COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
JOINT COMMITTEES ON JUDICIARY
AND HEALTH AND WELFARE

In re: House Bill 624

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Stenographic report of hearing held
in Room 8E East Wing, Main Capitol
Building, Harrisburg, Pennsylvania

Thursday,
April 27, 1989
10:00 a.m.

HON. THOMAS CALTAGIRONE, CHAIRMAN, JUDICIARY COMMITTEE
Hon. Gerard Kosinski, Subcommittee Chairman on Courts
Hon. Kevin Blaum, Subcommittee Chairman on Crime and Corrections

MEMBERS OF COMMITTEES ON JUDICIARY AND HEALTH AND WELFARE

Hon. Paul I. Clymer
Hon. Patrick E. Fleagle
Hon. Babette Josephs
Hon. Nicholas Moehlmann
Hon. Christopher McNally
Hon. Robert Reber
Hon. Jere Strittmatter
Hon. Jean Wilson
Hon. Christopher Wogan

Also Present:

David Krantz, Executive Director, Judiciary Committee
Phillip Parrish, Executive Director, Health and Welfare Committee
William Andring, Counsel, Judiciary Committee

Reported by:
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INDEX

CHAIRMAN CALTAGIRONE: We are expecting additional members to arrive, and what I'd like to do, since the hour of 10:00 o'clock has come and gone, we might as well get started.

I'm State Representative Tom Caltagirone, Chairman of the House Judiciary Committee. My counterpart, Chairman Nick Moehlmann, from the Judiciary Committee; Representative Robert Reber, member of the Judiciary Committee, and I know there are some other members, but Representative Babette Josephs is a member of both the Health and Welfare and Judiciary Committees; Representative Kevin Blaum, Representative Chris McNally, and Paul Clymer. You're on Health and Welfare, right, Paul?

REPRESENTATIVE CLYMER: Yes.

CHAIRMAN CALTAGIRONE: We will have some additional members from Health and Welfare and Judiciary that will be arriving. This is a joint venture, so to speak, between the Health and Welfare and the House Judiciary. We will be collaborating together and working together on developing an approach to the AIDS question and/or problem and hopefully seeking some type of legislative solutions. I have already discussed with the executive director from the Health and Welfare Committee, Phil Parrish, since chairman Dave Richardson cannot be

here, he had a death in the family, that we will be getting together to mutually select five members from each of the committees - Nick will be picking two, I'll have three from the Judiciary Committee, and hopefully an equal number from the Health and Welfare, if Chairman Richardson would agree to that - to at least examine these types of issues to see legislatively what we might be able to do in addressing this particular area. I know that Chairman Richardson has a particular interest in this subject matter and that he is developing several proposals that I think we can collectively work together in addressing.

And without any further adieu, I'd like to get right into the matter of the testimony. We have the Honorable N. Mark Richards, M.D., Secretary of Health, Commonwealth of Pennsylvania, and we'd like your testimony, sir.

SECRETARY RICHARDS: Thank you very much, Representative Caltagirone and members of the two committees. I have provided for you an outline of what of I'm prepared to say. Since I wasn't exactly sure how you wanted this testimony to be provided, let me just indicate briefly what I'm prepared to do and then if you'd like to do something different or if you'd like to take it out of the order that I have brought with me, I can certainly do that.

First of all, I thought that I would review quickly for you what AIDS is and the disease control options that we have available to us and say a little bit about what we are doing in the department. Then I thought I would discuss briefly what kind of legislation we have on the top of our list and then talk about some legislative options that might be also considered in relatively conceptual terms. If you would like to ask questions specifically about our opinion about specific bills, we could do that at the end during questions and answers. So does that seem to be appropriate for your needs?

CHAIRMAN CALTAGIRONE: Certainly.

SECRETARY RICHARDS: Fine. Thank you.

As I'm sure you know by now, AIDS is caused by a virus that affects and destroys cells that protect you against virus and bacterial infections. It infects cells in your bloodstream which are destroyed, and when these cells are destroyed, you are no longer able to protect yourself against a number of infections of a variety of kinds that you ordinarily can, and because of that you eventually then begin to develop infections or a kind of cancer, which ultimately is what provides the final blow.

The virus infects a person but resides in

the body for years, currently thought to be 9 to 10 years, before these other lethal infections begin to appear. For a time these infections can be treated, for a time the cancer can be managed, but ultimately the person is about almost always to die with these infections.

The virus is transmitted from person to person by a fairly small number of ways, and the ways that the virus is transmitted is well understood by this time so that we can be really pretty clear about what things can be done by a person who is at risk of getting infected or who has a virus and could transmit it. The things that person needs to do to reduce or eliminate that risk are really very well worked out by this time.

The virus can be transmitted by sexual transmission, like any other sexually transmitted disease. It can be transmitted by receipt of infected blood, such as needle sticks. Rarely now can be infected by blood transfusions, although the testing has made blood transfusions very safe. Prior to 1985, however, blood transfusions with infected blood were a common way to transmit the virus. And thirdly, it can be transmitted from an infected mother to her infant before its birth. Each of these means of transmission can occur with different degrees of frequency.

Now, the first important concept is that a

person in fact is apparently quite well for many years before the illnesses begin to occur. The average period of -- this is called a latent period, and the average period of time before illness occurs is now thought to be somewhere around 9 to 10 years, although these estimates keep changing, and for the longer period of time.

There are five general levels of illness that you can describe. The first illness really is the period of infection but with no symptoms. The person apparently has no reason to believe that he is sick and would not know that he is infected, unless a blood test were done which could demonstrate the infection. Actually, what you demonstrate is your reaction against the virus, the production of antibodies. The screening tests now used don't actually measure the virus, they measure antibodies you produce against it, which sometimes is important in some considerations, but that's what the blood test is. Okay. This period with no illness, no symptoms at all, can last for years.

Then when illness begins to appear, there are four general kinds of illness. The most recently recognized kind of illness is dementia, and you can have dementia occur with very few other symptoms, but these four kinds of illnesses can occur lumped together, too. The most common presentation is with the kind of pneumonia

caused by an agent called pneumocystis carinii. It's now known to be a fungal infectorate. And this can be treated and you have repetitive bouts often with this pneumonia.

There are a series of other infections which can also occur less commonly. Thrush, as an example, tuberculosis. A wide variety of other infections can also occur.

Then you can have a kind of cancer called Kaposi's sarcoma. It's a cancer which is a growth of elements of the blood vessels which produce dark blotches in the skin, both visible and internally.

And then lastly you can have a wasting syndrome in which the person loses an extraordinary amount of weight, becomes weak, has swelling of his lymph nodes, and so forth, fever, diarrhea, and so forth.

So these are the kind of illnesses that make up AIDS. These can be treated, in many cases, until repetitive bouts occur, in the case of infections, but eventually it does in the person who has this infection.

The next concept is that a person who has the infection with the virus is communicable during all stages of the illness, all stages from the very beginning, including the asymptomatic period. That means that it's critical for the person who is infected to know that so that he can then modify his behavior so he doesn't

transmit it.

So that's the illness and how it appears. It's very clear that unless you engage in risk-taking behavior, you're not at risk of getting AIDS. The single exception to that probably is an infant who is born to a mother who has the infection. That, of course, is involuntary, but with all the other usual means of spreading, the risk of getting infected depends on your engaging in risk-taking behavior. Sexual behavior, as an example; needle sharing behavior. These are the most common kinds of behavior. And the implication of that is that the only way we have to control this disease, since we really can't treat it, is to persuade people to change their behavior. This education or counseling or behavior modification attempts, if you will, are the only control means that we have. And not only that, but the control means need to be exercised long before the illness occurs. They need to be exercised at a point when a person doesn't even know he's infected. That makes it difficult.

Now, let me then say a few words about how the illness and the infection appear in Pennsylvania. We have been counting up the number of cases as the primary surveillance mechanism or tracking mechanism since 1981 when it was first recognized, and to date, Pennsylvania has had 2,540 cases, that's as of April 17th. 59 percent

of those patients have now died, and there are almost no patients that have lived once infection has -- once illness has occurred. There are a few, but very few.

86 percent of these patients are between the ages of 20 and 49, so that 86 percent of the patients occur during the period of most greatest economic productivity, when a person is relatively young and healthy, at a time when he expects to have very small chances of illness. 92 percent of these cases are in males, and this reflects gay homosexual activity and IV drug use as a primary means for transmission now. 8 percent are female, and this represents largely IV drug use and it represents heterosexual activity with infected sexual partners. So that of just the males, 72 percent have thought to have been infected by male homosexual activity, 12 percent by IV drug use, and an additional 8 percent by either one of the two. The distribution in females is quite different because you don't transmit it by homosexual activity in females. That means that 37 percent of women were infected by IV drug use and 31 percent, about a third, by heterosexual contact with infected male partners.

Relative to distribution by race and ethnic group, it's very clear that blacks and Hispanic people are infected in far greater proportion than the proportion of

the population. This has nothing to do with genetics, it has only to do with risk-taking behavior of blacks and Hispanics, and because there are large overrepresentations of these two groups in intercities where a lot of the risk-taking behavior occurs, it is not a surprise that they should also be overrepresented in terms of disease.

Because of the cultural differences between the majority and these minority populations, it requires different techniques which are sensitive to these cultural needs, and you'll hear a lot about that today.

In terms of the geographic distribution, Philadelphia County and city alone provide over one-half the cases of the entire Commonwealth. If you add on to Philadelphia the four surrounding counties, that constitutes two-thirds of the cases in the Commonwealth. Allegheny County and Pittsburgh constitute about 10 percent of the cases, and the rest of it is spread throughout the State.

Now, these cases are only those that have been reported to us as having been diagnosed in Pennsylvania. There are many more people in the State which we do not have reports about because they became sick out-of-state and then came back home to live and they require care here. So that if you ask how many patients with AIDS are living in the State, we have an

underrepresentation of these figures. There are more than the 2,540 living in Pennsylvania at this time. If you ask how many patients are going to occur in Pennsylvania in the next 5 or so years, we can give you answers which are relatively imprecise. They are based on extrapolations and educated guesses because, and the reason for that is because we do not know how many people are actually infected with the virus. All we know is the number of people that have come down with the disease.

We don't know that for two reasons. First of all, infection with the virus is not reportable to us, and second of all, there are many, many people who do not know that they are infected. They have not been tested. So the information I've given to you is very soft. There may be as many as 60,000 cumulative cases by 1991. It could be more or less.

More important than that, however, is that there is likely to be 50 or more times that many people infected with the virus. And that's the critical point, because these people can transmit the virus further and infect others. And these estimates are based on a guess and based on no effect of public health control efforts if no effect was by our efforts.

How much is this going to cost? Well, again, we can predict what the costs for these kinds of

care, the necessary kinds of care are going to be, but since the number of cases are such a soft estimate, the amount of money necessary is also pretty soft. We estimate at this time that between $150 and $175 million are going to be required for all kinds of care - acute hospital care, long-term care, in-home care, hospice care, physician's fees, and so forth and so on. So that's a ballpark estimate, but it's likely to be revised, and my guess is that it will be revised upward.

So just to summarize, that is a description of the illness, it's a description of how the disease is distributed throughout the State. And I'd like to then move on to what kinds of control methods are available to public health agencies and other agencies in Pennsylvania. In deciding what you can do about it, I've already said that the only way you can control it is by reducing people's risk-taking behavior. And since, except for children who are born of infected mothers, it's voluntary behavior, there are serious limits as to what can be done. What you have to do in any illness like this is to identify what risk factors are associated with the illness and then try to modify those. In this case, risk factors are drug use, unprotected receptive anal intercourse, unprotected heterosexual intercourse, the continued screening for blood supplies, and so forth and so on.

So what we have to do is to try to find ways most effectively to persuade people to change some very basic behaviors, which is difficult. These persuasion methods are best implied face-to-face and during a circumstance when a person knows for sure what he's doing that could, or she, that could spread it or cause one to become infected and to be able to discuss what a person can do about it. These are intimate discussions; therefore, they are best applied face-to-face.

How effective are these? There is some evidence now that, particularly in San Francisco, middle class, well-educated gay men have in fact changed their behavior. There is no evidence at all that any population of drug using people have changed their behavior. In fact, there's plenty of evidence that they have not. You are well aware of the outbreak of syphilis in Chester city that we are trying to deal with at this point. Most of these are occurring in drug users, and it's also occurring in prostitutes because of the need to prostitute -- women prostituting themselves in order to support their drug habit. This syphilis would not be occurring if they were practicing safer sexual practices and if they were not continuing to use drugs. So there's no doubt in my mind that we have not made any dent at all in transmission of the virus by drug users. So that's persuasion methods,

educational and counseling, or whatever words you choose, for the people at risk of either getting infected or transmitting it.

Now, what about education of the general public? We see this as important from a couple different points of view, although we think that our efforts aimed at high-risk people are more important. For the general public, we think that a better understanding of the illness and who is and who isn't at risk should be able to lead eventually to less discrimination against those persons who are likely to be infected. We also think that the general public will be less likely to engage in occasional risk-taking behavior, and we also think that the general public, by these means, will be in a better position to want to support public health efforts in the future. So we think there's also a need to provide general education, although it's less important than high-risk people.

Let me say a few words about control programs as they exist in Pennsylvania. I will not go into as much detail as you may want, and I thought details could come out in questions and answers if this is important. First of all, AIDS programming needs to involve most State agencies. Department of Health is obvious, but Department of Public Welfare provides Medical

Assistance reimbursement for patients who have AIDS and provides AZT through Federal funding sources for patients who have infection and also patients who have AIDS. Department of Corrections needs to manage properly activity within that department, and so forth and so on.

So almost every State department has something that is necessary to do relative to AIDS. The same is true for county and State and municipal health departments. They operate on a smaller jurisdiction. They have the same needs as we do at the State level, and they are much closer, of course, to their largely urban populations and have similar kinds of responsibilities. Community-based support groups are absolutely critical because no public agency has enough manpower to do what needs to be done to provide support for patients who have AIDS, and no public agency can operate on an intimate person-to-person, face-to-face scale as a community-based support group does. There are community-based support groups that represent and can relate much better than we can to Hispanic and black populations and can provide information to us as to how to do that. So that community-based support groups are absolutely essential and must be supported.

Within the State structure, there are two advisor groups to our department. One is a professional

group of experts which advise us as to whether what we're doing makes scientific and epidemiologic sense, and then there is another interagency group which is for the coordination of policy, to make sure that we're doing things appropriately across the Commonwealth.

The Department of Health sees its mission as two-fold. First of all, to reduce transmission, find ways to reduce transmission of the virus, and second of all to promote the provision of medical and personal supportive care for people who have infection of the virus, and we do this by several general means. First of all, to reduce transmission, we feel that it's critical to provide counseling opportunities for people taking risks. The two largest means we're doing here are we provide now 84 publicly funded counseling and testing sites where a person can go to get tested to see if he's got the infection and then get the appropriate kind of counseling to get him to change whatever behavior is necessary. And we operate newly a telephone line which is primarily a referral source and a source of information for people who would like to know. Now, bear in mind that what we are doing is also duplicated in many areas on county jurisdictions, and you'll hear about that later on this morning.

In terms of promoting the provision of

medical and personal care, we have had a task force which has completed an analysis of current and future needs for these, and that analysis is now being reviewed for adequacy by the Centers for Disease Control and by the epidemiology group at the School of Public Health in Pittsburgh. This report, as soon as we have these analyses, should be available for public discussion.

The Pew Memorial Trust in Philadelphia has already released a voluminous report which tries to predict what the needs are going to be, and that I recommend to your reading as well. We have heavily depended on that for some of our analyses.

In terms of public education, we carry on extensive educational efforts via the news media, public speakers, local conferences, and so forth, preparation of educational materials. We have contracts with several people to help us provide this material and speakers in ways sensitive to the needs of black citizens and Hispanic citizens as well.

So the major goals we have can be listed along these lines: First of all, to track the course of it and provide descriptive reports for those who are trying to deal with this epidemic; to persuade people to change their behavior; to increase the public's understanding of HIV infection; to promote the

availability of appropriate medical and supportive care as we've talked about; and to coordinate as much as we can not only State agencies but private agencies with whom we need to work. We provide technical and financial support to other State agencies, to local health departments, and to private groups within the Commonwealth, and this uses a combination of State and Federal funding. And to do this we have organized within the Health Department an AIDS unit which for the most part is working full-time on AIDS, and it's headed by an AIDS coordinator which reports to me and has full authority to speak to me not only to the public but to direct this unit.

So that was a description of what we are doing in the Health Department in general terms. You may need to ask specific questions. Now, let me change gears to talk about legislation that's at the top of our list for our wish list. We think that the most important thing that needs to be done is to have legislation which deals with the confidentiality of medical records and which deals with appropriate use of the HIV antibody blood test and how the information from that test is also to be used. The reason we think this is so important is because the potential for discrimination against patients with this virus is extraordinary. You are well aware, I'm sure, from your constituents of instances in which disastrous

discrimination has occurred, and it has important impact on people's lives. It's also important because we think that the HIV test has been used inappropriately in many circumstances and it's been done without the person's knowledge, it's been done without the kind of counseling that's necessary to help that person come to grips with it and to change his behavior and so forth. So we think this is the most urgent need.

The administration prepared a bill which was introduced on our behalf by Representative Pistella last session and we have now modified that bill. It's still under discussion by the administration, but we think we'll soon be available, we're hoping to find somebody willing to sponsor that for us again. Although I don't have the official administrative position here, I am prepared to talk to you about all the elements of that as it now stands, and I'd like to do that for you at this time.

The first section of that bill relates to testing for the virus, HIV virus. This bill would require informed consent before the test is administered. That means that the test cannot be administered in secret. Second of all, it requires counseling of the person before and after they get the test. Before, so that he has an understanding, or she, has an understanding of the implications of the test and its reliability, and second

of all, so that the person is better able to understand what he should do with that information and so that person can be gotten into the appropriate kinds of supportive care if that becomes necessary.

Thirdly, this bill requires that the patient be informed of both positive and negative results. And that's necessary so that the person knows what to do about it. Now, there are exceptions to this, and our bill, like other bills, list a certain number of exceptions. Some of these exceptions have to do with when one donates a body part, such as a cornea or an organ. It's critical that the recipient of that organ not receive an organ which has come from an HIV-positive person. It's not necessary, of course, for that person to know who donated that, so it's critical that this be considered.

Certain types of research do not require names and addresses of persons. In fact, most epidemiologic research does not. Exceptions are relative to that. Our bill would provide the ability to the Health Department to require and mandate a test on an involuntary basis, rarely, if that were necessary. It just gives the Secretary of Health the ability to mandate performance of the test, and that's if that should become necessary.

Then the next section, relative to medical records confidentiality, it sets strict limits on how the

test results can be disclosed and to whom. It requires that no secondary disclosure be provided. In other words, if the test results are disclosed to a certain person, such as a physician who ordered the test, it means that before that physician can release a test to anybody else, say an insurance company, or whatever, that the person again needs to give consent.

There are certain institutional procedures about confidentiality that are discussed in this bill to limit their ability to know and to provide information, and there are instructions to the court because when information needs to be released to somebody else and if the person is unwilling to give the consent, then the court needs to decide whether the person's right to know, how it bounces off against the general society's right to know. So it requires a court decision in all these cases. It requires first that a person, informed consent be sought, and then it gives some guidelines to the court as to the kinds of considerations it needs to use when it's trying to balance the rights of a person against those of society.

It provides a very limited degree of immunity for physicians who want to notify the sexual or needle- sharing partners of their patient who is known to be infected. It requires him first to ask the patient to

notify the person he or she is putting at risk, and if that person refuses, then it provides limited immunity so that physician can either notify the Health Department or notify the person directly. Physicians are in a real bind now and partners of their patients are sometimes at risk unknowingly. It provides for penalties for a violation of this law and it assigns authority to the Health Department to write regulations and to administer it.

The Bar Association will probably be discussing their bill with you later on today, and let me first say that these bills in many respects are very similar to each other. Many of the differences are minor differences and of very small importance. There are few important differences. The Bar Association does not provide an exception for a physician who orders the test to receive the results, it's my understanding. It doesn't provide exceptions to permit the collection of this information for vital statistics in reporting to the department. It does not provide the department access to the information for disease control investigations. And it does not provide access to this information for oversight bodies of regulated institutions, such as hospitals and nursing homes, so that, for example, when the department reviews for quality purposes and licensing purposes these institutions, it would not allow us our

usual access to records, medical records within those institutions, at least relative to AIDS. It does not authorize the department to promulgate regulations under this bill and therefore administer it. It does not permit the department to order mandatory tests on the rare occasion that it might be necessary. And their bill does permit in camera disclosure of protecting information in the courtroom. I'm not sure how important that is, but that is a difference which needs to be discussed.

The differences between these two bills will need to be looked at very carefully because although many of them are minor, some of them, at least to us, are important.

Now, in conceptual terms, let me discuss a few other comments about other legislation which has been introduced. First of all, we have not been in favor particularly of legislation when it can be taken care of, the same thing, by the regulatory approach. If we as a department can deal with the issue in a regulatory fashion, we would prefer that simply because it's easier to amend it as needs change. We would like as much as possible for the appropriate legislation to fall within the purview of our existing disease control laws so that it becomes less a special case than it might otherwise.

Next, in terms of mandated screening, we see

that it's important that low-risk populations not have mandated screening, such as people who apply for marriage licenses. People applying for marriage licenses have got to be very low-risk populations. It turns out that the number of cases you'll find are much lower than the number of false positive tests you'll get. That means that a person is much more likely to think he's positive when he isn't and undergo all the stresses involved with that than to find real cases of infection. That also, of course, needless to say, would require a lot of expense regardless of who bears that expense. So that we would urge you not to consider legislation which would mandate screening in low-risk populations. High-risk populations are different.

Then, we would urge you also, in relationship to drug users and prostitutes, to consider the traditional voluntary approaches, at least relative to our department. Our department has maintained access to high-risk populations, such as drug users, such as prostitutes, and so forth, in terms of sexually transmitted diseases and blood transmitted diseases. We have maintained our relationship with them by keeping their information in strict confidence. Our sexually transmitted disease clinics take care of many -- I mean, large numbers of prostitutes and large numbers of drug

users. We do not report them, even though technically they are violating the law. We don't report them because for our purposes, we can keep them into treatment. We can bring them in, provide the counseling, and for the case of treatable sexually transmitted disease, we can treat them. We are really afraid to become agents of the law enforcement system.

In other words, we are really afraid to be required, as a part of the law enforcement system, to report these cases, to go out and inform them because of a court directive and so on, because if this happens, we will then lose confidence and we're going to lose access to these populations. We're not saying necessarily that as an example prostitutes shouldn't be required to be tested. We're not saying that it shouldn't be considered -- transmission of the virus shouldn't be considered a criminal activity. We're not against that necessarily. What we are afraid of is to become agents of the court, because then we're going to lose access to these populations of all people. And that, we think, would be detrimental. We think there are other ways for these things to be carried out than for us to become agents, and these remarks are directly related to Bill 624.

We also -- I'm no attorney, obviously. We wonder, however, whether involuntary search, in other

words mandatory testing, just as a consequence of criminal activity, raises constitutional questions. We're not prepared to answer that but we are a little concerned about it.

Then there is another body of legislation which could be considered relating to discrimination. The Human Relations Commission for the State informs us that they believe they have the ability by existing regulations to enforce anti-discrimination measures, and the limits there are largely limits of manpower to carry out enforcement of these and the ability of people and willingness of people to report infractions. It's not clear to the Human Relations Commission, and therefore us, that we need new legislation in this area, although this is a very important topic which I would think you would need to consider very carefully.

Relative to criminality of willful exposure of somebody else to HIV, knowing that you are infected and exposing somebody else anyway is abhorrent to us. We are certainly not opposed to the designation of this as criminal behavior, it's just that we do not want to become agents of the court or agents of law enforcement agencies in carrying out the interests of the court.

So those are relatively general statements and comments. I'd like, I think, next to try to answer

any questions that you might have.

Thank you.

CHAIRMAN CALTAGIRONE: I'd like to introduce some of the staff that's here with us also. Chief counsel to the Judiciary Committee, Bill Andring; Jere Strittmatter, Paul Dunkleberger; and Pat Fleagel and Jean Wilson from the Health and Welfare Committee.

BY CHAIRMAN CALTAGIRONE: (Of Secretary Richards)

Q. Doctor, I have some concerns about your department and the budget and funding, and I'm curious as to what funding did the Pennsylvania Department of Health request for the AIDS program and how are you using that funding and have you in fact used all of the funds that have been allocated for this fiscal year?

A. The short answer to the last question is, yes, indeed.

Q. You have?

A. We have been -- of the Federal grant -- well, first of all, let me talk just about State funding, which is what your question is. The money available to us for this current fiscal year was $2 million. Of that $2 million, only $83,000 is as yet uncommitted or unexpended. 1,916,000-some-odd-dollars are expended or committed of this, so we do not expect to go lapse any of this, any substantial degree of this money at all. Of this, $1.69

million is allocated to contracts, and these contracts go to a variety of community-based organizations, county and municipal health departments, and others. Of that, $105,000 is the for personnel, $26,000 is for equipment, and $90,000 for operations. So we think that the money is getting where the need is. We don't expect a lapse there. I have a detailed breakdown of those contracts, if that would be of interest to you.

Q. I certainly would appreciate it if you would share that with the committee.

How much have you requested? And I image you've appeared recently before the budget committees of the House and the Senate. How much have you requested for the coming fiscal year?

A. The Governor's budget contained an additional $3 million for the State.

Q. $3 million?

A. Um-hum. I would prefer that these questions be couched in terms of what do you need to do rather than how much money do you want, because you could always crank up a budget figure to match almost anything. I think the important question is not so much how much money do you have but what do you expect to do and can you do it with the money that's been requested?

Q. Well, in information that I've been able to

gather independently from various sources, I think your figures are very, very low on the number of people that have been in fact infected and the number of people that are potentially to be infected, The number of people that are being infected every day with not only IVs but active prostitutes that remain on the streets throughout our urban areas that continue to infect men without them knowing it. That concerns me.

In addition to that, the city of Philadelphia has already set aside, at least tentatively, $10 million in their budget to face the problem that they have, understanding that they have the largest incidence of any urban area in the State. What concerns me, the policy of this State, if we in fact do have a policy, and how we are reacting financially to that policy with only $2 million and a projected $3 million for next year, and we're talking about an education program, a massive education program, which I think should be undertaken not only from the Health Department but many other departments, especially the Department of Education. In addition to that, you're talking about the possibility of extending some research grants, dovetailing that in with the Federal, of course not trying to duplicate, but we have some very fine research facilities in this State that I don't think we've really utilized to the fullest extent

possible, medically.

And in addition to that, and probably the most important, is the way we're going to care for these people that are infected. We cannot duplicate or incarcerate and use mass concentrations of people. It wouldn't make any sense. We're talking about hospice centers or home health care where the medical community, in addition to the nursing community, would provide those types of services and facilities at the least expense, I think to the State and to the taxpayers, but at least providing some affordable mechanism of care and treatment to those that would need it. Those are some of my thoughts that I have on it, but the concerns that I have about the budget and the funding are absolutely related to that. And you can't do any of those things unless you have adequate sources of funding and a dedication and a commitment through the development of a policy that needs to be carried out.

Would you like to address any of those areas?

A. I sure would.

The first place, relative to the estimates of the number of infected people, I said 50 to 100 times 16,000. I'm under no illusion that this is a widespread virus. And I also said that people unknowingly are

continuing to spread that virus. That 50 times 16,000 I indicated was a very soft estimate, and it's likely that's the current estimate for 1991. So there's no question in my mind that it's very prevalent and that it continues to be spread.

Relative to budget, now you asked me for my own budget figures and I gave them to you. But I did not give you budget figures for Department of Public Welfare, which funds, through its Medical Assistance program, many of the patients who require hospitalization. Nor did I give you the budget for the Department of Education for school districts, nor did I give you the budget for other departments involved with AIDS. Only our department.

Now, if you want to know what the Commonwealth itself is expending, because many of these areas are being expended outside our department, that I could try to collect for you, but by no means does our budget reflect the entire State contribution. The Department of Public Welfare spends tens of millions of dollars at this point on the care of patients who are sick.

Now, can we expand our efforts? Of course.

Q. Do you think we should?

A. I think that to the degree of expansion that we can contribute with the $3 million budget request

is what we can do responsibly. The rapid expansion of Federal and State money to us has happened over the past two years. It's been -- our staff has been working very hard to develop new contracts and with new agencies through the usual RFP process, which is time consuming, as you know. We think that we can continue this rate of expansion responsibly. To just dump money on us and say, "Spend it all," is not likely to be done very well by us, I think.

Q. No, I wasn't proposing that. I think what I was proposing was there are community-based organizations established throughout the Commonwealth that have a need for those types of services and medications and other services that I think should be and possibly could be provided through the State, that that concerned me because I think we're going to reach epidemic proportions with this, and I think everybody's being very polite and very quiet about it, but I think literally it's probably scaring the hell out of some people that are doing the actual projections of what really could be taking place in our society and in this Commonwealth.

A. No question. A good portion of that new funding will go to community-based organizations for that reason. Many of these organizations are new, have not been used to spending large amounts of money. They're

volunteer and they have to become organized. Our initial grants to them were small, many of them about $50,000, which doesn't buy a lot of time and people. But it's been a help, it's been enough to allow them to organize themselves in a way they can spend large amounts responsibly. It's now time to do that.

CHAIRMAN CALTAGIRONE: I'd like ask the rest of the panel if they have questions.

Chairman Moehlmann?

REPRESENTATIVE MOEHLMANN: Thank you, Mr. Chairman.

May I point out a misstatement? I hesitate to do this because you make so few of them, but you introduced Jere Strittmatter as a member of staff, and Jere is in fact a member of the legislature from Lancaster County sitting in the back of the room.

CHAIRMAN CALTAGIRONE: I'm sorry. Jere, come up and join us.

He once was staff.

BY REPRESENTATIVE MOEHLMANN: (Of Sec. Richards)

Q. Thank you for being with us, Secretary Richards.

I have a thousand questions on this subject and will quickly tell you that I'm not going to take much of your time, but one of the things you stressed was

confidentiality, with which I have some concern because I believe there is a perception in the public, and I share it, that the medical profession has made absolute statements through the years as to how one can and how one cannot contract AIDS and has been shown from time to time to have been wrong about some absolute statement. Every year or so one hears a new announcement of some new way to get AIDS, and I think so long as that's so, that the public has a reasonable concern about how confidential it should be, the contraction of AIDS by an individual, should be made. Would you have a comment on what your perception is of how well we really know how one can get AIDS and how not?

A. I can give you the facts and you're going to have to draw your own conclusions, I'm afraid. I've drawn mine, and I'd be glad to tell you what they are.

The primary means of transmission by sexual activity, infected blood, and by giving birth were identified within the first two years or so of working with this outbreak. These have not changed in any way to the present time. It is a new disease and we do learn a lot of new things about it. But, as an example, one of the early fears was that it could become explosively spread within women because of heterosexual contact. It hasn't happened. Everything that we think we knew within

the first three years of 1980-83 is still the case. And the early projections have remained the same.

A lot of family studies have been done, as an example, trying to see if you can transmit it by casual contact - shaking hands, drinking water out of the same glass, that kind of stuff, sharing toothbrushes. And many families have been studied carefully who have an AIDS patient living with them. The only means for transmission within those families has been sexual contact, or the occasional needle sharing contact. That gives us additional comfort that we're not going to find new means of transmission, or at least anything that approaches any kind of significance.

Now, that's the basis on which I've decided that we can be pretty confident that if we control behaviors which do those things, everybody else doesn't have to worry. Now, those are the facts as I see them, and I don't know any way else to tell you how I interpret those myself.

Now, if you ask the question, suppose that the public, say, knows the names and addresses -- which is what I'm talking about here, confidentiality -- of everybody in their block who has an HIV infection, how would that help them? How will that help them to avoid infection? The answer is it isn't going to help them

avoid infection. It isn't going to help a school teacher avoid infection, it isn't going to help school children, it isn't going to help the fire and police. Okay? It isn't going to help. And so I don't see that confidentiality has anything really to do with how this is transmitted.

Q. Well, that knowledge isn't going to help them so long as the number of ways one can contact AIDS is definitely and absolutely known. If that's not so, then the statement that that wouldn't help them is perhaps and perhaps not correct.

A. Well, you see, how do you approach this? Supposing that you're a policeman or supposing that you're a physician or a nurse in a hospital and you know darn well that there are many, many people infected with the virus who don't even know it themselves. Supposing you come across an accident crash, you know, a policeman working up an accident, EMT. Supposing that you're a physician who has got a bleeding patient in his emergency room. Supposing you're a dentist that is working in somebody's mouth. Supposing that those people knew everybody in the community that had a positive test. What they don't know is that people that never had a test and they're still positive, and there are far more people that have never had a test and they're still positive.

So the only rational way to go about it, in my view, is to pretend that everybody is and take the precautions that will prevent infection, because unless you do that, you're going to get infected, if there are any chances of it. That means to me that knowing the people that are infected won't save you because there are a lot of people that don't know it themselves. You have to do the same thing for everybody under the assumption that everybody is positive.

Q. May I ask you briefly about something else that really is, I guess, more a matter of curiosity. But you mentioned earlier in your testimony that there are a few people who have lived. What did you mean by that? They haven't died yet or it appears they will survive to live through a normal lifespan?

A. There are probably fewer people than you have fingers on two hands that have been diagnosed as AIDS, you know, in the early and mid-'80's that are still living and they apparently have improved. Nobody knows if that improvement is permanent or not, but they have improved. But it's out of over 70,000 cases reported nationally, fewer than 10 have lived. Now, we don't know what's going to happen to them. All we can say is that they look like they've improved for the present time, and that's a lot of hope because, I mean, if we can discover

why, then maybe we can do that for the people. But it really is a very small number.

Q. Thank you, Mr. Secretary.

CHAIRMAN CALTAGIRONE: Bob.

REPRESENTATIVE REBER: Thank you, Mr. Chairman.

BY REPRESENTATIVE REBER: (Of Sec. Richards)

Q. Doctor, two quick questions. First topic I just want to get straight in my mind. When you referenced how you can contract the virus, you specifically said through the enumerated sexual acts as well as through needle drug interdiction in the body, if you will. How then can a physician be at risk, or a dentist be at risk, in carrying out traditional treatment, whether it would be an emergency room setting where there is a broken bone and what have you and potential piercing of his surgical gloves with that splinter which may in fact be infected or the dentist scenario? I don't quite see how those two jive, and I've often had that question so while I have the opportunity, I'll pose it to you.

A. The virus is present in pretty high concentrations in blood, in semen, and lower concentrations but still present in cervical fluids. Now, what you need to do is get any one of those fluids under your skin, not just on your skin but in your bloodstream.

Now, a dentist, for instance, if he has a patient that he is working on and is bleeding from his gums, if he snags his finger on a sharp tooth or on one of his instruments and drags some of that infected blood under the skin, that transmits the virus.

Q. Okay, that is a way then of transmitting it.

A. Yes.

Q. So we have the sexual, the drug IV needle type concept, as well as this type of interjection into the system through infected blood into a person who's working on that individual, correct?

A. Yeah. I didn't speak very carefully there.

Q. Okay.

A. What I should have said instead of saying IV needle users, I should have said anything which gets infected blood through your skin. And that includes needle sticks, accidental hypodermic needle sticks for a nurse or physician or aide or somebody. It includes IV drug use because it's the same thing. What I was talking about when I talked about IV needle users is because that and unprotected anal intercourse are the two most common means for spread, and so that's why I used those terms. But anything which gets the virus under your skin is potentially capable of transmitting it.

Q. Okay, fine. Getting off that subject and going to another one.

Through the course of your testimony I detected a concern, and I can appreciate the concern and even in your outline you've referenced that the health agencies are afraid to become agents of the law enforcement systems. My question to you is one: To date in the Commonwealth of Pennsylvania, to the best of your knowledge, how has the Department of Health and in how many instances, if you could hazard a guesstimate as to that number, how many instances has the department been involved in either a criminal prosecution or a form of civil action where this issue is related in some way, shape, or form? Can you give the committees some idea?

A. Oh, probably over the past 10 years, 5 or 10 times. I'll give you a couple of examples. You may be aware because of the newspaper reports that some of our staff, in working up this outbreak of syphilis in Chester, proposed to the judge that he require that all prostitutes be -- not prostitutes, drug users, be required to have a test as a condition for getting bail. Now, that was a direct involvement, if you will. What happened there was that our own staff, our own attorneys, when they found out about that recognized the constitutional questions that it gave rise to, as did many other legal experts in the

community, and that policy was changed very fast because of that.

Now, what's happening at this point is that because convictions for drug abuse are public record, the court is going to get from our staff the names and addresses of those persons so that we can then follow them up in our usual procedures, i.e. contact them directly, offer them a test, try to talk them out of doing whatever it is they're doing. That's one example.

Another example, and a very distasteful one from our point of view, was an instance in Allegheny County in which an infant was thought to be, accused of being sexually abused by a male who had gonorrhea, and part of the defense rested upon the demonstration that that child either contracted gonorrhea or had evidence of gonorrhea. The child was seen in a Health Department clinic in Allegheny County, and so the courts wanted to subpoena the records of that child in order to build its defense. I say difficult for us simply because you had the principle of wanting somebody who does this horrible thing to come to justice, and if that clinic has the evidence that could allow that court to come to an appropriate decision, one would think, gee, it ought to provide that information just like that. On the other hand, there were legal restrictions against providing this

kind of sexual transmitted disease confidential information without informed consent. And that was a very difficult argument. That's a another example of how we might get involved. So it does happen but it happens rarely.

That last case is particularly instructive because it involved a question of whether public records that deal with sexually transmitted diseases should be subpoenable by a search warrant, of which was the attempt that was originally made. Whether the court itself had to ask the question, how does one balance off the personal risk with the risk of society and come to a formal conclusion? So our request is that the court does decide. I mean, this information is in fact in the public's interest to know sometimes. But our interest would be that the court decide that itself using some guidelines, but also not to ask that health agencies become the agents of the court on routine basis because that then doesn't allow us access anymore to these high-risk populations.

Is that responsive to your question?

Q. Somewhat. I guess to a great extent I was concerned also whether you have been directly involved in any kind of proceedings, either criminally or civilly, to the extent of an action brought about as a result of someone, and using your words, who willfully exposed

someone or willfully and knowingly transmitted the disease with some type of reckless disregard, thoughts along those lines.

A. No, we have not to this time. That will come. I mean, this is in other courts across the nation. One in Texas, a couple I think in Washington, and there may be others.

Q. With that in mind and my last question, Mr. Chairman. Could you provide to the committee your thoughts as to what type of setting an individual who in fact is infected would be told that he is infected, would be appropriately instructed as to how to risk manage his life, if you will, and what have you, and then what type of line would he then go over to put him in a criminally willful category? I guess what I'm trying to say is, could you structure for us what should be done to appropriately inform a person, and if that type of informing then is carried out, where does that person cross over the line where we don't have someone or do have someone, I should say, who is willfully transmitting or exposing to someone else?

A. First of all, the setting should always be face-to-face with somebody trained in dealing with crisis counseling. Not my by mail or telephone, but face-to-face so you can deal with the expected shock that comes.

Second of all, we would instruct that person, if they are infected, not to have unprotected intercourse with anyone, male or female, if this person is a male. We would instruct them not to share needles with anyone, or if they insist on sharing needles, to sterilize them with bleach between times. The first attempt, of course, would get them to stop using the needles all together. If it was obvious and apparent that the person had no intention of complying, the next step would be to try to talk them into using some sort of sterilizing solution, like bleach, between sharing needles.

Now, those are the usual situations. There are probably others. The most difficult question, of course, is what to tell a lady who is infected who is pregnant. And what we would do simply at that point is simply to inform her that she has about a 50-percent chance of infecting her baby, and that would be the extent of our informing her. We would then, depending on, you know, we would then refer her to an obstetrician to discuss that matter further. But ours would be limited to informing her and the risks of her baby becomming infected.

Now, when does a person cross the line? If a person has been told that they can transit the virus by doing any of these things and if they do them, that

constitutes, in my mind, very serious activity. Whether it's criminal or not would be dependent on whether there's a law that says it is, I guess. That's more for an attorney. But to put somebody else knowingly at risk of getting a lethal infection is just wrong and inappropriate and should not happen. So I think the question is, has that person knowingly put somebody else at risk by sharing a needle, by having unprotected intercourse, whatever?

Does that answer your question?

Q. You're getting lot closer in your responses, doctor, thank you.

REPRESENTATIVE REBER: Thank you Mr. Chairman.

CHAIRMAN CALTAGIRONE: Kevin.

BY REPRESENTATIVE BLAUM: (Of Sec. Richards)

Q. Doctor, you talked about screening high-risk groups and not screening those that are relatively low-risk. Do you have any feelings on inmates in State correctional institutes, perhaps even those incoming inmates who may have been part of high-risk groups who are now going to be confined for what may be an extended period of time in one of our State correctional facilities?

A. Yeah, I do. Let me first say that the Commissioner of Corrections has established a program,

having thought through it pretty carefully and following discussions with our staff, and he does some things. He has a lot of things that he has considered in making his decisions.

First of all, because many people in prisons have had IV needle use experience, it's pretty clear that if you can identify those persons, then if you believe they are going to be putting somebody else at risk in the prison, you ought to know whether they are infected or not. If you, as a prison official, know that there is needle sharing going on within the prison, or if you, as a prison official, know that homosexual rape is common, then I think that you have the obligation to protect those people who are uninfected from those things. You can either do that by testing the person and then isolating them, or you can do that by eliminating the behaviors that were transmitted, such as finding some way to control homosexual rape or finding some way to control needle use within the prison.

So there are two ways to go about doing that. If you believe you can control transmission in the prison by controlling those behaviors, then there's no real need to know who is infected because transmission isn't going to occur. If you believe you can't control those, then I think you have the obligation to identify

the infected person and isolate them from those who are not infected.

So it depends on whether the prison official believes he can control it by controlling behavior. It's my understanding that these considerations were taken into account when the current system was established.

Q. Among the people who are concerned about that would be prison guards, for instance, who would be interested in knowing -- some prison guards from my area who are interested in knowing because of situations, unlike the policeman who stops for the accident, they may be in positions of breaking up serious brawls and cutting their skin. It would be more likely than a doctor who stops to be a Good Samaritan. Do you have any feelings about that?

A. Yeah. I think that the same considerations also hold for emergency medical technicians and paramedics. They also hold for anybody that deals with acute trauma of any kind. I think you first have to ask yourself, what's the risk, and try to distinguish that from what's a real risk and what's a potential risk. There are a lot of situations in which it would seem obvious that the risk is there and you should do everything in your power to eliminate it but turn out not to be a real problem, even though it looks like it might

be. And there are other situations in which the risk is real and genuine and you must manage it.

So the Federal Department of Corrections has -- Department of Justice has done a number of studies asking the question, how often do prison guards get infected with the virus as a result of being on duty in the prison? And the answer is, surprising enough to me, is that this happens almost never, even though potentially it could. You might be exposed to, you know, blood from a fight. That means for some reason the conditions aren't good enough to transmit it. I don't pretend to understand that exactly, but that's what the studies seem to show.

So based with that kind of knowledge, that would be some evidence you don't necessarily need, for instance, to separate the infected from the noninfected. Pretend for a minute that you did know everybody that was infected and you segregated them. You had a prison for the infected people and you had a prison for the noninfected people. How would you staff the prison for the infected people, and what would you do with those guards that was different than the other guards? That is a very real operational problem.

The answer is that the protection necessary for the guards in the infected prison can be applied to everybody. So it isn't necessary to know this to protect

the guards. The guards that will be working at the infected prison, those protections can be adopted by everybody, and so, I mean, if you choose to do it, that isn't the reason to do it. You would choose to segregate them and mandate tests for other reasons, but that's not one of the reasons.

It's a real problem for emergency medical technicians and ambulances. How do they deal with accident cases? Because blood often is much greater. The same is true for emergency room nurses, physicians, aides, and so forth.

So the general approach has been to pretend that everybody is infected, because you can't tell, and then protect yourself by that means.

Q. Thank you.

A. Now, that's not a very satisfactory answer. If I were a prison guard, I wouldn't like it, but to me it makes rational sense.

BY REPRESENTATIVE McNALLY: (Of Sec. Richards)

Q. Yes, Doctor. I have questions on two subjects. First was in relation to AZT, which is a drug, an experimental drug, for combating AIDS.

A. It's no longer experimental. It's in formal use for treatment of AIDS. It is experimental in terms of preventing AIDS from occurring if you're

infected, and there's evidence that it may help.

Q. And is that drug being administered to patients in Pennsylvania?

A. Yes.

Q. Today?

A. Yes. It's being administered from several different places, physicians. Physicians who become familiar with its use can prescribe it. It's expensive, but they can prescribe it. It can be available from hospital clinics, it can be available from -- a couple universities have research protocols that they are studying other drugs, too, in comparison with it and they are using it. The drug is expensive and it's being funded by the Department of Welfare using largely Federal funds at this point. The Governor has committed himself to continuing that source of money if Federal funds dry up, so it is available through public insurance as well.

Q. And the second subject, and it's more of a policy question, is that I think you indicated that the primary way to control the spread of AIDS is through reducing risk-taking behavior. And now I'm really thinking more in terms of AIDS as a sexually transmitted disease. I recall several years ago there was and great hue and cry in say San Francisco, maybe New York, when there were attempts made or in fact, perhaps, bath houses

were actually shut down, and it strikes me that was, in effect, an attempt to reduce risk-taking behavior, but not in a voluntary way. And so my first question is, with any sexually transmitted disease, it seems that there is a greater likelihood that the disease will be spread and that an individual has a higher risk if they are -- I don't know if it's a good word, but they are promiscuous, and that the greater degree of promiscuity, the greater risk you have of contracting a sexually transmitted disease.

I guess my first question is, is there any reliable evidence of the degree of promiscuity among various populations - homosexuals, heterosexuals, racial and ethnic groups, age groups? And secondly, if we know, for example, of prostitution, those types of activities which have a high incidence of or those groups that have a high incidence of promiscuity, can we have a legislative initiative that -- or an administrative initiative that can reduce risk-taking behavior directed in that area?

A. There's enough evidence to -- well, first of all, there is some evidence that's pretty good relative to the degree of promiscuity. For instance, I mean, there's surveys of gay men and gay organizations who will tell you. There have been some studies actually done too to make estimates of the number of sexual partners and the

kinds of contact that there has been. There is some. But the information is limited because by and large it's information that has been derived from relatively well-educated middle class kinds of men, and we have a relatively poor understanding of the degree to which the homosexual male activity occurs in black communities and Hispanic communities. So we do have much more limited information in those. It's almost anecdotal.

Now, in terms of whether or not the State can close down or a city can close down bath houses like that, yes, there's a long tradition of regulation of institutions which serve the public. The State regulates restaurants, the State regulates hospitals, and so forth. And so by extension, if the State believes that an institution serving the public puts the public at risk, there's very clear precedence to do that. It's very clear that these bath houses promote extraordinary degrees of promiscuity. Just extraordinary. And so I think there is clear evidence that those bath houses should not exist.

There has been a great reduction in the number of people using those bath houses now, and there's evidence that it's been effective. In San Francisco, as an example, the number of men coming in with sexually transmitted diseases commonly transmitted by their homosexual route has dropped off to very low levels now.

There's now evidence years later that the amount of new infections for AIDS has dropped off, too.

So yes, there is good evidence that would permit and even suggest the State could regulate those kinds of institutions.

Q. Thank you.

CHAIRMAN CALTAGIRONE: Paul.

REPRESENTATIVE CLYMER: Thank you, Mr. Chairman.

BY REPRESENTATIVE CLYMER: (Of Sec. Richards)

Q. Mr. Secretary, you had spoken briefly about the needs of medical personnel for the future, if obviously this AIDS epidemic grows. We in Health and Welfare recently did a report on the nursing crisis in Pennsylvania. Now, if we're having a problem in securing nurses now, isn't the problem going to be magnified as the epidemic expands? Will that not be a deteriorating factor of young men and women wanting to come into the nursing profession? And how do you then perceive that four or five years from now?

A. The answer is a clear yes, it will be a real problem. I think that whatever action needs to be taken to increase the number of nurses needs to be taken quickly for this reason, so that at the time they're needed they could be present. I don't know how else to

answer your question. I think the nursing shortage is serious and needs to be addressed right now, and that's a good reason for it.

Q. What we may see then is many patients that need assistance from staff, from nursing staff, from nursing and other nursing personnel, and it could be very critical where that person is not receiving the treatment. And then just reflecting, there's been a number of young men and women who are going into the practice of being a doctor, where that has fell dramatically. Would not the epidemic also contribute to fewer people going into the practice of medicine, and do you see that then becoming a problem as well?

A. Well, I guess that may be possible. Frankly, I don't know enough about physician manpower needs in the future to be able to comment responsibly for you. I can see that that might happen. One of my kids wants to be a doctor at the minute, and so I think there are going to be some that will want. But I don't know whether we have enough staff now to carry us through this and whether this is really going to cause a reduction in physicians. I don't know. I just -- I can't tell you.

Q. Yeah.

A. I think there's reason to believe that we need to establish different kinds of medical care system.

For instance, many patients of AIDS don't need to be in institutions all the time. They need free access and rapid transfer between levels of care because their needs change rapidly, but many patients now being taken care of in hospitals don't have to be there. So I think we need to further develop medical type personnel health workers that can deal with patients in the homes, small group homes. We need to find out how we can encourage access to nursing homes, other kinds of long-term care institutions. And it may be that non-traditional staff would be useful for that kind of thing. We maybe don't need, for instance, more physicians; we need other kinds of workers in addition.

Q. I guess my concern then, my final question, comment, really is that collectively within the health care service industry, as this problem becomes worse and as you need nursing homes to put the patients, the fact that if we're having problems now providing adequate staff in many areas, and the urban areas would be one where certainly there's an acute problem, that I perceive that the matter compounding itself, that we're going to have more patients who need more intensive work, perhaps, and we don't have the qualified people to be there, and you know, this could be one of the reasons. I know it's difficult to say what indeed the situation will be five or

six years from now, but certainly there is a problem.

And I don't have the article in front of me, but I just read recently where, and I hope I phrased this correctly, where in I believe it's in the State of New York, a number of doctors had gone to a particular hospital, they really fought to go to this particular hospital to deal with patients during their training process and because of the AIDS problem, they have dramatically cut back and now the hospital has a problem in getting the interns and residents to come to the hospital. I don't know if you saw that article, but it sort of reflects on what's happening today.

A. I have seen -- I don't know if I saw that one, but I've seen similar articles. I know that's happened. The medical profession is finding this very difficult, as well as other health professions, is finding this very difficult to deal with. I mean, they don't want to take this home and give it to their kids or their wives or their husbands. They are human beings and it's been very difficult. The physicians who find it most difficult are surgeons who have contact with a lot of blood, and there's a lot of discussion going on within the profession as to what's appropriate and what isn't and what you really obligate yourself for when you enter the profession. It's tough.

There are two steps that I'm aware of now that are trying to address this problem. The most important and comprehensive step was taken by the Philadelphia AIDS Commission in which they examined carefully the need in the future for different kinds of health workers and institutions and looked at settings in which care best ought to be given. That's something that can be used as a framework for trying to make the projections and designing the appropriate number of students. We did something like that on a smaller scale, trying to extend this kind of thing statewide. As I said, that's still being reviewed for its final publication. We expect that to come soon.

So with this in mind, it's going to have to be used by deans of medical schools and nursing schools and so forth to try to estimate how much manpower is needed. We will, as a Health Department, need to work with them in trying to make those projections.

CHAIRMAN CALTAGIRONE: Jere.

BY REPRESENTATIVE STRITTMATTER: (Of Sec. Richards)

Q. Good morning, doctor.

A. Good morning.

Q. I'm Jere Strittmatter, from Lancaster County.

Doctor, would you please share with the

committees the Department of Health's policy relative to the testing of a newly born?

A. The Centers for Disease Control have awarded us some $400,000 to test children, infants born to mothers, all infants in the State, and this will be done by folding it into our newborn screening program and testing some of the bloods for HIV. Now, this has given a lot of concern to people, it's not been implemented, and the concern is that this is to be done anonymously and without permission of the mother. The reason it's recommended to be done that way and done in a number of other States now is because if you ask permission, you have a lot of people who will say no, they don't want that to be done, and that's most likely to happen to people who are at greatest chances of having the infection. For that reason, you don't get good information that way. You can't identify what the infected population is if you request permission.

Now, is that a problem or isn't it? I think that it's not that great a problem because every woman ought to be tested twice. Let me first say that the test, although it's done on the core blood, the blood from the placenta, really is a reflection of the mother's state of infection. Okay? It reflects the state of the mother as well the infant.

Now, every woman who is pregnant in the State ought to be tested twice. The first time she ought to be asked for permission by her obstetrician to do this test because we think that the obstetrician and the woman ought to know her status if she's at high risk of getting this infection. This needs to be done in a confidential situation with her permission. That then gives her the information she needs to ask, and we think this ought to be routine and standard. Then this gives the person the option to say no, and if she doesn't choose to know, she doesn't choose to know and doesn't get tested.

And then this is followed up by an anonymous and mandatory test, which is what the question you asked. So that test is never done in the situation which the person hasn't already had the opportunity to know. And if she chooses to know, she can. The first test in which the obstetrician offers it for her will always have serious biases built into it and you won't be able to get the information you need simply because 30 or more percent will deny the permission. And for that reason, it's not particularly useful from an epidemiologic point of view.

I see no reason, therefore, for not doing the testing of newborns. In that case, there is no way that the person collecting the test information knows, however, who gave that test, because when the test is

collected, the blood sample is separated from the identifying information and can never be connected again. And therefore, all you have is aggregate information. You can say from such and such a county, 13 infants were found to be antibody positive born this year, but that's all you can say. You can't trace it back to the person. This does not allow you then, knowing that there is a positive baby, to go back and figure out who that was, because it's collected in a way that protects the confidentiality of that person. It gives you epidemiologic information, it does not give you information you can use for the benefit of the person. But you should already have done the test before that for the benefit of that person, with her permission.

Now, if this is a procedure, I don't see a conflict here. I think that many people do see a conflict, and for that reason, we have not made the decision to go ahead with this. It's still being considered both from a moral and ethical point of view.

Q. Thanks, doctor. My main question was why are the parents not being notified, and I think you have explained that in your answer, because I would just make a comment, which you can comment on it afterwards, but it seems that we're trying to protect research dollars and not about the people who are infected, and it seems better

to use the money not being used in testing to inform the families. Unlimited dollars for care should not be wasted. Research should be going into taking care of people that aren't being cared for. There are too many people out there not being cared for, and to spend $400,000 for a research project we're going to be into studies and studies, and I don't think we need to do that any longer.

A. Bear in mind that I said this should not supplant the first test, that the patient should be asked for a chance to be tested and know. So this does not supplant patient care dollars. It does not. If we don't spend it, it doesn't get spent. But the question is, you know, is this research for no benefit? And the answer is, no, it's a clear benefit. How is it that we know whether we're doing any good in trying to control this outbreak? Can you tell from the number of cases? You can't tell until 9 or 10 years later. I mean, you have no idea what you did until 9 or 10 years later because it takes that long to get sick. What you really want to know is do you cut down on the number of people who got an infection? How do you find that out? This is one means to do that.

Another means to do that is to screen military recruits, and so forth. There are family surveys that are being done across the nation to answer the

question, are the epidemic control procedures doing any good or not, and so yes, it's research, but it's really to tell you whether you're doing something appropriate or whether you need to change what you're doing.

Q. Well, and once again, the $400,000, when you say, well, if we don't spend it, we don't spend it. It could be spent, you know, in other ways, and it will be. What I worry about is that that infant, just because his mother decides not to have the test, will go without treatment, and I think that they have rights as well to be protected, and if we're going to spend $400,000, then let's protect them and not worry about the, you say 30 percent of the people probably in high risk won't get the test.

A. Would you test that woman before or after delivery, if you were to mandate that she receive the test?

Q. I'm talking about the newly born.

A. I understand. So you would test a fetus--

Q. What you're doing is you're testing someone, you're testing a newly born, you're not testing someone, you're testing a newly born, and then you're taking all those tests and you're randomly saying that yes, out of these 100,000 babies, we have 10 that are infected, but there's no way to tell which 10 are infected

and go back and give them the care. That's what I object to wasting $400,000 when you know that you can be identifying groups that you're not going to be able to reach.

A. If you're testing newly born, you really test the condition of the mother. Okay? Because the mother transfers her antibodies across the placenta to the baby, and all you can measure during the first six months or so of life is the mother's antibodies. You don't know -- okay, the baby loses those antibodies at about six months of age. They gradually decline at about six months of age. You can't find the mother's antibodies anymore. Therefore, the only antibodies you measure at about six months and after are the baby's. So you can't test a newborn until about six months of age. Just so that you know that you couldn't do it until then. Before then, all you can know is for sure what the mother is. If the mother is positive, maybe the baby is too and maybe not. Do you understand it? And I'm just saying this is a technical limitation.

Q. You're confusing me even more now. It raises the question of why are we doing the test on a newly born if it doesn't mean anything until they're six months old?

A. We're testing the mother, really. This is

an easy, cheap way to get information about the mother. We're not really testing the baby, because you can't. What we're really doing is testing whether the mother herself is infected.

Q. But yet you said, I'm not being precise, that probably what you advise mothers is that there is a 50/50 chance possibly that you would be contracting. So what you're going to do is extrapolate this again and double it?

A. Supposing that of 100 women, say 40 of them turn out to be positive when you test them before delivery. That means that you'll have those 40 mothers eventually with AIDS, and 20 of their infants eventually with AIDS, just playing the statistics. So that would be, you know, one way of illustrating it.

Q. After you take the test, you perform the test on a newly born, you come up in 100 cases that there are 20, will you then say that there are 40 mothers that are infected?

A. Okay, of 100 bloods from infants, if 20 of them come up positive, that means that 20 women were positive. And likelihood is that 10 of their babies will be positive, too. See, the baby donates the blood, but it really has the mother's antibodies in it, which is what you're measuring. So baby's blood, 20 positive, that

means that 20 women have the infection. The estimates are that 10 of the infants will get it, too. You don't do this test for the benefit of the infant. That's not the purpose.

Q. You do it for the benefit of the researchers.

A. You do it for the benefit of the control program to see whether you're doing any good.

Q. Thank you, doctor.

CHAIRMAN CALTAGIRONE: Representative Josephs.

REPRESENTATIVE JOSEPHS: Thank you, Mr. Chairman.

Thank you, Dr. Richards.

BY REPRESENTATIVE JOSEPHS: (Of Sec. Richards)

Q. Sometime before you posed a question to yourself about the budget and your ability to deal with this epidemic. I wonder if you would pose it to yourself again and then answer it for us?

A. The question is, do we have enough money to do what needs to be done? Is that the question?

Q. I think that was the question you objected to. You then said, I would like to look at this from a programmatic--

A. Oh, I see. Okay, the reason I reacted that

way is because people commonly come up to me and say, hey, you need, to operate this program properly, $40 million, or some other figure. And I say, well, how do you come up with that figure? How is it that you arrive at that particular amount of dollars? Because it's real easy to give me a statement that a certain amount of money is required. Maybe it is and maybe it isn't. I'd just like to know in most cases what is it that is necessary that we're not now doing and how is it that you crossed that out? It's much easier for me to respond to that kind of thing because I don't know how to deal with a certain dollar figure. If you said to me, for instance, I think instead of 84 counseling and testing centers you ought to have 160, how much will that cost? I can tell you that. Or if you say there are 11 community-based organizations which need funding which haven't got it yet and the level of funding ought to be sufficient to allow them to double the number of clients that they serve, I could cross that out too. It's just easier for me to handle that kind of question.

Q. Well, perhaps you would now answer your second question to yourself. There are 11, is that so, 11 community-based organizations?

A. I made that up out of my head. There are some number of them.

Q. There are a number of them.

A. There are a number that have not yet been funded. Yes, I think that as soon as a community-based organization demonstrates that they are in fact caring for a substantial number of clients and can do it responsibly and are in a position to spend public money in support of those efforts, that they should be funded. I think that if those organizations lie within the jurisdiction of one of the county health departments, municipal health departments, we ought to share the expense with those departments. And if there are none, the State ought to bear the expense itself. If there is Federal money that's appropriated to that purpose, I would expect to share Federal money with the State money.

Q. We seem to be, in Philadelphia, in a situation where the AIDS budget to the Department of Health will be cut by half. I would like to work on this legislature so that you would have enough money to supplement that budget. If we got for you, say, $5 million, would you contract that out immediately to our Health Department in Philadelphia?

A. First of all, my position is that I support the Governor's budget as he's now requested it. If, in fact, the legislature awarded more money than the Governor asked for, I would do everything in my power to work with

you and with others that can give us a sense of the priority. I would say that community-based organizations are very high priority. That's an indirect way of saying that if I got more money, a lot of it would go to community-based organizations.

Q. I'd like to also clarify what I said. I'm emphasizing Philadelphia because of the dramatic amount of money and the number of cases, but certainly when I say that the proportional -- I'm also advocating for a proportional amount of money to go to other health departments and to other community-based organizations. I'm really concerned that you're not putting this money out fast enough, and I'm very anxious to get your detailed budget which you promised earlier on, and as a matter of fact, I am in the process of writing, with Representative Pistella, a memo to you, which I expect to have signed by many House members, maybe many members of the Senate, asking you for such detailed analysis. My information, from contact with people in grassroots organizations and in county health departments, is that State money is not reaching them. I'm particularly concerned because I was the lead person in augmenting the Governor's request last year, and I am perfectly willing and eager to go to the wall again on that, regardless of your position, which I must say I find less than admirable and very frustrating,

if that money will be spent.

So I'm looking forward to this with great eagerness and will speak with Representative Pistella about the advisibility of continuing our procedure with our memo. We may continue to do it anyway because I think that it would serve the purpose of educating members of the General Assembly that there appears to be some problem about disbursing this money from the Health Department to the places where it needs to go.

A. Well, let me comment that we expect to lapse no money from this budget. Let me also say that it's taken us longer than we wanted to to award the money simply because they are new grants and it takes all that time to go through the contracting procedures. We have more than 70 grants we've had to administer from scratch this year. It's not been easy. We would like to have done it faster than we did, but we did. Part of the problems with a small organization is that they can't manage delayed receipt of funds. They have serious cash flow problems, and for that reason, since some of our contracts were put into place relatively late, it's given them difficulties. Working with what we've got, we moved as quickly as we could, and, you know, I can't -- I'm not saying this to excuse what your perception is. I'm just saying that it's not been easy.

Q. I understand some of those problems. My background before I came here was working with grassroots organizations, not in this field but in other fields, and I understand about what you speak. I nevertheless think this process has been, my information tells me, this process has been extraordinarily slow. I'm quite relieved to hear that no money will lapse, which was going to be one of my questions. Very difficult to ask for more money if money has lapsed, and I'm happy to hear that none will.

I urge you to continue putting this out as fast as you possibly can, and I do urge you that there are many programs that are perfectly capable of taking this money, and they are at least the Allegheny County and Philadelphia County health departments, who need it.

A. Well, we offered more money to the Philadelphia Health Department than they could spend.

Q. Well, we will hear from Mr. Fair on that point, I'm sure, later on.

A. Yeah. But some of the award was refused. So it's not just us. The problem is spending money real quickly, and it impacts on them just like it does us. Not because they didn't want to, I don't believe. It was because they couldn't move fast enough because of the procedures required.

A. No, I understand some of those problems.

I wonder, in the press there have been several descriptions, I believe two clean needle programs, both accounts are -- the accounts that I have read have quoted researchers and workers with drug users saying that clean needle programs do not promote the use of drugs and seem to be acceptable by a part of the drug using population. I wonder whether you would comment on that from a professional point of view and whether you would advocate for such programs in Pennsylvania?

A. Okay, if you mean by "clean needle" programs which permit the use of bleach or other sterilizing stuff to clean needles rather than distribution of new needles?

Q. I mean distribution of new needles.

A. Okay. First of all, I do not think that the availability of needles has anything to do with how much drugs have been used. Needles have just not been a problem. They are always accessible. That's why shooting galleries have become popular in some areas, because you can go there and you can rent your works or borrow them, as long as you buy the drugs. Then you don't have to carry the works around with you and increase your chances of getting caught. But in any case, needles are freely available everywhere. So they are not the choke point in how much drugs are being used. If you had more needles,

it wouldn't matter. The choke point is whether you can buy the drugs or not, not whether you can get a needle. So to be clear about it, I do not believe that the distribution of needles or the cleaning of needles has anything at all to do with how much drugs are being used.

Now, do I think that the distribution of sterile needles, new ones, will be effective in getting people to change their needle using behavior? No, I don't think so. I've talked to a number of addicts myself and I asked them the question, "Supposing that I gave you 50 sterile needles, would you stop sharing them?" And the answer was, "No. What I would do was I'd use it and then pass it around the circle and then when that was used up, I'd get out a new one." It's part of the culture in some cases for some drug using communities.

Now, based on that fact, just my own personal, you know, very small anecdotal surveys, plus the larger studies which distributed needles, so far the differences have been very minor. You have to look for them using statistical tricks. There has not been a major drop in new infections. New York City, of course, is doing the biggest one so far, and I'm waiting to see what happens there. But I don't think that the distribution of needles will change their behavior at all.

On the other hand, use of bleach to kill the

virus between use has been shown to be effective in a couple of cases, and my understanding is that addicts find this acceptable, just to draw up some bleach between uses and rinse it out has been usable, and I think that's probably the more appropriate way to go. Of course, a public agency should never say I'm going to do anything which would promote drug use. I think the first thing you need to do is to try to get them to stop. We have failed miserably, and realistically, if you can't get somebody to stop using drugs, maybe the next step is to try to get them to do it without transmitting the virus, and on that basis, I think that's the appropriate way to go.

Q. If we had a group someplace in the State that was, in your judgment, able to supplement your anecdotal surveys and come up with some real hard or better hard facts on this, would that be a program you'd be willing to fund?

A. Yes.

Q. I'm also interested, and this is a little bit difficult to ask because I don't want my questions to be interpreted in any way to have anybody believe that I don't fully appreciate the seriousness of this public health crisis, and I am sort of hoping that my work in increasing the appropriations will have people understand that, but in terms of transmitting this virus, it seems to

me that we're looking at it in isolation as if no other medically deteriorous -- let me see if I can say it right, no other disease, no other medical condition which is bad for people, is ever transmitted, just AIDS. And I remember when I was on another committee at this legislature talking to dental hygienists who were concerned that the dentists didn't supply them with rubber gloves when they examined people. They were not concerned as much about AIDS as they were about hepatitis, which although it is not invariably fatal is very serious and I believe more contagious or at least as contagious -- let the record show the doctor is nodding.

A. Oh, yes.

Q. It is at least more contagious--

A. Far more contagious.

Q. --than AIDS. And I bring this up because the questions of looking at transmittal of AIDS in a criminal light seem to me to be so extraordinarily abnormal that I think what we're witnessing is some sort of panic reaction on the part of the legislature and other public officials, and I have at some time in my life called that type of behavior on our part high-risk behavior, which is as dangerous to society, I believe, as any transmission of the AIDS or any other virus.

For instance, I can see us backing ourselves

into a corner where we might look at a woman who is known to be infected who gets pregnant as some sort of criminal. And I find this extraordinarily alarming, both in terms of the lives of the people that we are controlling here and because it appears to me that we are not going to control this epidemic with that approach and indeed are going to make the situation much worse.

I'll give you, I know this isn't a question, Mr. Chairman, but I would beg your indulgence. Another example appears to me, we don't have Representative Pistella for me to pick on, but were he here, he would be smoking. Criminal behavior? I don't know. I mean, I can certainly, it seems to me, in most situations avoid having a sexual contact with somebody I don't want to have that contact with, but if I'm going to be a legislator on the Health and Welfare Committee, I cannot avoid sitting in a room with somebody who smokes on me.

REPRESENTATIVE KOSINSKI: But it is criminal behavior in certain circumstances, and increasingly we're passing administrative and criminal penalties. For example, if you smoke a cigarette on a public conveyance, you're eligible to have a fine or a jail term.

REPRESENTATIVE JOSEPHS: I agree with you. I see those kinds of things, but I don't see them being approached with the same kind of panic, hysteria, that we

do with this virus, and I guess I really--

REPRESENTATIVE KOSINSKI: Talk to Mike Dawida.

BY REPRESENTATIVE JOSEPHS: (Of Sec. Richards)

Q. I guess I really do want to bring some kind of sanity towards the way that we're looking at this, which reminds me more of the way leprosy was regarded in biblical times, a disease which is very, very difficult to transmit and whose victims were segregated and quarantined for no medical reason.

A. You know, I understand your point very well and I agree with you. If you look at the number of the things that kill people or make them sick, other things kill far more people than AIDS does. I mean, cigarettes kill more people than any other single preventable cause of disease. More years of productive life are lost by accidents than anything else, anything else, because they occur to younger people and they have more to lose. That's true. And there's the risk that your response to AIDS may then diminish services to somebody else who needs them as well because it either drains resources or facilities or attention. So that's exactly right.

It is a brand new, it is a highly emotional topic. For a lot of reasons it's frightening: It's deadly, it deals with people that many of us find

difficult to come to grips with, you know, personally, so that it's a very emotional topic, and this always happens when you have this. If you recall Legionaire's Disease and how much fright and panic there was about Legionaire's Disease. With time, that's calmed down. Of course, that's treatable and it's not lethal and it's actually a small thing, but still, the emotional response is there. My suspicion is that with time the same will happen here, but it will take some time. I think there are very good reasons to guard against responses which are not well considered

Q. I'm not trying to guard against giving enormous amounts of resources to this so we can deal with this problem. I'm trying to guard against the responses that are going to be really counterproductive. And I wonder, through the series of questions that you were asked about criminality where you kept saying health providers don't want to be police, don't want to be agents of the court, aren't suited to do it, can't do it ethically, are you recommending somebody else be agents of the court? Police? Are you recommending some other agency of the State arrest folks who are willfully, supposedly willfully, passing this virus?

A. Yeah, by implication I am. First of all, I'm not saying that somebody who is simply infected is a

criminal. What I'm saying is that I wouldn't be opposed to that designation if that person willfully exposes somebody else. If that person, by their behavior, puts somebody else at risk. The general police power, you know, could be exercised I think in that manner, so I want to be real careful to say that just because somebody's infected, I don't think that makes them bad in some way.

Now, in terms of our department, the point is that we depend on confidential treatment to get access to a lot of people who need treatment. If every time a prostitute came to one of our sexually transmitted diseases clinics we say, ah-ha, you're a prostitute and when you go, I'll report you to the police tonight, we'd never see another single one. Without this requirement, we can treat large numbers of people. My fear is that if we become the reporters and agents of the courts and the police, we will lose access and lose ability to treat these people.

Q. I understand that.

A. That's my concept. And so if it turns out that something has to be done that does require notification to court, we prefer not to be it. Now, if somebody says that they've discovered that somebody has engaged in willful behavior, and first of all, they must have known about it ahead of time or else how can it be

willful transmission of the virus, that gives us a chance to interact with this person but without being the person to notify them or not being the person to turn them in. We can then relate to a person in a different way.

REPRESENTATIVE JOSEPHS: Mr. Chairman, thank you.

Thank you, Dr. Richards.

(Whereupon, Representative Kosinski assumed the Chair.)

ACTING CHAIRMAN KOSINSKI: I'd like to introduce Representative Chris Wogan. Do you have a question?

REPRESENTATIVE WOGAN: I do. Thank you, Mr. Acting Chairman.

BY REPRESENTATIVE WOGAN: (Of Sec. Richards)

Q. Dr. Richards, I'm somewhat confused. It was my understanding that health authorities in Pennsylvania do contact tracing for diseases such as syphilis and gonorrhea. Is that correct?

A. That is right.

Q. And it was my understanding that was not done when persons who have AIDS come to the attention of public health authorities.

A. We are, in fact, notifying the partners exposed to somebody with AIDS.

Q. Right.

A. Okay, we are doing that. If somebody comes in with AIDS, we say to them, will you please notify your needle sharing partner or your sexual partner because you're putting them at risk so they can come in and get tested, too? We, ourselves, have not gone out to try to identify that person with that.

Q. So in fact, you're not as aggressively searching out contacts who may or may not have AIDS as you are in searching out possible victims of gonorrhea or syphilis, which are much less serious diseases?

A. I think that's a fair statement.

Q. What would be the reason for that, Dr. Richards?

A. The only treatment we have to offer in this case will be to try to change that person's behavior. For that reason, we think it must be done. We think there are good reasons to notify partners, and if the source is not willing to do that, I think we should. In order for us to do this properly, however, we need much better protection of medical records than we now have because the State laws that now exist do not protect medical records well enough to prevent unauthorized releases.

Q. Well, have there been many situations where people with syphilis or gonorrhea, their privacy has been

compromised in any way? Situations that you're aware of?

A. Some. The degree of discrimination and our loss of access to those people isn't as severe though because there's a treatment, and because much more time has gone by and it isn't seen as, you know, such a serious problem. People don't lose their housing, people don't lose their jobs because of that.

Q. They just lose their lives?

A. That's right. And if we treat them -- okay, I'm talking about syphilis and gonorrhea now. If you treat them, they can have their health restored. All right, we are, in fact, attempting to notify partners of patients who are HIV positive. Yes, we are.

Q. Thank you, doctor.

(Whereupon, Chairman Caltagirone resumed the Chair.)

CHAIRMAN CALTAGIRONE: Any further questions?

Mr. Parrish.

BY MR. PARRISH: (Of Sec. Richards)

Q. Dr. Richards, I have a couple questions on behalf of the chairman who could not be here this morning, so I would just ask, and in light of the time that you have been testifying before the committees, that you can reply to both the Chairman of the Judiciary Committee and

the Chairman of the Health and Welfare Committee in writing as opposed to spending any length of time responding.

A. Sure.

Q. The first question is, how can Pennsylvania monitor trends and costs of care for HIV-infected persons while maintaining the confidentiality of individual patient records?

A. I'll give you a five-second answer to that. We should have access to all the information. Confidentiality doesn't mean that nobody knows. We, as a responsible State agency, should know and therefore have the ability to do things such as monitor costs.

Q. Okay. Representative Richardson would also like to know what difficulties must Pennsylvania overcome in assessing costs of care information related to HIV infections?

A. The major barrier is not knowing how much HIV infection there is. It's not a reportable condition at this time, although eventually I believe it should be. We simply do not know how many people and who are infected and where they live. That's the major barrier.

Q. The last question, I don't know, may be directed to you but also may be directed to the Secretary of the Department of Welfare with regard to Medicaid

waivers, and maybe you and Secretary White have discussed this in your interagency meetings. What type of programs can Pennsylvania design to take advantage of Federal legislation permitting them to apply for Medicaid waivers to target services to HIV-infected populations?

A. The waivers have been applied for by DPW. DPW has also responded to further questions from HCFA, Health Care Financing Administration, and they are now waiting to hear the results of their application. DPW expects to have those results in June of this year. What those waivers permit you to do is spend Medicaid money in nontraditional places, primarily homes. A lot of home health care that you cannot now spend Medicaid money for, it allows you to provide the services in a different, less expensive site.

REPRESENTATIVE WOGAN: Thank you, Mr. Chairman.

(Whereupon, Representative Kosinski assumed the Chair.)

ACTING CHAIRMAN KOSINSKI: Representative Josephs.

REPRESENTATIVE JOSEPHS: Thank you, Mr. Chairman.

Dr. Richards, I'm confused. You are or you are not notifying partners of HIV-positive people? I

think you said both.

SECRETARY RICHARDS: We are.

REPRESENTATIVE JOSEPHS: You are.

Thank you.

ACTING CHAIRMAN KOSINSKI: Further questions from the committee?

(No response.)

ACTING CHAIRMAN KOSINSKI: Thank you, Dr. Richards.

On request of the Chair, I have been asked to call the next three people up en masse. That would be Mr. David Fair, J. Thomas Menaker, and I hope I pronounced it right, even though I was introduced to you before, and Rashidah Hassan. She's not here?

Mr. Kerry Stoner? Kerry is not here also.

Would Scott Burris of the ACLU like to come up at this time?

This is at the advice of the chairman to do this, and what we will do is we will have Mr. Fair, Mr. Menaker, and then Mr. Burris present their testimony and then we'll open a firing line for questions.

Mr. Fair.

MR. FAIR: Thank you, Mr. Kosinski.

I appreciate the opportunity to share with you our experience in Philadelphia this morning. This is

the first opportunity we have had to testify in Harrisburg about our experience in developing AIDS programs in Philadelphia, and hopefully to clarify some of the misinformation which I think was presented by the Health Secretary this morning in terms of the relationship between the City Health Department and the State Health Department on this question.

In light of Dr. Richards' testimony, I will differ slightly, very slightly, from the written testimony which has been submitted to you. I'd also like to let you know that you will be receiving in the mail or delivered to your offices over the next few days this document, which is the status report of the Philadelphia AIDS Activities Coordinating Office activities. It's a 234-page document that will go into much more detail as to our activities than I will this morning in my testimony.

Again, my name is David Fair, and I am Executive Assistant to the Philadelphia Health Commissioner for AIDS programs. The AIDS Activities Coordinating Office in Philadelphia is the arm of the Department of Public Health charged with stopping the spread of AIDS in Philadelphia and insuring that services are available and accessible to people with AIDS.

We live in a society that values statistical definitions of its social problems, and the impact of the

AIDS epidemic is one problem that has been subjected to exhaustive statistical analysis. You have heard this morning statistics citing percentages of homosexual and bisexual men infected by AIDS, percentages of heterosexual males and females, percentages of intravenous drug users, percentages of whites and non-whites, who are thus neatly categorized as the population that are afflicted with this deadly disease. But today, in 1989, most people who are getting and spreading AIDS are not gay. Most of them do not shoot drugs. The sad fact is that the people who are most likely to contract AIDS today are teenagers and young adults who continue to engage in unprotected sex in an environment where thousands of their friends and peers are already infected.

Unprotected sexual activity among Pennsylvania teenagers and young adults is rampant. Fueled by sexually enticing media and drug use and in the age of AIDS are a deadly health risk to us all. In Philadelphia, our rates of teenage pregnancy, infant mortality, and sexually transmitted diseases are among the highest in the industrialized world. These numbers are even more ironic when one considers a recent survey conducted by the U.S. Public Health Service in the Philadelphia School District which found that two-thirds of Philadelphia's 10th graders reported having sexual

intercourse by the age of 15. The majority of these teens said that they didn't and don't use condoms.

Unfortunately, it is easy for many to discount such facts when they are presented concerning an urban area, such as Philadelphia, but let me remind you that it was only a few years ago that AIDS was thought to be a mysterious disease affecting only gay males and Haitians. It was something limited, for the most part, only to big cities such as New York, Miami, Los Angeles, and San Francisco. It was something to be concerned about only if you lived in or near one of those places, and then only if you were a gay man or a Haitian, or someone who had sex with gay men or Haitians. Remember, that was only a few years ago. Today, AIDS affects every country in the world, every State in this country, and every county, school district, and neighborhood in Pennsylvania.

With over 2,500 diagnosed cases through out our Commonwealth, we are at the beginning of the AIDS epidemic in Pennsylvania. Estimates are that as many as 45,000 persons are infected with the AIDS virus in Philadelphia, and as many as 100,000 in Pennsylvania. Most of these individuals still have shown no symptoms of this disease and will not for several years, and most probably don't even know they're carrying this deadly virus. Most of them, if other indicators of sexual and

drug activity are accurate, are probably still engaging in the behavior that got them infected in the first place and they are spreading the infection unknowingly to others. Based on the best data available, it is estimated that at least half of these individuals will develop full-blown AIDS within the next nine years. By the year 2000, Philadelphia alone will see an additional 20,000 cases of AIDS. By comparison, the total of 622 Philadelphians died in all the years of the war in Vietnam.

The subject of today's hearing is specifically House Bill 624, and tangentially a host of other similar measures, most of which seek to establish punitive criminal sanctions against persons who are infected with HIV, the virus that causes AIDS. HB 624 seeks to mandate the testing of all convicted prostitutes for HIV antibodies. It would enact unusually severe penalties for subsequent prostitution convictions of those testing positive. The assumption behind this legislation is that AIDS is spread by prostitutes, that they serve as vectors in carrying this disease from the underworld of prostitution and drug abuse into the law-abiding heterosexual community at large.

Such attitudes are popularly held. It is understandable, perhaps, that we should try to cast the blame for this deadly disease onto a population that is

readily identifiable and already outside the pale in our society. Historically, prostitutes have often been blamed for spreading syphilis and gonorrhea to innocent American families, and for hundreds of years we have seen numerous unsuccessful attempts by lawmakers to control the spread of venereal disease by testing and incarceration of prostitutes. But public health studies have shown that in fact in the case of AIDS, prostitutes actually have played no significant role in the spread of HIV infection in the United States.

It is true that many prostitutes are infected with the AIDS virus, but they are infected because many are also intravenous drug users and have been infected by sharing needles. Others have husbands or boyfriends who share needles and have passed the disease onto them through unprotected sexual intercourse. But aiming legislation at prostitutes as a way to control the spread of AIDS while failing to create a real statewide AIDS prevention program is misdirected, at best. Heterosexual males are becoming infected by sharing needles for intravenous drug use and by repeated sexual intercourse with women who use IV drugs, yet we are doing little on the State level to intervene in those modes of HIV transmission.

In effect, HB 624 would attempt to control

the spread of disease by punishing women and men who receive money in exchange for their sexual favors, yet it would not apply comparable sanctions for the individuals who pay for engaging in these sexual acts. The justice of such a measure is questionable.

From a purely pragmatic public health perspective, this legislation also misleads citizens of Pennsylvania by promising them that HIV-infected prostitutes will be looked up and suggesting that prostitutes remaining on the streets are therefore safe. This legislation does not and cannot guarantee that, and thus will fail in its intended purpose and potentially make the risk of infection worse.

Our efforts would be better directed, we believe, at educating the public, including those who hire the services of prostitutes, about how to protect themselves from HIV infection. Meanwhile, prostitutes and other IV drug users must be educated not to share needles and to use condoms for their own protection. Especially we must expand our efforts at treatment for substance abuse, for then in many, if not most, cases we could eliminate the very reason these young women and men engage in prostitution in the first place. Such strategies are beginning to work in Philadelphia. They are practical, real tools that help us stop the spread of AIDS. They may

not generate headlines, but they do work.

Public health experts have found that in controlling any infectious disease, cooperation is the key. At present, prostitutes in Philadelphia are frequently treated voluntarily at our clinic for sexually transmitted diseases. In this context, we are able to offer face-to-face counseling, testing, and education which encourages risk reduction and behavior change. It is our experience in these programs that prostitutes are in fact among the most sexually educated and aware citizens, that safer sex behaviors are becoming increasingly more common, especially among those who do not also have serious addiction problems, and that of all sex, decidedly less risky behavior is by far the most frequent kind of sexual contact they have. However, were contact with health care to become associated with criminal sanctions such as those proposed in this legislation, it is unlikely that prostitutes would voluntarily approach the Health Department for HIV antibody testing, or for that matter for any other health care. Thus, their own health, as well as that of their sexual and drug contacts, would be seriously endangered.

The principle of cooperation is an essential element of the progress we have been able to make in reaching those who are most at risk of contracting and

spreading the AIDS virus. The overwhelming majority of legislative initiatives being proposed in this legislature are aimed at seeking out and identifying those individuals currently infected with the AIDS virus. Several proposals would criminalize various behaviors which may transmit the virus. These initiatives have been drafted in the hope that the public at large can be protected. But all of these initiatives are counter to current public health efforts. Measures of this sort will only serve to drive underground the persons most at risk, the persons most likely to be currently infected and spreading the AIDS virus unknowingly to their sex and drug partners, the persons that we are most aggressively, and in Philadelphia successfully, attempting to reach. Such laws would discourage people from seeking voluntary testing and education. Criminalizing transmission of this virus will provide an actual disincentive to knowing one's HIV status. Because actual knowledge of infection would be a predicate for a criminal offense, only those persons who have been tested for HIV infection could be charged with the crime. It is crucial that the delicate balance of trust and cooperation which has been established between health care providers and those at risk not be undermined at this crucial time. This legislation would do that.

One of the primary and most basic tenets of

the AIDS Activities Coordinating Office's response to the AIDS epidemic in Philadelphia and our leading role in formulating Philadelphia's public health policy on AIDS has been and continues to be that people with AIDS and HIV illness are not outcasts, are not criminals, are not people being justly punished for their sins. People with AIDS are simply just like everyone else, except that they are people who are ill. People with AIDS are as entitled to respectful and compassionate treatment as any person with any other illness. Our department will continue to advocate for humane, compassionate and culturally sensitive care for those affected by the epidemic. Our care for individuals and our response as a society must be based on a basic knowledge of the facts and absolutely cannot be formulated out of hysteria, fear, ignorance or other irrational and emotional biases. Every citizen affected by this illness has an inherent right to quality, dignified, and compassionate care. One of the primary missions of my office is to see that Philadelphia meets this challenge.

The Commonwealth of Pennsylvania, however, has yet to take an active role in combating the AIDS epidemic in our State. Since the epidemic began, the State Health Department has provided only $420,000 in financial support to Philadelphia AIDS activities - in

fiscal year 1989, less than 4 percent of our total funding.

As part of its legislative strategy in Harrisburg, Mayor Goode has proposed an agenda for AIDS programs to the Commonwealth in 1989. It included implementing a statewide broad-based public information effort which would include the production of printed materials and mass mailings, developing of a curricula for service providers which would introduce AIDS into the education of the State's medical students, nurses, mental health clinicians, and other providers of health care. These materials could then be disseminated throughout the private sector health education system in the Commonwealth. This program also asked for the provision of statewide community-based education targeted at those individuals of highest risk of contracting and transmitting the AIDS virus.

In terms of budgetary actions, the mayor's proposal asked for State funds for follow-up services to those individuals who have been identified as HIV-positive and who require additional counseling services relative to their own health and directed towards prevention of further transmission of the virus. We've asked for State funds for the provision of direct services to individuals with AIDS and those with HIV-related diseases. These

directed services would include but not be limited to community residential programs, case management and social services for children and their families, and partial hospitalization services. We've asked for State funds for local education and prevention initiatives. We've asked for State funds to increase local coordinating activities, such as monitoring research projects, grant applications, and study results. We have asked the State Department of Public Health to expand the number of nursing home beds available for patients with AIDS and condition licensure of nursing homes on a statement of nondiscrimination with respect to people with AIDS. We've asked the Department of Public Welfare to secure a waiver in order to provide enhanced services to people with AIDS under the Medical Assistance program. Such enhanced services would include but not be limited to adult daycare, mental health counseling, and in-home drug therapy. And we've asked the Department of Public Welfare to develop a plan to provide for enhanced compensation for hospital costs not covered by Medical Assistance reimbursements for patients with AIDS. We have seen no action in Harrisburg on these requests. Our attempts to work with State officials have met with stonewalling, at best, and with usually silence.

In spite of the lack of State response, our department continues to meet the demands that this

epidemic is placing on the city of Philadelphia. Among these operations are education and prevention services, including minority outreach programs and innovative programs specifically targeting high-risk population, education of city workers and city employees, public information campaigns, peer counseling campaigns, and special projects aimed at clergy, at workers, and at sexually active teenagers. Direct services to persons with AIDS and HIV-related diseases include case management, housing, transportation, legal services, homemaker, personal care, skilled nursing and other specialized home care services, as well as mental health and substance abuse treatment services. Our division of Medical Affairs Policy and Planning is responsible for tracking the AIDS epidemic through ongoing surveillance and selected seroprevalence studies, as well as policy development activities. As the primary source of medical information on AIDS within the department, this division also ensures that all educational materials, infection control protocols, HIV testing practices, and AIDS prevention and treatment activities are consistent with current knowledge of the disease and accepted standards of care.

We have a plan to combat AIDS in Philadelphia. Harrisburg has no plan. Philadelphia is

responding to the AIDS epidemic, however the spread of the AIDS virus is not confined to Philadelphia alone. The citizens of this Commonwealth have the right to respect the same range of services which has been developed in Philadelphia to be developed by the State and to be made available to residents throughout Pennsylvania. This epidemic requires leadership. As elected officials, you have the opportunity as well as the responsibility to provide such leadership. The time is long overdue for the Commonwealth to acknowledge this growing health crisis which is killing our citizens. The answers are not in criminalizing the disease. We urge you to look thoughtfully at the needs brought about by this epidemic - funding needs, the need for protecting the confidentiality of HIV information, the need for education of Pennsylvania citizens and children, and our many, many other needs.

The Philadelphia Department of Public Health AIDS Activities Coordinating Office remains ready to assist you in any way we can as you continue to consider these most serious issues, and we deeply hope that we will have a more positive response from you than we have had from the officials at the State Health Department.

Thank you.

(Whereupon, Representative Blaum assumed the Chair.)

ACTING CHAIRMAN BLAUM: Thank you, Mr. Fair. We'll ask that you remain there and take questions from the committee.

Mr. Menaker and Mr. Burris, in that order, I would ask that you summarize your testimony. I don't think there's any need for you to read it as long as we have the printed copies, but to summarize your testimony and hit the high points that you believe this committee should know.

MR. MENAKER: My name is Tom Menaker. I'm a partner in a Harrisburg law firm. I've been practicing for 26 years primarily in the field of employment relations law.

The AIDS problems, as they relate to the law, first arose with regard to employment relations. The Pennsylvania Bar Association, a couple of years ago, established a task force to study the problem of AIDS as it relates to the law. The task force is comprised of interdisciplinary members from the medical profession, research scientists, officials of State administrative agencies, including their chief counsel. We've had excellent cooperation with the Pennsylvania Medical Society. We have one of their staff members on the task force. We have the president of the society, Dr. Andriole; we have Dr. Bob Sherrar from the Philadelphia

Department of Health, their epidemiologist, who has been most helpful; A virologist from the Hershey Medical Center, Mary Kay Howett, et cetera. And we've put together and published just a year ago a report entitled, "AIDS Law in Society," which I think has been made available to every member of the House. I certainly hope that every member of these two committees has received a copy. If you haven't, our legislative Representative John Catone is here and will make is sure that you all have that. And I would urge you, in addition to reading the prepared text which I've prepared for our statement today, that you read that. It is not lengthy, it is not difficult to read, it is not in scientific terminology. We have defined our terms and we have received acclaim from throughout the country, not just from legal sources and organizations but medical as well, on that report. I think it could serve as a guide to legislation that may be necessary in this Commonwealth.

The bills that we're asked to comment on today include House Bill 436, which our task force refers to as the Rock Hudson's lover's bill. As you may recall, Rock Hudson's alleged last lover filed a lawsuit, a civil suit in California against Hudson's estate seeking damages for emotional trauma and anxiety. He alleged that Hudson never disclosed to him that he was HIV-positive and

suffering from the disease, and even though the medical tests on the lover, the plaintiff lover, indicated that he had never been infected himself, the jury was permitted to take the case and render an award well in excess of $10 million, I think it's about $14 million, subsequently reduced by about half by an appellate court. But this bill would guarantee that Pennsylvania would have the same cause of action for someone who is not infected just because they had sexual relations with a partner who was infected and knew it.

Now, AIDS is not a disease that someone gives to you like a cold or the flu. You have to do something to take it from an infected person. Ninety percent of infected people don't even know that they are infected with the virus, so we have to assume and we have to require every member of our society to assume that everyone's infected with the disease and that every unprotected act of sexual intercourse or needle sharing puts us at risk of infection. If you pass a law like this, it actually gives a monetary reward to someone who was careless in his behavior, who engaged in high-risk behavior and assumed that he had a right to be told by his partner that the partner was positive or infected. I think that's the wrong message to give to the public, and for that reason, we oppose House Bill 436.

House Bill 437. This would make it a first-degree misdemeanor punishable by a $3,000 fine and three years imprisonment for a known HIV carrier to engage in sexual intercourse without warning his partner that he's infected with the virus. We feel this bill is unnecessary because the described conduct already clearly violates the existing and more serious criminal statute prohibiting recklessly endangering another person, and I'll read the act that's on the books. This is 18 Pennsylvania Code, Section 2705. It very simply says, "A person commits a misdemeanor of the second degree if he recklessly engages in conduct which places or may place another person in danger of death or serious bodily injury."

I fully agree with Secretary Richards' comments this morning that this is reprehensible and should be criminal behavior for someone to knowingly expose his disease to someone else, but the law's already on the books. It can be enforced. There's no need to describe it specifically for AIDS any more than it should be for infectious hepatitis or gonorrhea or syphilis or anything else that's a dangerous disease.

House Bill 624. This would amend the current criminal prohibitions against prostitution. It's already been discussed here in some detail, and we'll

comment only on that portion of the bill that deals with mandatory testing of defendants who are convicted of prostitution, and we oppose this legislation for two reasons. First, we're against -- the task force is against all forms of mandatory testing for the AIDS virus with the exception of blood, body parts, body fluids, and semen donors. Those are obvious exceptions. Just within the last month, the United States Supreme Court has held in two separate cases that urine testing for drugs constitutes a search, a body search, that must comply with constitutional safeguards of the fourth amendment and it its probable cause requirements. And certainly the taking of one's blood is a more invasive procedure than having someone urinate in a bottle, and therefore would be subject to at least that or higher requirements.

The mere conviction of prostitution isn't likely to justify a probable cause finding authorizing an invasive body search and would, I think, be struck down on constitutional grounds as a violation of the fourth amendment. Most prostitutes infected with the virus have contracted it from sharing intravenous drug needles rather than from sexual partners. Male partners of female prostitutes are not considered to be a high-risk group for HIV infection. We're also against this legislation because it would provide prostitutes who test negative

with some official sanction that they're clean, and they would then go out and use this competitively to solicit customers by saying, you know, I've been tested by the Pennsylvania Department of Health under this law and I'm clean, pick me instead of Susie down the street. Well, she may have been clean the day she was tested and could well have been infected the very next hour. Why give a substantial portion of prostitutes any excuse to proclaim their AIDS-free condition?

I think the need is to educate society, the customers, in particular, that all prostitutes are high risk and you engage in relations with them at your own risk. None of them is clean, and there shouldn't be any State test that they can wear on their forehead.

House Bill 824. This would criminalize an assault by an HIV-positive individual if the assault would likely transmit the virus to the victim. This comes under the reckless endangerment statute which I already referred to and read, and our comments are the same as they would be for House Bill 624.

And the last, the fifth and last bill that we've been asked to comment on today is a bill that comes from the State of Oregon. It has not been adopted into law there. It's House Bill 2471 of the 1989 Regular Session from Oregon and would require judges to inform

defendants and victims in criminal cases involving possible transmission of body fluids of the availability of AIDS testing and counseling. We would support that proposal because it encourages voluntary testing accompanied by counseling, and Dr. Richards described that this morning, and our task force fully agrees that this is the way you've got to go. You've got the encourage people who consider themselves to be at risk, people in groups engaging in high-risk behavior, to voluntarily go get tested, and the only way you're going to do that is if they feel and believe that this is confidential testing, that it will not leak out, that it will not come to haunt them if they test positive and that they would lose their jobs or their housing or their friends and family. If it's confidential, people believe that, they will get tested and they will know that they have the virus and they will then be able to engage in the kind of counseling that's necessary to change their behavior so that they don't continue to spread the virus elsewhere.

However, the Oregon bill does go forward and further than that by permitting court-mandated AIDS testing of convicted defendants either on the court's own motion or on the request of the victim. Now, we oppose mandatory testing, as I indicated earlier, so we oppose that portion of the bill. If the victim or the court have

a legitimate concern that the victim may have been infected with the AIDS virus as a result of the crime, would normally be as a result of a rape, the best way to determine that is to test the victim. By the time a defendant is convicted and therefore subject to the mandatory testing under that bill, enough time would have gone by for the virus to have caused antibodies to appear in the blood of the victim. Normally this occurs, it's a period called seroconversion. It occurs within two weeks to eight weeks. Hardly ever more than six months after the date of infection, and you don't get convictions in criminal cases involving violent attacks in less than six months. So by that time, hopefully the victim, if he or she feels that they've been put at risk, would have gone for voluntary testing and would know whether they were infected. We feel that only a well-executed education policy and continuing pressure for avoidance of high-risk behavior will curtail the AIDS epidemic.

As has been said earlier, particularly by Mr. Fair, we're really only seeing the tip of this iceberg. Ninety percent of infected people aren't even aware that they carry the virus and that they are transmitting it. We have to encourage voluntary confidential testing of persons engaged in high-risk behavior. The Pennsylvania Bar Association urges the

General Assembly to develop a positive approach to this catastrophic health threat. It's believed that well over 2 million Americans are already infected, and more than 100,000 of them are Pennsylvanians. Nearly all of them will be dead within 10 to 12 years. We can't even scratch the surface of this problem by enacting criminal legislation or repressive testing schemes.

The Pennsylvania Bar Association, through its AIDS Task Force and with the invaluable participation of the Pennsylvania Medical Society, is now in the process of drafting a proposed bill that would encourage voluntary testing and counseling while closely safeguarding confidentiality. Secretary Richards alluded to the bill that's being prepared by the Department of Health. As he indicated, it's quite parallel to the one we're putting together and we hope we can resolve the few differences between them, or that you will. Only when confidentiality is assured will the public feel secure in volunteering for these HIV tests. We'll submit this proposed legislation to you in the very near future, and we will, again, be available to discuss it with you at that time.

Thank you.

ACTING CHAIRMAN BLAUM: Mr. Burris?

MR. BURRIS: Good afternoon. I'm Scott Burris. I'm the staff attorney of the AIDS and Civil

Liberties Project of the American Civil Liberties Union of Pennsylvania. I thank you very much for your interest in this subject and for holding these hearings today.

I have been working on AIDS now from a law and policy standpoint for about five years. I've written several articles about the technical matters in public health law. I've also edited this book, "AIDS and the Law, a Guide for the Public," which is the first, as far as I can tell, still the only book about AIDS public policy and law directed at people who are not lawyers but rather people in your shoes, people who have to deal with this from another perspective.

I find myself a little troubled by some of the things that Secretary Richards talked about today. In particular, I think there's a problem of tone and I think there's a problem of scale. I want to try and suggest to you in my testimony today that one of the chief things that you can do as policymakers and as leaders for the people of Pennsylvania is to identify what we really need to worry about in terms of the transmission of AIDS and what we really need to do that will stop the most transmission. I have an analogy which might, I think, make this clear for the purposes of my testimony today.

I'd ask you to imagine that you're in your living room and the phone rings and it's your grandmother

across town. She's asking you to come right away and take her to the hospital because she thinks she's having a heart attack. Now, you're not too worried about this because although you know that granny's heart isn't what it once was, she calls you every week. She always is having a heart attack. There's always the chance this is the big one, but probably she just needs someone to hold her hand and reassure her. You want to do that and you start to leave. All of a sudden, you realize your house is on fire. Upstairs you have 10 children asleep. Now, you've got a choice here. You can go up and get those 10 kids out of the house to safety, save their lives, or you can go to granny. Now, that's a kind of tragic choice. There is always the possibility that granny is really having a heart attack, but basically, you know that the chances are 9,999 out of 10,000 that granny is fine and you know that if you do not go up and get those kids, they will surely die.

Now, that's a hard choice, but I think we'd all choose to save those 10 kids. I think when we talk about testing prostitutes, when we talk about testing criminals when they're arrested for rape, or when we talk about criminalizing biting and scratching, we're talking about going and talking to granny and letting the 10 kids die. It's vitally important that we focus on the real

risk of AIDS, not the possible or theoretical or symbolic risk of AIDS, and save lives that need to be saved right now that we can save.

I want to talk to you a little bit about how that conflict develops and how we can resolve it. It seems to me first we need to look to the past. For nearly all of human history, there really wasn't much that we could do about disease. Besides praying, about the only thing that people came up with as a method to fight disease and protect public health through all the time up until the 19th century was to quarantine, in a large sense, the people who were sick. And by quarantine, I mean not just lock them up in a house, but in a larger idea of identifying people who were sick or were thought to carry a disease and then doing something to them, stigmatizing them, isolating them, letting them know that they're different from us. To a certain degree, this had a rough correlation with reality. Very often if you had sick people around, disease was being spread. But, of course, it had very little real correlation.

People used to get boarded up in their houses when there was plague, but plague wasn't spread from person to person, it was spread by fleas carried by rats. No one boarded up the rats. People used to, in this country, even through the early 20th century, isolate

people who had yellow fever. But yellow fever wasn't spread from person to person, it was spread by mosquitos. Leprosy, of course, is the traditional pariah disease and people, once they were diagnosed as having the disease, were outcast from society in the most profound way. In the Middle Ages, there were even church services that people went through in which they were declared as if they were dead and put into a state of purgatory on earth. Now, these people were past the infectious stage. They spent their entire lives as outcasts for no purpose at all.

I think you should understand that none of these things ever worked at all. Quarantine, isolation, stigmatization has never stopped disease, just like no law has ever stopped sex, just as no law has ever stopped drug addiction, no law has ever stopped the spread of a disease. It simply has never happened. Mass rounds-ups of prostitutes in World War I never stopped syphilis. Leprosy was never stopped by our quarantine system. Tuberculosis was not stopped by the sanitarium system. The only thing that has ever happened in all of human history that has made the least bit of an impact on the transmission of epidemic disease was the realization, the discovery in late 19th Century that diseases are spread by germs. Viruses, bacteria, specific epidemiologic agents

spread disease. Once we had that and once we began on the long road of medical advance that has marked this century, we began to have some handle on disease.

The whole thrust of this effort based on the germ theory was to be very specific about what spreads disease. Find out what causes the disease, find out what transmits the disease, and then take specific action that it deals with just those areas, routes of transmission. And we often hear it said that there's a conflict between civil liberties and disease control; between individual rights and the public welfare. And I can tell you as a civil libertarian and as a person who is really involved very deeply in public health matters that that's just a cliche. It's just not correct. As a legal matter, the Supreme Court long ago said that if an action was necessary to protect public health, civil liberties would not stand in the way. Ever since then, the real issue in all public health law has been what's necessary? How do you figure out what's necessary? On what basis do you choose the measures that you're going to take against disease?

I think in this sense then the real question that we face, the real conflict that is before us and before you as leaders in this fight is the conflict between a modern approach to disease and an old-fashioned

one. Between science and reason, and superstition and fear. Right now, the very things that are necessary to protect the public health that you've heard described today - protecting confidentiality, assuring people that if they come in and get the help that we need them to get they'll not be punished - are going to help civil liberties. No conflict there. By contrast, the things that we think are going to hurt civil liberties - locking people up, forcing them to be tested, stigmatizing them in some way, criminalizing them - are the very things that public health experts are telling you far from being necessary are going to cause the spread of the virus. You can save granny, but those 10 kids are going to die.

Now, the problem that I think that we face in getting across that message to the public is that the scientific knowledge that we've developed in the last hundred years about disease has not really trickled down to the general population to the extent that we might like. Furthermore, people just don't trust scientists a lot of the times. They don't believe it when the CDC tells them they're not going to get AIDS from mosquitos. They don't believe it when the CDC says it's safe for a child to go to school with another child who's HIV-positive. It seems to me that you in the legislature do know these things. You understand modern medicine, you

understand modern public health as we do it in the 20th Century, and you can set an example both in the things you say and in the problems that you identify as needing legislative remedy. I think you're in a unique position to really help us now get the whole population mobilized in dealing with AIDS as a health problem that we can handle if we just keep our heads and keep our hearts open.

Let me offer you just a few guidelines about how you can handle this, ways that I think will promote this, approaches that will make this a little clearer. First of all, it seems to me that you have to look at the whole picture. Every part of the AIDS problem is connected to every other part. It's very difficult to just solve one little question, make one little problem go away and have it have no impact on what other people are doing. A very good example of this was House Bill 37, the bill which Mr. Menaker was just speaking about which made it a crime for people to have sex if they're HIV-positive and do not tell their partner. Now, I know that the sponsor of this bill was concerned about some essential legal problems, the fact that various kinds of actions were taking place across the country to punish this kind of conduct, but it wasn't clear what standards should really be applied, and he tried to carefully draft a bill that would address that legal problem. But it seems to me

that once we put that solution to a legal problem into the picture of the whole AIDS epidemic, that's where we started to see all the problems that have already been raised about that bill, and another one which I think hasn't been mentioned which was that since we don't really have strong statutory protection of confidential public health records, that one of the very first things that would happen once those kinds of prosecutions began was that prosecutors would be subpoenaing public health records to get evidence of HIV positivity at the time of the crime.

The second thing, it seems to me, is choosing the kids over granny. That is to say, focus on the biggest problems first. I can say I wrote the book on AIDS and policy and I know how many different areas AIDS touches. I have 20 chapters in this book, all of them going into great detail about technical problems in all areas of law and society, and all the problems aren't in here. But that doesn't mean that AIDS touches every area of life to the same degree. It doesn't mean that every problem poses the same amount of danger. People may be worried about sex between Johns and prostitutes, but that's not the behavior that's spreading AIDS. AIDS is being spread by people who give it away for free. AIDS is being spread by lovers to other lovers. That's how it's

spread. Those are the 10 kids upstairs. The prostitutes and the Johns who may get it, who theoretically can get it, their granny across town is just having an anxiety attack.

Now, it seems to me that since we know, as a matter of fact, that we've never succeeded in controlling prostitution or controlling communicable disease by trying to control prostitution, what we're really doing is giving people this false sense of security. We're telling them, yeah, you were right, it's those prostitutes. It's those bad people that get this disease. You don't have to worry about that. Don't ask your new boyfriend or your new girlfriend who she's been sleeping with. Don't wear a condom. It's prostitutes that spread AIDS. It seems to me that more than that, it's telling the public that we don't really care about what's really spreading the disease. We're going to go for these sort of sexy issues, if you'll excuse the expression. We're not going to worry about the 10 kids upstairs. We're going to say that we're a society, we're a group of policymakers who deal with the high profile, easy-to-explain problems and we leave the problems that are actually spreading AIDS for somebody else to handle.

I think related to this is avoiding the temptation to make meaningless gestures. I mean,

oftentimes it's a very good idea for a legislature to take symbolic action, to send out a message to people, but I think when we do that with AIDS, it can really be kind of dangerous. These proposals such as House Bill 824, which would create a crime of assault by an HIV carrier, are a really good example. I can tell you, and I don't think Secretary Richards made this clear enough, biting, scratching, throwing feces, they have never caused a case of AIDS that has ever been reported anywhere. Studies have looked not just at what's happened across the reported incidents, and there have been hundreds of reported incidents of this, but have actually looked at specific cases in a clinical setting over a two-year period and found even with very aggressive and violent patients who were attacking their health care workers on a regular basis and there was no seroconversion, there was no transmission of this virus. It seems to me that if we pass a law that tells people we've got to criminalize this, we're not telling them, we're not reassuring them, we're not giving anybody a benefit, we're not directing people to be worried about the things that are going to cause them to die. We're telling them that this is a problem. You know, when a prosecutor brings that action and gets up there and says this person was trying to spread AIDS by biting, however reprehensible that kind of

conduct may be, we're telling people that's a problem. Otherwise, why would the legislature pass that law? Why would some respectful prosecutor bring that indictment?

I think the same thing is true of the movement to let people know. I mean, a basic part of the old-fashioned attitude towards disease was if we know, somehow that will help. If we know who has it, we won't get it. Modern public health practice realizes that knowing has very little to do with getting the disease. With most diseases, once you know somebody's got it, just as with AIDS, they've already been infectious for some period of time before that. Oftentimes with AIDS they've been infectious for years. We talk about informing emergency medical workers, for example, that they have in fact transported someone who has HIV after they've transported them. I refer to that as a next-of-kin bill because it doesn't help the emergency medical worker. It's too late for that worker if he or she has been exposed to HIV. It's nice for the heirs.

If you really want to protect emergency medical workers, if you want to protect ambulance drivers, if you want to protect nurses and doctors and dentists, you don't worry about them knowing, you worry about teaching them how to use universal precautions for all people that they deal with, and you worry about providing

them with adequate equipment - gloves, masks, the kind of little devices they can use to do mouth-to-mouth resuscitation without having fluids come into their mouths. That will save their lives. Now, of course, they wouldn't know who it is that they're dealing with. They won't know about their health, but on the other hand, they won't die of AIDS.

Fourth, I think it's very important not to reinvent the wheel. I think that you can and should follow the advice of the many people who have really put a lot of thought and study into this problem. One of the things that's really amazed me throughout the last six years of the epidemic is the degree to which study of AIDS creates consensus. Especially on the Federal level. We started with flaming members of the ACLU. We've had people like C. Everett Koop or Admiral Watkins, people who are either avowedly, deeply conservative people or people who come from a technical background or a military background, people who oftentimes came on to things like the President's AIDS Commission with very definite ideas about the need for more control or the need for more mandatory testing, people who have found in the course of getting the facts about AIDS that there was a lot more to it than they had originally thought.

Now, these people have come up with, I

think, one set of recommendations that has been endorsed by just about everybody who has studied the problem as a first legislative priority, and that is passage of confidentiality laws and passage or strengthening of anti-discrimination provisions. There is nobody, nobody, who has studied this problem, starting with the President's Commission, moving down through the National Academy of Sciences, Philadelphia AIDS Commission, the American Bar Association - Pennsylvania Task Force, every one of these groups has come up with the same recommendation: You've got to protect confidentiality. I can tell you another thing, this is just the first step, because AIDS is making, I think, everybody realize that their medical records are completely open. The Bork hearings, I think, also made us realize how much people value their privacy. I think it's very important that we see that confidentiality has become both a big social problem when it comes to all medical records and an important public health problem now when it comes to HIV information and that there's virtually no dispute that that at least is a good idea, and I urge you, when the bills that are being talked about here come before you, that you feel free to rely on the expertise of people who have given this considerable thought already.

Finally, I want to leave you with one last

piece of advice, and that's trust your constituents to follow your example. Just last November, Proposition 102, which was a ballot proposition in California which would have essentially gutted any confidential or anonymous testing, was soundly rejected by the voters. There was a real concern that people were going to, out of fear or ignorance, support that kind of bill, and in fact, I think the people came through. People are afraid, and I think no one would know better than you the kind of fear and anxiety that the people have out in hustings. I don't think we make it better when we get rid of that fear. I don't think we make it better when we tell them that they're right, biting is dangerous. It will make them perhaps feel that they're not crazy, but it's not going to help them direct their attention to the ways that they really are at risk.

I'd like to leave you with the image of Ryan White, the young hemophiliac in Indiana who, for several years, was barred from going to school in his hometown, despite the fact that he really posed no risk at all to his fellow students. But the leadership in that town sent out the message that he was dangerous, and people were terrified and everything possible was done to keep him out of school. Finally, he moved to another town where the leadership was a little different, where there was

discussion and education for the public at large about AIDS and about Ryan and about the danger or lack of danger that he posed and where he was fully accepted into the community. Now, that's a school that doesn't have an AIDS problem, and it's a person with AIDS who doesn't have a school problem. That's how we can fight this disease. We can set the right example, and I urge you in the coming months to keep your role as leaders, your role as identifiers of the real problems, your role as supporters of serious efforts to fight this disease foremost in your mind as you look at the laws that are proposed to you.

Thank you very much.

(Whereupon, Chairman Caltagirone resumed the Chair.)

CHAIRMAN CALTAGIRONE: Thank you.

Since I'm one of the proposers of the particular piece of legislation dealing with the prostitution issue, let me throw a question at you gentlemen. I'd like any of you or all of you to come to my district office sometime. I'm in the "red light district" in the city of Reading, and I'd like you to talk to some of the wives of some of the men that have been infected with the AIDS virus from the prostitutes that ply their trade there and hear the stories that I've heard about their husbands coming home with the disease,

infecting them. Okay? And why are these girls still on the street? They've been arrested, they pay their fine, they do their time, and off they go and they're back on the street again. Now, how do we protect society? Where do you draw that line? Where are the rights of the people that send us here?

MR. FAIR: Somebody should have told those men to use a condom.

CHAIRMAN CALTAGIRONE: Well, you know how that is. Years ago they picked up other types of diseases, right? And they were able to get cured through medical science. Now they pick up this disease, and it's a death warrant.

MR. FAIR: I'd have to say, Mr. Caltagirone, that I don't know how many of those women you have talked to in your office, but out of over 80,000 cases of AIDS that have been diagnosed and reported to various health departments across this country, each one of those cases having been subjected to enormously intensive and expensive analysis, not a single one of those cases has been traced to prostitution activity.

CHAIRMAN CALTAGIRONE: You think they want to publicize that? You talk about confidentiality. Do you think people want to publicize that fact?

MR. FAIR: I would only suggest that when it

comes to establishing a public policy direction as significant as this, that we should be basing that public policy direction on more concrete evidence.

CHAIRMAN CALTAGIRONE: You'll get the concrete evidence, I think, and society is probably going to cry out for this legislature and legislatures across this country to do something because if these figures are correct from what we're hearing, then we are going to have to take some kind of action.

MR. FAIR: Mr. Caltagirone, there is no money being paid, no serious funding being provided to the city of Philadelphia by the State Health Department or the State Welfare Department to provide drug treatment services for the vast majority of the prostitutes on our streets who are prostituting in order to get the money to purchase their drugs.

CHAIRMAN CALTAGIRONE: I agree.

MR. FAIR: The way to protect the customers of those women, who I don't believe are at significant risk of HIV infection, but assuming that they were, the way to protect them is to develop a plan on the State level that would combat the enhancement of prostitution that our failure to deal with the drug epidemic has resulted in. That solution would be cheaper and more effective in stopping the spread of AIDS than simply

passing this legislation. I don't disagree with you that if your facts were correct that there may be the need for that kind of legislative initiative, but as Scott was saying in his testimony, it really is not the place where we can make the impact that you want to achieve today.

CHAIRMAN CALTAGIRONE: Oh, that's only one facet, believe me. It is a multi-faceted problem that we're facing here. Don't let me fool you or don't fool me that this one bill or any one of these bills is going to solve the problem. I understand that we need to put additional funds into education, into caring for the people that are infected. I understand that and I agree, and those of us that will try to get the additional funds to support that will try that. How successful we'll be, I don't know. You know, everybody's clamoring for more money out of the budget, and I don't think the State has made a big enough commitment in that area. I agree with you there. But in these other areas, I do think that we're going to have to take a look, a very close look, at the rights of society in exactly how we're going to deal with that. And there's been many, many precedents for this type of thing throughout the history of this country.

MR. FAIR: But they haven't work, Mr. Caltagirone. The fact is, they haven't worked. We can pass this legislation today in the city of Philadelphia

where the prostitution problem is probably significantly worse than it is in Reading and in no way be able to enforce that situation or in any way have a significant impact on the level of infection.

CHAIRMAN CALTAGIRONE: First of all, if you take a girl off the street that's been infecting or has been diagnosed, and whether she infects a guy tonight or tomorrow, suppose she has 10 Johns a day, 70 in a week. One girl.

MR. FAIR: Why doesn't she get charged with assault? Why do you need a special legislation in which to imprison her or punish her?

CHAIRMAN CALTAGIRONE: I wish we had a magic wand that we could wave to make things go away legislatively that we want to.

MR. FAIR: But there is legislation on the books through which we can bring criminal prosecution against an individual who is consciously infecting another person.

CHAIRMAN CALTAGIRONE: Proving it. Proving it.

MR. FAIR: But your legislation doesn't allow us to do that any more easily. What it does do, however, is misrepresent to the people of Pennsylvania that you can make prostitution safe, and we cannot make

prostitution safe.

CHAIRMAN CALTAGIRONE: No, that's not the point. I'm saying that those that have the AIDS virus and know they have it and continue to ply their trade, they're committing a felony. They're giving somebody a potential death warrant, and I think that's wrong. I think they're wrong, and I think steps should be taken to correct that.

MR. BURRIS: Mr. Caltagirone, I think that there is an important distinction between setting norms, which is one of the functions of criminal law, and preventing the transmission of an epidemic disease, which is a public health function. Now, your law will set a norm, although it's a norm that I think all of us would agree is already crystal clear: It's absolutely reprehensible to infect or expose someone else to the risk of infection with a fatal virus. On the other hand, we will not stop transmission by passing that law.

CHAIRMAN CALTAGIRONE: Oh, I absolutely agree. I indicated to you earlier there are other things that have to be done, and I think there are certain commitments that have to be made. I think the confidentiality law is going to have to be looked at in areas there that have to be examined, and how do you protect people? There's more research that has to be done. There's a lot of things that have to be done, but

we've got to start somewhere, don't we?

MR. BURRIS: Well, let's start with getting people off the streets who are on the streets selling their bodies because they need drugs and they can't get a treatment slot.

CHAIRMAN CALTAGIRONE: How do we stop the drug problem?

MR. BURRIS: Well, it's not how do we stop the drug problem, it's how do we offer drug treatment slots to everyone who will use them? And it seems to me that that remains an incredible unsolved problem. It's a problem that unfortunately can't be solved by criminal law but only by an appropriation, and it seems to me that it is very important, both from a practical and from a symbolic point of view, that we do those things which are most urgently needed and which will most directly and most effectively stop transmission first. You know, I realize that you see this as part of a whole package, but I think we see from our side of the table years and years and years in which the money hasn't been there to do the first step, and that, you know, we're always going to stress and continue to stress that we've got to go through the big important steps first, whatever else we do.

CHAIRMAN CALTAGIRONE: Um-hum.

Nick.

REPRESENTATIVE MOEHLMANN: Thank you, Mr. Chairman.

I know we have a very serious time problem and I'll be very brief.

BY REPRESENTATIVE MOEHLMANN: (Of Mr. Menaker)

Q. I'd like to ask Mr. Menaker, in his comments on House Bill 437 suggesting that we use instead the recklessly endangering statute, has that been applied in Pennsylvania to an AIDS situation?

A. I don't know of a single prosecution. There is an AIDS litigation reporter which I read, not faithfully every week, maybe Mr. Burris knows more about it, but I haven't seen a report of a single prosecution in Pennsylvania. There have been in some other States. The law is available. If prosecutors want to use it, they can. I don't think it's a big problem. I don't think there have been too many cases. I think they're rare. They get in the papers because of the sensationalism that the headline creates. But there are very rare cases where someone who knows he is infected with AIDS or any other horrible disease purposely exposes another person in a criminal attack. So that's why there haven't been prosecutions. I don't think it's because the DAs aren't doing their job.

MR. BURRIS: The only case that I know of

involving an assault involving AIDS was a prisoner in, I think, Rockview who had been in isolation for some time and at one point through feces or blood or some kind of body fluid on a guard and has been charged with, last I heard, attempted murder.

REPRESENTATIVE MOEHLMANN: If you were going to use the reckless endangerment statute in that situation, would you have to show that it was the purpose of the actor to transmit AIDS? Supposing you couldn't show -- you could only show that the actor had AIDS.

MR. MENAKER: Let me try and respond to that.

The way the reckless endangerment statute is worded, I don't think it's necessary to show that was his prime purpose because the definition of "recklessly engages in conduct which may place another person in danger of death" doesn't require that purpose. I think if you show that he knew he had it and he knew that what he was likely to cause the infection in another person, that's sufficient under that statute. I don't really think you need a new statute to do it.

REPRESENTATIVE MOEHLMANN: In theory. We will have to get it past the Supreme Court though, which will take X number of months.

MR. MENAKER: Well, you can't even try with

the Supreme Court until someone gets prosecuted under the law to begin with.

Most of the things that would be envisioned as recklessly endangering even do not constitute a risk, like throwing feces, the example from Rockview. There's no way you can transmit AIDS by throwing feces at someone. It's very difficult to transmit this disease. I mean, you literally got to pull a needle out of you and stick it into someone else in order to transmit it by the blood contact. Biting won't work, spitting won't work, kissing wont' work. Even superficial scratches don't work. You don't bleed in, you bleed out. That's why the needle has to be pushed deep into the skin to transmit. And even in the medical community there have been only nine known cases of transmission by a needle stick to a medical technologist or a health care provider. That's out of about 1,900 documented cases where the stick took place from an AIDS patient who was being treated. So it's not a very likely means of transmission.

REPRESENTATIVE MOEHLMANN: Thank you, Mr. Menaker.

Thank you, Mr. Chairman.

REPRESENTATIVE REBER: Thank you, Mr. Chairman.

I don't know how my nine years in the

legislature I always get involved in these easy issues like surrogate parenting and like unilateral one-year divorce, and now today we sit here and we talk about AIDS, but I guess if for no other reason--

REPRESENTATIVE MOEHLMANN: Could have just stayed at home and practiced.

REPRESENTATIVE REBER: Could have done that as well, as my wife often says to me every evening, when I do show up on occasion.

I guess the thing that bothers me most about all these kinds of issues is I think the thing that is criminal is where the legislature does not act or delays in acting to define the scope of an issue, to define the issue itself. That transcends itself on the funding issue. I think that's criminal that the legislature does not move in the areas specific to the Philadelphia scenario where there is an obvious pocket cell of need for that remediation through the fiscal process, and I hold the Governor accountable. I'm not going to sit here today and listen Dr. Richards take all the blame. As I do recall, it was the Governor's budget that he is supporting and proposing, so let's just put the finger where the finger belongs.

REPRESENTATIVE REBER: Second of all--

REPRESENTATIVE JOSEPHS: Absolutely. You're

absolutely right.

REPRESENTATIVE REBER: With all due respect to Representative Josephs, I sat very quietly and listened to you, so I wish you would do it to me. Regardless of your agreement.

Second of all, I think something that's sort of comical, and I recall when I was in law school, Ninth Circuit California, correct? I don't rely on too many circuit court cases any longer, but I used to enjoy reading Judge Scaly Wrightman and everyone out of that ninth circuit, and it's always interesting, and I chuckle to rely upon California as a precedent for anything, with the mind set of the people in that socioeconomic environment, if you will; subculture almost, if you will. But I do think something that is interesting in the California scenario on the Rock Hudson's lover's case, as opposed to the Rock Hudson's lover's bill, as we hear about here today, first of all, I think the legislative concept of this legislation as proposed predated the case in California. It was introduced last session, and I must say, unfortunately, I haven't heard, up until today, from anyone representing any interest on this issue about how to move or not to move in this area, so I'm glad, if for no other reason, that with the reintroduction of this legislation and some of the legislation that the chairman

has introduced we have finally at least brought to the forefront a forum for the discussion, the open and robust discussion which I think is necessary on these issues.

I think there is something, though, that is concerning to me, and that is the fact that so often in the legal profession where there are novel situations developing, there's also a need to seize upon novel procedural nuances, if you will, to move forward to bring that about, and to some extent, that's what we see in the civil side with what happened in California. It's my concern if there is going to be that isolated case to be brought, let's know for sure what is public policy on how that case should be viewed both procedurally and substantively. I think that's the reason why we have to discuss and have to define exactly where a civil action, if a civil action is to be brought, is going to go.

It's obvious to me that you have two things that came out of California. You have a jury that found an award in excess of $10 million, as the testimony noted. There you have a mind set within the community that finds the conduct to be reprehensible. Additionally, I also find it that the appellate court, where you have a different type of mind set and a different type of professional expertise, if you will, that's viewing that particular set of facts and the award that came as a

result of that jury trial granted cut the award in half, but still found it so reprehensible that they're awarding $5 million for the conduct complained of by the plaintiff in that case.

Again, I think if this is going to happen in Pennsylvania, we have an obligation to the members of the Bar, to the particular plaintiff and defendants that might be out there involved in this type of issue, to have set forth a public policy through the legislative process to aid and assist all party litigants, as well as their professional counsel, as to where this is going to go. I certainly welcome the thoughts, and I think that's the reason behind strictly defining where this can go.

There's something also that bothers me a little bit about using criminal statutes for prosecution of acts, of criminal acts, that from my research on the legislative intent behind the adoption of the recklessly endangering statute there was never any discussions or, from my review, any intent that is to be used for a recklessly endangering type of conduct vis-a-vis transmission of some type of disease.

One thing I think we have to remember when we're talking about AIDS is we're talking about a disease that has absolutely no cure whatsoever, and I would respectfully submit that in those kind of cases or in this

case of case, we are talking about action that is tantamount to homicide conduct when in fact it is being willfully carried out, and I'm not so sure that a misdemeanor of the second degree, which is the recklessly endangering statute, falls within the purview of the type of sanction or penalty that should be inflicted upon someone that willfully and with criminal intent moves forward with such conduct that is tantamount to homicide. A little bit of public policy concept again behind 437 and where that particular scenario is going.

I don't think there's anything that we have to look any further from in the fact that in many instances we have failed in our educational process, in our counseling process, in our medical process, when we allow some of these heinous acts to ultimately come to the situation where we have to be looking for a type of criminal or civil redress which these particular proposals, and that's all they are, proposals, and as I think Mr. Burris can attest and did elude to, they were brought out for this purpose and they were respectfully pulled back and requested to have hearings on all of these concepts so there could be the opportunity to have people come forward and present their concerns that we're hearing today, and as I know it really for the first time on many of these topics, and I think the chairman was admirable in

scheduling and coordinating these hearings to really get this topic to the front lines of the legislature, and I commend him for that as well.

One last thought, and then I'll certainly subject myself to cross-examination as well vis-a-vis my comments.

REPRESENTATIVE MOEHLMANN: Did you have a question?

REPRESENTATIVE REBER: Yes, I'm coming up. I'm laying the foundation, I think.

On the mandatory testing, I don't think there's anyone in the legislature that has been more outspoken, or I should say anyone else outspoken, on civil liberties than myself, and I do hold very high the constitutional concerns relative to mandatory testing, but don't we really require mandatory testing of all our DUI people? Don't we really require mandatory testing, if you will, of those that are convicted of driving under the influence, of involvement in various types of drug cases? I don't see where there is much, much difference from that as part of the probationary sentence scenario as is set forth in Representative Caltagirone's bill relative to those that may be, and as I read the legislation, I believe it said convicted of prostitution. I think we have an obligation in the General Assembly to move forward

in whatever ways we can constitutionally move forward to aid and assist in stemming what is an obvious concern to the public and the public health arena, or however else you want to characterize it, and I think these concepts have to be looked at. I think they have to be massaged, I think the confidentiality issue is very, very paramount because we don't want to drive these people underground, but I do think in many of these instances we're talking about very, very isolated situations, but nonetheless isolated situations that have to be reviewed and viewed for purposes of taking care of that potential harm that could befall an innocent victim if in fact we do not take the time and carry out our obligation.

They are just some rambling thoughts on the very well put thoughts of our three panelists and I think are some of my views as to why we have to enter in and engage in this kind of discussion, and I thank the chairman and I thank those in attendance for giving me the opportunity and the forbearance, if you will, in allowing me to run on with some of those thoughts.

But I do think that's the reason why we're here. No one called the bills up, no one has asked the committee to vote on them, no one has put them on the calendar, no one has attempted to amend into some other vehicle on the floor a Crimes Code bill or a Title 42

bill. Believe me, I don't think anyone on this committee is looking forward to ramming anything on such a sensitive issue in any direction, and I think if there is anything that comes out of these hearings today on these topics, it should be that we are desirous of entering into as full, robust discussion as we can get on these sensitive issues, and I certainly will be looking forward to both the administration -- of course, I've been looking forward to a lot of things from the administration on various proposals over the past two years, but I'm looking forward to the Health Department vis-a-vis the administration's proposal, as well as the Bar Association's Task Force product on these particular subjects.

Thank you, Mr. Chairman.

CHAIRMAN CALTAGIRONE: Thank you, Representative Reber.

Representative Blaum.

REPRESENTATIVE BLAUM: Thank you, Mr. Chairman.

I learn a lot when I come to these hearings, and I've learned a lot today, and when I think I understand this issue, I come to one of these hearings and I get a little bit more confused.

Dr. Richards said that obviously this disease is transmitted through intimate sexual contact,

but we've had testimony here today that the people who would patronize prostitutes are not in a high risk. In fact, it was said that male partners of female prostitutes are not considered to be a high-risk group for HIV infection, and then Mr. Fair says in his testimony that the sad fact is that the people who are most likely to contract AIDS at this very minute are our young people who continue to engage in unprotected sex. I would assume they are a lot less active than our prostitutes. And then Mr. Burris suggests that our EMT professionals be protected with devices when they're giving mouth-to-mouth, and that's to avoid the transmission, I guess, of saliva.

What's what?

MR. MENAKER: Let me try to deal with some of these apparent inconsistencies.

Number one, I didn't say that prostitutes were are a high-risk group. They are.

REPRESENTATIVE BLAUM: I understand that.

MR. MENAKER: And I don't know what the results were, Mr. Chairman, in Reading when they tested prostitutes there. I do know the studies in Newark, New Jersey, and it was more than half of those tested who were positive. Now, as I understand it, the likelihood is they did not get it from the males that they consort with as customers. They got it either from using drugs, and a

very high percentage of street prostitutes are IV drug users, or from the men that they live with and sleep with who are themselves IV drug users. That's how the prostitutes got it.

REPRESENTATIVE BLAUM: I understand.

MR. MENAKER: They are not nearly as likely to transmit it to their male customers as a man is to a man. Male homosexual activity is a very high-risk sexual transmission compared to heterosexual, although eventually it will be a much higher incidence in the heterosexual population, and that's what Mr. Fair alluded to. We have not yet seen much of that, and they thought by now the percentage would be higher in the heterosexual population, but it's coming. It's going to happen.

The concern is that there are some things that can transmit it and some things that are not likely to. With the saliva, they don't know of a single transmission by saliva; not one. It's possible because they have found the virus in saliva that very low concentration, a low type of, and if the person who had mouth contact with the person who's infected had an open sore in his or her mouth, it's conceivable it could be transmitted that way. In order to make the emergency medical technician more comfortable, I think it's a good idea, as Mr. Burris suggested, to supply an airway, a

plastic airway, and I've suggested to my clients in an industrial setting that these be included in first aid kits in industrial plants. I personally don't think it's necessary, but if it will encourage one more person to give mouth to mouth who would have been reluctant to do it otherwise, God bless them. Let's give them the airway.

Mosquitos, the same way. There's never been a known transmission by mosquitos. And you might say, well, how do they know that? Mosquitos sting somebody and get blood on them and go sting somebody else. Well, they've done studies in the swamps of Florida where there's a high concentration of Haitians who had a higher incidence of HIV-positive status. And the kids are the ones who are out playing outside where the mosquitos bite them all day long. Not a single child in those communities, in Immokalee and that area of Florida, not a single child contracted AIDS. The transmission was sexual and needles from one adult to another.

So as Dr. Richards said, for some time we've known how the disease is likely to be transmitted and how it's not. The public perception is different from that, and that's part of the educational process. We have to let people know that they're not going to get it from kissing or sharing toothbrushes or whatever, but they are when they go down to the local singles bar and pick

someone up. The same nurse who's paranoid about taking care of a patient in a hospital and puts on a gown and a mask and a hood and looks like Darth Vader when she walks in the room to pick up a dietary tray perhaps will leave work at 11:00 o'clock at night and go to the local bar and be picked up and go home with a guy she doesn't even know his name or who he slept with the night before. That's where we've got to do the education.

REPRESENTATIVE REBER: Does that really go on?

MR. MENAKER: Yes.

REPRESENTATIVE REBER: Okay.

MR. MENAKER: Not testifying from personal experience, only from reading material.

REPRESENTATIVE MOEHLMANN: Terrible thing to suggest about nurses.

REPRESENTATIVE BLAUM: Is she in greater danger? Is the nurse in greater danger when she picks up at the single bar--

MR. MENAKER: Yes.

REPRESENTATIVE BLAUM: --than the male partners of female prostitutes who you say are not considered to be a high-risk group for HIV infection?

MR. MENAKER: Yes, because semen has a very high concentration of the virus, as high as blood, and

male-to-male or male-to-female transmission is much more likely than female-to-male.

REPRESENTATIVE BLAUM: So then my question to Mr. Fair is then are teenage girls perhaps more susceptible to it than heterosexual?

MR. FAIR: Absolutely. Absolutely.

In a city like Philadelphia where we have incredible epidemics of other sexually transmitted diseases such as syphilis and very little capacity to treat those diseases, in our STD clinic we turn away over 150 people who come in every week exhibiting symptoms of syphilis and gonorrhea because we don't have the resources to do that. A woman with syphilis frequently will not be aware that she has syphilis, and the lesions in her vagina will put her at greater risk of infection if she has sex with a male who is infected with the virus.

Also in Philadelphia, the direct connection between sex and drugs is one of the more dramatic indicators of where this virus is going to be spreading. The Crack epidemic, and most Crack in the city of Philadelphia is smoked, about a corridor of the people who shoot drugs in the city are shooting up cocaine, but most of the Crack that is used, and that's the cheapest and most commonly used street drug, the people doing that are young people, people under the age of 22, people 23 or

younger, primarily. There's a direct correlation between sexual activity and Crack use. Kids who do Crack frequently believe, whether it's chemically true or not, they believe that their sexual potency increases and as a result have more sexual activity that might be common. More and more frequently, because of the economics of the Crack epidemic, kids are unable to pay for the drug out of their own resources and sell their bodies to others in order to get the money, or sell their bodies to the person who sells them the drug. That's the most risky behavior yet because the person who sells them the drug is more likely to be connected in some way into the intravenous drug spread of the AIDS virus. There was a study done by the STD program in Baltimore which showed that on average, a female Crack addict in a Crack house in the city of Baltimore had sex on average six to eight times per day. Full-fledged sexual intercourse six to eight times per day in order to get the drug, in order to feed the addiction. That is a prescription for AIDS virus infection.

MR. BURRIS: Do you mind if I give you a couple of answers to these questions already raised?

REPRESENTATIVE BLAUM: Sure.

MR. BURRIS: First of all, when I talked about barrier precautions in the mouth for emergency medical workers, I certainly didn't mean to suggest that

saliva was a problem. Instead, I think those are useful when there has been trauma and there may be blood in the mouth, and blood is considerably more likely to spread HIV than is saliva, and that's when that's really an important safety precaution for anybody who is giving mouth-to-mouth resuscitation.

On prostitution, I think actually it may be important to focus on it a little more closely than we have so far. First of all, prostitution covers a lot of activities by a lot of different kinds of people. There are what are often referred to as call girls, and we're talking about female prostitutes, although most of this also applies to male prostitutes, people who charge a relatively high amount of money, have a relatively select clientele, often with many repeat customers or regular customers and who may or may not, but generally are not, using intravenous drugs. And there are also street prostitutes who have more anonymous encounters with people who are not repeat customer, who may disproportionately be involved with intravenous drugs. Across the board, it's the connection with IV drugs that is related to a high prevalence of AIDS in a prostitute population. It's also true that on a national level, prevalence is not high among prostitutes. It is there but it's not high. And Newark was, from the time it was initially studied, much

higher than any other place in the country. In many places in the country there was no HIV among prostitutes, or a very, very small amount. That's not to say it's not a concern. It's something that we shouldn't generalize too broadly about prostitution.

Another important thing when we're thinking about why male customers of prostitutes may not be at that high risk as heterosexual partners of men in the singles bar is the kind of sex that is purchased. Nearly three-fourths of the sex that is purchased from street prostitutes, to the degree that we have information, and this is an area that we just don't have exhaustive information on, is passive oral sex on the part of a prostitute. That poses virtually no risk to the John because of the lack of transmission through saliva and the relatively -- and general difficulty of getting infected with HIV through the penis in that form of sex. Prostitutes, especially female prostitutes, are not going to practice active anal intercourse with a John as a matter of sheer physical impossibility. Therefore, the kind -- and even unprotected heterosexual intercourse in this country among a population that is not, for example, highly afflicted with venereal disease has not proven yet to be as efficient a means of transmission as, for example, passive anal intercourse. So we're talking about

a range of probabilities that's considerably lower than other forms of sex.

And the other thing I think finally we have to keep in mind when we talk about how we approach prostitution and the way we educate people is that prostitutes, generally speaking, work in a market in which supply exceeds demand. Prostitutes very frequently express a willingness, and in fact generally speaking, as far as we know, are fairly sophisticated about using condoms, but they cannot enforce it upon their clients. And so when we talk about using condoms and changing prostitutes' risky behavior, it's very important that we don't focus on prostitutes only because their willingness to use a condom is not going to be as decisive as teaching people who go to prostitutes that if they're not going to abstain from that kind of behavior, then they had very well better use a condom.

REPRESENTATIVE BLAUM: Mr. Fair, in light of your statement that those who are most likely to contract AIDS are our young people continuing to engage in unprotected sex, if you had your way, what would you tell the administration as far as how to address this problem among the young people in Philadelphia as well as across the State?

MR. FAIR: We need more drug treatment.

Basically, the problem in Philadelphia in terms of the spreads of the AIDS virus is the connection to the astronomical increase in Crack and other street drugs and our total inability to provide any alternatives to that drug use in our city. In the longer term, obviously, if these kids felt that they had some kind of a future that was worth protecting, if they were getting a quality education out of our school system, if they were able to see a career path beyond making $6 in McDonald's, then maybe they wouldn't choose to get into the drug trade, where they can make a lot more than $6 an hour. So the longer term solutions are much more complex, but the immediate solution, the two things that I would like to be able to do today, one of which I can do to some extent, the other of which I can't, is to get to those teenagers with the AIDS prevention message, to talk to them about the risk of this behavior, to encourage those teenagers who are not having sex not to do so until they are capable of doing so in a responsible fashion, and if they are having sex, to be able to talk to them in a way that they can understand about how they can do so safely, and to provide drug treatment to those who need it. We currently have in our system in Philadelphia, through the coordinating Office of Drug and Alcohol Abuse Programs, a waiting list of approximately 2,500 people under the age

of 22 requesting drug treatment that we can't provide. So I would say that the answer is in that area.

MR. BURRIS: I could also give you another anecdote. This is an incident that's going on right now that I'm involved with as the attorney of the person it happened to. But a student at Central High School yesterday morning undertook, as her own personal contribution to fighting AIDS, to pass out condoms and leaflets about safe sex and drug use across the street from her school, off school property, before school started. As soon as she got into school, security personnel came and removed her from her classroom, took her to a security office where the assistant principal told her that she was not allowed to pass out condoms or information about safe sex to any Central High School student at any time in any place.

Now, two-thirds of the students in that school are having sex by the time they're in 10th grade, and the school is not telling them how to be safe. And in fact, now that someone has undertaken to fill that void, the school has prevented her from doing it. So we have a long way to go.

MR. FAIR: I am a public health official responsible for stopping the spread of AIDS in that very community and I'm not allowed to do that either.

REPRESENTATIVE BLAUM: I want to thank the three gentlemen for their testimony and tell Mr. Burris, good luck with your case.

CHAIRMAN CALTAGIRONE: Babette.

REPRESENTATIVE JOSEPHS: I'm going to give everybody here a break. I don't have any questions.

Thank you very much, all three of you.

MR. PARRISH: I'd just like to say, being from Philadelphia, that's very disheartening news to hear that they can't even pass out literature across the street, and I know there's an apartment building right across the street from Central High School where lots of kids go when they're not in classes and have sex in that area. It's very distressing.

MR. FAIR: I would like to beg your indulgence. There was a clear misrepresentation that the Health Secretary brought up here that I would really like to correct. We have at no time refused to accept any money from the Commonwealth of Pennsylvania for AIDS programs. In fact, in January of this year when we were renewing our contract with the State for the Federal fund which is passed through Harrisburg to Philadelphia, a contract for close to $5 million that was received based on a proposal written in Philadelphia, not written by the State Health Department, we were informed at that time

that the State was going to offer us $300,000 for this fiscal year. This was in January, after the contract period had begun.

In late February, I received a phone call from Grace Verrano, the Special Assistant to the Health Secretary, informing me that the State was going to add in an additional $600,000 into what would be an 18-month contract, January 1, 1989 through June 30 of 1990, bringing the total State funding in that contract to about $960,000. That was very good news. The bad news was that one of the preconditions was that we spend $700,000 of it before June. This was in late February we were informed of this, that we spend $700,000 of it before June. None of the money could be spent on any services to anyone who was sick or anyone who was likely to get sick during the course of the fiscal year. None of the money could be spent in support of community-based organizations and doing AIDS prevention activities. In fact, most of the money had to be concentrated on broad public awareness activities, television commercials, posters, things of that nature, and in encouraging people to call the State's 800 number, the AIDS Fact Line, which is one telephone answered by untrained personnel and if somebody is on the phone, everybody else in the State gets a busy signal.

We said we weren't willing to do that. We

said we were willing to take $960,000 and redrafted a counterproposal that spread that funding out over an 18-month period, and that is, I believe, the proposal that was ultimately accepted by the State. And I did ask Ms. Verrano why it was so important to spend the money so quickly, and her answer was that they had been unable to allocate the funding and the Governor intended to make reference to his million dollars of AIDS funding in Philadelphia in his budget message, and we decided not to be cooperative with that particular political strategy because it didn't serve our purposes in stopping the spread of AIDS. We are grateful for the additional $600,000 and we have proposed a plan to spend that in a responsible fashion. The State dumped that money on us without any plan, without any coordination, without attempt to work with us on how it could be spent. And as far as I'm concerned, given the urgency of significant increases in State funding for AIDS programs not only in Philadelphia but throughout the State, the conscious misrepresentation that the Health Secretary represented to you this morning is criminal.

CHAIRMAN CALTAGIRONE: Gentlemen, thank you very much.

At this time, we'll take a 15-minute break and resume again at 2:00 o'clock, at which time we'll have

the next three participants come up and testify.

(Whereupon, a recess was taken at 1:45 p.m. The hearing was reconvened at 2:15 p.m.)

(Whereupon, Representative Reber assumed the Chair.)

ACTING CHAIRMAN REBER: We'll reconvene this hearing.

At this time, we have present at the witness table Anna Forbes, David Hawk, and Toni Leggett.

MS. FORBES: Thank you very much.

My name is Anna Forbes, and I work with Action AIDS. Action AIDS is a communities-based organization in Philadelphia that's currently providing direct services to approximately three-quarters of the people living with full-blown AIDS in the Philadelphia area. To give you some idea of what that means, our caseload has increased by 450 percent in the last six months. We're now serving approximately 400 people with AIDS, and two days ago we received death notifications for three people who were very well known to me, having been notified of the deaths of all three in one day. I mention this only to say that I think that it would be hard to dispute the fact that Action AIDS has a very, very clear interest in seeing the AIDS epidemic stopped as rapidly and as efficiently as possible.

Nonetheless, I'm here today to say that I think that House Bill 624, while intended to restrict HIV transmission, would necessarily fail to meet that goal and would necessarily be a dreadful waste of valuable resources. Stopping the AIDS epidemic now rampant in Pennsylvania will require every dollar that we have, and we can't afford to waste any of them.

As was mentioned this morning, approximately 100,000 Pennsylvanians are now HIV-positive, and most of them are not now and never have been prostitutes. In fact, many studies, including one conducted by the CDC in seven different research sites throughout the country, demonstrated that the incidence of HIV positivity among prostitutes was virtually identical to the known seroprevalence among non-prostitute women in the same geographical area. It stands to reason when one considers that the consistency of condom use among prostitutes as compared to the consistency of condemn use among non-prostitute heterosexual women, the prostitutes working the streets account for only about 10 to 20 percent of the estimated 1 million women working as prostitutes in the United States at any given time. The other 80 to 90 percent work in brothels, massage parlors or escort services, or independently. This vast majority of prostitutes are almost universally cautious about condom

use and safer sex practices. They are, in fact, much more effective in their AIDS prevention efforts than is the average non-prostitute woman.

Street prostitutes, the 10 to 20 percent minority, are those who are the most frequently arrested, those most likely to be IV drug users, and those at highest rate of HIV infection. In New York City, it is estimated that one-third to one-half of the approximately 20,000 street prostitutes are IV drug users and are, therefore, an extremely high risk of HIV infection. I fully understand that it is prostitute population that HB 624 intends to test and possibly to prosecute, but even with these odds, House Bill 624 cannot possibly work for AIDS prevention because no one can give you AIDS, you have to take it from them.

Think about this for a minute. You can subject arrested prostitutes to testing. If they test positive, you can inform them that the added penalties will apply if they are rearrested for prostitution, but what you can't do is demonstrate in any way whatsoever that these measures will reduce the total number of HIV-positive prostitutes on the street and that any customer will be any more protected from HIV transmission than he would have been without House Bill 624. Because the only one who can protect the customer is himself.

When any person makes the decision not to take HIV-bearing fluids into his or her body, and in terms of sex, this means using a condom every time, then no one, whether it be a prostitute, a lover, a spouse, or whoever, can give that person HIV. 100,000 Pennsylvanians at least are HIV positive. They live in our neighborhoods, they go to our churches, and some of them are sitting in this room. But unless we permit ourselves to take HIV into our bodies, we are not at risk of HIV, regardless of who around us is carrying it. And if each of us does not act to prevent transmission during sex, we may be at risk of HIV, whether that sexual act occurs with someone we dated for a year, with someone we met at a bar, or with a prostitute that we just hired.

Let me illustrate this further by pointing out that men who refuse to use condoms may actually be infecting each other when they visit prostitutes. This can happen as a result of exposure to traces of the previous client's semen in the prostitute's vagina. You can test prostitutes forever but you can't prevent that risk, no matter what the prostitute's HIV status is, unless you educate people about the importance of protecting themselves through condom use.

The removal of some prostitutes from the streets through whatever means won't prevent HIV

transmission because it will in no way lessen or prevent the occurrence of high-risk behaviors. More prostitutes will replace those arrested, more people will go to greater lengths to avoid arrest and thus to avoid testing. When the names of those hiring prostitutes were published in the newspapers in Reading, Pennsylvania, does anyone really think that it decreased the number of acts of prostitution being committed in Reading? When my home State, Illinois, started to require HIV testing as a condition of getting a marriage license, do you know what happened? The rate of new marriage licenses being issued in Illinois dropped, and the rate soared in neighboring Wisconsin.

People who don't want to be tested will go to great lengths to avoid being tested. Nobody seriously involved in the field of AIDS, from the Surgeon General Koop on down, believes for a moment that any kind of mandatory testing whatsoever has ever or will ever reduce the risk of HIV transmission and stop the deadly sweep of AIDS.

The State does have a clear and legitimate interest in stopping the epidemic that has already killed 1,400 Pennsylvanians and will kill tens of thousands more. So rather than talk about methods that are demonstrably ineffective and wasteful, let's talk about what will work.

Again, no one can give you AIDS, you have to take it from them.

Pennsylvania, the 5th largest State in the Union, ranks 7th in incidents of AIDS, and yet of 38 States funding AIDS services, Pennsylvania ranks 37th. Pennsylvania is proposing to spend the same amount per capita on AIDS prevention in this year's budget as the States of Iowa, Mississippi, and Alabama. But Iowa, Mississippi and Alabama aren't in the top 10 of AIDS incidents. We are. We rank 7th in terms of State residents diagnosed with the fatal syndrome. We rank 37th in meeting the demands of this epidemic. We are a State with a budget surplus, and yet our budget says we cannot afford to fight AIDS effectively. Among intravenous drug users, the incidents of AIDS has skyrocketed. It clearly follows that Pennsylvania must adequately fund the operation of detoxification and treatment programs if the rapid spread of AIDS has any hope of being arrested.

Last year, approximately 5,000 people were admitted to Philadelphia's residential IV drug abuse programs, just one-tenth of the known population of drug addicted people. Theoretically, the State is obliged to provide approximately 90 percent of the funding to these treatment centers, to which the city adds 10 percent in matching funds. The reality is that year after year, the

State funding for this hasn't been provided in anywhere near that level, and the city overmatching to the extent of its limited ability has attempted to compensate. The result has been a desperate lack of facilities, resulting in long waiting periods for access to appropriate treatment.

A few months ago, a young drug-addicted woman with a history of prostitution who had just given birth to HIV-positive twins came in to Action AIDS. She desperately wanted to get into drug treatment, conquer her addiction, and take care of her babies. For six weeks we struggled to get her into a program, to help her hang onto these good intentions despite the drug infested environment in which she was living. Then one of the babies died of AIDS. In her grief and despair, the mother resumed her drug use. She disappeared back into the streets, taking the other baby with her. We have not seen or heard from her since.

No one can give you AIDS, you have to take it from them. No quarantine, no criminal penalties, can keep the virus from you. You have to take responsibility to keep it from yourself. If we're serious about stopping AIDS, we have to be serious about providing appropriate, effective AIDS prevention education and drug treatment.

I would like to conclude by quoting from an

article in the Mortality and Morbidity Weekly Report published by the U.S. Department of Health and Human Services. Quote: "Traditionally, medical care, therapy for drug addiction, welfare benefits, and vocational rehabilitation have not been routinely offered to women apprehended for prostitution. Now some organizations are introducing innovative approaches to prostitutes. The California Prostitutes Education Project attempts to warn prostitutes about the danger of unprotected exposure and provides educational sessions on how to prevent infection. Children of the Night in Los Angeles, Covenant House in New York City, the Ryan House in Seattle, and other social service organizations offer counseling and sanctuary to homeless adolescents, including those involved in prostitution. State and local health departments often work closely with these organizations," close quote.

This is a model that can stop the AIDS virus. House Bill 624 can't. All it can do is cost us money, time, and lives.

Thank you very much for hearing my testimony. Unfortunately, I need to leave soon, so if there are questions, I'd be happy to entertain them.

BY REPRESENTATIVE STRITTMATTER: (Of Ms. Forbes)

Q. Thank you. When you were quoting the figures about Pennsylvania being the 37th in funding, can

you tell me what your funding figure was for Pennsylvania?

A. I was basing that on the $3 million of actual AIDS-specific funding that are allocated in the proposed State budget.

Q. Okay, fine.

A. It's $2 million in the previous budget, with $1 million added. And I realize that that's a figure of some controversy, but I would like to point out that Bill Fisher of the Department of Health acknowledged in the press last week that only $1 million had in fact been added in new money for AIDS prevention efforts.

Q. Are you aware of any Department of Education funding or Department of Public Welfare funding?

A. Not to my knowledge.

Q. Thank you.

ACTING CHAIRMAN REBER: Thanks.

MS. FORBES: Thank you very much. I will be sending copies of my testimony to those attending this hearing. I apologize for not having copies in print to offer to you today.

ACTING CHAIRMAN REBER: Thank you. That's all right. If you want to send them to the attention of the chairman, he'll see that they're disseminated.

Toni, I guess you're next on the agenda.

MS. LEGGETT: I guess so.

My name is Toni Leggett. I teach at Penn State, Harrisburg, Department of Criminal Justice. I'm the individual who found the Oregon bill. I have been doing research in AIDS in the correctional system and criminal justice issues now for about two years, and I was at an AIDS symposium recently and that is where the bill was introduced, and then I was encouraged to send it up here, so that's the story about how originally it got here.

In 1988, the chairman of the President's AIDS Commission called for sweeping measures to fight the AIDS epidemic, which Admiral James D. Watkins called for States to adopt laws making it a crime to transmit the virus knowingly, sex offenders be tested for HIV and their status be taken into account at sentencing or parole hearings, and testing of prisoners should be voluntary.

I have offered a bill for consideration that will offer some information to victims of sexual assault regarding the status of their assailant's AIDS testing and possible diagnosis. If this bill is passed, then the victims would have at least 18 months in which the assailant will be offered testing and finally be ordered to undergo testing as a means of protecting the victims from possible physical and psychological damage and possible transmission of the AIDS virus to his spouse,

significant other, or fetus. This bill is most effective if it can be combined with a voluntary program in which prisoners can request an AIDS test without having to go through the current policy mandates. Bluntly put, it is not within the expertise of a guard, counselor, or a friend to identify symptoms before a referral is made to a physician who will then decide if an AIDS test is necessary. The individual prisoner knows his history and should have the right to request an AIDS test. Does it bother anyone else that education and training in AIDS is required, and when a prisoner recognizes that his lifestyle has made him a high-risk individual, there is a policy that will actually prevent him from being tested.

The Federal Bureau of Prisons allows for voluntary testing once every 12 months. Random testing occurs in 10 percent of the new commitments. The major provisions of the Omnibus Health Legislation, which is Public Law 100-607, which was passed 11-4-88 states -- it's Title 9 -- "Authorized such sums for fiscal 1988-90 for States to test convicted sex offenders or illegal intravenous drug users in State penal facilities for exposure to HIV. Define such offenders as those convicted of a crime other than simple possession of a controlled substance punishable by more than a year in prison. In order to receive Federal funding for prisoner testing,

required States to establish a program to provide for confidential testing, education, and pre- and post-test counseling. Test results could be revealed only to necessary correctional personnel as determined by the State's health department, and rape victims in cases in which convicted rapists test positive. States would be required to pay half the costs of such testing."

The testing will range from $4 to $100 for the same test, depending on where you go to get it done and who is doing it.

BY ACTING CHAIRMAN REBER: (Of Ms. Leggett)

Q. Do you have anyone presently in the Commonwealth of Pennsylvania that is going to be proposing the so-called Oregon bill that we've heard about, now that you now claim authorship of?

A. No, I do not claim authorship of it. No, I do not know of anyone that is going to be presenting that. I'm presenting that as -- I worked in sex crimes for 10 years before I went and decided to get a Ph.D. The situation is that as part of my work, I ran into a lot of victims who are now coming up with post-traumatic stress syndrome situations in which they have been married for four years, have never told their significant others that they were raped, thought they had put it away, and now they are reliving this experience that is it possible that

I could have AIDS or that I could be a carrier? You know, not wanting to go get the test. I'm very, very concerned about it.

The comment that was made that a victim of rape can go and get herself tested, well, that's fine as long as you are making a determination that the victim is capable emotionally, physically, and financially of getting that test. You have to understand that a lot of our sexual assault victims will start at three weeks of age and go all the way up to the age of 89, and we have known of even older individuals who have been victims of sexual assault. Males and females. We understand about those children that are living on the streets. So we are not just talking about an adult female who has the ability to do that, nor is it incumbent upon the victim to have to undergo this once again.

Q. I noted that Counselor Menaker referenced in his testimony the support of the Pennsylvania Bar Association for the concept embodied in Oregon House Bill 2471.

A. The first part, yes, not the second one. The Crime Commission.

Q. Okay. Could you please provide us with an in-depth copy of the entire text of that proposal?

A. Certainly.

Q. Okay. And you can send that, likewise, to the chairman and he'll see that it's disseminated to all the members of the committee. I certainly think if and when the committee does move on any of these procedural or substantive types of legislation that we certainly would want to consider some of the concepts embodied in that, so it would be very helpful.

A. What is interesting about the Oregon bill is that it stems from a lot of research that was dealt into the Department of Corrections. There was a determination that needed to be made if mandatory testing was necessary, or if you gave voluntary testing, what was going to be the difference in response? They got more of a response from voluntary testing than they would have ever expected, so that it matched the mandatory testing and the results.

Secondly, they had prisoners actually stating, you know, I have committed these sexual assaults and this is where it occurred. I do know some of the individuals' names. Go into the Department of Health and have the Department of Health contact these individuals, offer them counseling and AIDS testing. So it has been very, very successful. It is also used by the Child Protective Services units for asking mandatory testing for fathers who are arrested for sexual child abuse. This

goes along with the syphilis and the gonorrhea tests that occur. So, you know, the generic issues in this particular bill do offer a lot of protections.

ACTING CHAIRMAN REBER: Okay. Thank you very much.

Doctor, I guess it's your turn.

DR. HAWK: Thank you very much, Mr. Chairman and members of the committee.

My name is David Hawk, and I'm a physician and the Director of the York City Bureau of Health in York, Pennsylvania. I want to first of all thank you for this opportunity to speak with you this afternoon about this very serious problem, AIDS, or Acquired Immune Deficiency Syndrome. In the text of my -- for presentation, I'm going to skip over my CV portion and just let you know that I did get a medical degree from the University of Pennsylvania, and a master's degree in public health from Johns Hopkins University.

During the past 15 years, I have served in the Navy, I have been in private practice, I've held administrative and academic positions. Since 1985, I've been the Director of Health for the York City Bureau of Health, one of eight county and municipal health departments in the State of Pennsylvania funded by the State legislature.

At the York City Bureau of Health, I and my staff have been involved in the AIDS epidemic since 1985, when the HIV antibody test become available. We provide HIV antibody testing and counseling, partner notification, and AIDS education to anyone who will listen to us. We receive reports of AIDS cases who reside in the city of York, and we assign a public health nurse to gather required information and provide supportive services as indicated.

In the city of York, since the first AIDS cases were reported in 1987, we now have 21 confirmed cases of AIDS. Recent trends in our AIDS cases and in those testing positive for HIV antibody show more intravenous drug users, more minorities, and more women becoming victims of this deadly disease. And with more women, almost all of whom are in the child bearing age range, it can be tragically predicted that infants born with HIV infection will also be on the increase. In many ways, York is a microcosm of what is happening elsewhere in the State and the nation currently. AIDS has changed the field of public health and medicine also drastically during the past nine years. Changes will continue and complex issues will continue to confront us in the foreseeable future.

As legislation is considered here in

Pennsylvania, there are several key points I would like to recommend to you to keep in mind. First of all, HIV is spread from one person to another in very limited ways. Sexual intercourse, an IV drug needle, and syringe sharing with infected persons predominate. Blood transfusions, blood products, and donated organs should disappear as sources since HIV antibody testing has become widely adopted. Newborns can become infected in utero or at birth from their infected mother. Casual contact is not a method of transmission. Saliva and spitting has also not been shown to transmit this virus. Blood, semen, vaginal secretions and possibly breast milk are the only body fluids that apparently transmit this infection.

Two. For the vast majority of us, a drug-free lifestyle and a monogamous relationship with an uninfected partner will provide sufficient protection. Safer sex practices and an ounce of common sense will provide added protection for those who are more adventuresome. In the words of Dr. C. Everett Koop, Surgeon General of the United States, "Education is our best weapon." Drastic measures are unnecessarily and probably unscientifically based or excessively costly.

Three. Voluntary testing and education are preferable to mandatory measures. Mandatory testing is usually cost-ineffective. People with high-risk behaviors

will be even less likely to come forward for voluntary testing and education. After the test, then what? Testing won't change behavior, but education can. If we must mandate something, let's mandate education.

Four. Testing for HIV antibodies should be accompanied by written informed consent. Without such, it can be considered an invasion of privacy.

Five. Testing and test results should be strictly confidential. Confidentiality, a cornerstone of medical ethics, must be safeguarded. The need to know generally is unnecessary unless one is about to participate in unsafe or high risk behaviors with another person.

Six. Discrimination based on HIV infection, AIDS disease, or the fear of suspicion of such should not be permitted. HIV-positive individuals have lost jobs, housing, life and health insurances. Anti-discrimination laws covering this situation, if not in place, should be put in place.

Seven. Avoid coercive or punitive measures and criminal penalties whenever and wherever possible.

Eight. Treat all people fairly and equally, black or white, rich or poor, HIV-positive or not. And just as importantly, treat all people with compassion and caring.

Again, I want to thank you for this opportunity to share with you some of my ideas about the AIDS problem. If I can be of any further help to the committees as they consider legislation, please do not hesitate to contact me.

At this point, I will be glad to try to answer any questions you may have.

BY ACTING CHAIRMAN REBER: (Of Dr. Hawk)

Q. Doctor, just for my own edification, if in fact all of these suggestions that you set forth were put into place, maybe not be operating but appropriately funded, procedurally operating and in place, at that point in time with all those things being done and a person then very knowingly and intelligently but yet willfully and criminally carried out the transmission, do you feel under that kind of setting the legislature would be, in good conscience, establishing public policy criminalizing that type of conduct?

A. I would have to say that there is a part of me that says, yes, that there should be criminalization of that type of conduct as a last resort. The thing that I hear being said, and I'm not an expert at legislation and I don't know when legislation is needed and when it isn't, but what I believe I heard you say earlier--

Q. I share those same comments virtually every

day on the floor of the House. But go ahead.

A. Well, my feeling is, I wonder, we all probably have in the back of our mind certain anecdotes. Certainly Toni has some anecdotes she was sharing with me before we began, the Chairman has anecdotes about what's happening in Reading, and what disturbs me, I guess, is that we look at individual cases and we try to make broad, sweeping legislation that will prevent all of those things from ever happening again. And I just really don't know that for these isolated cases we should have hundreds of laws on the books because I really do think that if we're going to try to cover all the scenarios, all the permutations and possibilities, gosh, we'll be having hearings and you'll be passing legislation for years just on AIDS alone. So I don't know how to handle some of those more difficult cases. We've had things like that come up in York, and I'm sure they've come up in your locations also. They're very difficult to handle. There are no clear legal guidelines most of the time as to how to proceed, but as far as easy answers or this law will cover all of those possibilities, I just can't see it. I just really wonder if we can craft such a perfect law.

ACTING CHAIRMAN REBER: Thank you. Thank you very much.

Toni, thank you.

I'll return the microphone and the gavel to the Chairman.

CHAIRMAN CALTAGIRONE: You're doing well.

ACTING CHAIRMAN REBER: Dave, who do we have next?

MR. KRANTZ: David Houseknecht, Laura Cantrel, Eduardo Caceres and his interpreter, Carlos, and Carlos L.

ACTING CHAIRMAN REBER: Okay. Dave, do you want to lead off, if you would, please?

MR. HOUSEKNECHT: I'm Dave Houseknecht. I'm the coordinator of services for the AIDS Service Center of the Lehigh Valley. During 1984, I was a therapist in a community-based hospital here in Pennsylvania. My lover was diagnosed with AIDS. We lived our whole lives there. It was a rural area, and I had been employed for 14 years as a professional therapist. He died of AIDS in the hospital where I worked, and I lost my job and my home and was forced to move from the area that had always been both our families' home. I had to move to the Poconos to find a place where people didn't know me so I could get a new job and start over again. I found an apartment, and during the next couple of years really started getting my life together both personally and professionally. I was promoted to supervisor and I was running a group home for

a private agency.

During the summer of 1987, I experienced an attack of bronchitis. My physician required that I rest for a couple of weeks and just take it easy and I'd get well and go back to work, and it was during that time that I suggested perhaps it was time for me to have HIV screening. So he performed that, and I think at the time it cost me $455 for that test. He called me from his vacation site to let me know that I had AIDS. Then he called me back in about 15 minutes again and said, "Don't do anything crazy." At this point in time, I was pretty numb to be able to do anything at all. He referred me to an infectious disease specialist in the Poconos who explained that it's time for me to write my will, that I was going to die very shortly and there was no real cause for treatment.

When my doctor came back from vacation, he gave me a statement saying that I was able to go back to work, that I was certainly free from contagious disease. I returned to work, I worked a full day, my supervisor asked me into the office to talk with her, and she explained that she believed that I had AIDS. She also stated that all employees were being required to be tested for HIV. She then stated that I would not be able to return to work without releasing this information to the

company. I stated that I felt that that was private and confidential information that had no bearing on my job or my job duties. The following day, my supervisor called and again explained the need for me to reply with the request for information. She stated that she would send me a form. I called an attorney and I requested advice. During the weeks and months to follow, I was not allowed to return to work, my salary was stopped, my benefits were reduced, and fellow workers were told that I had AIDS.

The attorneys involved settled out of court and attempted to restore what had been lost during the six months I was prevented from working. The people I supervised still believed though that I had AIDS, and they were afraid to work with me. I lost my apartment two miles from where I was employed, was forced to live with a friend who provided food and my basic needs during the time I was unable to work. I had to commute 96 miles a day to work after being reinstated. The physician refused to see me in his office anymore, was afraid I would affect his business. Co-workers placed posters over my desk with large lettering announcing the AIDS hotline number. Each employee spoke with me expressing their concern and anger at the risk of working with me. They were concerned about allowing me to have contacts with residents of the program. In-service education programs were supposed to

be provided before I returned to work in order to get the staff more accustomed to HIV and assist them in understanding about AIDS in the workplace. This was not done. I attempted to schedule this educational training, and my supervisor canceled it. She stated that there were not enough employees available to attend.

Several months passed, and I continued to work and the staff expressed their concerns and I attempted to educate as they would allow, but no formal education was provided. My supervisor called me and explained an opportunity was developing with dual diagnostic individuals in Pennsylvania, those individuals which were mentally retarded but also carried psychiatric diagnosis. She expressed her beliefs in my abilities to develop and carry out this program. I followed it up and I contacted representatives for the Department of Mental Retardation. She also told two other co-workers about this opportunity and they pursued it as well.

After many interviews with the Department of Retardation and the family and the county involved, I was selected and contracted with to provide those services. I provided the services appropriate to the needs of the individual in compliance with the contract provided. The client was hospitalized for medication changes. The attending psychiatrist, the Office of the Department of

Mental Retardation, the family of the client, the county administering the contract were all in agreement that the best discharge plan was to my care.

The program and care plan were progressing well, as was documented in the client's records. The client was to be discharged to my care at the end of the week. I was working with the client in his workplace located in the institution where he had previously resided. I was requested to meet with a representative of the Department of Retardation and the county administrator of MH-MR providing my contracts. I was asked if I had AIDS. I explained that I was certainly willing to discuss the progress of the client but not my personal information. They explained they needed to know. I asked why, and they explained that the client might bite me or somehow become exposed or infected with AIDS, and they had to be able to represent his needs. I explained that I felt that the information that they were requesting had no bearing on the quality of care or my ability to administer care to the client. They asked, "Do you have AIDS? We need to know." I told them that this was not something that I was able to discuss any further and that my attorney needed to be included in any and all conversations regarding this subject.

On the morning of the client's discharge, I

went to the State Hospital to pick him up. During the client's discharge, I was told that an attorney for the Department of Welfare had stopped the discharge and the county withdrawn my contract. For the third time I lost my job, my home, and another relationship that had become important in my life. I was forced to take shelter in an abandoned house located in a used car lot. I had no medical benefits or resources. A previous coworker who had taken my job called and encouraged me to return to work at the group home. Due to my lack of alternatives, I returned and commuted approximately 136 miles a day for approximately $5.36 an hour and no benefits. I worked my 40 hours and always accepted 10 to 20 hours overtime to attempt to pay bills left by my former living arrangements and the cost of health benefits.

In February of 1988, I was hired as a consultant to the AIDS Service Center of the Lehigh Valley. I resigned from the group home. On May 16, 1989, I had a stroke while doing an educational program at the AIDS Service Center and I lost part of my vision and the ability to direct my speech. I finished my work and was taken to the hospital where I was seen in the emergency room by my physician. I was put on medication, returned to work the following day.

On June 1, 1989, I was diagnosed with

pneumocystis pneumonia and I was hospitalized for 72 hours. I insisted on a semi-private room. When the wife of my roommate heard the word AIDS, she had her husband moved. The following roommate was an emergency appendectomy. The nurses changed his bed, provided his food in bed, and assisted his personal needs. The sheets and towels from my side were left on a chair by the door. My food was left by the door. I was not told about medications by the nursing staff that my doctor had made available. I was not given assistance with bathing or personal needs. I requested to be discharged. I felt safer at home.

I think it would be a lot easier if we were guaranteed confidentiality before we were required to be tested. I think many of us, given that our rights were being protected and that the information would not be used to disable us or to prevent us from having equal rights in the State, we would then want to know and want to be able to communicate that effectively.

Thank you.

ACTING CHAIRMAN REBER: David, I just have two questions.

First of all, the dates in your testimony, that's a typographical error, I assume, 1989 being 1988.

MR. HOUSEKNECHT: Did I do that? This is my

first attempt at using a computer.

ACTING CHAIRMAN REBER: It's all right. It's a lot better than mine, because I haven't even taken a first attempt yet.

Just out of curiosity, what hospital were you at in June of '88?

MR. HOUSEKNECHT: Lehigh Valley Hospital Center in Allentown. It should be noted that I was one floor away from the area normally used for people with AIDS, and on that floor a very high quality of care existed. For many people, I was dealing with their individual fears as expressed in their professional capacity, so it was a one, and I still believe it is, a one-to-one relationship with professionals.

ACTING CHAIRMAN REBER: Okay, thank you, Dave. Thank you for taking the time to come and present your experience to us.

MR. HOUSEKNECHT: Thanks for the opportunity. I'd be glad to any time.

REPRESENTATIVE REBER: Laura Cantrel, the Lehigh Valley AIDS Service.

MS. CANTREL: Okay. My name is Laura, I'm 32 years old, and the mother of four children. I was 24 years old living in New York City. It was a depressing time of my life. I just split up with my children's

father and lost my apartment. I ended up moving into a small room about the size of a bathroom in a building where 90 percent of the people were IV drug users. I soon became one of them. This lasted about three months. During that time, I met a man who took me away from that life. We moved to Far Rockaway, Long Island. I was six months pregnant, then had a son. At a year old, my son developed pneumonia. After that, he was always sick and no one knew what was wrong with him. Doctors came from the Bronx and tested him positive for the AIDS virus. At this point, I was already pregnant with another son. The baby's father and I were both tested. I tested positive, his test was negative.

Then when my son was two months old, he and I were both having problems with diarrhea and had trouble keeping food down. We were both running fevers. He was admitted to the hospital. He almost died the same night. He was transferred to a hospital in the Bronx. Meanwhile, I started getting rashes on my face and my other son started running high fevers and had constant diarrhea. He was admitted to the same hospital. They shared rooms together, their cribs were next to each other. They went through hell. Some good days, some bad days. They had IVs everywhere. They both died at the age of 3, with one year apart from each other.

After the death of my two sons, I started to do drugs and alcohol heavily. I didn't want to deal with all this. The drugs and the alcohol must have suppressed my immune system even more. I soon developed Herpes Zoster in my left eye. Shortly after that it was Bell's Palsy. Hepatitis, Herpes Zoster again, this time my whole right side. I got Bell's Palsy a second time. It affected my whole right side instead of just my face. After that, I developed pneumonia and had bronchial problems.

I haven't been hospitalized in the last two years. I spent a month in jail due to my problems with drugs. After that, I started losing weight. I lost 20 pounds and my hair started falling out. My T-cell count dropped. I was having problems eating and problems with thrush. I was taking AZT for a year and a half and then stopped taking it for six months. I started taking it again, but the second time I took it every six hours instead of every four hours. My body tolerated it much better and my hair stopped falling out and my stomach problems disappeared.

After jail, I met some wonderful people, people that helped me with my drug problems and I stopped drinking. My life was changing. I started going to AIDS support groups and I am a volunteer at the AIDS Service

Center. I went to AIDS Buddy Trainings. I've learned I am living with AIDS, not dying from AIDS. I believe that changing my attitude and changing my lifestyle is keeping me alive. I will not give in to AIDS. I will survive. I plan on being a grandmother. It was hell for me and my children getting kicked out of everywhere. Nobody wanted to deal with people with AIDS. We still have a long way to go, but I'm happy to see people are coming around.

ACTING CHAIRMAN REBER: Thank you, Laura.

Any questions from any members of the panel?

(No response.)

ACTING CHAIRMAN REBER: Okay. Our next witness is Eduardo Caceres, and I think Carlos is translating for Eduardo, is that correct?

MR. VARGAS: Yes.

ACTING CHAIRMAN REBER: Okay. Do you want to take over?

MR. VARGAS: Hello. My name is Carlos Vargas, and I'm a volunteer at the Lehigh Valley AIDS Service Center, and I wanted to translate Eduardo's letter here.

(Whereupon, Eduardo Caceres delivered his testimony in Spanish, and the following was translated by Carlos Vargas.)

MR. VARGAS: "Hi. My name is Eduardo

Caceres. I'm a person with AIDS. June 3, 1980, I left Cuba, leaving with my mother and brothers. I came to the United States looking for a better lifestyle. September 1989, I was diagnosed with pneumocystis carinii pneumonia in the State of New Jersey. They did not tell me I was suffering from AIDS. I knew I was getting ill.

"In December 13, 1987, I moved to the State of Pennsylvania. I met a social worker from Bethlehem. He gave me a test to see if I had been infected with the AIDS virus. It came out positive.

"I am living with AIDS, not dying from AIDS. Being Spanish is hard because my people don't understand the situation I'm dealing with. They need more education. Let's tell the truth about AIDS, not hide it or ignore it. It's a problem everyone has to deal with. It is time to come out of hiding. Education is our only weapon against this epidemic. Education, not isolation."

And I want to say that it is true. Most of the Spanish people don't understand about the AIDS virus. They get scared, they get afraid, just to be next to someone that is infected with the AIDS virus, and we have to teach them more about it. It's all right to be next to a person with AIDS and you're not going to get infected by it at all.

Thank you.

REPRESENTATIVE REBER: Okay, Carlos. Thank you very much, and would you please tell Eduardo that we thank him for educating us today about the problem.

MR. CACERES: Thank you.

REPRESENTATIVE MOEHLMANN: Could I ask you, Eduardo, could I ask you a question? You say in your testimony that the Spanish speaking people don't understand. I think that's a problem among the entire population.

The first question is, do you think that it is a greater problem among the Spanish speaking people than it is among English speaking? And if that's so, is that just a language problem or is it more than just a language problem there?

(Whereupon, Carlos Vargas translated the questions for Eduardo Caceres and further translated his answer as follows.)

MR. VARGAS: It's not the language problem. The thing is, they really don't understand about the disease at all, and especially in the Spanish community.

On my behalf, I think they need more education, you know, because they really don't understand nothing at all about the disease.

REPRESENTATIVE MOEHLMANN: More education generally, a higher level of education in addition to more

specifically AIDS-related education? Is that the sense that I'm getting?

MR. CARLOS L.: Excuse me, my name is Carlos also. Basically, with the Hispanic community, they have the fear like everyone else of the AIDS epidemic. They need the education as well as everyone else. They are -- they have different lifestyles. They try to isolate themselves because they are afraid if I touch you, being infected with the virus, that you will get it. That is the communication gap that's missing. They need the education, basically. They need more funding in the Hispanic community.

REPRESENTATIVE MOEHLMANN: That sounds to me as though it's the same problem as with English speaking.

MR. CARLOS L.: Absolutely. Absolutely. Overall, it's an education, a need that society needs because it's an epidemic. Everybody thinks that if you have AIDS, it's like leprosy. You shake my hand and you're going to get the virus. It doesn't work that way. You could hug a person with AIDS and not be infected.

REPRESENTATIVE MOEHLMANN: Thank you.

Thank you, Mr. Chairman.

ACTING CHAIRMAN REBER: Chief of staff for Chairman Richardson has a question.

MR. PARRISH: I'm sorry I didn't hear the

beginning of your testimonies, I apologize for that, but I do have this question about community-based organizations and the Hispanic community that are in the business of either educating people about the AIDS virus or are doing outreach for drug education generally. Do they exist and what groups are you aware of that are doing that kind of work in your community?

MR. CARLOS L.: Basically what I know, there isn't anything that I'm aware of at this moment. There is just the drug treatment programs that which, again, up to date and educating the IV drug user, and basically it's the Hispanic, black, and a low percentage of whites. But drug community rehabs, as we call them, are starting to educate. But as a regular layperson that doesn't use drugs of the sort or are not gay, they're the ones that have the fear of the virus. They're the ones basically that need some type of help, education program in the school system, the grammar school, elementary schools, middle schools, high schools. By the time they get to college, they're starting to do reports on it. There's a few high schools in the area in the Lehigh Valley that like to have somebody come and speak about the situation with AIDS. So it's basically the system that's not giving the opportunity to educate.

MR. VARGAS: Excuse me, we do get people

that teach about AIDS, that teach them, but the people inside their home ignore it. They turn off the TV or they change the channel because they don't want to be bothered with it. They are afraid, and we need more education and we need more Spanish people that will go in front of them and tell them getting AIDS is not something that you're going to die of, you know. We have to teach them that you're going to live, and I know a lot of people with AIDS that live more than 8 to 10 years and they're doing good, but the Spanish people think if they get AIDS, they will last for two years and that's it, you're a goner. And we have to teach them, and its a problem in our community. Especially my family. When they found out I was HIV, they ignored it and they turned their back at me. They don't want to be bothered. And I want to teach them that being an AIDS person is not a big deal. I'm not saying I am proud to be an AIDS person, but I just want a little understanding with my family and I want them to understand about the epidemic because one day theirself could get sick from it, and I don't want that to happen, but they need more education in the Spanish community, and they need it now.

MR. PARRISH: Thank you very much, Mr. Chairman.

ACTING CHAIRMAN REBER: Carlos, I understand

you brought a statement from Richard Charles Jones, is that correct?

MR. CARLOS L.: That's correct.

REPRESENTATIVE REBER: Okay. I'm going to offer that to the reporter and have that entered into the record so it's complete as to this proceeding, if that's all right with you.

MR. CARLOS L.: Absolutely.

ACTING CHAIRMAN REBER: Is there anything else that you wanted to verbally add at this time or present to the committee in addition to that statement that you want in the record?

MR. CARLOS L.: Well, basically, is it okay if I read the testimony?

REPRESENTATIVE REBER: You can do whatever you want to do.

MR. CARLOS L.: Hello. My name is Carlos L. I am a volunteer at the Lehigh Valley AIDS Service Center, and I'm here to speak for a person who is not well today. Dr. Richard Charles Jones.

(Whereupon, Carlos L. read the following prepared statement for Richard Charles Jones.)

MR. CARLOS L.: "My name is Richard Charles Jones. I have a graduate degree in education. I am a retired concert tenor having performed for a Pope, the

Queen of England, and most notably at the second inauguration of a former President of the United States. I am an Episcopalian and have served as a salaried church musician and composer faithfully for the last 18 years of my career, most notably at the National Cathedral in Washington. I am a citizen of this country, this Commonwealth, and Lehigh County. I am a taxpayer and a registered voter. I am also a recovering alcoholic, and I have AIDS-related-complex, ARC.

"In the course of forging a public career against the tide of public opinion, it has been my privilege and blessing to wear the rewards of acceptance from the enlightened public, but also to endure the burdens and pain of discrimination and open abuse from an unenlightened public.

"In 1986, I was diagnosed as being HIV-positive, infected with the AIDS virus. My thoughts immediately were death-mortality-suffering, the setting in order of one with so much to offer and not yet 40 years of age. If you or one you love have ever been diagnosed with cancer, leukemia, heart attack, stroke or diabetes, then you know that the thoughts of those people and the thoughts of people infected with AIDS are the same. Since 1986, I have declined in health. My T-4/T-8 ratio is below normal parameters, my white cell count has dropped,

and I have been hospitalized eight times with opportunistic infections. I am now classified as having ARC, AIDS-related-complex.

"In November of last year, I entered Eagleville Hospital in order to seek rehabilitation for alcohol and drug dependency. Eagleville was the only facility out of 18 contacts over 2 days and $81.78 worth of long distance calls before being accepted. The reason for refusal of the remaining 17 facilities was consistent, inadequate numbers of welfare beds, and inadequate facilities to deal with an AIDS patient. What is ironic to me is that in 28 days of in-patient quality care at Eagleville, I was not treated for AIDS, I was treated for the alcoholism and drug dependency. My disease of addiction is no different than any other addict/alcoholic. What is different about chemically dependent AIDS patient is that when left without rehabilitative resource, an already impaired immune system becomes further debilitated. Breakdown progresses more rapidly and mortality figures are much, much higher.

"After 28 days in rehab, it was recommended that I enter a halfway facility for three to six months of reinforced living. Without follow-up after rehab. Statistically, one in three people will relapse over two years. Nine facilities in three States were contacted,

and none would take me because of being infected with AIDS. Hence, after 28 days, I was sent back into society with all the best wishes of all. I am clean and sober today. With AIDS, as with alcoholism, today is all I have.

"I live on $97.50 twice a month and food stamps through the State Department of Public Assistance. My child support payments total $80 per month. The Lehigh Valley AIDS Service Center, ASC, has been helping me pay utilities before they have been shut off. I am past due on my rent. I have been told twice by the SS Disability that I am not disabled, even though my physicians have certified my condition, and my welfare application says I am subject to repeat infections and chronic, almost daily, fatigue. I am currently in appeal. The bet seems to be that I will die before I will collect."

Thank you.

ACTING CHAIRMAN REBER: Thank you, Carlos.

Mr. Chairman, I think at this time I'll turn the microphone to you for whatever.

CHAIRMAN CALTAGIRONE: Thank you. And I want to thank everybody that testified today and participated in this hearing, and I'll adjourn.

(Whereupon, the proceedings were concluded at 3:15 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me during the hearing of the within cause, and that this is a true and correct transcript of the same.

Ann-Marie P. Sweeney

ANN-MARIE P. SWEENEY

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