transmitted, to reduce high-risk behaviors and to avoid unnecessary fears and actions."

103. Marzuk, P. and others. (1988, March 4). Increased risk of suicide in persons with AIDS. Journal of the American Medical Association 259(9), pp. 1333-1337.

"The suicide rate for New York City residents diagnosed with the acquired immunodeficiency syndrome was compared with the rate for residents without AIDS in 1985. There were 668 suicides in New York City residents, yielding a rate of 9.29 per 100,000 person-years. Men aged 20 to 59 without a known diagnosis of AIDS had a rate of 18.75 per 100,000 person-years. Men in the same age group who were diagnosed with AIDS for all or part of 1985 had a suicide rate of 680.56 per 100,000 person-years. Thus the relative risk of suicide for the men aged 20 to 59 who had AIDS was 36.30 times that of men in the same age group without the diagnosis and 66.15 times that of the general population." (For related editorial commentary in the same issue, see R. Glass, "AIDS and suicide," pp. 1369-1370.)

104. McCormick, A. (1988). Trends in mortality statistics in England and Wales with particular reference to AIDS from 1984 to April 1987. British Medical Journal 296, pp. 1289.

Mortality statistics were compiled for England and Wales to determine deaths due to AIDS or HIV infection that were not so noted on death certificates. "From calculations of excess deaths between the beginning of 1985 and the end of April 1987, compared with 1984, at least 495 deaths possibly associated with HIV infection were estimated to have occurred among men aged 15-54." The author concludes that "accurate notification of the underlying cause of death and associated diseases is required for the precise monitoring of unrecognized conditions associated with HIV infection."

105. Milberg, J. and others. (1988, May). Geographic and demographic features of the AIDS epidemic in New York City. New York State Journal of Medicine 88(5), pp. 227-232.

"Using surveillance and vital record data, this report analyzes basic epidemiologic features of AIDS in NYC, stressing racial/ethnic and geographic patterns. Borough-specific incidence rates indicate that Manhattan has been affected most severely, with a rate more than 2.5 times that of the borough with the next highest rate, the Bronx. Manhattan is the only borough in which

whites have the highest incidence of AIDS; rates in blacks and Hispanics are higher in every other borough and citywide. The disproportionate racial/ethnic impact of AIDS is also evident in mortality rates. Compared to whites, blacks and Hispanics, particularly women, are at a considerably increased risk of dying of AIDS. Mortality rates in small geographic units are also presented in order to provide a more detailed picture of AIDS in NYC."

106. Osborn, J. (1988). The AIDS epidemic: Six years. Annual Review of Public Health 9, pp. 551-583.

This extensive review article, embellished with 142 references, describes many facets of the AIDS epidemic from 1981 to 1987. Relying on data from an October 1986 Institute of Medicine/National Academy of Sciences (IOM/NAS) report and several recent reviews, the author focuses on specific data and concepts that have emerged since the IOM/NAS study. She reviews the evolution of terminology and definitions; virology of human immunodeficiency viruses; and vaccine strategies. The author also discusses the pathogenesis and modes of HIV transmission; worldwide distribution of HIV infection; projections on the future spread of the epidemic; determinants and markers of disease progression; and immunologic insights into pathogenesis and host response. Finally, the author addresses the clinical facets of HIV infection; strategies of care; and legal, ethical, and social issues.

107. Peterman, T. and others. (1988, April). The challenge of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) in women and children. Fertility and Sterility 49(4), pp. 571-581.

This article is an extensive survey of current literature on the magnitude of the risk of AIDS/HIV transmission to women and children. The authors point out that most women with AIDS acquired the infection by needle sharing but that there is wide geographic variation in transmission categories among AIDS-infected women. The geographic distribution of children with AIDS is similar to the distribution of infected women. In a discussion of prognosis,it is suggested that for women, the "immunosuppression of pregnancy may accelerate progression to AIDS." In a concluding section, the authors stress the need for studies to determine the effects of potential cofactors in HIV transmission and to evaluate the effectiveness of alternative prevention strategies..

108. Pindyck, J. (1988). Transfusion-associated HIV infection: Epidemiology, prevention and public policy. AIDS 2(4), pp. 239-248.

This paper reviews "the evidence supporting the transmission of AIDS by transfusion, the strategies which have been employed to

control transfusion-associated AIDS, and some of the social, moral, and ethical issues which the strategies have had to address." The author presents extensive epidemiologic documentation for a cause-and-effect relationship between transfusion and the development of AIDS in recipients of blood or blood products. U.S. experience with transfusion-associated AIDS (including experience of hemophiliacs) is presented.

109. Seage III, G. and others. (1988, May). Patterns of blood donations among individuals at risk for AIDS, 1984. American Journal of Public Health 78(5), pp. 576-577.

"Of 978 respondents to an anonymous questionnaire targeted to reach homosexuals in Boston during October 1984, 88 (9 percent) reported recent blood donation. When compared to non-recent donors, high-risk respondents who were recent blood donors were younger, less open about their sexual preference, and more likely to obtain their information about AIDS (acquired immunodeficiency syndrome) from television and newspapers. These results suggest that particular subgroups of the population at risk for AIDS would benefit from expanded educational programs."

110. Selik, R. and others. (1988, July). Distribution of AIDS cases by racial/ethnic group and exposure category, United States June 1, 1981-July 4, 1988. Morbidity and Mortality Weekly Report 37(SS-3), pp. 1-10.

"The data presented here support the findings of earlier analyses...that AIDS patients are disproportionately black and Hispanic and that the portion of IVDA-associated AIDS cases is substantially greater in U.S. blacks and Hispanics than in U.S. whites....Black and Hispanic communities in the United States and Puerto Rico should be especially targeted for measures to prevent HIV transmission by treating drug abusers and by counseling drug abusers and their sex partners on the risk of HIV infection."

111. Sikes, R. and others. (1988, March). AIDS. Epidemiology and future projections in Georgia. Journal of the Medical Association of Georgia 77(3), pp. 154-161.

Projections of the numbers of AIDS cases, costs of care for patients with AIDS and estimated bed capacity needs in hospitals, nursing homes, and inpatient hospices through 1991 are presented for the State of Georgia. The case projection methodology used was that introduced at the 1986 Coolfont Conference on AIDS. The authors point out that Georgia's Department of Human Resources "predicts a total of approximately 5800 to 6200 cases of AIDS in Georgia by the end of 1991, with health care costs of approximately 150 million dollars in 1991 alone."

112. Wycoff, R. and others. (1988, June 24). Contact tracing to identify human immunodeficiency virus infection in a rural community. Journal of the American Medical Association 259(24), pp. 3563-3566.

"This report describes a contact investigation conducted in rural South Carolina to identify, counsel, and educate persons infected with or exposed to the human immunodeficiency virus (HIV). Starting with one HIV antibody-positive man and his 19 sex contacts,...83 sex contacts of HIV antibody-positive men [were identified]....Comparing reported numbers of sexual contacts for the six-month periods before and after [the researchers'] initial investigation, the mean numbers of named sex contacts decreased by 82% for antibody-positive men and 54% for antibody-negative men." (For related editorial commentary in the same issue, see G. Rutherford and J. Woo, "Contact tracing and the control of human immunodeficiency virus infection," pp. 3609-3610.)

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113. Baer, J. and others. (1987, December). Challenges in developing an inpatient psychiatric program for patients with AIDS and ARC. Hospital and Community Psychiatry 38(12), pp. 1299-1303.

"The presence of patients with AIDS and AIDS-related complex (ARC) on a psychiatric unit requires education of and adaptation by staff and other patients as well as changes in the psychiatric milieu. The authors describe their experiences with 36 AIDS and ARC patients admitted to a psychiatric unit over an 18-month period. They address issues related to staff reactions to terminal illness and to increased demands to provide physical care, milieu management that takes into account the limitations of AIDS patients suffering from dementia, diagnostic complications arising from mixed psychopathology in some AIDS patients, and the increased susceptibility of AIDS patients to side effects and toxicity from psychotropic medication. Other issues relating to infection control, ethical concerns, needs of friends and family, and disposition planning are also discussed."

114. Beers, V. and others. (1988, Winter). Service characteristics of U.S. public and teaching hospitals treating AIDS patients. AIDS & Public Policy Journal 3(1), pp. 51-57.

Patient characteristics and service characteristics are reported for AIDS patients treated at public and private teaching hospitals. Results of the 1985 survey are discussed in terms of regional and hospital differences; data are provided on risk group, sex, age, and race of AIDS patients as well as type of hospital resources/services they utilized. The authors conclude that large urban and teaching hospitals were treating a disproportionate share of AIDS patients in 1985.

115. Cotton, D. (1988, July 22/29). The impact of AIDS on the medical care system. Journal of the American Medical Association 260(4), pp. 519-523.

This review article addresses the medical care issues raised by AIDS. The author notes that ethical and legal issues on worker risk have not been adequately faced. He suggests that detailed guidelines on specific employee concerns must be drafted with the help of psychiatrists, infection control experts, and health educators. Other issues the author covers include attracting, training, and retaining health care workers, psychological burnout among health workers caring for AIDS patients, physician hardships in caring for at-risk groups and meeting patient demand for experimental therapy, and the impact of AIDS on hospitals. The author concludes that health care workers must face the fact that

AIDS will change the medical care system dramatically over the next several years.

116. Feldman, I. and others. (1988, Winter). AIDS center designation/AIDS intervention management system. AIDS & Public Policy Journal 3(1), p. 29-31.

The authors describe AIDS centers in New York and present the 13 standards/requirements that a hospital in the State must meet in order to be designated as an AIDS center. Included are requirements relating to levels of care, care settings, mental health services, housing and hospice care, and case management.

117. Fenton, T. (1987, November). AIDS-related psychiatric disorder. British Journal of Psychiatry 151, pp. 579-588.

"The background to HIV infection, its mode of transmission, and its neurological and psychiatric complications are described. The management of AIDS-related psychiatric disorders and problems encountered among staff involved in the management of patients suffering from AIDS are considered. There is a need for appropriate educational programmes. Although the incidence of AIDS in the UK has been appreciably lower than in many other countries, there are no grounds for complacency; psychiatric disorder associated with HIV infection will be encountered much more frequently in the future. Psychiatric staff are urged to inform and prepare themselves in anticipation of this development."

118. Furth, P. and others. (1988, June). Rehabilitation and AIDS: Primary care and system support. Maryland Medical Journal 37(6), pp. 469-471.

The authors point out the place of rehabilitation hospitals in education, counseling, and infection control. It is maintained that "a proportion of patients with AIDS who can benefit from rehabilitation therapy will be seen, and a majority of these can be managed within standard models of rehabilitation.... Rehabilitation hospitals will be delivering both primary care and system support to the individual and the health care delivery network."

119. Goldstone, I. (1987, December). AIDS care: An institutional delivery model, St. Paul's (Vancouver) experience. Journal of Palliative Care 3(2), pp. 38-41.

This article details the model of care for AIDS patients at St. Paul's Hospital in Vancouver, Canada. Vancouver, described as "Canada's San Francisco," has a large gay, drug abuse, and prostitution community. The hospital cares for about 70 percent of the AIDS patients in British Columbia. Its model of care includes research, clinical care, a specific administrative structure, and

education. Research studies range from zidovudine treatment regimens to lymphadenopathy. The hospital's AIDS Care Group, which takes a multidisciplinary approach to care, forms the core of the clinical care program. An AIDS Advisory Committee provides much of the administrative structure for the program. Finally, the education program focuses on safe work practices, overcoming homophobia by the staff, and infection prevention training.

120. Hull, F. (1987). The role of socio-behavioral scientists in health care practice. Social Science and Medicine 25(6), pp. 679-687.

"This paper attempts to analyze some of the complex problems that face primary health care practice in the developed world today. These are shown to be a degree of depersonalization, that has come with greater efficiency, and a reduction in the quality of the doctor-patient relationship, which has accompanied increased medical effectiveness. These changes are in turn related to changes in diagnostic methods in primary care, to changes in the organization of primary care and to change in the stress laid on interventive, preventive and rehabilitative care. All these inter-related problems have to be viewed against a background of shortage of resources which demand a far more stringent system of accountability than has been common until now. A possible solution lies in redefining the traditional medical role and the philosophical basis which underlies that role at a time when primary health care is confronted by the special problems of the AIDS pandemic. This would require major alterations in medical attitudes and in established medical education which may be impossible for the doctors to achieve by themselves. It is suggested that a most important role of socio-behavioral scientists lies in helping the medical profession to remove the attitudinal and educational barriers which prevent the realization of the concept of a new sort of doctor who may cope with the demands of primary health care as we approach 2000."

121. Iseman, M. (1987, December). Is standard chemotherapy adequate in tuberculosis patients infected with the HIV? American Review of Respiratory Disease 136(6), p. 1326.

This brief article questions the adequacy of standard chemotherapy in HIV-infected tuberculosis patients. The author is concerned for several reasons. Because this opportunistic infection often occurs early in HIV infection, patients have a relatively long time to risk a relapse. He cites one study reporting the failure of a potent six-month chemotherapy regimen in an HIV-infected patient. Its results support similar evidence in animal models of tuberculosis that show high rates of failure for treatments that were completely successful in "immunologically intact" animals. The author suggests extending the chemotherapy beyond six months to nine months. Another option is to stop the standard regimens at six

or nine months, but put the patient on lifetime isoniazid preventive therapy.

122. Kaplowitz, L. (1988, May). The AIDS challenge: Clinical care, testing, education, research. Virginia Medical, pp. 227-229.

This article outlines the four-part AIDS program of the Medical College of Virginia (MCV), which includes clinical, testing, research, and education programs. The clinical program includes a hospital-based clinic for people suffering symptoms of the entire range of HIV infection. The multidisciplinary care approach includes infectious disease specialists, primary care physicians, social workers, psychiatrists, chaplains, and nurses, who provide support to both patients and their families. The testing program includes an HIV antibody testing site at MCV. MCV's AIDS-related research program focuses on basic virologic and immunologic research, clinical studies, and health policy planning research. The College's AIDS program educates health care workers throughout the State and emphasizes the importance of a multidisciplinary approach to patient management.

123. Marier, R. (1987, October). AIDS in Louisiana: Programs at Charity Hospital. Journal of the Louisiana State Medical Society 139(10), pp. 59-61.

This article describes the AIDS program at Charity Hospital of Louisiana in New Orleans. The hospital serves as the center of the State's health care system for the medically impoverished. As such, its AIDS program represents the State's response to AIDS and related conditions. The hospital's AIDS care program is provided via the medical services of the Louisiana State University and Tulane University Schools of Medicine. The program includes a primary care and case management program and an AIDS Treatment Evaluation Unit. The hospital's outpatient services have been reorganized to cope with the increased number of AIDS cases (The number of patients have doubled in the past year.) and to better coordinate medical, psychosocial, home, and long-term care services. Finally, the hospital works in partnership with the community and the State.

124. McCarthy, C. (1988, May-June). The role of the American Hospital Association in combating AIDS. Public Health Reports 103(3), pp. 273-277.

This article details the role of the American Hospital Association (AHA) in combatting AIDS and describes the recommendations of a Special Committee on AIDS/HIV Infection Policy. "The committees first set of recommendations, approved in November 1987, reaffirmed the use of universal precautions,provided guidance on the appropriate uses and application of HIV testing, and stated that the delivery of care should not be conditioned on the willingness

of a patient to undergo testing. The second set of recommendations, which were approved in January 1988, focused on the need to distribute the responsibility for AIDS care among a wide variety of health care providers, to seek creative financing approaches that involve both the private and public sectors, and called on hospitals to provide leadership in ensuring that a continuum of services is available to AIDS patients. Continuing efforts to assist hospitals in the care delivery issues associated with AIDS are described."

125. Raske, K. (1988, May). The impact of AIDS on New York's not-for-profit hospitals. New York State Journal of Medicine 88(5), pp. 247-250.

The costs of treating AIDS patients in New York City are examined both in terms of dollars and in terms of staffing demands in the hospital setting. Also discussed is the concept of designating some hospitals as "AIDS Centers" to address concerns of coordination and quality of care. It is argued that the response of the health care community to the AIDS epidemic "will determine not only the future treatment of AIDS but the future of the health care system as well."

126. Advisory Group on AIDS. (1988, April 16). Strategic plan for the containment of AIDS in South Africa. SAMJ/SAMT 73(8), pp. 495-497.

The plan specifies that "intervention strategies by public health authorities must be aimed primarily at prevention. These measures should include: (i) infection and disease surveillance, including HIV testing; (ii) identification of at-risk people and populations and intervention strategies appropriate to the epidemiological pattern of transmission and aimed at specific groups at risk; (iii) health education and dissemination of information on AIDS to the public and health professions; (iv) provision of health services for HIV-infected patients; and (v) evaluation of antibody testing methods and proficiency testing."

127. Bird, A. (1988, April). HIV infection: the Swedish approach. A Medicine-Gilliland Fellowship report. Journal of the Royal College of Physicians, London 22(2), pp. 114-117.

Various aspects of HIV infection in Sweden are considered, including epidemiology, screening, government action, education, research, and inpatient care. "Sweden is planning to support the majority of AIDS cases in existing outpatient or inpatient infectious diseases facilities and is making little provision for community based care of severely affected individuals."

128. Brorsson, B. and C. Herlitz. (1988). The AIDS epidemic in Sweden: Changes in awareness, attitudes and behavior. Scandinavian Journal of Social Medicine 16(2), pp. 67-71.

"Questionnaire surveys concerning awareness, attitudes and beliefs about HIV virus and AIDS in Sweden were conducted in March/April of 1986, February/March of 1987, and May 1987....The surveys indicate that the general public views the AIDS epidemic with growing concern. They feel that researchers and public officials cannot effectively combat the problem. To a growing extent they feel that it is up to individuals to appropriately adapt their behavior if we are to slow the spread of the disease, and to a certain extent changes in sexual practices also seem to have happened. Changes in awareness, attitudes and beliefs have accelerated since the start in March, 1987 of the Swedish AIDS information campaign."

129. Chin, J. and others. (1988, May 13). Update: Acquired immunodeficiency syndrome (AIDS)--worldwide. Morbidity and Mortality Weekly Report 37(18), pp. 286-288, 293-295.

The authors report the numbers of AIDS cases reported to the World Health Organization as of March 21, 1988. Three distinct patterns are discussed: pattern I, common in industrialized countries with large numbers of AIDS cases, most of which occur among homosexual or bisexual males and urban intravenous drug users; pattern II, observed in parts of Africa and some Caribbean countries, with most cases occurring among heterosexuals; and pattern III, found in parts of Eastern Europe, Middle East, Asia, and most of the Pacific, with small numbers of cases that occur among persons who have travelled to endemic areas or who have had sexual contact with individuals from endemic areas.

130. Christakis, N. (1988, June/July). The ethical design of an AIDS vaccine trial in Africa. Hastings Center Report 18(3), pp. 31-37.

The author discusses the ethical issues associated with conducting a vaccine trial in Africa, in the context of "Proposed International Guidelines for Biomedical Research Involving Human Subjects," published in 1982 by the World Health Organization and the Council for International Organizations of Medical Sciences. Crossing sociocultural barriers presents special problems which must be considered. The author discusses the design of vaccine trials, assembly of a suitable study group, risks and consent issues, beneficent treatment (including corollary principles of "do not harm" and "maximize possible benefits and minimize possible harms"), and the cross-cultural aspects. Minimum principles are proposed in conclusion.

131. Comprehensive AIDS study released. (1988, May). Dimensions in Health Service 65(4), p. 8.

This news brief reviews a report of The Royal Society of Canada that covers the AIDS epidemic in Canada. The report, entitled, "AIDS: A perspective for Canadians," is the result of a year-long study by medical, social, economic, and legal experts. It estimates that as of September 1987, there were about 30,000 HIV-infected persons in Canada. The report documents AIDS-related costs to Canada and outlines a new health care system for HIV-infected persons and persons with AIDS. It proposes certain social benefits for these patients and their families, and calls for spending $35 million a year in new funds for AIDS and HIV research. The report makes 48 recommendations. Some, like those addressing human rights legislation, testing, and condoms, are controversial.

132. Froland, S. and others. (1988, June 11). HIV-1 infection in Norwegian family before 1970 [Letter]. Lancet 1(8598), pp. 1344-1345.

The authors document the medical histories of a child and her parents who contracted AIDS in the mid-1960s and died in 1976. It is pointed out that these were the first proven cases of AIDS in Europe, but no evidence exists that they gave rise to other cases in Norway.

133. Ijsselmuiden, C. and others. (1988, April 16). AIDS and South Africa--towards a comprehensive strategy. Part III. The role of education. SAMJ/SAMT 73(8), pp. 465-467.

This is the third of a three-part series in which the authors emphasize the need for a comprehensive strategy to control HIV infection in South Africa. Highlighted are the critical essentials for an educational campaign, which include discussion of the role of the State in program administration, the design and tasks of a multidisciplinary working group, and the need for open and appropriate communication with the public and at-risk groups.

134. Kay, K. (1988, March/April). The global struggle against AIDS: WHO's strategy. International Nursing Review 35(2), pp. 35-40.

This article is based on a presentation at the ICN Forum on AIDS at the Council of National Representatives meeting in New Zealand last August. The epidemiology of the disease, social, and public health issues are discussed. "WHO's global strategy to prevent HIV transmission and to reduce morbidity and mortality is described."

135. Kolbe, L. (1987). International policies for school health programmes. Hygie 6(3), pp. 7-11.

This survey article on the health of children in the developing world addresses the role of international organization policies in advancing and promoting school health programs. While recognizing vast regional differences, the author notes that death rates among infants and children have been cut almost in half. Further, children entering school increased from less than 30 percent to more than 80 percent. In discussing the global strategy for health for all by the year 2000, the report describes the roles and contributions of such organizations as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), the United Nations General Assembly, and the United Nations Educational, Scientific and Cultural Organization (UNESCO). The author concludes that "... there may be no more important function of schools and nations than to assure that individuals develop the greatest capacity to determine their own physical and mental well-being."

136. Krauser, J. (1988, June 15). AIDS and the OMA [Letter]. Canadian Medical Association Journal 138(12), pp. 1083-1084.

This letter--which responded to a "Viewpoint" article (pp. 560-561) in the March 15, 1988, issue of Canadian Medical Association Journal--briefly summarizes the 1985-87 activities of the Ontario Medical Association in providing information and guidelines to HIV-infected individuals, physicians, hospitals, and provincial medical officers. (For related comment in the same issue, see letter by I. Mackie, pp. 1084-1085.)

137. Lange, W. and E. Dax. (1987, September). HIV infection and international travel. American Family Physician 36(3), pp. 197-204.

"Screening international travelers for human immunodeficiency virus (HIV) antibodies does little to prevent the spread of the acquired immune deficiency syndrome. Individuals who are seropositive for HIV antibodies and wish to travel abroad will be subject to varying restrictions, depending on the severity of their illness and the entrance requirements for specific countries. International travel is not a risk factor for HIV infection, since routes of HIV transmission appear to be uniform
worldwide. However, prudent precautions are recommended because international travel may modify an individual's risk profile."

138. McCormick, A. and others. (1987, December 5). Surveillance of AIDS in the United Kingdom. British Medical Journal 295, pp. 1466-1469.

"The surveillance of cases of the acquired immune deficiency syndrome (AIDS) in the United Kingdom is described and a preliminary analysis made of the 1012 cases that were reported to the end of August 1987. Homosexuals were the largest risk group. For the first time...cases [are presented] by the date of diagnosis and by the regional health authority of residence. The rate of increase of new cases shows no sign of slowing down. One third of patients with AIDS lived in a different regional health authority from that in which their disease had been diagnosed. The geographical distribution varied with the risk group. The commonest presenting clinical feature at diagnosis was Pneumocystis carinii pneumonia. Kaposi's sarcoma was considerably more common among homosexuals than among people in other groups at risk."

139. National surveillance program on occupational exposure to the human immunodeficiency virus among health care workers in Canada. (1988, January 1). Canadian Medical Association Journal 138(1), pp. 31-33.

Results are reported from a Canadian program that implemented a national surveillance protocol to monitor the extent of HIV

transmission in the health care setting. Evidence of a low risk of HIV transmission in this setting is presented.

140. Nelson III, L. (1987). The need for an international strategy to combat AIDS. Medicine and Law 6(4), pp. 303-311.

This article describes the spread of AIDS globally and discusses a developing trend toward the restriction of international travel caused by the fear of AIDS. The author notes that this developing trend contrasts with policies of the World Health Organization (WHO), one of whose goals is to reduce the emphasis on quarantine. Arguing that "increasing barriers to international travel alone is not an appropriate means of dealing with the AIDS epidemic, ... ," the author concludes with a call to action by the world community for an international educational campaign. He also advances the belief that an immediate priority is increased assistance for developing nations since, for example, in "... some Central African nations as much as 50 percent of the population may be infected with HIV."

141. Ohi, G. and others. (1987). AIDS prevention in Japan and its cost-benefit aspects. Health Policy 8(1), pp. 17-27.

The first case of AIDS in Japan was reported in 1985 and only 21 cases were reported as of September 1986. The authors estimate the future incidence of AIDS in Japan using the Delphi prediction technique and explain the rationale for their "conservative" predictions. The cost effectiveness of preventive programs that focus on counseling and education is stressed.

142. Okware, S. (1987, December). Towards a national AIDS-control program in Uganda. Western Journal of Medicine 147, pp. 726-729.

This summary report of the incidence of AIDS in Uganda covers the country's control program, a 5-year plan of action, and health education efforts. From 1983--when Uganda identified its first AIDS case--until March 1987, a total of 1,138 cases of AIDS were reported. The author cites high-risk heterosexual behavior as an important mode of transmission. A survey of household contacts revealed that among household members only the sexual partners were seropositive. In Uganda's 5-year plan, the focus is health education. The effort also includes blood screening, improved sterile procedures, and improved surveillance as well as notification, research, and terminal patient care. The report mentions the dilemma of funding, since one screening test costs about the equivalent of $1.00, while a confirmatory Western blot method runs about $0.65 per test. The report notes that the average per capita expenditure on health in many African and developing countries is about $1.70 in U.S. terms.

143. Richards, T. (1988, May 28). BBC and ITV concerted blitz on AIDS. British Medical Journal [Clinical Research] 296(6635), p. 1527.

This article reviews the impact of the British Health Education Authority's media campaign aimed at increasing awareness of and changing attitudes toward AIDS and modifying high-risk behaviors. Results were assessed through personal interviews of individuals in their homes. The consensus was that although the general public is well informed about AIDS, greater benefit would result from targeting specific risk groups for an educational program that highlighted selected topics using all media forms, particularly those considered to have greater public credibility.

144. Rogan, E. and others. (1987, October 1). A case of acquired immunodeficiency syndrome before 1980. Canadian Medical Association Journal 137(7), pp. 637-638.

The authors report the medical case history of a Canadian who manifested AIDS symptoms in July 1978 and died in 1980. He had received a blood transfusion in 1976 while in Zaire in an area where AIDS has been found to be endemic. The medical evidence suggests that this was one of the earliest cases of transfusion-associated AIDS in North America.

145. Schmutzhard, E. and others. (1988, March/April). Treatment of severe malarial anaemia in East Africa's under-fives--an unsolvable problem since the advent of AIDS? Transactions of the Royal Society of Tropical Medicine and Hygiene 82(2), p.220.

The authors point out that routine screening tests for HIV are not available in many district hospitals or in rural hospitals and health centers in Africa, including areas where life-threatening malarial anemia occurs regularly. They conclude, "As long as there are no definite prevalence figures for HIV infection in rural East African areas...it is not justified to withhold a life-saving blood transfusion on the grounds of preventing a possible HIV infection."

146. Siegman-Igra, Y. and others. (1988, March). AIDS in Israel, 1987. Israel Journal of Medical Sciences 24(3), pp. 131-136.

This article describes the epidemiologic and clinical aspects of 35 cases of AIDS diagnosed in Israel between mid-1982 and January 1, 1988. "Risk factors for AIDS were identified in 34 patients: homosexuality in 18, hemophilia in 14 and blood transfusions in 2....Sexual relations abroad of local homosexuals and receipt of imported clotting factors by Israeli hemophiliacs are currently the most important risk factors for AIDS in Israel. However, the prevalence of HIV infection among Israeli homosexuals is still low and is probably indicative of the more conservative life-style, the

later introduction of the virus, and the earlier application of safe sex, in comparison with other Western countries."

147. Singer, M. (1988, June). AIDS in Africa: Transmission and prevention. AIDS Patient Care 2(3), pp. 13-14.

This general news feature describes the AIDS epidemic in Africa, noting that by January 1988, more than 75,000 AIDS cases were reported to the World Health Organization, with 12 percent from African countries. The author covers the modes of transmission of AIDS in Africa, noting that it follows a different pattern from the United States. She also addresses the impact of AIDS deaths on the African economies as well as their focus on prevention and the distribution of condoms. The author warns that Africa shows that the risk of AIDS is not limited to sexual orientation.

148. Tamashiro, H. and others. (1987, December). AIDS prevention and control in Japan. Western Journal of Medicine 147, pp. 719-722.

This summary report of the incidence of AIDS in Japan, the country's educational efforts, and legislation highlights its programs of surveillance. Japan started AIDS surveillance in September 1984 and extended the program to seropositive carriers of HIV antibodies in February 1987. Japanese hospitals and clinics participating in the program number 2,000. In July 1985, the country started an educational program for health care workers. The initial effort centered on the issuance of a series of government memoranda and the distribution of pamphlets and posters. In November 1986, Japan began screening all donated blood. In early 1987, politicians in the Parliament proposed a new law on the prevention of AIDS. It aims to determine the necessary measures for preventing the spread of AIDS and to contribute to the improvement and advance of public health. The proposed law does not affect international travelers, foreign students, or immigrants.

LEGAL AND ETHICAL ISSUES

149. Alvig, O. (1987, November). An argument against secrecy and AIDS [Letter]. Journal of the Medical Association of Georgia 76(11), p. 742.

This brief letter to the editor contends that secrecy has no place in dealing with the AIDS epidemic. The author chastises the State of Georgia for being "... totally unprepared ..." for dealing with the AIDS crisis. He notes that there are no nursing homes and that lack of information paralyzes public health.

150. Annas, G. (1988, July). Not saints, but healers: The legal duties of healthcare professionals in the AIDS epidemic. American Journal of Public Health 78(7), pp. 844-849.

"This essay explores the legal framework within which health care professionals must work as 'healers' in the AIDS (acquired immunodeficiency syndrome) epidemic, and suggests ways in which the law can reinforce an ethic of professionalism...." Values in health care and the obligation to treat are explored from common law, statutory, and contractual frames of reference. The place of professional standard setting by medical societies, statewide licensing boards, and State antidiscrimination statutes or private contract provisions is examined in detail. The author concludes that "a multifaceted approach is likely to prove effective in assuring access to medical care [for AIDS and HIV infected patients] in the long run."

151. Appelbaum, P. (1988, January). AIDS, psychiatry, and the law. Hospital and Community Psychiatry 39(1), pp. 13-14.

The author discusses legal issues surrounding the admission of an AIDS patient or HIV-positive person to a mental institution. Quarantine and commitment laws and the issue of confidentiality are also discussed.

152. Association of American Medical Colleges. (1988, July). Professional responsibility in treating AIDS patients. Journal of Medical Education 63(7), pp. 587, 589-590.

The AIDS epidemic has presented the medical profession with numerous moral and ethical issues. Of central concern is the "physician's responsibility to provide care to all patients. The Association of American Medical Colleges has taken special note of the fears and concerns of medical professionals and those in training to care for patients infected with HIV virus. This article presents the policy statement regarding the responsibilities and duties of medical colleges in teaching students to cope...and encourages medical schools and teaching hospitals to articulate a

clear policy on the physicians responsibility to provide care to patients without regard to their illness."

153. Birchfield, J. (1987). AIDS: The legal aspects of a disease. Medicine and Law. 6(4), pp. 407-426.

This detailed article, textured with numerous case examples, focuses on the legal issues and arguments that attorneys are raising with the advent of the AIDS epidemic. For example, the author notes that lawyers for the first time are challenging the medical service immunity laws on blood transfusions as well as the right to privacy. A third issue is discrimination against AIDS patients, not only from health care professionals, but also from employers and the insurance industry. Yet another area in which the author sees legal issues likely to evolve is personal liability for transmitting AIDS. She implores attorneys, whether prosecuting, defending, or advising AIDS cases, to draw upon compassion and creativity in helping to protect all persons involved.

154. Brahams, D. (1988, April). AIDS in the United States: Education and litigation. Lancet 1(8588), pp. 779-780.

This article attempts to address the question of balance between moral and legal issues in curbing the spread of AIDS and points out that considerable litigation has resulted from the epidemic.

155. Brennan, T. (1987, October). The acquired immunodeficiency syndrome (AIDS) as an occupational disease [Editorial]. Annals of Internal Medicine 107(4), pp. 581-583.

The author lists "several problems with using workers' compensation as the sole source of compensation for work-related AIDS in health care workers. Workers' compensation applies only to salaried employees of a particular institution,..." for example. Also mentioned are unavailability of compensation for pain and suffering and the tendency of some workers' compensation boards "to provide poor compensation for long-term disability and death...." The author cautions that ..."hospitals can probably expect more litigation, especially if health care workers perceive that the workers' compensation benefits are not available to them or that those available are inadequate."

156. Bridge, T. (1988). Legal and ethical issues in the neuropyschiatric research in AIDS. In T. Bridge et al (Eds.). Pychological, Neuropsychiatric, and Substance Abuse Aspects of AIDS (pp. 241-247). New York City: Raven Press.

This book chapter identifies and examines questions the author deems critical to developing a clinical research policy applicable to both mental health and drug abuse aspects of AIDS. The author covers the areas of confidentiality, risk assessment, and

involuntary restraint and quarantine. He concludes that the accomplishments recorded by researchers and scientists in identifying the causative agent of AIDS and developing the antibody test emphasize the need to mobilize behavioral and social research experience. To move forward in combating AIDS, the author believes it is imperative to recognize the behavioral component of AIDS and to draw on those fields that have addressed issues of behavioral management and treatment.

157. Burda, D. (1987, August 20). Employment issues dominate hospital AIDS suits. Hospitals 61(16), p. 49.

This news article covers the sources of suits against hospitals in AIDS-related cases and suggests procedures to avoid employee-related claims. The author notes that the main source of lawsuits are employees and cites two specific legal actions to illustrate the predicament hospitals face. One remedy to avoid employee-related claims that the author suggests is adherence to guidelines from the Centers for Disease Control. These guidelines refer to employees with AIDS and employees who treat AIDS patients.

158. Christakis, N. (1988, June/July). The ethical design of an AIDS vaccine trial in Africa. Hastings Center Report, pp. 31-37.

This article raises the question of possible differences in clinical trials held in developed and developing countries, specifically citing the case of Zaire. The author references the guidelines for human subjects research established jointly by the World Health Organization and Council for International Organization of Medical Sciences. In discussing this issue, he covers the design of an AIDS vaccine trial, assembling a suitable study group, the risks involved and consent, and the beneficent treatment of subjects. He also addresses ethical standards in cross-cultural perspective. The author concludes that "proper conduct of an AIDS vaccine trial must be informed ... by the ethical norms and cultural constraints prevailing in such settings." Further, he states, "what is essential is that the research manifest a culturally sensitive and ethically sophisticated concern for the wellbeing of subjects throughout the world."

159. Cohen, L. (1987, November 15). Cashing in on AIDS: Turning a disaster into a business proposition. Canadian Medical Association Journal 137, pp. 932-933.

This news feature profiles the commercialization of AIDS by quoting a number of publications, including business newspapers and newsletters. It also notes the possibly questionable practices of several businesses in promoting the fear of AIDS while strongly implying rewarding investment opportunities. The author briefly describes the impact of AIDS on insurance companies as well as on

business start-ups, such as blood testing services and dating services guaranteeing AIDS-free clientele.

160. Council on Ethical and Judicial Affairs, American Medical Association. (1988, March 4). Ethical issues involved in the growing AIDS crisis. Journal of the American Medical Association 259(9), pp. 1360-1361.

This article contains the AMA policy statement on AIDS in terms of the ethical issue faced by physicians who treat AIDS patients. The policy that a physician may not ethically refuse to treat a HIV-seropositive patient is reaffirmed if the patient is in the physician's "current realm of confidence." (For related commentary see, S. Updegrove, "Ethical issues in the AIDS crisis: the HIV-positive practitioner," in the August 12, 1988, Journal of the American Medical Association, p. 790.)

161. Crompton, D. (1987, November 16). AIDS and the ethics of disclosure [Letter]. Medical Journal of Australia 147, p. 522.

This letter to the editor questions the advice of J. Goldbaum (1987) when he suggests that the attending doctor withdraw when a patient refuses consent to AIDS antibody testing. The writer argues that this allows the patient to avoid counseling that may have proved necessary. Further, the writer feels that J. Goldbaum leaves unexplained the way to deal effectively with patients who fail to respond to persuasion that they should think of others.

162. Dickens, B. (1988, June 17). Legal limits of AIDS confidentiality. Journal of the American Medical Association 259(23), pp. 3449-3451.

The article looks at various aspects of the law's protection of medical confidence as it relates to persons with AIDS, ARC, or HIV infection. The author states that "while some laws appear to require and provide secrecy of medical data, others compel disclosures; moreover, justifications and excuses of breaches of confidentiality exist under transcending legal doctrines....The most effective use of legislation is not simply to seek to enact further protections of confidentiality of data which would be subject to the same exceptions, but to reinforce laws against discrimination on grounds of an individual's affliction with AIDS, ARC, or HIV infection."

163. Doyal, L. and B. Hurwitz. (1987, September 22). The recent BMA ruling on AIDS: The patient's right to informed consent versus the doctor's right to protection. The Practitioner 231, pp. 1217-1222.

This article describes a hypothetical case to highlight the majority decision of the BMA conference to support the right of

general practitioners to test for HIV antibodies without necessarily obtaining the patient's consent. The authors believe that one argument influencing members' decision was the right of general practitioners to protect themselves, other health workers, and the public. It is this argument that the hypothetical case explores. The authors conclude that there are very few circumstances in which testing without consent is justifiable.

164. Dunton, A. and K. Meyers. (1987, October). The ethical and scientific considerations of human immunodeficiency virus antibody screening in volunteers for clinical pharmacologic research. Clinical Research 35(6), pp. 511-516.

This technical paper addresses the issue of whether or not it is justifiable to screen for serologic evidence of HIV infection in all prospective volunteers for research studies. The question arose in the pursuit of clinical pharmacologic research, with the purpose of screening to prevent possible transmission of HIV infection to personnel and others who handle specimens. The authors conclude that they would be unable to get a legitimate informed consent. Further, they realize that there is the risk and emotional devastation of a false positive antibody test. Thus, they decided against the screening until researchers develop a more accurate method of predicting "infectivity."

165. Emanuel, E. (1988, June 23). Do physicians have an obligation to treat patients with AIDS? The New England Journal of Medicine 318(25), pp. 1686-1690.

The author maintains that..."three points about the physicians's obligation to treat patients with AIDS need emphasis. First, this obligation depends on viewing medicine as a profession, not a commercial enterprise. Second, it follows that physicians who join the profession assume an obligation to care for the ill even at some reasonable personal risk. Because of this inclusive obligation, physicians have a specific obligation to patients with AIDS. Third, this obligation can be limited by several factors, especially excessive personal risk." Other limiting factors evaluated are those of questionable benefits, obligations to other patients, and obligations to self and family.

166. Emanuel, E. J. and L. L. Emanuel. (1987, September). Is our AIDS policy ethical [Editorial]? American Journal of Medicine 83(3), pp. 519-520.

This editorial discusses the promotion of condoms by politicians, universities, and the media, among others, as a means of fighting the spread of AIDS. The authors question the ethics of the condom campaign. They point out that there are only three studies on the prevention of AIDS transmission by condom use and that the studies are seriously flawed--either they are small, lack confirmation, or

are limited in scope. While the data suggest that condoms are safer than unprotected sex, the authors point out that condoms do not ensure so-called safe sex. "Indeed," note the authors, "the entire concept of safe sex is a misnomer." The authors conclude that the message of the safe sex campaign is untrue and therefore unethical.

167. Federation Dentaire Internationale. (1987, Fall). Dentists' professional and ethical responsibilities for HIV-positive patients and patients with AIDS. Journal of the Massachusetts Dental Society 36(4), pp. 173-174.

This text, prepared by Drs. F. Scheutz and J. Pindborg of Denmark in collaboration between WHO's Special Programme on AIDS and the Oral Health Programme, raises and answers the question of the scope of professional and ethical responsibilities that dentists have for HIV-infected patients. The report summarizes the recommendations of the oral health section of WHO and elaborates on some difficulties in following those recommendations. For example, the text notes that "examination of the oral cavity alone is, however, not a suitable method for screening populations for AIDS or HIV positivity ..." It makes suggestions for follow-up in cases where, for instance, oral lesions are found. The text also mentions that WHO is in the process of starting an International Collaborating Centre for the Oral Manifestations of the HIV Infection in Copenhagen, Denmark.

168. Francisco, C. (1988, May). AIDS reprise--tests and records. Texas Medicine 84(5), pp. 69-71.

This article summarizes rules and guidelines from the Texas Department of Health and the Texas Communicable Disease Prevention and Control Act as they pertain to AIDS and HIV testing. Strict conditions for release of medical records are also extensively detailed.

169. Furth, P. and A. Markovitz. (1988, January). Acquired immunodeficiency syndrome (AIDS) as an occupational disease [Letters]. Annals of Internal Medicine 108(1), pp. 156-157.

Two letters addressing the question of whether AIDS should be treated as an occupational disease--and thereby covered under workers' compensation--are presented. One deals with difficulties of determining "discrete causal exposure to HIV" among health care workers who later test positive for AIDS; the other cites a California workers' compensation claim decided in favor of a construction worker who tested positive for HIV infection after engaging in sexual activity condoned by his employer.

170. Gerber, P. (1987, August 17). AIDS and the ethics of disclosure [Letter]. Medical Journal of Australia 147, pp. 199-200.

This letter to the editor addresses an ethical issue raised by the responses of physicians to a hypothetical question about AIDS and broadcast in an Australian television program. Specifically, the question covered whether the physicians would inform a husband's pregnant wife that he had been diagnosed as HIV-infected. In this context, the writer also addresses the New South Wales legislation--the Public Health (Proclaimed Diseases) Act 1985--which "... provides a penalty of $2,000 for the unlawful disclosure of information which may identify a person who is, or is reasonably suspected of, suffering from a `proclaimed disease'."

171. Gerber, P. (1987, November 16). AIDS and the ethics of disclosure [Letter]. Medical Journal of Australia 147, p. 522.

This reply to a letter to the editor by J. Goldbaum (1987) restates the writer's interpretation of the legal position of a physician, who refers a patient known to be seropositive for HIV, to a colleague without disclosing the status of the patient.
That first doctor, according to the writer, carries the legal duty of disclosure. He admits that the medical profession accepts risk as part of its "professional norms," but claims this does not apply to risks preventable with suitable warnings.

172. Goldbaum, J. (1987, November 16). AIDS and the ethics of disclosure [Letter]. Medical Journal of Australia 147, p. 522.

This letter to the editor questions the passage selected by P. Gerber (1987) when he quotes R. Gillon to substantiate his point that in a conflict between confidentiality and preventive medicine, the latter must prevail. The writer offers additional quotes from the same material of R. Gillon to defend his own position and interpretation of the conflict.

173. Goodman, M. and L. Goodman. (1987). Medicalization and its discontents. Social Science and Medicine 25(6), pp. 733-740.

"This paper raises the question of the ethically proper balance in health care policy between the medical-clinical-high technology model of health service and the grass-roots, community-based or traditional models of care. Paradoxical imbalances between the two approaches are traced to political, economic or prestige factors. Case studies examined include the hospitalization of non-contagious leprosy patients while protecting the anonymity of AIDS-infected prostitutes, medical resistance to the adoption of a clinical role by Community Cancer Centers, and the continued preference in some quarters for elaborate (and often delayed) hospital treatment for such problems as infant diarrhea, despite the availability of much simpler solutions, as in the case of the widely successful oral

rehydration therapy. A balanced approach to world health problems, we argue, rests not on inflationary lowering of health care standards to achieve nominal victories, nor on stainless steel high technology panaceas but on mobilizing resources around human needs."

174. Holthaus, D. (1988, July 20). Consent advised before AIDS-antibody tests. Hospitals 62(14), pp. 40, 42.

The author maintains that the concept of "informed consent" should be applied to situations involving HIV-antibody testing. Two studies are cited in which consent was obtained in only a minority of HIV test situations. "Liability can be established, [according to a risk-management consultant and physician]...because a standard of practice has evolved through the policy statements of several leading health care organizations. The American Hospital Association, Chicago; the Centers for Disease Control, Atlanta; the American Medical Association, Chicago; and the American College of Physicians, Philadelphia, have issued policies recommending that HIV testing be performed with full informed consent only."

175. James, A. (1987, November-December). AIDS and the physician: A policy crisis. Alaska Medicine 29(5), pp. 165-168.

This article discusses a conceptual approach to developing an AIDS policy for a health care facility that addresses such issues as universal precautions, patient rights, and health care workers with AIDS. The authors briefly review Centers for Disease Control infection prevention guidelines and OSHA regulations requiring protection of health care workers from blood-borne diseases such as AIDS and hepatitis B. The authors note that patient care issues, including test policies, are the core of any AIDS policy. They assert that the key policy issues to address for a testing program involve who should be tested, where testing is done, and how pre- and post-testing counseling will be provided. Patient confidentiality and consent are critical issues as well. The author concludes that the "most sensitive issue in the development of an AIDS policy is to address one's own profession and the profession's response to the disease." She cites two concerns of physicians, the seropositive practitioner and the practitioner who will not treat AIDS patients.

176. Kelly, K. (1987, September). AIDS and ethics: An overview. General Hospital Psychiatry 9(5), pp. 331-340.

"AIDS has generated a host of ethical questions that are urgent, poignant, and sometimes unprecedented. These questions fall into several familiar categories of ethical problems, including civil liberties vs. public health, distribution of scarce resources, truth telling, confidentiality, and discrimination, among others. Established ethical principles apply in each of these areas, but

certain features of this epidemic require new considerations. Factors such as our current uncertainty about the natural history of infection with HIV, the lack of evidence for transmission through casual contact, the social status of the groups at high risk, the unavailability of any definitive treatment, the tendency of AIDS to affect the central nervous system, and the availability of psychiatric evidence about the effects of hearing the diagnosis should affect the calculation of competing values. In general, there is little ethical justification at this time except in specific and limited situations for infringing on individual civil rights, for permitting discrimination against AIDS patients or those at risk, or for violating confidentiality."

177. Lo, B. and others. (1987, November-December). Ethical dilemmas about intensive care for patients with AIDS. Reviews of Infectious Diseases 9(6), pp. 1163-1167.

"AIDS presents ethical dilemmas about intensive care. Even with intensive care the outcome for patients with AIDS is poor. Care givers have no ethical or medical obligation to provide futile care. Decisions concerning competent patients should be made jointly by physicians and the informed patients themselves. For incompetent patients decisions should be made jointly by physicians and appropriate patient-surrogates in light of the previously expressed wishes of the patients. Care givers should encourage patients with AIDS to express their preferences about life-sustaining treatment in order to avoid dilemmas should these patients later become incompetent. The AIDS epidemic may force more explicit discussions about the allocation of limited health-care resources, such as intensive care. Such allocation decisions should not discriminate against patients with AIDS."

178. Logan, M. (1987, September). Legal, ethical issues for dentists. Journal of the American Dental Association 115(3), p. 402.

This short article answers two questions on the legal responsibilities of dentists. The first covers the treatment of patients with infectious diseases such as AIDS, herpes, or hepatitis, while the second asks about the active practice of dentists who are carriers of infectious diseases. The author notes that while dentists have historically had the right to decline treatment to new patients, there are special circumstances in which such a refusal can lead to legal problems. In the second case, the report references the Centers for Disease Control's recommendations on precautions that practitioners with infectious diseases should exercise in their practices.

179. Logan, M. (1987, December). Legal implications of infectious disease in the dental office. Journal of the American Dental Association 115(6), pp. 850-854.

This detailed article points out that dentists, based on surveys and statistics, appear to be ignoring the potential impact of infectious disease in the dental office. In a series of questions and answers, the author alerts the dental profession to the legal ramifications of such issues as the potential liability to others if the dentist or staff members contract AIDS or other serious communicable diseases and the restrictions imposed by State dental practice acts on the practice of dentistry if the dentist or staff carry an infectious disease. The author also addresses the issue of whether or not the dentist carries a responsibility to inform staff if the dentist or staff have AIDS or hepatitis B. The author suggests that dentists and staff consider vaccination against hepatitis B and the use of CDC recommended barrier techniques. The author states, "... many dentists seem content to take a legal gamble by failing to adhere strictly to infection control precautions."

180. Melton, G. and J. Gray. (1988, January). Ethical dilemmas in AIDS research. Individual privacy and public health. American Psychologist 43(1), pp. 60-64.

"Research on the acquired immune deficiency syndrome (AIDS) presents a stark example of the dilemmas involved in balancing individual rights and social welfare in conducting psychosocial research. These dilemmas are pronounced in research on public health. Unfortunately, significant legal threats to confidentiality are matched inadequately by legal means of protecting privacy. Researchers are advised to request certificates of confidentiality from the Public Health Service. A privilege statute is needed to protect the privacy of participants in research on AIDS."

181. Nary, G. (1987, October). The AIDS pandemic: Ethical and financial issues [Letter]. Quarterly Review Bulletin 13(10), pp. 330-331.

This expansive letter to the editor reviews the stresses that the advent of AIDS as a major, costly illness places on all aspects of the health care delivery system. The author's focus is the role of his non-profit organization, the AIDS Medical Resource Center (AMRC), in responding to these stresses. He details the initiatives that AMRC developed on the broader issues of AIDS such as ethics, cost containment, patient care, and government policy. AMRC programs that the author describes include The AMRC-Chicago area AIDS study, Project Lifeline, Steppenwolf House, The Kingdom Project, and Med/Ed.

182. Radensky, P. and D. Buron. (1987, September). AIDS: Legal issue spotting for the health care practitioner. Journal of the Florida Medical Association 74(9), pp. 667-670.

This technical article surveys legal issues that are "by-products" of the interaction of health care workers with HIV-infected patients and co-workers. The authors group these legal issues and problems under three headings: (1) patient care; (2) health care practitioner's workplace; and (3) sociopolitical matters. For example, in group one, the article notes that "failure to warn a patient about his/her infectivity may hazard a claim by a third party for causing the third party to become infected by the patient." In group two, one issue the authors highlight is the possible legal claim by patients, trash handlers, and delivery persons against a health care worker who failed to take reasonable care to make the workplace safe for those invited into that work area. In group three, the authors note that health care workers, for instance, physicians, should remain alert to the effect of proposals made to policymakers.

183. Restaino Jr., J. (1988, February). AIDS: Professional liability implications for the podiatrist. Journal of the American Podiatric Medical Association 78(2), pp. 92-97.

The author considers the potential for legal liability incurred in the treatment of AIDS/HIV infected patients. The four general areas addressed are diagnosis and treatment aspects, information disclosure to the patient, improper disclosures to third persons, and required (statutory and other) disclosures to third parties.

184. Rothrock, J. (1988, June). Ethical concerns discussed at World Conference-V. AORN Journal 47(6), pp. 1492-1496.

This brief review of a discussion group on the ethical problems and concerns of perioperative nurses describes a session conducted at the World Conference of Operating Room Nurses. The text covers such areas as visitors in surgery, right to obtain or refuse treatment, discrimination toward HIV-infected patients, informed consent, and the patient's right to self-determination. On the question of AIDS, the article notes that the session participants agreed that patients have a right to health care and that this right precludes health care professionals from refusing to treat or care for any patient.

185. Rubenstein, H. (1987, December 12). AIDS and medical ethics [Letter]. Lancet 2(8572), pp. 1401-1402.

This letter to the editor questions a correspondent's report on the behavior of physicians during the Black Death and other epidemics. In disagreement with the correspondent, the writer notes that physicians did not stay with their patients and die with them.

In support of his claims, he cites not only the study by Zuger and Miles (1987) on occupational risk, but also historical figures such as Hippocrates, Galen, and Guy de Chauliac. As one solution to the problem of physicians' response to the current AIDS epidemic, the writer suggests the re-creation of plague doctors, that is, AIDS specialists.

186. Shapter, D. (1987, September). AIDS and dentistry: The legal and ethical issues [Conference Call). Dental Management 27(9), pp. 38-39, 42, 44.

This edited transcript of a conference call conducted by the magazine brings together four dentists to discuss such questions as the chances that the average dentist will come in contact with an AIDS patient, the dentist's ethical and moral obligations in treating AIDS patients, and the obligation of dentists to protect their staff. Interviewed are Drs. C. Barr, D. Greenspan, E. Zinman, and Kotnour. [The last dentist's first name was omitted to preserve confidentiality.]

187. Smith, L. and R. Brennan. (1987, October). Legal ramifications of the development of an AIDS vaccine. New Jersey Medicine 84(10) pp. 702-704.

This feature article describes the medicolegal issues raised by the possible development of an AIDS vaccine that would protect the general public. The authors address such questions as: Can States require people to be vaccinated? and Should everyone undergo vaccination or only risk groups? They fashion their answers in light of the State-mandated smallpox vaccinations earlier this century and the subsequent Supreme Court decision of Jacobson versus Massachusetts. The authors also raise several objections to imminent compulsory inoculation against the AIDS virus. Overall, the authors conclude that inoculation would have to be carried out on a nationwide basis.

188. Stanley, T. and D. Martin. (1987, December). Ethical considerations involved in AIDS/HIV care. Oklahoma Nurse 32(5), pp. 12-13.

This question-and-answer-format article presents an interview of two Texas registered nurses, Sr. Teresa Stanley and Darlene Martin, on nursing ethics. Both offer expansive answers to such questions as the most critical AIDS/HIV issues, the impact nurses can make on these issues, the methods for handling the financial burden of the treatment of AIDS, and the pro-active role nurses can play in the AIDS crisis.

189. Zinman, E. (1987, December). Assistant with AIDS. Dental Management 27(12), p. 56.

In this "Dentists and the Law" column, in which the author answers general questions on legal issues affecting dentists, a writer asks about the legal impact of terminating a dental assistant who was recently diagnosed as AIDS positive. Dr. Zinman answers that 20 States and the District of Columbia consider AIDS a discrimination-protected handicap. He suggests that the writer consider getting a letter from the assistant's physician stating her seropositivity won't affect working in a non-treatment environment.

190. Zuger, A. and S. Miles. (1987, October 9). Physicians, AIDS, and occupational risk. Journal of the American Medical Association 258(14), pp. 1924-1928.

The authors reviewed medical responses to historic plagues and found no consistent professional tradition. "A new professional ethic to guide physicians in the acquired immunodeficiency syndrome pandemic is needed. This ethic cannot be entirely derived from these patients' right to health care, which is primarily a claim against society rather than individual practitioners. Civil and professional proscriptions against negligence or abandonment apply only to therapeutic relationships after they are contracted. However, a professional duty to treat human immunodeficiency virus-infected persons could be based on the understanding of medicine as a moral enterprise."

PREVENTION

191. Acquired immunodeficiency syndrome (AIDS): Precautions for health-care workers and allied professionals. (1987, November). OHIO Medicine 83(11), pp. 776-777.

This short article presents AIDS guidelines and precautions prepared by the Centers for Disease Control. It offers detailed precautions specifically for dental-care personnel and those performing postmortem examinations or providing morticians' services. The article states, "These ... recommendations outline good infection control and laboratory practices and are similar to the recommendations for prevention of hepatitis B."

192. AIDS--a woman's concern. (1988, March-April). International Nursing Review 35(2), p. 55.

This article summarizes presentations from the first national conference on Women and AIDS held in London in April, 1987. The social, medical, and economic impact of AIDS in women both as vectors for the disease and as caregivers were addressed.

193. Anderson, P. and R. Mayon-White. (1988, February). General practitioners and management of infection with HIV. British Medical Journal [Clinical Research] 296(6621), pp. 535-537.

General practitioners were surveyed to determine their current practice and knowledge of HIV and AIDS. Ninety percent of those responding were providing their patients with information about infection, 50 percent were testing patients for HIV, and 25 percent were caring for infected patients. Some practitioners indicated uncertainty about transmission risk and need for patient educational resources. The authors suggest the introduction of a "facilitator" to work with the practitioner in managing patients, and particularly in developing the skills needed for prevention.

194. Baker, J. (1988, July). What is the occupational risk to emergency care providers from the human immunodeficiency virus? Annals of Emergency Medicine 17(7), pp. 700-703.

"This report addresses the extent and nature of risk of HIV infection to emergency care providers and reviews the current management of significant exposures." References to relevant literature are included.

195. Brown, L. and G. Fritz. (1988, July). AIDS education in the schools: A literature review as a guide for curriculum planning. Clinical Pediatrics (Philadelphia) 27(7), pp. 311-316.

"As plans for massive public AIDS education grow, pediatricians will become increasingly involved with school systems as consultants and leaders. A review of relevant literature on students' current level of knowledge about AIDS and on educational efforts to date with high-risk groups (homosexuals and intravenous drug users) provides the rationale for school-based AIDS education. Literature describing the approaches used and the impact of programs for sex education, drug abuse prevention, and reduction of prejudice towards the disabled is reviewed to extrapolate that which applies to AIDS education. Important developmental characteristics of adolescents are discussed insofar as they have implications for the planning of AIDS curricula."

196. Centers for Disease Control. (1988, January 29). Guidelines for effective school health education to prevent the spread of AIDS. Morbidity and Mortality Weekly Report 37(Supp. S-2), pp. 1-14.

"The guidelines provide information that should be considered by persons who are responsible for planning and implementing appropriate and effective strategies to teach young people about how to avoid HIV infection." Essential information about AIDS is summarized in sequence for three grade-level ranges--early elementary school, late elementary/middle school, and junior/senior high school. Assessment criteria are also presented.

197. Centers for Disease Control. (1987, August 21). Recommendations for prevention of HIV transmission in health-care settings. Morbidity and Mortality Weekly Report 36(2S).

The recommendations presented here consolidate and update previous CDC recommendations on preventing HIV transmission in health care settings. Several studies are cited that relate to the potential risk to health care workers of acquiring HIV in the workplace. Six general precautions in handling blood and other body fluids are followed by specific precautions to be implemented for invasive (surgical) procedures, dental care, autopsies or mortician's services, dialysis, and laboratory settings. The report also addresses the issue of testing preoperative patients for HIV, pointing out that if testing programs are developed, they should adhere to principles of patient consent, confidentiality, assurance of care, provision of test results to the patient, and prospective evaluation.

198. Clever, L. and G. Omenn. (1988). Hazards for health care workers. Annual Review of Public Health 9, pp. 273-303.

This review article, replete with 142 references, details the workplace hazards that cause 65 percent of health care workers to become sick or injured each year. These hazards range from exposure to infectious diseases to work with dangerous solvents. Often these hazards are confronted by personnel who are stressed or fatigued from rotating shifts, and whose vigilance is weakened. The authors review pertinent AIDS literature on risks, safe work practices, and emotional and ethical problems that affect personnel working with AIDS patients. They also provide an overview of chemical hazards such as commonly used sterilizing agents and widely used antineoplastic drugs, and suggest ways to prevent exposures. Finally, the authors discuss back injuries, video display terminals, and stress that are an integral part of the health care worker's environment.

199. Flaskerud, J. (1988). Prevention of AIDS in blacks and Hispanics: Nursing implications. Journal of Community Health Nursing 5(1), pp. 49-58.

This technical article profiles the incidence of AIDS in black and Hispanic populations. It contends that while most prevention programs are still targeted toward white homosexual men, these may be inappropriate for other ethnic and racial groups as well as for women. The author argues that prevention programs for black and Hispanic populations must account for different at-risk groups, routes of transmission, educational and cultural differences, and access to health care services. Among the conclusions she reaches is that nurses must become involved in community education programs to prevent the spread of AIDS.

200. Gerbert, B. and others. (1988, Spring). AIDS and dental practice. Journal of Public Health Dentistry 48(2), pp. 68-73.

A randomized survey of California dental health care workers (DHCWs) was conducted to determine the extent of responsibility they felt to practice infection control procedures aimed at controlling the spread of AIDS and other infectious diseases. Participating in the study were 297 dentists, 128 hygienists, and 177 dental assistants. Results indicated that DHCWs who were more willing to treat people with AIDS or HIV infection practiced thorough infection control. Respondents who believed they were seeing more high-risk patients were more likely to use infection control procedures, were more willing to treat such patients, and were more likely to assess patients for AIDS by taking a thorough medical and sexual history. The authors conclude that since attitudes toward AIDS and the perception of one's practice group as either at high or low risk influences the use of infection control procedures,educational programs designed to enhance

knowledge about the extent of the HIV infection problem are advisable.

201. Ginn, D. (1987, October). The AIDS information crisis: Confluence of the roles of information creator, seeker, and provider. Bulletin of the Medical Library Association 75(4), pp. 333-341.

"The dramatic increase in the number of cases and deaths from AIDS since 1981 has been accompanied by an information explosion on the topic. The government, health professionals, service organizations, consumers, and the media are each vital links in both formal and informal AIDS information networks. New information sources and systems have emerged from these five sectors, and their roles as information creators, seekers, and providers have come together. The need for integrative or synthesizing databases and systems which reflect the sectors' interdependence and acknowledge their roles in the information process is discussed. Databases and systems which reflect a multi-sector approach, such as the Computerized AIDS Information Network (CAIN), are suggested as potential solutions to the AIDS information problem."

202. Goldsmith, M. (1988, August 12). Stockholm speakers on adolescents and AIDS: 'Catch them before they catch it.' Journal of the American Medical Association 260(6), pp. 757-758.

This general roundup article describes the presentations on AIDS and adolescents by a variety of speakers at the Fourth International Conference on AIDS in Stockholm, Sweden. The author focuses on the need to persuade young people to avoid the sexual activity and IV drug use that put them at high risk. She spotlights the urban, economically and socially disadvantaged black and Hispanic young men and women in the United States, whom studies have identified as the easiest target of AIDS at the present time. The author also addresses the differences in AIDS occurrence and sexual transmission between adults and adolescents. Among the countries covered in the discussion are the United States, England, Italy, France, Spain, Denmark, and Sweden.

203. Goldstein, M. and F. Yuen. (1988). Coping with AIDS. An approach to training and education in a therapeutic community--the Samaritan Village Program. Journal of Substance Abuse Treatment 5(1), pp. 45-50.

"The emerging demographics of AIDS related disease and disorders suggests a redistribution toward the population of intravenous drug users (IVDU) and the sexual partners of IVDU's. Risk reduction strategies employing education and disease prevention appear to have had significant success within the gay community as borne out by changing epidemiologic data. This paper focuses upon one such approach that has been used in a residential therapeutic

environment. It offers a practical working model that might be applicable in a variety of settings. It should be emphasized that this is not a one-step presentation of AIDS information, but rather that it is an ongoing program of AIDS education."

204. Gordin, F. and others. (1987, September). Knowledge of AIDS among hospital workers: Behavioral correlates and consequences. AIDS 1(3), pp. 183-188.

"Incidents of suboptimal care being rendered to AIDS patients have been documented. Using a voluntary anonymous questionnaire, we surveyed the employees of a large urban hospital in order to evaluate the knowledge, attitudes and professional behavior of the staff regarding AIDS. Responses were obtained from 1194 (60%) of the staff. Poor knowledge of the transmission of AIDS was documented, with 50% of workers stating that AIDS can be spread through ordinary non-sexual contact and 23% through the air by a cough or a sneeze. One-third of employees believed that they should be able to refuse to care for patients with AIDS. Extreme anxiety in dealing with AIDS patients was noted by 25% of employees, and only 16% of the employees would volunteer to work on an AIDS ward. Knowledge regarding AIDS was demonstrated to be a predictor of positive attitudes, appropriate professional behavior and lower anxiety in dealing with AIDS patients. The goal of hospital education programs on AIDS must be to ensure the incorporation of accurate information into the belief system of workers."

205. Gundlach, D. (1988, May). Protecting health care workers from the occupational risk of disease. Quarterly Review Bulletin 14(5), pp. 144-146.

"Recent medical literature has voiced growing concern over the potential spread of human immunodeficiency virus and hepatitis B among health care workers. In response to this concern, the Central Ohio Medical Group developed an infection control policy involving employee immunizations, needle stick protection protocols, and protocols for handling potentially infectious material. Although it is too soon to measure the infection control policy's health effects, the existence of a consistent set of policies and procedures has succeeded in alleviating apprehension among employees."

206. Hargraves, M. and others. (1987, October). Hemophiliac patient's knowledge and educational needs concerning acquired immunodeficiency syndrome. American Journal of Hematology 26(2), pp. 115-124.

"The Patient Knowledge Assessment Study (PKAS) was conducted among 107 male hemophilic patients, aged 15 to 67 years, at 19 hemophilia treatment centers (HTC). Participants were given a 30-item questionnaire concerning the cause of acquired immunodeficiency

syndrome (AIDS), the groups at risk, and modes of transmission. The questionnaire included questions on the participant's status in regard to antibody to human T-lymphotropic retrovirus, type III/lymphadenopathy-associated virus (HTLV-III/LAV), and the meaning of this test result. HTC health-care providers were asked to complete a separate questionnaire containing 17 questions about information given patients concerning their HTLV-III/LAV antibody status and its meaning. Overall, patients had a good base of knowledge about AIDS; however, there were gaps in this knowledge. Twenty-nine percent of patients did not know that spouses of AIDS patients were at risk for AIDS; 47% did not know that sexual partners of persons with hemophilia were at risk; and 32% did not know that hemophilic children were at risk. Further, only 69% understood that antibody-positive individuals had had contact with the AIDS virus. Identifying these and other areas of misunderstanding will provide the information needed to design educational strategies and psychosocial support programs appropriate for the hemophilic population, and which may serve as a model for other populations."

207. Holmes, J. (1987, October 14). AIDS: Information for health professionals [Letter]. New Zealand Medical Journal 100(833), p. 641.

This brief letter to the editor notes that a booklet on AIDS designed for all health care personnel and circulated in an issue of the New Zealand Medical Journal (1987) omitted doctors from its descriptive list of all personnel. The writer asks whether this is an admission by the Department of Health that doctors are nonessential members of the group of health care providers.

208. Johnson, J. and others. (1988, July). A program using medical students to teach high school students about AIDS. Journal of Medical Education 63(7), pp. 522-530.

This article reports the results of an educational project in which 20 medical students taught senior high school students about AIDS and AIDS prevention. The medical students received basic science and clinical instruction about AIDS in preparation for the project. High school seniors completed a 15-item knowledge test about AIDS both before and after the educational program. High school student attitudes toward the program and having medical school students as teachers was overall favorable. Results of the test showed "a significant increase in knowledge by students" about AIDS. The authors concluded that "this program provides an example of how medical institutions can develop a collaborative community education project that contributes to the education of medical students."

209. Joseph, S. (1987, August 15). Toward a national AIDS prevention strategy [Editorial]. Hospital Practice, pp. 15-16.

This editorial argues the need for a comprehensive national prevention strategy to control the spread of AIDS while rejecting mandatory HIV antibody testing. The author offers necessary conditions for developing such a strategy. They are: (1) a major national public health education program; (2) quick expansion of voluntary and confidential counseling and HIV antibody testing to private and public health care clinics and institutions; and (3) major efforts to slow AIDS transmission by IV drug abusers. The author believes that "a national prevention strategy demands a moon-shot, war-footing approach to Federal resource commitment, ...," among other things.

210. Joseph, S. and others. (1987, September). AIDS policy and prevention in New York City. Bulletin of the New York Academy of Medicine 63(7), pp. 659-672.

This symposium presentation profiles the broad scope of the AIDS epidemic in New York City by offering projections on the epidemic in the city and nationally, analyzing current and developing policy in the city, describing the epidemic's epidemiology, and outlining specific prevention issues. The authors project that by the end of 1991, New York City will experience over 40,000 cumulative AIDS cases, with almost 30,000 deaths. In the area of prevention, the authors state, "At present, the only feasible way to alter the course of the AIDS epidemic is by education of the public, training of health and social service professionals, and personal risk reduction counseling and referrals for people at risk." They conclude that the epidemic in the city will continue as a medical, social, and political problem for the next 5 to 10 years.

211. Kehrberg, C. and others. (1988, January). "AIDS" infection control policies for Kansas health care agencies and "AIDS" education for registered nurses in Kansas: Final report. The Kansas Nurse, pp. 1-3.

This report describes the results of a survey conducted by the Council on Economic and General Welfare of the Kansas State Nurses' Association. The survey sought to validate the presence of established AIDS infection control policies and to assess the availability of AIDS education for registered nurses provided by employing agencies. The report notes that 238 health-related institutions received the one-page, six-question survey and that 139 responded. From the questionnaire data, the authors derived three conclusions on control policies and education. They also offer five recommendations to institutions to help improve their programs.

212. Klein, R. (1988, January). Low occupational risk of human immunodeficiency virus infection among dental professionals. New England Journal of Medicine 318(2), pp. 86-90.

Thirteen hundred and nine dental professionals (DPs)--1,132 dentists, 131 hygienists, and 46 assistants--completed questionnaires on dental practices to determine potential occupational exposure to HIV. The following risk data were collected: 50 percent of DPs were located in high-risk areas; 72 percent worked on high-risk or confirmed AIDS patients; 94 percent reported accidental puncturing of the skin. Compliance with recommended infection control procedures was reported to be low. Serum samples showed one dentist to have HIV antibodies. Based on their findings, the authors conclude that "despite infrequent compliance with recommended infection-control precautions, frequent occupational exposure to persons at increased risk for HIV infection, and frequent accidental puncturing of the skin with sharp instruments, dental professionals are at low occupational risk for HIV infection."

213. Kuhls, T. and others. (1987, October). Occupational risk of HIV, HBV and HSV-2 infections in health care personnel caring for AIDS patients. American Journal of Public Health 77(10), pp. 1306-1309.

"We have prospectively followed for 9-12 months, 246 female health care workers (HCWs): 102 with high exposure (HE), 43 with low exposure (LE), and 101 with no exposure (NE) to AIDS (acquired immunodeficiency syndrome) patients. No HCWs have clinical, serologic, or immunologic evidence of HIV (human immunodeficiency virus) infection. No HCWs in the HE group seroconverted to cytomegalovirus (CMV). One HCW in the HE group seroconverted to hepatitis B virus (HBV), another HCW in the HE group seroconverted to herpes simplex virus type 2 (HSV-2) although all three groups were similar with respect to HBV and HSV-2 seropositivity. If hospital infection control practices are employed when HCWs care for AIDS patients or work with their biological specimens, the risk of occupationally acquiring a HIV, CMV, HBV or HSV-2 infection appears to be low."

214. Lee, P. and A. Moss. (1987). AIDS prevention: Is cost-benefit analysis appropriate? Health Policy 8(2), pp. 193-196.

This article is a commentary on an article by Ohi about cost-benefit analysis of AIDS prevention in Japan. The authors note that cost-benefit analysis is only one of several factors considered in the analysis of policy options. In the case of AIDS, "the application of cost-benefit and other rational planning criteria plays a relatively small part in the making of national policy related to the disease." After reviewing several features of the AIDS pandemic, the authors conclude that, although the means of

intervention may vary, the goal and types of efforts to prevent HIV infection remain the same.

215. Lehmann, P. and others. (1987, October). Campaign against AIDS in Switzerland: Evaluation of a nationwide educational programme. British Medical Journal [Clinical Research] 295(6606), pp. 1118-1120.

"The campaign against the spread of the acquired immune deficiency syndrome (AIDS) in Switzerland includes a nationwide educational programme. A booklet about AIDS was mailed to every Swiss household in March 1986, and in 1987 there has been a mass media campaign promoting the use of condoms. We evaluated the results of the first phase--the distribution of the booklet--using a separate sample pretest and post-test design. The pretest was carried out 15 days before the booklet was mailed (sample n = 1056) and the post-test two months after the booklet was mailed (n = 1278). Of the population aged 20-69, to whom the book was sent, 56% read the booklet. For those who read the booklet compared with those who did not the results showed an improvement in knowledge and a better understanding of the risks of specific behaviors and of exposed groups and thus less fear of becoming infected through daily activities. The mean indices of knowledge and beliefs were significantly different when tested by the Kruskal-Wallis method. Having better information does not imply that people will change their behavior, but both the high reading rate and the increase in knowledge suggest that the Swiss educational programme reached its objectives. Moreover, the success of this campaign helps to support other campaigns that are being developed to promote the use of condoms."

216. Mann, J. (1988, Winter). AIDS epidemiology, impact, and control: The World Health Organization perspective. AIDS & Public Policy Journal 3(1), pp. 10-13.

The perspective of the World Health Organization on the pandemic of AIDS is presented in terms of the following principles: (1) the spread of HIV can be stopped; (2) education remains the key to prevention and control; (3) a long-term and sustained effort is required; and (4) strong national programs and international leadership are required.

217. Mason, J. and others. (1988, May/June). Current CDC efforts to prevent and control human immunodeficiency virus infection and AIDS in the United States through information and education. Public Health Reports 103(3), pp. 255-260.

This article describes the Centers for Disease Control (CDC) national information and education program, with activities designed to prevent HIV infection and AIDS in the United States. "The target populations include the general public, school- and

college-aged populations, persons infected or at increased risk of infection, minorities, and health workers....To reach school- and college-age youth, CDC, in consultation with governmental and national private sector organizations, developed guidelines for effective school health education to assist school health personnel in determining the scope and content of AIDS education. CDC also works with State and local education agencies to help carry out and evaluate educational efforts to prevent the spread of HIV among school- and college-age youth."

218. Meyer, A. (1987, December). A new world with AIDS--Health promotion as a catalyst for change. Western Journal of Medicine 147, pp. 716-718.

This article defines and discusses health promotion in the context of recent experience within a broad range of public health programs. The author argues that increased sophistication is needed to apply social science in health promotion. In order to control the AIDS epidemic he suggests the implementation of seven tasks and consideration, as an analogy for AIDS prevention, of the model to reduce adult cigarette smoking in the United States. The author concludes that "the challenge to health promotion presented by AIDS prevention is to enter into both programmatic and societywide communication processes as a catalyst to accelerate their interaction, their efficacy for positive change and their ultimate impact."

219. Nyanjom, D. and others. (1988, Winter). Sexual behavior change among HIV-seropositive individuals. AIDS & Public Policy Journal 3(1), pp. 71-73.

The authors report on an evaluation of a counseling and educational program of HIV-seropositive patients in Washington, DC, to determine what behavior change occurred among three groups who served as subjects of a study on the natural history of HIV infection--homosexual and bisexual men, intravenous drug users, and blood transfusion recipients and heterosexual contacts. There was a notable increase in the use of condoms. After a year of counseling, each of the three groups reported a reduction in number of sex partners.

220. Power, R. and others. (1988, June). Drug injecting, AIDS, and risk behaviour: Potential for change and intervention strategies. British Journal of Addiction 83(6), pp. 649-654.

"This paper examines a sample of 127 regular illicit drug users (both in and out of treatment) in terms of injecting and needle sharing patterns....Those who were in contact with agencies were more likely to have substantially reduced their risk behaviour than those not in contact with agencies....In two consecutive time periods, similar proportions reported that they were still sharing;

but by the second time period almost all reported some attempt at change....Availability of clean injecting equipment was given as the prime reason for sharing [needles], and the free supply of needles and syringes is advocated as a complement to effective health education."

221. Prevention and control of AIDS: An interim report. (1987, September). Journal of the Tennessee Medical Association 80(9), pp. 543-549.

This American Medical Association (AMA) 1987 annual meeting report offers 17 recommendations on AIDS that are driven by a concern to maintain a "judicious balance between the well-being of HIV-positive patients and the protection of the public health." The recommendations cover the areas of national policy, public awareness, counseling and educating counselors, testing, resources, anti-discrimination, confidentiality, research and data, third-party warnings, and sanctions for the reckless disregard for the safety of others. The report notes that education continues as the chief weapon against the spread of HIV infection and that physicians should assume a leadership role here, both for themselves, their patients, and the public.

222. Prevention and control of AIDS: An interim report of the American Medical Association's Board of Trustees. (1987). Cleveland Clinic Journal of Medicine 54(6), pp. 477-487.

This 1987 annual meeting report of the American Medical Association (AMA) offers 17 recommendations on AIDS. The goal of the recommendations is to strike an equitable balance between the well-being of HIV-positive patients and the protection of the public health. The report also presents the three resolutions on AIDS--Substitute resolutions 18, 176, and 29--adopted by the AMA House of Delegates. The recommendations cover the areas of national policy, public awareness, counseling and educating counselors, testing, resources, anti-discrimination, confidentiality, research and data, third-party warnings, and sanctions for the reckless disregard for the safety of others. The report notes that education continues as the chief weapon against the spread of HIV infection and that physicians should assume a leadership role here, both for themselves, their patients, and the public.

223. Schmidt K. and H. Zoffmann. (1987). AIDS and social medicine: Strategies for research. Scandinavian Journal of Social Medicine 15, pp. 1-2.

This paper stresses the importance of strengthening AIDS surveillance to furnish health authorities with the information needed for planning for patient care needs and to develop appropriate prevention strategies. The authors recommend sero-epidemiologic investigations to determine the extent of AIDS

infections, and suggest anonymous HIV testing without informed consent in specific at-risk groups, for example, patients with venereal disease. They call for follow-up studies of HIV-infected persons to elucidate the social and psychological consequences for persons infected with the AIDS virus. The authors emphasize the need for social and sexological studies of homosexual and bisexual men and drug addicts to better target health promotion programs, which should employ "modern commercial marketing principles." They conclude that the success of preventive strategies will largely depend on additional research in social medicine, sociology, and sexology.

224. Schobel, D. (1988, March). Management's responsibility to deal effectively with the risk of HIV exposure for healthcare workers. Nursing Management 19(3), pp. 38-40, 42.

This article addresses the responsibility of management to effectively protect health care workers from HIV exposure. The author begins with a brief review of the literature, which indicates "the very minimal risk of transmitting HIV during routine (noninvasive) care," as well as the low seroconversion rate of those exposed to infected parenteral blood. The author draws out the relationship of these studies to nursing practice and their implications for health care managers. She focuses on reassessment of standard CPR practices and cites Centers for Disease Control recommendations for CPR administration. The author concludes that it is the responsibility of management to: educate all employees on exposure risks and prevention; provide appropriate supplies to protect them; and provide access to mouth-to-mouth devices in all areas of patient care.

225. Selwyn, P. and others. (1987, December). Knowledge about AIDS and high-risk behavior among intravenous drug users in New York City. AIDS 1(4), pp. 247-254.

"Two hundred and sixty-one intravenous (IV) drug users, distributed between a methadone maintenance program and a large detention facility in New York City, were interviewed about knowledge of AIDS, needle use practices, and risk-reduction efforts. Ninety-seven per cent of subjects recognized needle-sharing as an AIDS risk factor; subjects showed less awareness about the effectiveness of certain risk-reduction techniques and tended to over-estimate the risk of casual contact. Of those still sharing needles at the time of first becoming aware of AIDS, 63% reported having subsequently either stopped needle-sharing or ceased IV drug use entirely. Logistic regression analysis indicated that continued needle-sharing behavior was associated with the detention facility site and lower scores on an AIDS knowledge questionnaire; reduced needle-sharing was more evident among methadone program patients and among subjects with greater knowledge about AIDS. The most common reasons for continued needle-sharing among those who

continued to share needles despite knowledge of risk were: 'need to inject drugs, with no clean needle available' and 'only share with close friend or relative', offered by 46 and 45% of subjects, respectively. Results suggest that certain subgroups of IV drug users have adopted risk-reduction measures in response to AIDS. Expanded educational programs, increased drug treatment capacity, and additional strategies addressing drug users' access to sterile injection equipment and the social context of needle-sharing may be necessary to curb the further spread of AIDS among IV drug users."

226. Shapter, D. (1988, March). AIDS: What dentists are doing about it. Dental Management 28(3), pp. 32-35.

This article provides the results of a telephone poll of dentists to determine their response to the AIDS threat both in attitude toward patients and prevention practices. Respondents indicated that they and their staff used barrier methods such as gloves, masks, and eye wear. Dentists reported few problems getting staff to work with patients, in general, but indicated staff and personal hesitancy to work with known virus carriers. Overall, dental staff exercise particular caution when working with sharp objects--orthodontists note their increased risk of injury from metal orthodenture materials. The survey touched upon a dentist's right to refuse care and the option to refer to dentists who are willing to work with AIDS patients.

227. Skillman, D., and C. Clark. (1987, September). HIV infection and the acquired immunodeficiency syndrome: A strategy for public education [Editorial]. Military Medicine 152(9), pp. 479-480.

This editorial presents a "stepwise" educational scheme that was devised and implemented at the Supreme Headquarters Allied Powers Europe (SHAPE) in Belgium. Its goal is to reduce the public fear of AIDS and cut down the spread of the epidemic. The authors note the special problems in implementing the program in an international military community. These include national pride; national groups' concern not to become coupled with AIDS in the public mind; the interaction of military rank with medical authority; and the barriers of language. Their stepwise program started with SHAPE military commanders and then proceeded gradually down from one echelon of authority to the next, with separate presentations for each level of personnel. The authors believe a key factor in their plan was the avoidance of opposition from authority figures by informing them first. They conclude that "our educational program has resulted in more responsible and compassionate behavior toward the individuals identified as infected in our community since December 1985."

228. Spero, J. (1988, May/June). Educating nursing students about quality care and safe practices in the AIDS epidemic. Public Health Reports 103(3), pp. 278-281

"As health educators and practitioners, nurses play a major role in safeguarding the health care setting and the community....Nurses are and will continue to be responsible for administering the major portion of the direct health care that AIDS patients require and for teaching basic nursing skills to other care givers. According to a 1987 survey of 461 nursing programs conducted by the American Association of Colleges of Nursing, AIDS content is being incorporated into the curriculums of the majority of programs....Students require an in-depth knowledge of AIDS to enable them to address effectively the needs of AIDS patients and their families. Because of the complex psychosocial, ethical,and legal issues, careful attention must be given to the development of students' skills in making clinical decisions that will promote effective nursing intervention when addressing problems in nursing care....Schools of nursing in colleges and universities can serve as key resources for developing curriculums, policies, and practice patterns that will assist the nursing community and the public in responding to the AIDS epidemic."

229. Thomas, P. (1988, May). Immunization of children infected with HIV: A public health perspective. Pediatric Annals 17(5), pp. 347-351.

The author discusses the issue of immunizing children suspected to be infected with HIV. Noted is the consensus of the medical community to immunize if the child appears well. Substitution of vaccine is advised when there is seropositivity in the child or family member, particularly the substitution of IpV for OPV. HIV antibody testing prior to 15 months is not recommended because of the possible carryover of maternal antibodies. Measles vaccine is indicated "in outbreak periods and in endemic areas" and at "15 months when the child manifests no overt symptoms." The author concludes that "Immunization with OPV and MMR have not yet been noted to cause adverse effects in HIV-infected individuals and may be efficacious at least in the younger child..."

230. Valdiserri, R. and others. (1987, Winter). Applying the criteria for the development of health promotion and education programs to AIDS risk reduction programs for gay men. Journal of Community Health 12(4), pp. 199-212.

"As a result of the AIDS (Acquired Immune Deficiency Syndrome) epidemic, many community health agencies are faced with the task of planning and implementing programs to prevent or reduce the risks of HIV (Human Immunodeficiency Virus) infection. Furthermore, the urgency of AIDS will force community groups to develop prevention programs prior to an analysis of substantial data

relating to intervention efficacy. By using the five criteria for the development of health promotion and education programs enumerated by the American Public Health Association, planners can benefit from the experience of past health promotion initiatives, and insure a comprehensive approach to planning. The authors describe, using specific examples, how these criteria were used to develop and implement an AIDS risk reduction program for gay and bisexual men."

231. Weller, T. (1987, November 15). Lessons for the control of AIDS. Hospital Practice, pp. 41-53.

This extensive essay on the role of the educational process in combatting the spread of AIDS focuses attention on the absence of a balanced perspective, which views AIDS in terms of the social needs of a global society. The author offers comments on trends, programs, and problems within the health field over the last 40 years with the goal of contributing material to help formulate a balanced perspective on AIDS. His discussion ranges over such topics as population mobility, resources, and major global initiatives in the health field. He suggests that a first priority in addressing AIDS is an understanding of its natural history and epidemiology.

232. Williamson, K. and others. (1988, July). AIDS education at the worksite. AAOHN Journal 36(7), pp. 262-265.

This article, directed at occupational health nurses, describes the factors that comprise an effective HIV/AIDS education program in the workplace and suggests some resources for implementing these programs. The goal of the education program is to allay unnecessary fears of managers and employees and to provide them with up-to-date information to reduce their risk of acquiring HIV infection. The article stresses the pivotal educational role of the occupational health nurse in the workplace, particularly in light of indications that only 10 percent of American corporations have HIV workplace policies in effect. The authors suggest that to be effective, an occupational health nurse must first work through personal feelings about drug abuse, homosexuality, and sexually promiscuous behavior; keep up to speed on pertinent research and information; and make use of resources such as the county health department, Red Cross and pertinent professional organizations. They recommend that a comprehensive workplace program can include use of audiovisual presentations followed by question-and-answer sessions, expert outside speakers, seminars, and company newsletters.

233. Gonzalez, J. and M. Koch. (1987, December). On the role of transients (biasing transitional effects) for the prognostic analysis of the AIDS epidemic. American Journal of Epidemiology 12(6), pp. 985-1004.

"A transient is usually defined as a temporary phenomenon occurring in a system prior to reaching a steady-state condition." In this article, the authors present mathematical evidence for considering whether the rate at which the AIDS virus is exponential or not. They state that "predictions for the AIDS epidemic should be carefully reconsidered in order to eliminate spurious effects due to transients." A fictitious model of the behavior of transients is presented, along with a comparison of this model with the AIDS epidemic and its actual spread in several countries, particularly Canada. The authors state that the "main point we wish to make in this paper is that transients occur for diseases having long and highly variable incubation periods." If the rate of incubation is markedly longer for some groups other than homosexuals, "the more recent AIDS epidemic for promiscuous heterosexuals, say, could be described by a simple exponential model for some years to come."

234. Green, J. and others. (1987, Fall). Projecting the impact of AIDS on hospitals. Health Affairs 6(3), pp. 19-31.

This detailed article evaluates the reactions of hospitals to the AIDS crisis by looking at the practical ways that these health care institutions respond to the impact of the infectious disease on staffing and financial patterns. The authors use a variety of methods to project such variables as resource consumption, patient admissions and length of days per stay, hospital cost, and bed days. The article also addresses the possible impact of AIDS-related complex (ARC) and other HIV-related conditions on hospitals as well as the higher use of nursing services by AIDS patients. Results of their analysis indicate, among other things, that "... by 1991, 12.4 percent of all available medical/surgical beds and more than 16 percent of all hospital treatment costs in San Francisco will be devoted to AIDS treatment." Numbers for the New York metropolitan area are 2,081 beds and more than 8 percent of the medical/surgical beds in the city.

235. Kushner, J. (1987, October). A health-care industry trend analysis. Maryland State Medical Journal 36(10), pp. 843-846.

This commentary on trends in the health care industry likely to impact the entire population identifies and describes seven major tendencies. They are: (1) increased health care costs and cost-containment programs; (2) the liability insurance crisis; (3) costly technological innovations; (4) increased alternative

delivery systems for outpatients; (5) growth of investor-owner, for-profit chains; (6) a glut of physicians; and (7) the AIDS epidemic. The author feels the two most critical trends are the cost-containment programs and the liability suits. He offers a series of recommendations, for example, that hospitals, if they are to survive, must improve utilization controls, and that the health care industry should support the Administration Task Force report.

236. Novick, L. (1987, September). New York State in the AIDS epidemic. Bulletin of the New York Academy of Medicine 63(7), pp. 692-712.

This symposium presentation, studded with charts and graphs, offers projections on the incidence of AIDS in New York State. It also profiles the actions which are needed to slow the growth of the AIDS epidemic. The author contends that action must be founded not only on an understanding but also on distribution and determinants of HIV infection in New York State. Also important is establishing effective interventions to reduce transmission. Using surveillance data, the author shows the occurrence of HIV infections in growing numbers in the State. One conclusion the author reaches is that the solution to retarding further growth of AIDS is "... to educate and encourage behaviors among the public that will interrupt the transmission." He also details the continuing role that the New York State Department of Health will continue to play in the AIDS crisis.

237. Palenik, C. and C. Miller. (1988, Winter). AIDS in Indiana. Alumni Bulletin of the School of Dentistry of Indiana University 2(2), pp. 42-47.

This review article cites present and projected statistics of AIDS cases in Indiana, and suggests an approach for educating Indiana children about AIDS. As of November 6, 1987, there had been 225 AIDS cases in the State. The authors note that aside from Indiana's small drug abuse population, the State reflects national figures, with homosexual and bisexual males representing the majority (73.3 percent) of cases and a larger proportion of cases among blacks. Based on national statistics, and with the number of cases in the State doubling each year, the authors project 2,750 cases will be on the State's books by 1991. They contend that Indiana is a leader in AIDS education, legislation, and health care. They detail these activities, including three new laws on AIDS and control of communicable diseases. The authors conclude that educational programs for adolescents must address their own questions, perceptions, fears, and convictions.

238. Weinberg, D. and H. Murray. (1987, December 3). Coping with AIDS: The special problems of New York City. New England Journal of Medicine 317(23), pp. 1469-1473.

This article presents a predictive model of the present AIDS situation in New York City, with the problems posed by drug abusers a major focus. Statistics collected by the New York City Department of Health through May 15, 1987, showed 500,000 persons in the city to be infected with HIV. According to the authors, New York City is coping with difficulty. Despite strong efforts by city and State agencies to initiate innovative educational and advertising campaigns, set up testing and counseling centers, and collect good data, the virus continues to spread rapidly. The article outlines three problems that must be faced: the increased frequency of the disease among drug abusers, who have not responded to educational or motivational efforts; the demand for hospital beds, which may outstrip the supply; and the lack of home care, long-term care, and hospice care. The authors propose several steps: make methadone more readily available to drug abusers; establish a large hospital dedicated to AIDS; and develop a system to extend out-of-hospital care.

239. Benfer, D. (1987). Health care policy issues related to AIDS: Lessons learned from the Henry Ford Hospital experience. Henry Ford Hospital Medical Journal 35(1), pp. 52-57.

This technical paper describes the experiences of the Henry Ford Hospital in developing a strategy, not only to modify the health care delivery system in southeastern Michigan, but also to reevaluate their financing mechanisms. The backdrop for the discussion is the impact of AIDS on health care institutions. The author reviews the AIDS situation in Michigan, details the history of the Henry Ford Hospital with AIDS cases, and outlines several solutions to the problem of institutional management of AIDS patients developed by the Greater Detroit Area Health Council Task Force on AIDS. The task force submitted a grant application to Michigan for funding, which was approved. The task force is now implementing its recommendations in southeastern Michigan.

240. Board of Trustees, American Medical Association. (1987, October). Prevention and control of acquired immunodeficiency syndrome: An interim report. Journal of the American Medical Association 258(15), pp. 2097-2103.

Seventeen recommendations on prevention and control of AIDS form the basis of this frequently cited report which calls for a "national" (as distinct from Federal) AIDS policy to be developed jointly by the public and private sectors. A "special" role for physicians and other health care counselors in educating and advising the public in addition to treating AIDS patients is detailed. The question of testing is treated at great length, and over half the recommendations deal with testing-related issues. The report advocates regular, voluntary testing of certain defined high-risk groups who give informed consent. Mandatory testing is recommended for donors of blood or other body tissues and fluids, immigrants, Federal or State prison inmates, and military personnel. The need to clarify antidiscrimination laws to cover those who test HIV-antibody positive is stressed, and the issue of "warning to third parties" is also addressed from a statutory viewpoint.

241. Dunne, R. (1987, September). AIDS in New York City: Policy and planning. Bulletin of the New York Academy of Medicine 63(7), pp. 673-678.

This article reviews how the health-care and social-welfare system in New York City have responded and adjusted to the AIDS crisis, what problems have occurred, and what needs to be done in the future. One problem cited is the inadequate number of physicians wiling and able to treat persons with AIDS (PWAs). The Gay Men's

Health Crisis's referral list includes only 35 out of the city's tens of thousands of physicians. The situation, according to the author, is exacerbated by the number of medical students uninterested in treating AIDS patients. He suggests incorporating AIDS into the medical school curriculum and reviewing residency programs to correct the imbalance in physician supply and care demand by PWAs. The article cites important factors that must be considered in planning, ranging from the impact of life-prolonging zidovudine, and the availability of alternatives to acute care facilities, an area where the author believes the worst planning job has been done. The author cautions against overreacting to the cost of AIDS care, and concludes that the current system, which depends heavily on acute care facilities and volunteers from community-based organizations, "barely works at present and is likely to get worse with time."

242. Goldsmith, M. (1987, November 13). Businesses, Federal government move to pick up AIDS gauntlet. Journal of the American Medical Association 258(18), pp. 2479-2480.

This general news article surveys two major efforts to confront the AIDS crisis. The author summarizes a meeting for senior executives called "AIDS: Corporate America Responds," which was convened to heighten awareness of the need to develop policy guidelines for dealing with AIDS in the workplace. The author also highlights the second major effort, the Federal government's first national AIDS information and prevention campaign, called "America Responds to AIDS."

243. Greene, R. (1988, January). Some comparisons between MAG and DHR's policy statements on AIDS. Journal of the Medical Association of Georgia 77(1), pp. 50-51.

This brief article highlights some of the similarities and differences between two policy statements on AIDS, one by the Medical Association of Georgia (MAG) and the other by the Georgia Department of Human Resources (DHR). The author notes six areas of similarity between the two, including more education about AIDS, criminal sanctions against HIV seropositive individuals who knowingly expose others, and support for counseling HIV patients, among others. He notes the main disagreement between the two reports is the issue of AIDS-specific strict confidentiality legislation, supported by the DHR. MAG opposes such legislation since it holds that HIV, ARC, and AIDS information should be treated the same as any other medical information. He cites three other areas of disagreement.

244. Hatziandreu, E. and others. (1988). AIDS and biomedical research funding: comparative analysis. Reviews of Infectious Diseases 10(1), pp. 159-167.

"The extent of the federal government's investment in AIDS-related research in relation to research investments in cancer, coronary heart disease, and unintentional injuries is examined. Appropriation levels for fiscal year 1986 are divided by indexes of projected disease burden for 1991 to create a research investment ratio for each health impairment. Indexes of disease burden include numbers of total deaths, early deaths, expected life years lost, and discounted life years lost and direct economic costs. Despite the uncertainty about the future of the AIDS epidemic, there is no indication that AIDS is being overfunded relative to cancer and heart disease....Confident conclusions about research priority depend upon resolution of qualitative considerations and better understanding of the dynamics of the AIDS epidemic."

245. Healey, J. (1987, September). Facing AIDS: Health practitioners and public policy. Connecticut Medicine 51(9), pp. 625.

This brief column considers aspects of the special roles that health professionals must play in the development of a public policy for AIDS that is fair and compassionate to all. The author identifies two starting points--precedents and the special obligations of health professionals--for developing such a public policy. He stresses the need to promote realistic policies and to control the bias that is part of exaggerated fears about AIDS.

246. Health and Public Policy Committee, American College of Physicians; and Infectious Diseases Society of America. (1988, March). The acquired immunodeficiency syndrome (AIDS) and infection with the human immunodeficiency virus (HIV). Annals of Internal Medicine 108(3), pp. 460-469.

This report updates a 1986 AIDS policy statement by the American College of Physicians and the Infectious Diseases Society of America. Ten positions are set forth and detailed. "Particular issues emphasized include an explicit acknowledgment of the ethical imperative to care for all patients; recognition of the low but definite risk for transmission of human immunodeficiency virus (HIV) in the health care setting and of the need for observation of universal precautions to minimize this risk; expanded recommendations for routine testing of high risk patients; recognition of the other ethical duties that may conflict with the need for confidentiality; and recognition of a national leadership gap in public education and public policy development."

247. Holthaus, D. (1988, January 5). AIDS-testing issues top State agendas in '88. Hospitals 62(1), p. 44.

"AIDS and the civil rights issues that surround testing for the fatal disease will be topics that [three-fourths of] state legislatures will debate in 1988." According to the article, although testing-related issues like confidentiality and potential discrimination against AIDS patients by employers, insurers, and providers are expected to be the most frequently discussed questions, patient care will also be considered.

248. Iglehart, J. (1987, Winter). Views of a health policy activist: A conversation with Henry Waxman. Health Affairs 6(4), pp. 20-29.

This question-and-answer article focuses on the views of Representative Henry Waxman, a Democrat from California and chairman of the House Energy and Commerce Subcommittee on Health and the Environment. The discussion ranges over the Federal budget and administration policies as well as the fight against AIDS and catastrophic health insurance.

249. Iglehart, J. and others. (1987, Fall). The socioeconomic impact of AIDS on health care systems. Health Affairs 6(3), pp. 137-147.

This general feature presents a summary of a Project HOPE conference on AIDS and its socioeconomic effect on health systems worldwide. Sections in the summary describe the presentations of the participants. These include J. Mann on the global epidemic, G. Monekosso on Africa, R. Gallo on the biological dimensions of AIDS, F. Young on speeding drug approvals, and M. Barzach on the French fight against AIDS. Other speakers covered the economic costs of AIDS, State and local approaches to AIDS, the private corporate sector and AIDS, and the social impact of AIDS.

250. Judson, F. and T. Vernon, Jr. (1988). The impact of AIDS on State and local health departments: Issues and a few answers. American Journal of Public Health 78(4), pp. 387-393.

The role of State health departments in surveillance and control of the HIV epidemic is discussed. The authors address issues related to health policy measures such as implementation of convenient, free HIV testing and counseling, expanded services in sexual disease clinics, notification programs for contacts, restrictive measures for carriers, regulation of public establishments in which infection may result, and confidential reporting of test results to public health departments. Also discussed was the need to change or modify certain legal and other aspects of individual State health department programs in order to effectively implement newer AIDS policies.

251. Lewis, H. (1987, November 6). Acquired immunodeficiency syndrome: State legislative activity. Journal of the American Medical Association 258(17), pp. 2410-2414.

This review article covers the extensive State legislative activity on AIDS occurring in the United States--more than 450 bills introduced in State legislatures in 1987. The author focuses on ten major subject areas that are matters of State law. These include antibody testing, blood and blood products, confidentiality, employment, housing, informed consent, insurance, marriage, prison population, and reporting. The information in the review is current through October 6, 1987. [A published erratum appears in the January 15, 1988 JAMA 259(3), p. 356.]

252. Lewis, J. (1988, May 14). AIDS policy. Lancet 1(8594), p. 1118.

This commentary is on the anticipated announcement of the British government regarding its policy on mandatory screening for AIDS. The ethical problems of proposed unauthorized screening of hospital patients and the government's rejection of a program of mandatory screening of immigrants, servicemen and prisoners are discussed. The need to increase awareness of government officials regarding infectivity among these populations and methods to step up the government's campaign to halt the spread of AIDS is emphasized.

253. Marwick, C. (1988). AIDS Commission's next report focuses on four critical issues. Journal of the American Medical Association 259, pp. 169-170; Presidential commission recommends campaign against drug abuse to help combat AIDS. Journal of the American Medical Association 259, pp. 2195-2199; AIDS commission making its final report. Journal of the American Medical Association 259, p. 3529; AIDS recommendations leave Federal officials to ponder: Where do we go from here? Journal of the American Medical Association 260, pp. 16-17.

This group of articles documents the recommendations of the Presidential Commission on HIV. The first report describes four issues identified by the commission that must be addressed in dealing with the HIV/AIDS crisis: (1) the variance among estimates of HIV prevalence; (2) the need for out-of-hospital facilities for care of AIDS patients; (3) the need for new approaches and methods for developing drugs and vaccines both for treatment and prevention; and (4) the need for drug abuse treatment/prevention programs, since intravenous drug abuse is the principal HIV transmission route. Later reports identify specific programs to respond to these issues, particularly in the areas of drug abuse and education. The commission recommends an "integrated national strategy for tackling AIDS," and that "health care delivery services be adapted to cope adequately with the epidemic." Suggestions include a comprehensive educational program, Medicaid

reimbursement strategies, expansion of biomedical research, and use of home and hospice care. The commission has stated that "to neglect any issues would lead to long-term health problems."

254. Medical Association of Georgia. (1988, January). Medical Association of Georgia's 1987 report on human immunodeficiency virus, AIDS related complex, and acquired immunodeficiency syndrome. Journal of the Medical Association of Georgia 77(1), pp. 41-49.

This document presents the Medical Association of Georgia's (MAG) 1987 report on HIV, ARC, and AIDS and notes that MAG intends to continually review its evaluation. Incorporated in the text are 20 recommendations. The purpose of the report is to provide guidance and suggestions to health care providers, government, and the public. The recommendations range from "Fight fear With facts" (number 1) and "Counseling and testing should be strongly encouraged and offered for the following individuals in the following settings:" (number 9) to "Children who are HIV seropositive or have ARC or AIDS should be allowed to attend school. Additionally, they recommend that "Sex education including AIDS information should be included in the school's curricula" (number 20).

255. Minnesota Department of Health. (1988). Report to the Minnesota Interagency Committee on AIDS Financing Issues. [Background report compiled by the Disease Prevention and Control Division and the Health Systems Development Division].

This comprehensive report is divided into four chapters. Chapter 1 "presents epidemiological data, projections of numbers of AIDS and ARC cases through 1990, demographic data on AIDS cases and estimates of numbers of individuals infected with the AIDS virus. [Chapter 2] presents information on the types of services needed and the rationale for each, identifies problems in obtaining services and analyzes the cost-effectiveness of various types of services. [Chapter 3] presents AIDS case cost data and estimates and projections of the cost and fiscal impact of AIDS on state programs. The focus of the fourth chapter is on health care coverage and service gaps in the health care delivery system."

256. Oklahoma State Department of Health: AIDS Task Force recommendations to date. (1988, January). Journal of the Oklahoma State Medical Association 81(1), pp. 13-29.

Recommendations are presented from the four advisory committees of the Oklahoma State Department of Health AIDS Task Force: infectious disease, education, health care services, and law and ethics. A statement of need and separate detailed recommendations are presented for each of the four areas. AIDS case statistics and preliminary projections for the State through 1991 are included.

257. Osborn, J. (1988, February 18). AIDS: Politics and science. The New England Journal of Medicine 318(7), pp. 444-447.

This general article addresses the adoption of policies and the public debate on AIDS as well as considerations that should drive political decision on AIDS. The author finds it unsettling that "much of the AIDS dialogue these days seems to be detached from the realities of the situation." She covers the response of politicians and other groups to such issues as public education, mandatory tracing of the sexual partners of persons with AIDS, voluntary testing programs, and free needles. She urges politicians to adopt frank and sensible approaches to the AIDS situation.

258. Osterholm, M. and K. MacDonald. (1987, November 20). Facing the complex issues of pediatric AIDS: A public health perspective [Editorial]. Journal of the American Medical Association 258(19), pp. 2736-2737.

This editorial raises the question of the implications for primary prevention of pediatric AIDS of a survey by Landesman et al (1987) of women giving birth at King's County Hospital Center in Brooklyn, New York. The authors cite that survey, along with other data, to highlight the need for practitioners to realize that "... the great weight of pediatric AIDS will continue to fall on our communities of color, particularly in the inner-city areas." They urge clinical and public health communities to address the issues of pediatric AIDS with the same energy and effort devoted to other aspects of AIDS.

259. Richland, J. (1988, May/June). Role of State health agencies in responding to AIDS. Public Health Reports 103(3), pp. 267-272.

This article describes the role of State health agencies and State health officers in particular in developing public policy on HIV infection. It details how the Association of State and Territorial Health Officials (ASTHO) and its AIDS Committee has become a vehicle through which State health officers communicate their views to the Federal government. Across-State AIDS program variations and consensus, as well as ASTHO's role in developing national health department policies, are highlighted.

260. U.S. Conference of Mayors AIDS Program. (1988). Local AIDS Policies. Washington, DC: United States Conference of Mayors.

"Local AIDS Policies is designed to provide local officials with guidance in developing appropriate AIDS-related policy positions vis-a-vis concerns regarding employee health and safety; protection of citizens against unwarranted discrimination; protection of the municipality against liability claims; and maintenance of public confidence in the operations of the local government. Included in this document are brief outlines of major policy issues along with

sample AIDS-related policies in the following areas: discrimination, police, emergency medical services (EMS) personnel, fire safety workers, correctional facilities, and health care workers."

261. Valdiserri, R. (1988, May). The new horizon: Programmatic responses to the HIV epidemic. New York State Journal of Medicine 88(5), pp. 219-220.

In this commentary, the author maintains that..."federal coordination of a programmatic response to HIV infection is no less important than the coordination of a similar response with regard to biomedical research and vaccine development." The relationships between health services delivery, prevention of HIV transmission, and health care financing initiatives are also discussed as parts of this response.

262. Allain, J. and others. (1988, February). Compulsory premarital screening for HIV [Letter]. Journal of the American Medical Association 259(7), pp. 1011-1015.

This letter responds to an earlier article analyzing the value of compulsory premarital screening for HIV. The original premise was that the incidence of HIV in marriage applicants would be similar to that occurring in the blood-donating public and raises some questions about the accuracy of testing methods. The authors argue that these populations are, in fact, dissimilar. They point out that certain indicators, such as the number of HIV-positive infants being born, and the incidence of HIV in civilian applicants for military service, lend credence to the premise that the incidence of HIV in marriage applicants is much higher than previously estimated. The authors also state that ELISA tests with greater sensitivity and specificity are currently available.

263. Bazaral, M. (1987). Preoperative testing for human immunodeficiency virus infection [Letter]. Anesthesiology 67(2), p. 278.

This letter to the editor underscores the writer's disagreement with a review by Kunkel and Warner in which the authors state that AIDS patients should not be treated differently and that surgical patients do not warrant serological screening for HIV. The writer argues that routine screening of patients before elective major surgery is warranted. The text includes Kunkel and Warner's reply to the writer.

264. BMA advice on insurance AIDS tests [News]. (1988, August 6). Lancet 2(8606),p. 347.

This article discusses the British Medical Association (BMA) criticism of the Association of British Insurers over its advise to test all patients for AIDS without informed consent and to pass the results straight from the laboratory to the insurance company without the patient's knowledge. The BMA is concerned that patients will not know they have a positive test until their insurance is refused and that adequate counseling with not be provided to these individuals.

265. Burda, D. (1987, September 20). Insurer counsels on preemployment testing for AIDS. Hospitals 61(18), p. 35.

This brief article addresses the AIDS-related concern of workers' compensation carriers, who sell insurance to hospitals. The concern, as the author points out, arises from the fact that the health care industry is one where getting AIDS from a work activity

is a real risk. The author also discusses a related report that covers employment-related legal issues created by AIDS, specifically preemployment AIDS testing.

266. Carlson, M. (1987, December). AIDS testing. Ohio Medicine 83(12), pp. 837, 839.

The author discusses four types of reasons for AIDS testing--prognostic, diagnostic, screening, and monitor therapy. How test results should be treated and to whom they should be made available are also considered. (For comment on this article, see letter by A. Davies in the March 1988 issue of Ohio Medicine, pp. 163, 165.)

267. Cleary, P. and others. (1987, October 2). Compulsory premarital screening for the human immunodeficiency virus: Technical and public health considerations. Journal of the American Medical Association 258(13), pp. 1757-1762.

"The effectiveness of a mandatory premarital screening program was examined as a means of curtailing the spread of the human immunodeficiency virus (HIV) infection in the United States. The epidemiology of the HIV, the technical characteristics of tests for antibodies to HIV, and the logistic, economic, and legal implications of such a program were considered. In one year, universal premarital screening in the United States currently would detect fewer than one tenth of 1% of HIV-infected individuals at a cost of substantially more than +100 million. More than 100 infected individuals would be told that they were probably not infected, and there would likely be more than 350 false-positive results. Public education, counseling of individuals, and discretionary testing can be important tools in reducing the spread of HIV infection, but mandatory premarital screening in a population with a low prevalence of infection is a relatively ineffective and inefficient use of resources."

268. Frank, J. and others. (1988, August 15). Testing for HIV infection: Ethical considerations revisited [Editorial]. Canadian Medical Association Journal 139(4), pp. 287-289.

The authors discuss false-positive and other risks of HIV antibody testing and argue against large-scale testing. They feel that the risks are "substantial" for those with low likelihood of HIV infection; for asymptomatic persons aware they are at high risk of infection, the argument against "aggressive testing" is, according to the authors, even stronger. (For related editorial in the same issue, see I. Kleinman, "An examination of HIV antibody testing," pp. 289-291.)

269. Fulks, M. (1988, June). Testing for the human immunodeficiency virus (HIV) by insurance carriers [Letter]. Annals of Internal Medicine 108(6), p. 907.

The author points out that testing by insurance companies "must be applied uniformly across age, sex, and geography."

270. Gostin, L. and others. (1987). The case against compulsory casefinding in controlling AIDS--testing, screening and reporting. American Journal of Law and Medicine 12(1), pp. 7-53.

"The spread of acquired immune deficiency syndrome (AIDS) demands a comprehensive and effective public health response. Because no treatment or vaccine is currently available, traditional infection control measures are being considered. Proposals include compulsory testing and screening of selected high-risk populations. The fairness and accuracy of compulsory screening programs depend upon the reliability of medical technology and the balancing of public health and individual confidentiality interests. This article proposes criteria for evaluating compulsory testing and screening programs. It concludes that voluntary identification, education, and counselling of infected persons is the most effective means of encouraging the behavioral changes that are necessary to halt the spread of AIDS."

271. Hagen, M. and others. (1988, March 4). Routine preoperative screening for HIV: Does the risk to the surgeon outweigh the risk to the patient? Journal of the American Medical Association 259(9), pp. 1357-1359.

The authors argue against routine preoperative screening for HIV infection because of the potential for unacceptably high numbers of false-positive results. They do not feel that the risk of HIV transmission per surgical patient--which is equated to the HIV transmission risk per heterosexual encounter--merits mandatory screening of low-risk surgical patients. Clinical and ethical considerations of the issue are addressed.

272. Henry, K. and others. (1988, January 8). Analysis of the use of HIV antibody testing in a Minnesota hospital. Journal of the American Medical Association 259(2), pp. 229-232.

"[The researchers] retrospectively studied the clinical use of human immunodeficiency virus (HIV) antibody serology at one 450-bed medical center and affiliated clinics from April 1985 through August 1986. No restrictions were placed on the use of HIV antibody serology during that time, although it was recommended that consent be obtained and risk-reduction information be provided. Testing was performed for 275 patients; results for 25 (9 percent) of these were positive. Nearly half (44%) of the patients had no recognized risk factor for HIV infection recorded in their charts. For an

additional 44% of the patients, the test was medically indicated but consent and counseling were not documented. For only 10% of HIV antibody tests was there notation that consent was obtained and that risk-reduction information was provided. These results indicate that HIV antibody testing is often done without consent and that opportunities to provide risk-reduction counseling are being missed."

273. Henry, K. and others. (1988, March 25). Human immunodeficiency virus antibody testing. A description of practices and policies at U.S. infectious disease-teaching hospitals and Minnesota hospitals. Journal of the American Medical Association 259(12), pp. 1819-1822.

"A questionnaire that asked about policies concerning the use of human immunodeficiency virus (HIV) antibody tests was sent in January 1987 to the 200 hospitals in the United States that conduct infectious disease (ID) fellowship training (US ID hospitals) and to all 171 short-term-care Minnesota hospitals. Information was received from 189 of the US ID hospitals (94.5%) and from 160 (94%) of the Minnesota hospitals. Only 49% of the US ID hospitals and 37% of the Minnesota hospitals had an HIV antibody test-ordering policy; 47% of the US ID hospitals and 39% of the Minnesota hospitals had a specific educational program for physicians about the HIV antibody test; and 62% of the US ID hospitals and 41% of the Minnesota hospitals had an HIV autopsy policy. Marked variety existed in approaches to handling test results, obtaining patient consent, and providing risk-reduction information among the hospitals surveyed. These data suggest the need for a consensus on optimal use of HIV antibody testing at hospitals."

274. Hiam, P. (1987-88, Winter). Insurers, consumers, and testing: The AIDS experience. Law, Medicine and Health Care 15(4), pp. 186-211.

This policy review essay takes a detailed look at the issue of insurance industry support for HIV antibody testing. The author examines why the industry desires to test applicants for HIV, why it has been so successful in keeping the right to do so, and whether its reasons for testing have merit. He explores the significance of AIDS to insurance, insurance and regulation, industry arguments in favor of testing--both financial and non-financial, and assesses the need for testing. The author also describes the problems with testing for insurance purposes. He concludes that "the use of tests to deny life and health insurance to those at risk of AIDS will be costly, ... It may also further discourage people from participating in public health testing programs."

275. Kaminski, M. and P. Hartmann. (1988, July). HIV testing: Issues for the family physician. American Family Physician 38(1), pp. 117-122.

"Human immunodeficiency virus (HIV) infection affects all communities. To provide optimal patient care, physicians must understand the ramifications of HIV-antibody testing and provide appropriate counseling before and after testing. The seropositive patient requires knowledgeable surveillance. In addition, the family physician must be prepared for the psychologic and social stresses that HIV infection imposes on the patient and the family."

276. Kleinman, I. (1987, October 1). Transmission of human immunodeficiency virus: Ethical considerations and practical recommendations [Editorial]. Canadian Medical Association Journal 137(7), pp. 597-599.

Patient, public health, and confidentiality issues regarding HIV antibody testing are addressed in this editorial. The author argues that the physician should recommend testing when indicated by individual circumstances but that testing alone will not contain the disease. (For comment on this editorial also published in Canadian Medical Association Journal, see letter by P. Chandarana in the December 15, 1987 issue, p. 1073; and letter by G. Noel in the March 15, 1988 issue, p. 490.)

277. Kovacs, J. and others. (1988, March 10). Diagnosis of Pneumocystis carinii pneumonia: Improved detection in sputum with use of monoclonal antibodies. New England Journal of Medicine 318(10), pp. 589-593.

"With the dramatic increase in the frequency of Pneumocystis carinii pneumonia associated with human immunodeficiency virus infection, there has been a need for more rapid and less invasive diagnostic techniques....To assess whether a recently developed indirect immunofluorescent stain using monoclonal antibodies was more sensitive than Giemsa or toluidine blue O stains in detecting P. carinii in sputum, two prospective studies [were undertaken]....The sensitivity of the three stains in detecting P. carinii was 45 of 49 (92 percent) for immunofluorescence; 37 of 49 (76 percent) for Diff-Quik (a Giemsa-type stain); and 39 of 49 (80 percent) for toluidine blue O. There were no false positive immunofluorescent stains....From these data it should be clear that the staining of induced sputum provides a safe, noninvasive method for rapidly diagnosing P. carinii pneumonia in patients with AIDS. The technique can minimize patient discomfort, simplify treatment, and be considerably safer and less expensive than bronchoscopy or open-lung biopsy."

278. Mohr, R. (1987-88, Winter). Policy, ritual, purity: Gays and mandatory AIDS testing [Editorial]. Law, Medicine and Health Care 15(4), pp. 178-185.

This editorial essay argues that the purpose of mandatory AIDS antibody testing is to degrade gays. The author also claims that the point of testing "... is the reconsecration of heterosexual supremacy as a sacred value ..." He advances the belief that AIDS-testing legislation can only be properly understood by comprehending the nature and function of social rituals, specifically, purification rituals. To support his arguments, the author discusses a variety of social structures as well as the use of testing in marriages and for immigration and the military. He recommends that gays begin to establish rituals through which they value and honor themselves.

279. Polesky, H. (1988, January 8). Update: Serologic testing for antibody to human immunodeficiency virus. Morbidity and Mortality Weekly Report 36(52), pp. 833-840, 852.

Quality assurance and proficiency in testing for HIV antibodies and interpreting results of such tests are discussed. The HIV antibody tests specifically detailed are the enzyme immunoassay for screening and the Western blot for validation. An editorial note to the article points out that..."predictive values of both positive and negative test results for HIV antibody are extremely high in laboratories that have good quality control and high performance standards...."

280. Sachs, B. and others. (1987, September). Acquired immunodeficiency syndrome: Suggested protocol for counseling and screening in pregnancy. Obstetrics and Gynecology 70(3, Part 1), pp. 408-411.

"The Centers for Disease Control (CDC) has recorded 35,900 cases of acquired immunodeficiency syndrome (AIDS) in the United States, including 2447 infected females, as of May 25, 1987. These cases include 503 children under the age of 13, of whom 80% were thought to have been affected through perinatal transmission. The prevalence of AIDS-related complex and human immunodeficiency virus in the United States is far greater than these numbers. The CDC has recommended screening those pregnant women with risk factors for human immunodeficiency virus. With the help of a wide range of professionals, we have developed a screening protocol for human immunodeficiency virus in pregnancy. In the first six months, 3-4% of prenatal patients used this counseling service, and 11 human immunodeficiency virus-positive women delivered. This paper discusses the medical and ethical issues that were raised and the problems that we faced in establishing this protocol."

281. Schwartz, J. and others. (1988, May 6). Human immunodeficiency virus test evaluation, performance, and use. Journal of the American Medical Association 259(17), pp. 2574-2579.

"This article reviews the scientific basis for the evaluation, performance, and use of the most commonly employed HIV assays. Current test performance could be improved by better standardization of test procedures and institution of mandatory proficiency testing and licensure of clinical laboratories that perform HIV testing. Test utility could be enhanced by sequencing tests more appropriately and by interpreting test results in conjunction with the clinical purpose for which the test is being used and the characteristics of the population under study. Finally, HIV tests should be evaluated in a manner that minimizes spectrum and referral bias and inadequate reference standard confirmation, problems that have affected the evaluation of current tests."

282. Sencer, D. (1987, Fall). Guidelines for physicians testing for HIV antibody [Letter]. Law, Medicine and Health Care 15(3), p. 160.

This letter to the editor addresses the scope of the Federal AIDS Policy Act, proposed in the U.S. House of Representatives and the U.S. Senate, on HIV antibody testing. The author notes that both Congressional bills take into account the responsibilities of the doctor. He makes several recommendations to health care professionals on testing and disclosure, for example, "a physician under no circumstances should test an individual for the presence of HIV antibody without the fullest explanation of the significance of both positive and negative test results ..."

283. Testing for HIV infection. (1988, June 4). Lancet 1(8597), p. 1293.

Presented here is a summary of recommendations of a working group on the monitoring and surveillance of HIV infection and AIDS. The group suggests that antenatal testing for HIV infection on a voluntary basis in selected high-risk areas of London may be beneficial. Difficulties in implementation, bias and legal and ethical issues associated with named and unnamed testing are summarized.

284. Trent, B. (1988, June 15). Armed forces unveils AIDS policy. Canadian Medical Association Journal 138(12), pp. 1129, 1131-1132.

This article summarizes the Canadian armed forces policy on AIDS testing and compares it with that of the United States. Incidence data on AIDS in the Canadian military are presented. Reasons are given for the present Canadian policy of not requiring military

recruits or serving personnel to undergo mandatory testing for AIDS.

285. Ward, J. and others. (1988, February 25). Transfusion of human immunodeficiency virus (HIV) by blood transfusions screened as negative for HIV antibody, The New England Journal of Medicine 318(8), pp. 473-478.

"Since early 1985, blood donations in the United States have been screened for antibody to human immunodeficiency virus (HIV). To identify instances of HIV transmission by antibody-negative donations, [the researchers] investigated 13 persons seropositive for HIV who had received blood from 7 donors who were screened as negative for HIV antibody at the time of donation....On evaluation 8 to 20 months after transfusion, HIV-related illnesses had developed in three recipients, and the acquired immunodeficiency syndrome had developed in one. All seven donors were found to be infected with HIV. On interview, six reported a risk factor for HIV infection, and five had engaged in high risk activities or had had an illness suggestive of acute retroviral syndrome within the four months preceding their HIV-seronegative donation....[The researchers] conclude that there is a small but identifiable risk of HIV infection for recipients of screened blood. To minimize this risk, the reasons for deferral of donation need to be communicated more effectively to blood donors who are at high risk of HIV infection, and new assays that detect HIV infection earlier should be evaluated for their effectiveness in screening donated blood."

286. Weiss, R. (1988, April 2). Improving the AIDS test: Genetic engineers offer a new approach to AIDS-antibody testing. Science News 133, pp. 218-221.

The article reports on "several varieties of second-generation AIDS tests--which use either synthetic proteins or proteins made by genetically engineered microorganisms, instead of proteins from real AIDS viruses--[that] have for the most part shown that the newer tests are at least as sensitive and specific as current tests....In many cases the newer tests are able to detect AIDS antibodies in blood at earlier stages of infection than can the currently approved tests." The author maintains that the new tests "reflect a changing biomedical and political climate in which AIDS testing is increasingly being performed for purposes other than blood donor screening, making it more important than ever to minimize false positive or ambiguous results."

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16. Abstract (Limit: 200 words)

This report updates the first NCHSR AIDS bibliography, which was published in September 1987; articles annotated in this update were published between August 1987 and August 1988. Content divisions differ slightly from those in the 1987 bibliography. Special issues of scholarly publications and State medical association journals devoted to AIDS have been included. Provision of care is addressed in separate sections on community care (outpatient services, hospice or home care, and other support services) and inhospital care (resource utilization, system support, and inpatient management). Issues related to costs, financing, or insurance (including Medicare and Medicaid expenditures) are treated in a single section. Guidelines for disease control, risk reduction, and education are included in a prevention category. AIDS-related public health iniatives at the Federal, State, and local level make up a general public policy section. Finally, a new section on legal and ethical issues addresses physician liability, confidentiality questions, treatment dilemmas, conditions of releasing medical records and test results, and considerations for AIDS research.

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