U.S. COMMISSION ON CIVIL RIGHTS

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These edited proceedings of a community forum held by the District of Columbia Advisory Committee to the U.S. Commission of Civil Rights were prepared for the information and consideration of the Commission. Statements and viewpoints in the proceedings should not be attributed to the Commission or to the Advisory Committee, but only to individuals participating in the community forum where the information was gathered.

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U.S. COMMISSION ON CIVIL RIGHTS

HANDICAP PROTECTION FOR AIDS VICTIMS IN WASHINGTON, D.C.

DISTRICT OF COLUMBIA ADVISORY COMMITTEE TO THE U.S. COMMISSION ON CIVIL RIGHTS

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II

A SUMMARY REPORT MAY 1989

LETTER OF TRANSMITTAL

District of Columbia Advisory Committee
to the U.S. Commission on Civil Rights

MEMBERS OF THE COMMISSION

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Murray Friedman, Vice Chairman
Mary Frances Berry
Esther Gonzalez-Arroyo Buckley
Sherwin T.S. Chan
Robert A. Destro
Francis S. Guess
Blandina Cardenas Ramirez

Melvin L. Jenkins, Acting Staff Director

The District of Columbia Advisory Committee submits this report of proceedings for the purpose of briefing the Commission on key issues and viewpoints concerning handicap protection for AIDS victims in the District of Columbia. The action follows a vote of 8-0 by the members present. The absent members were contacted later and expressed no objections.

The report of proceedings provides information received at a community forum convened by the Advisory Committee in Washington, D.C., on July 23, 1987. Every effort was made to assure a balanced perspective on the issues by inviting participation from legislators, officials, and representatives of organizations with opposing points of view. Mindful of the Commission's jurisdiction, special reference was made to possible civil rights implications of local policies on handicap discrimination.

While the information provided does not result from an exhaustive review of issues pertaining to handicap protection for AIDS victims in the District of Columbia, it will be of value to the Committee for further program planning.

Respectfully,

WALTER E. WASHINGTON, Chairperson
District of Columbia Advisory Committee

DISTRICT OF COLUMBIA ADVISORY COMMITTEE

[redacted]
Walter E. Washington, Chairperson

James G. Banks

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John Hope II

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Acknowledgments

The District of Columbia Advisory Committee wishes to thank the staff of the Commission's Eastern Regional Division for its help in the preparation of these proceedings. The proceedings were the principal assignment of Edward M. Darden with support from Linda Raufu and TinaLouise Martin. John I. Binkley, Director, Eastern Regional Division, provided overall supervision.

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SUMMARY

The District of Columbia Advisory Committee held a community forum on handicap protection of acquired immune deficiency syndrome (AIDS) victims on July 23, 1987. The Committee's longstanding interest in handicap discrimination led to discussions about a swelling local controversy caused by public fear of AIDS. On two occasions, news reports featured Metropolitan Police officers making arrests, using heavy rubber gloves and face masks as protective equipment against potential AIDS infection. The reports said the officers believed they risked getting AIDS because some persons arrested might be homosexual. The Chief of Police eliminated the practice as unnecessary, reiterating the D.C. Public Health Service explanation that AIDS does not result from casual contact with infected persons.

Along with these controversial events, the Committee noted the enactment of the AIDS Health-Care Response Act of 1986, D.C. Code Ann. §§ 6-2801 to 6-2806 (Supp. 1987). The legislation requires local agencies to provide a general strategy to address the issues, problems, and mounting needs associated with AIDS.

These local developments prompted the Committee to convene a community forum on handicap protection for AIDS victims. District law grants a wider range of civil rights protection on this issue than Federal laws require, thereby raising the question, how does the District carry out its legislation on AIDS?

The Committee invited speakers representing key District agencies to address questions of local AIDS policy. The Committee, however, recognized a need to first examine divergent opinions concerning the civil rights implications of AIDS. Therefore, the Committee initially consulted with three experts on AIDS policy, joined by Congressman William E. Dannemeyer (R-California). This panel provided background on the subject as a prelude to local issues.

The first panelists disagreed with one another on AIDS contagion, risk population, and public health policy. Their opinions ranged from views that the possibility of respiratory transmission of the AIDS virus is cause for general concern to views that public health policy should focus on high-risk behavior. A portion of the panel viewed homosexuality as a significant aspect of the AIDS problem. Other panelists highlighted a prevalence of blacks and drug abusers among victims, regardless of sexual practice. The panelists agreed that persons disabled by AIDS have the protection of handicap discrimination laws. They held conflicting views on whether the laws grant protection against discrimination based on the fearful perception others have of AIDS victims.

The Committee then turned its attention to the panel of local officials. The speakers represented the D.C. Office of Human Rights (OHR), the D.C. Metropolitan Police, the D.C. Department of Corrections (DOC), and the D.C. Public Health Service (PHS). Each agency has its own policy on AIDS and programs for public education and employee training in the area. The DOC reported a cumulative total of 12 deaths involving AIDS in all DOC facilities between 1985, the first year of testing, and the forum.[1] During the 31-month period, the DOC did 375 AIDS tests on inmates and found 187 persons who had been exposed to the virus. During 1987 until the date of the forum, the DOC had done tests on 100 inmates and approximately 48 were sero-positive. These data show a ratio of about 2 to 1 of AIDS tests to sero-positive findings.

The Commissioner of Public Health reported that 744 persons in the District have been diagnosed with the disease and 434 have died. He noted that among military recruits in the District, ages 18 to 30, 1 in 100 has tested sero-positive for AIDS. He said the word "educate" summarizes his view of

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[1]Dr. Jenkins verified these data as accurate for the entire population of persons in custody from 1985 until the forum. He added that there have been 3 more deaths since those reported at the forum, bringing the total to 15, at present. He reported also that 24 persons have been fully diagnosed with AIDS. Reginald Jenkins, MD, Assistant Director for Health Services, D.C. Department of Corrections, telephone interview, Jan. 30, 1989.

the best approach for controlling AIDS and protecting civil rights. More specifically, the Commissioner endorsed condom use for adults. He also advocated readily accessible, confidential, and voluntary AIDS tests.

PRESENTATION OF
WILLIAM E. DANNEMEYER (R-CA)

CONGRESSMAN DANNEMEYER: It is my pleasure to have this opportunity to be here this morning and share my thoughts with the distinguished members of the Committee.

As a beginning point, I suppose we can start with what Congress adopted back in 1973, the Rehabilitation Act, which proscribed discrimination against handicapped individuals. What Congress has meant by the term "handicapped individuals" has been an interesting exercise in the process of the courts and Congress itself since that term appeared in the law in 1973.

The Attorney General in the Carter Administration advised that the definition of "handicapped person," as used by the act of Congress, included drug addicts and alcoholics. Congress, in 1978, questioned that opinion and, by a subsequent act, made clear that a "handicapped person" did not mean a drug addict or an alcoholic.

That was the status of the law, until the U.S. Supreme Court recently handed down its opinion in School Board of Nassau County v. Arline [480 U.S. 273 (1987)]. The Supreme Court, interpreting the same term "handicapped individual," concluded that Congress intended to include persons with communicable diseases under the definition of a handicapped person.

In that instance, the plaintiff had tuberculosis and alleged the protection of the law proscribing certain discrimination against handicapped persons. The Court remanded the matter to the trial court to determine whether the definition of "handicapped person," included Mrs. Arline.

As a member of Congress, I disagree with the Court's interpretation that the definition of "handicapped person" includes a person with a communicable disease. I do not believe that was ever the intent of

Congress. One reason for making that observation is that with respect to clarifying the law and the meaning of that term, Congress took the action by saying expressly that it did not include a drug addict or an alcoholic.

If Congress could vote again on that issue, I think it would say that it did not intend to include persons with communicable disease. If we were to use the term "handicapped individual" to include persons with a communicable disease, we would be at cross-purposes with ourselves. For example, under Federal immigration law today, a person with certain designated infectious diseases cannot be admitted into the country. Among them are such curable communicable diseases such as syphilis or gonorrhea, leprosy, active tuberculosis, chancroid, granuloma, or lymphogranuloma. If you have any of those, you cannot come in the United States under the immigration law.

Note the paradox: You cannot come into the United States when you have one of those communicable diseases, yet we interpret the term "handicapped individual" to include within its ambit a person with a communicable disease. While the Federal Government is saying, "You can't come in here if you have a communicable disease," at the same time we say that you are going to be the beneficiary of a law protecting handicapped individuals if you do have a communicable disease.

The situation becomes absurd when we address the question of affirmative action. Is our law in such a posture today that when an employer has affirmative action obligations under a contract with the Federal Government, that employer is to go out into the prospective work force and find people with communicable diseases to be in their work force to satisfy the requirements of affirmative action?

I am not sure whether the Supreme Court even contemplated that absurdity when it rendered its decision. I am not sure any of us knows what the answer to that question is, but I have stated it as one of the reasons for my conclusion that I do not believe it was the intention of Congress to include a person with a communicable disease under the definition of a handicapped individual.

Some persons in America today claim that the Arline decision has applicability to the AIDS epidemic in America. I am not sure that it does. For instance, take the three stages of that disease: those with the virus

who can be asymptomatic, those with AIDS related complex (ARC), and those with fully developed AIDS. If a person has a case of fully developed AIDS, I think, they are clearly handicapped within the meaning of the law in the sense of satisfying the strict definition. They are sick people, but because they are sick they are not otherwise qualified. So I do not think they can fit within the definition. That is a person with AIDS.

Those persons with the virus who are asymptomatic -- because they are asymptomatic, they are not suffering any impairment at all, physical or mental. They do not, therefore, fit within the typical definition of "handicapped." Certainly, they are otherwise qualified because they are fully able to work.

So I do not believe that those with the virus for AIDS, or those with ARC, or those with AIDS are going to have any relief with respect to the Arline decision in terms of proscribing discrimination against persons who are handicapped, as that term is used by the act of Congress in 1973.

SAC MEMBER GALIBER: I would like to ask the Congressman if you have with you your definition of what you consider to be a handicap.

CONGRESSMAN DANNEMEYER: Within the meaning of the Act of 1973, there are, I think, five conditions: first, the individual must be handicapped, as defined in the act. That means he or she has a physical or mental impairment which substantially limits one or more major life activities, or has a history of such impairment, or is regarded as having such an impairment. That is a narrow definition of a handicapped person. That is the first criterion.

Secondly, the individual must be otherwise qualified; in other words, notwithstanding having that handicap, the individual must be otherwise qualified to perform the job. Third, the individual must prove he or she has suffered discrimination as a result of having that handicap. The individual must show that his or her employer is getting Federal money, the "Federal hook," so to speak. The last condition, the employer may not be put to an undue hardship as a result of accommodating that person in the work force.

That is the technical definition of the law; that is the definition that I would render. Whatever you define the law, sometimes it is easier to understand the law if you apply it to a certain factual situation,

establish a factual situation for a person you have in mind and then see how the law applies. It is the definition that I have adopted in coming to the conclusion that I did.

SAC MEMBER TOPPING: To extend Mrs. Galiber's question, the person with AIDS, as you view the law, is not in a protected class as the Commission on Civil Rights would be interested in?

CONGRESSMAN DANNEMEYER: I think persons with AIDS, fully developed AIDS, under the narrow definition that our medical friends have established, are sick, very sick. They are handicapped within the meaning of the law because they are experiencing a physical or mental impairment which substantially limits one or more life activities. I do not question that.

I do not think such a person can satisfy another requirement of the law, in terms of the definition of a handicapped person because, in that status, I do not think they are otherwise qualified to perform the job because of their sickness. I do not know how a person manifesting that degree of sickness can possibly perform a job.

MR. TOPPING: But if that person could perform that job, whatever the qualifications of the job, then that person falls within the protected group or protected class by that public law of 1973?

CONGRESSMAN DANNEMEYER: I concede that. If that person with AIDS could pass muster in terms of being otherwise qualified to perform that job, I think he or she would be able to pass muster as fitting within the definition of that law. But, I do not concede the point that a person with a communicable disease fits within the definition of what Congress intended to include within "handicapped individual."

MR. TOPPING: But not excluding AIDS, when a person is clearly sick?

CONGRESSMAN DANNEMEYER: I think the better way I would put it is that it was not the intention of Congress to include within the definition of "handicapped person" a person with a communicable disease, no matter of what variety.

In America, in my State of California, anyway, we report 58 communicable diseases. I think most States are the same. Most of those diseases are bad news for any of us. I don't think it was the intention of

Congress to include a person with any of those 58 communicable diseases within the category of "handicapped individual."

MR. TOPPING: But, Congressman, I gather that there would be two aspects that would be critical to a job-specific situation. One would be, presumably, the actual physical strength or physical capacity of the individual to handle the given job, to establish they are otherwise qualified there, whether one is talking about AIDS, tuberculosis, or a variety of other diseases.

I gather the other consideration would be, essentially, the transmission of that particular communicable disease as related to the particular job and, therefore, the likelihood that somehow there would be transmission resulting therefrom.

That ends up being a factual determination that would presumably be job-specific depending on the nature of the disease and work circumstances. If it were tuberculosis in an active state, obviously that would be a problem. In the case of another disease, it may be that, in a given setting, if a person physically had the strength to be able to perform, one may have a different balance. Would that be your conclusion?

CONGRESSMAN DANNEMEYER: I see what you are getting at is that some diseases are transferrable socially through the respiratory route, like tuberculosis. Other diseases are transferrable, we believe, mainly through transfer of body fluids, drugs, blood or donation of blood as with AIDS. That is the main means of transmission. But we cannot rule out social transmissibility, the respiratory route.

I am familiar with half a dozen cases in the medical literature where there has been casual transmission of the virus from one human to another within family settings or in health care workers. About 3 percent of the total cases in America, the Center for Disease Control cannot tell us how the person got it.

I never believed it was the intention of Congress to include, within the narrow purpose, the social purpose for which this law came into the books. For employment purposes, handicapped individuals essentially came in the law, in my judgment, to cover the situation where an individual can function relatively well and can do a job in spite of congenital or

physical impairment. It is for that person that this law came into existence.

I hate to use the illustration of having acquired a condition as a result of an act of nature as opposed to a willful act of an individual dissipating their human needs, because most of the cases of AIDS today in America is as a result of activities of humans, foolish and lax, over which they had control as to whether they wanted to pursue them.

As for the 3 or 4 percent of Americans today who have the virus from blood transfusions, all they did in life was to depend on the blood supply, and they have the virus. They are probably going to die. I am using that as an illustration. It was the act of Congress, I think, to provide this protection, to prohibit discrimination against those who were born with these defects, as distinguished from those who have a manifestation of a communicable disease as a result of activities in their life.

CHAIRMAN WASHINGTON: Congressman, do you believe that since 1973 and the advent or impact of AIDS upon our communities, there might be a need for updating the legislative intent and the nature of the protection within the confines of this particular handicap?

CONGRESSMAN DANNEMEYER: It is always appropriate to do that, sir. It has been 15 years since Congress adopted this law and 10 years since Congress said --

CHAIRMAN WASHINGTON: I was the Mayor back in that period, and I have seen the need for many things since then.

CONGRESSMAN DANNEMEYER: There is always a need to look at these things again in the light of evolving conditions in our society. I would expect that sooner rather than later, the 100th Congress will hold hearings on all aspects of this.

I am a senior member of the Health and Environment Subcommittee in the House, and up to this time the chairman of that Subcommittee, Mr. Waxman of Los Angeles County, has seen fit to hold hearings only as a means of permitting witnesses who choose to teach or treat the issue as a civil rights issue. Unfortunately, Mr. Waxman has not seen fit to hold hearings to permit witnesses who want to talk about the public health side of the issue.

Where this issue of a handicapped individual fits in, I am not sure, but it should. Congress, as the institution in America that forms social policy, should be holding hearings to determine what this decision should be rather than those nine unelected (sic) members of the U.S. Supreme Court setting social policy for all of us.

I mean no disrespect to any of them. Our system is better served, in my judgment, when those people on that Court recognize they are there to interpret the law in a narrow form and not engage in social engineering. We are getting into political philosophy here, perhaps.

CHAIRMAN WASHINGTON: We are getting close to it, but that's all right.

SAC MEMBER COOKE: Obviously, Mr. Congressman, the legislative history of the House and the Senate committees, back in 1972 and 1973, is not precise at all on whether it was not the intent of Congress to include communicable diseases. Therefore, we conclude that the legislative history was vague 15 years ago.

CONGRESSMAN DANNEMEYER: Fifteen years ago, that is true; but 10 years ago, Congress took time to say, with precision, we would not include drug addicts and alcoholics within the act.

SAC MEMBER CASTELLANOS: Outside of the committee process itself, you foresee -- although I know it is terribly riddled with pitfalls, trying to see what Congress will do -- do you foresee legislation being introduced specifically to overturn the Arline decision, or to limit that in some way?

CONGRESSMAN DANNEMEYER: I have done that. I have introduced legislation to do that.

MS. CASTELLANOS: And the bill number?

CONGRESSMAN DANNEMEYER: I don't think I have that here.[2]

MS. CASTELLANOS: What other legislative direction, besides your initiatives, Mr. Congressman, do you foresee? Have you approached Chairman Waxman on holding hearings on the public health issues, and just have not been able to go in that direction?

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[2]Congressman Dannemeyer later identified the legislation as H.R. 1396.

CONGRESSMAN DANNEMEYER: To answer your question, the earlier one, the bill that I introduced in the 99th Congress was H.R. 5111, but of course that is history now. I introduced that on June 26, 1986. I believe I have also introduced that bill in the 100th Congress. On your second question, are you talking now, or thinking now, in terms of the AIDS issue generally, or just this issue of handicapped individuals?

MS. CASTELLANOS: I will make it a general question.

CONGRESSMAN DANNEMEYER: I have introduced eight bills on the subject so far in the 100th Congress; six of them are gathering dust in the Subcommittee on Health and Environment on which I serve. Unfortunately, the issue is infested, to a very large degree, with politics and the current scene in America, which is a tragedy for all of us.

The political consideration is that the leaders of the Democratic Party in America have welcomed into their tent the activists in the male homosexual community who, to this day, insist on treating this epidemic in America as a civil rights issue as opposed to a public health issue.

I consider it a public health problem of major dimensions, and there are certain steps we should be taking in America to deal with it.

But when you come to the fact and reality that 73 percent of the cases in America are comprised of one special interest group, male homosexuals, when you talk about taking steps to deal with the epidemic or control it, you inevitably come into contact with that group. That group does comprise the largest category of AIDS cases in America and naturally, they say, "We should have a voice in that."

Mr. Waxman is carrying water, in the sense of the politics of the issue, for those who want to treat it as a civil rights issue. To this day, he is ignoring those who want to treat it as a public health issue. That is a tragedy for all of us.

As a result of his intransigence, I have introduced a discharge petition which will discharge the subcommittee and its chairman to bring the matter to the floor of the House so that the American people can have a debate on what we should be doing to control this epidemic.

There are certain fundamental, routine, customary, normal responses that public health has traditionally pursued in controlling any communicable disease. The cornerstone, the basic tool, the building block

of public health control, is reportability (sic) that those with the virus should be reported to public health officials. The tragedy of the matter is, except for eight States in the Union, it is not being done today.

It should be done in confidence. It is nobody else's business. That system of confidentiality has worked very well where it has been practiced for decades in America in controlling communicable disease.

Because we have not been pursuing these steps routinely, it is now likely to be a major political issue in the Presidential election next year because the American people are increasingly upset about the failure of leadership on the part of public health officials in this country to take normal steps to control the transmissibility of this virus.

COMMISSION GENERAL COUNSEL WILLIAM HOWARD: If I could pick up where you left off, Congressman Dannemeyer, with respect to the public health officials. It seems to me that the threshold issue here in the discussion of civil rights and the public health issue concerns the transmissibility of the AIDS virus.

We have heard a great deal in the past few years from our public health officials. I wondered to what extent you think we are getting accurate information from those officials.

CONGRESSMAN DANNEMEYER: I think they have been a little disingenuous with the American people. The reason I say that is that, historically in controlling communicable disease, we have pursued the policy of separating those with the disease from those who do not have it. Historically, we have done that.

In the case of AIDS, we have just turned the system around 180 degrees. Our public health officials at the national level -- I am talking about the Centers for Disease Control (CDC) and U.S. Public Health Service -- have essentially been saying to the American public, "Be quiet, don't panic. We will permit anyone with the virus, with the disease, to be in our society until it is proven conclusively that it can be transmitted."

That is a major policy change in public health activity in America. As a result, there are a lot of Americans at increased risk of getting the virus.

There is little doubt in my mind that if the group that contributed 73 percent of the AIDS cases had gray eyes, a highly disorganized group of

American people, politically speaking, I would suspect that a lot of public health officials in America would have treated that group differently.

But because 73 percent of the cases in America come from one highly organized, militant, activist group, male homosexuals in America, they have collectively intimidated the actions of public health officials to the detriment of the American people.

If you think about it for a moment, three cities in America have 52 percent of the cases: New York, Los Angeles, and San Francisco. You cannot get elected in those three cities unless you have made essentially your peace with the male homosexual activists residing there, and the public health officials who work in those cities reflect that bias.

When you look at where the leadership on the side of those treating this issue as a civil rights issue has come in America, you realize they have come from those three cities. They have had a powerful influence on how this Nation has responded to this epidemic, to the detriment of all of us.

It is a tragedy that we are today proceeding on the basis that it is better that a number of us die than for historians to record that we have infringed on the civil rights of some who are inflicted with this tragic disease.

MR. HOWARD: It is my understanding that the category of 3 percent of the cases that you alluded to, the origin of which cannot be determined by CDC, is in fact growing, that the percentage is upwards of 6 percent or 7 percent now. It all points to developing information. Would you care to comment on that?

CONGRESSMAN DANNEMEYER: The figure, the percentage of unclassified persons -- today the total of AIDS cases is around 40,000 -- 3 percent would be about 1,200. I have seen figures as high as 4 percent on the unclassified cases.

CDC says that, well, we are not sure. I do not know how many of you are familiar with the history that is recorded when anyone has a communicable disease. They take detailed information, and the CDC spokesmen sometimes say, that of those that are in the class that we cannot classify, that we suspect they are not leveling with us. We suspect

they fit into one of the high risk groups and they are lying to us about that. But who knows about that? Nobody knows for sure.

MR. HOWARD: You mentioned that 10 years ago Congress amended the Rehabilitation Act to exclude drug addicts and alcoholics, and that this was evidence of a congressional intent not to include communicable diseases. Could you discuss that at length? I do not see the link between alcoholism and drug addiction and communicable diseases.

CONGRESSMAN DANNEMEYER: I think it has relevance in this way. If Congress amended the law where the definition of handicapped individual, within the meaning of the Rehabilitation Act, so as to make clear that drug addicts and alcoholics do not fit within the definition of that protection, I would argue that it is logical to conclude that Congress also did not intend to include them in the definition of a person who has a communicable disease, no matter how one got it.

Most of us get communicable diseases, even though we are living the life where we think we shouldn't get it. We are all going to die one day, sooner or later, of something, and some of us will die of a communicable disease.

If Congress, as I say, said drug addicts and alcoholics do not fit within that definition, I think a person with a communicable disease also does not fit within the definition.

PRESENTATION OF
JOHN CONNELLY
THE INFORMATION, PROTECTION AND ADVOCACY CENTER
FOR
HANDICAPPED INDIVIDUALS

MR. CONNELLY: There are very few statements of the Congressman that I agree with, and I think that my presentation reflects some of them. Possibly, also what you hear from my colleagues this morning, as well as from the District of Columbia representatives this afternoon, will prove telling with respect to the Congressman's remarks.

My name is John Connelly. I am the supervisory attorney at the Information, Protection and Advocacy Center for Handicapped Individuals. My boss, the executive director of the Information Center, is sitting to your right, Mrs. Yetta Galiber. The Information Center is a nonprofit,

public interest, advocacy organization that has for the past 17 years or so represented the rights, and rights to services, of individuals with handicapping conditions.

We have operated on a number of different levels, not just legal and not even primarily legal, although I certainly have my hands full with court cases. We have 21 people, and most of them are lay advocates. We have successfully protected the rights of individuals and their rights to services for a long time.

We are involved in the AIDS issue because of law, not politics. Currently the law, both the Federal law and a majority of the human rights statutes in various jurisdictions, have posited AIDS as a handicapping condition.

In fact, the Federal law is so broad that one need not be handicapped to be, in a sense, part of the protected class. The perception that one is handicapped is, in and of itself, enough to permit such an individual to be protected under the Federal handicapped discrimination law. That is also true, by the way, of the D.C. Human Rights Act, the local human rights statute.

The purpose of this meeting, as I understand it, is to look at the AIDS problem, especially as it affects or as it impinges upon the civil rights of those who are afflicted. I want to spend a little time telling you some points about the condition. I am not a doctor, but I think it is important to keep these points in mind. I then would like to talk to you about the constitutional underpinnings. What you heard from the Congressman was merely an analysis of the Federal statute, the Rehabilitation Act, which is but one chip in the game. There is constitutional protection under the 1st and 5th and 14th amendments that directly bear on AIDS in particular situations. I will discuss just a few of those situations for illustrative purposes. Finally, I just want to end with a comment on some of the Congressman's points.

First of all, AIDS is a disease. It is a deficiency of the human immune system. It is caused by a virus which depresses that immune system and permits individuals who are afflicted to catch infections and diseases they would not catch otherwise. So, for example, the common cold to an

AIDS sufferer becomes a potentially lethal event. There is no cure for AIDS.

Not everyone who has the AIDS virus, as established through the current testing mechanisms that exist, will get AIDS, and that is an important point. I will speak a little bit more about that later.

There is a very important distinction to be kept in mind between three categories of individuals. First, those individuals with AIDS. The Centers for Disease Control in Atlanta define AIDS as the opportunistic disease that one catches by virtue of having a depressed immune system. There is a second category, AIDS-Related Complex, those individuals with ARC. These are a group, defined by individuals who have some signs and symptoms but not a full-blown opportunistic disease. Finally, there is the group that tests sero-positive, those who test positive on the antibody test.

One word about the test, or the tests. There are two of them, the Eliza Test and the Western Blot Test. These tests were originally designed to screen blood back in the late seventies. They do not test for AIDS; they test for the presence of antibodies that the immune system develops as a response to the AIDS virus. That is an important distinction to keep in mind.

AIDS is a contagious disease. I think the Congressman used the word "communicable." One needs to draw the distinction, that was drawn at least in some of the briefs in the Arline case, between infectiousness and contagiousness, it is a distinction that goes a little bit like this: If we are all in a room and someone coughs, I may indeed get the cold that he or she has. Infection contemplates ready communicability.

AIDS is not -- the only good thing about it is that it is not -- casually transmitted. The scientific evidence does establish that there is not casual transmission. One gets AIDS when one mixes infected blood with blood, when vaginal secretions or semen enter the blood stream of an individual.

Therefore, such high risk activities as sexual relations, use of contaminated needles, and transfusion of infected blood are the statistically overwhelming three causes of the condition. To argue that some causes, the etiology of some conditions, remain unknown is not to

suggest that there is casual transmission. The logic simply does not hold there.

AIDS is, finally, a health problem, a public health problem. Why? Because there is no cure for it. I mean it is virtually a death sentence at this point. It is also a problem not merely for a select group of individuals. For the District of Columbia, for example, it is an extreme problem for intravenous drug abusers of which we have a very large number.

There is a rapid increase in incidence of AIDS. The paper I have submitted in advance indicates that 1 to 1.5 million people in the United States would test positive if they were tested. Finally, AIDS is a handicapping condition, and that is what the Supreme Court said in the Arline case and what the State human rights statutes have been saying prior to that.

I will not address discrimination, statutory discrimination, because I think it is going to be the thrust of a lot of what we will be talking about, both in the morning and the afternoon. Let me just share three particular areas: institutions, mandatory testing, and the issue of segregation or quarantine.

Institutions, the problems that exist in institutions: We deal a lot with mental retardation and mental health facilities. The typical example might be the prison system. There you have a captive population. There you have the rather free exchange of urine, blood, and feces, and you have fights and you have sexual interactions, a ripe environment for, one would think, the government having some legitimate interest in effecting individual civil rights, privacy, and confidentiality.

The issue in these cases is, admittedly, a tough one, and another issue there, of course, would be mandatory testing. The situations are complicated, and there are certainly views on both sides.

The District of Columbia should be commended for having a very progressive policy with regard to the D.C. prison population. This is a policy which is in your packets: it promotes education, promotes the development of capabilities, to take care of individual persons with AIDS which includes those three groups, and also promotes the development of coherent policies.

Currently, my understanding of the system, the prison system in D.C., is that individuals who are tested and test positive are not at all segregated from the prison population. They are told of their positive test result, and they are returned to the general prison population.

Those individuals who have AIDS-Related Complex, who have some sickness or some residual illness, are treated as other patients are at the D.C. infirmary, the prison infirmary. Finally, those with AIDS are actually put in a separate wing of D.C. General Hospital.

With respect to the issue of mandatory testing, which can certainly arise in the prison context, it is all over the papers. You probably know that there are currently proposed regulations for the testing of immigrants to this country, which are in their proposed rulemaking stage. The testing issue is also a difficult issue. Let me make our position clear. We support voluntary testing, confidential testing, and even, preferably, anonymous testing.

The idea of mandatory testing is not a good one, for several reasons. First, testing will not halt the spread of this disease. Second, testing will probably drive underground those people who should be tested. Third, besides being counterproductive in that respect, testing costs a lot of money.

Various States established policies for their prison systems. I think there are about five States that actually established mandatory testing policies, and they discontinued those policies precisely because of the factors I just mentioned: too expensive, what to do with the results, and not therapeutic.

So, the testing issue has, at least with respect to that population, resolved itself. We have the specter of testing arising in other contexts, and I think that will become an increasing problem in the very near future.

Now, on the issue of compulsory reporting, which is to say reporting by physicians of medical knowledge about their patients. This has been around for a long time and affirmed by the Supreme Court as early as 1887. It is counter-balanced against, of course, the privacy and liberty interest that one has in his reputation and honesty and integrity.

The difficulty with reporting, the down side of it, is that there is concern about the guarantees for unauthorized disclosure, concern about the purposes for which the testing occurs, and whether the reporting will be used for purposes not associated with the epidemiology of the disease.

Just a word about segregation or quarantine, quarantine being the extreme form of segregation. If this class of individuals is not a suspect class that deserves heightened scrutiny under the Equal Protection Clause of the United States Constitution, an issue not yet decided, I admit I will be very surprised.

I am sure you are familiar that such heightened scrutiny for a class such as race, national origin or alienage demands that one look at how that class is treated by society, how the characteristics of that class, your skin color, for example, affects your ability to sit in other portions of the bus than the back.

I am sure, as a constitutional issue, this will arise with respect to persons with AIDS. There are other problems, of course, that relate to that, and heightened scrutiny is necessitated for analysis of whether a particular regulation should be constitutionally upheld. You have the whole issue of narrowly tailoring the means to achieve the statutory purpose.

Should one segregate all gay men because they are potentially AIDS carriers? I think that is obviously overinclusive. Or all intravenous drug abusers? It would not pass constitutional muster, precisely because it is overinclusive. It is also underinclusive because not everyone who has AIDS or is a carrier is white or gay.

The evolution of the definition of "handicapped" is, of course, something that the courts are very concerned with. It is certainly the proper posture for legislators to protect the public, but it is, ultimately, the task of the courts to determine whether legislators have performed correctly when individual rights are infringed.

The Congressman is wrong with respect to drug addicts and alcoholics and their coverage under the Rehabilitation Act. The Congressman is wrong to think that certain handicaps, because they are deemed willful and not of natural causes, should be treated differently.

In 1985 -- this is from the Congressional Record -- the Congressman, who is acknowledged in a footnote to a Harvard Law Review article, as a leading proponent of AIDS-control legislation, stated on the House floor that God's plan for man was Adam and Eve, not Adam and Steve.

My point is that Steve has just as much right to constitutional protection, regardless of his sexual preference, or the color of his eyes or anything else. That, really, is what the AIDS issue is all about.

The Arline case speaks in great detail about the legislative history and the stigma and prejudice and misinformation that too often accompany handicapping conditions. It is precisely that which is really the issue in this AIDS crisis.

CHAIRMAN WASHINGTON: We now have Bruce McDonald, advisory board member of the AIDS Education Bureau. He will be speaking under the aegis of the bureau and not the D.C. Bar.

PRESENTATION OF BRUCE McDONALD, ADVISORY BOARD MEMBER AIDS EDUCATION BUREAU[3]

MR. McDONALD: I am a local attorney, a member of the Bar, and I organized a conference under the auspices of the D.C. Bar Labor Relations Section earlier this year having to do with AIDS. However, I am not a representative of the bar. That is what I wanted to make clear today that the bar itself has no position on any issue having to do with AIDS.

CHAIRMAN WASHINGTON: That is so only because it is an order of the court. It has nothing to do with your presentation. Now, go ahead.

MR. McDONALD: That is correct. In any event, I am going to skip over some of the remarks that I prepared to give on the issue of discrimination, since it ties in with the handicap question, and it is being much discussed.

I would like to say that I think the debate now needs to move away from whether AIDS is a handicap. Even though the Supreme Court has left

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[3]Mr. McDonald is a practicing attorney with the law firm of Robbins and Laramie, Washington, D.C.

open the question of whether mere sero-positivity is a handicap, I feel confident that the courts will decide that it is.

The question is not whether it is a handicap; the question is what does this mean for the handicapped person? How does this affect his rights? What it means is that the employer will have a burden to show that the handicapped person is not qualified for a position before rejecting him or otherwise taking adverse action.

As we have noted here, the law states that you not only have to be handicapped, but you also have to be otherwise qualified for the particular position, or you could be otherwise qualified with reasonable accommodation from the employer.

For example, it has been decided by the courts that AIDS carriers are not qualified to serve in the Foreign Service in overseas posts or in the military. Other issues of employment the courts will decide are: In what other areas is an AIDS carrier not qualified? And what does it mean to be protected as a handicapped person if the employer can just turn around and say that you are not qualified?

Suppose you are a surgeon who is HIV-positive; in the regular course of your business, it may be common for you to cut yourself and bleed onto or into a patient. Does this mean you are unqualified to practice surgery?

Consider the food service worker. There may be an ample amount of evidence that the virus cannot spread from a food service worker to a patron in a food establishment, but there are also statutes and regulations dealing with communicable diseases that govern practices in the food service industry. Is AIDS a communicable disease? Yes. Does a person's HIV status entitle him to protection as a handicapped person if the same medical condition disqualifies him from employment by reason of another statute or regulation?

These are all issues that will be litigated and are coming up on the horizon. But one thing is clear: the fact that one may be considered a handicapped individual does not mean that he is immune from adverse employment decisions. It simply means that there is a burden on the employer to show that the person is not qualified for the particular employment because he represents a risk to the health and safety of others,

or because of some other legitimate reason. The employer would then have the burden to show that these shortcomings cannot be rectified by some reasonable accommodation.

In other words, the fact that a person is handicapped does not unalterably shift the balance of power from one party to the other. It simply means that the person is entitled to his day in court and puts an onus on the employer to come up with some reason.

I do not have a problem with that being the state of the law. I think it is time that we move on to the other issues, which I tend to identify as confidentiality, insurance, occupational health and safety, and testing.

On confidentiality, I would say that it goes right along with the handicap discrimination question. There are a number of bills pending in Congress now that aim to deal with these issues collectively.

The question is: To what extent does the need for confidentiality limit the goals that might otherwise be achieved by having the information concerning an individual's HIV status? For example, if a hospital is in possession of HIV information, the hospital has an obligation of confidentiality. But does this obligation extend so far as to prohibit the hospital from requiring the information in the first place?

What about the conflicting obligations that a doctor or hospital might have to disclose a patient's AIDS status to third persons known to be at risk? What about the patient, who is HIV-positive, and who exhibits an intention to continue having unprotected sexual relations with unsuspecting third persons? This is one of the legal questions that is at the forefront of internal debate at the Centers for Disease Control right now.

Insurance: The question of insurance has to do with the bottom line, i.e., "Who is going to pay for AIDS?" So far, no State in the country has gone as far as the District of Columbia, which prohibits an insurance company from requiring an individual to disclose his HIV status. As a result, many of the companies who were writing insurance policies in the District have stopped doing so.

It seems to me that insurance companies, being in the business of risk, are basically unable to operate in a rational fashion if they are not permitted to inquire about a medical fact as important as an individual's HIV status. However, whether this means that there is a "market solution"

to the problem of supplying health care to AIDS patients is an open question.

Occupational health and safety: One of the most difficult issues concerns the health and safety measures that may be necessary in certain occupational settings. There is a hearing taking place today in the House Government Operations Committee dealing with occupational health and safety standards in the hospitals. Some unions have petitioned OSHA for a rulemaking, and there is a lot of discussion going on about this.

The primary guidelines in effect at this time, for both hospitals and the food service industry in general, are those published by the Centers for Disease Control in November 1985, which have been subsequently updated, but there is a growing feeling that these guidelines are too lax.

Finally, the issue of testing: When we use the term "mandatory testing," we tend to conjure up images of a Government official coming to our front door and forcibly subjecting us to an antibody test.

Under the fourth amendment to the Constitution, however, which protects against unreasonable searches and seizures, the Government would have to have probable cause to suspect that we were guilty of a crime before doing this. Being sick or being infected with the virus is obviously not a crime. So I cannot see anything like this happening.

But what about testing in the military or the Foreign Service, which is already taking place? This is mandatory testing, as is the testing that is conducted by the Red Cross before it introduces blood into the Nation's blood supplies. How about testing in prison or in the case of aliens seeking entry into the U.S.? These are all forms of mandatory testing which are either taking place or will soon be taking place.

So there is a semantical problem here, and I submit that if we stopped calling it "mandatory testing" and started calling it "free testing," a lot of people would think it was a great idea and would come to get some of it.

The real issue is whether we should start routine testing for marriage license applicants, hospital admissions, persons seeking treatment at sexually transmitted disease clinics, and others.

What is the value of having this information? There is no doubt in my mind that there is great value in having this information for a number of reasons. First, our information about the prevalence of HIV infection is

extremely poor. We have been hearing the figure of 1.5 million Americans since June 1986 at the Coolfont Planning Commission. We also hear that the prevalence of infection is continually increasing, even exponentially, although we do not know how fast. If the number of Americans infected doubles every 12 months, and it was 1.5 million in June 1986, does this mean that there are now 3 million presently infected? Even assuming 1.5 million infected, we are already looking at health care costs of $10 to $20 billion a year in the 1990s.

What if we are wrong about the numbers involved? Do we not need to know the size of the problem in order to have a realistic plan for coping with it? And what about the value of epidemiologic data in general? Is it not helpful to know whether the city in which you are living has a significant prevalence of AIDS? How important is it to know that the AIDS population in New York derives mainly from needle users as opposed to the AIDS population in San Francisco? What kinds of questions would we ask ourselves if testing revealed an unexpected outbreak of new cases in a suburb of Cleveland or a rural community in Kansas? With limited dollars to spend on educational efforts, I think it is essential to target those areas in which the prevalence of HIV infection is the highest, and to aim those educational efforts at the relevant demographic group.

Finally, does anybody doubt that each individual has the obligation to know whether he or she carries the infection and to respond appropriately? I believe that the majority of Americans share this belief.

I also believe there are millions of Americans who would welcome the opportunity to take the antibody test but who are afraid to do so and/or lack the initiative to see a doctor for that exclusive purpose. Therefore, I think we should stop talking about mandatory testing and start talking about free testing that is available and routine in as many situations as possible. In the final analysis, routine antibody testing is a profound and ultimate form of education itself. For one thing, it drives the point home.

In any event, these issues are all parts of a complex problem. The debate has tended to be dominated by a combination of public health experts and gay rights activists. Each of these groups has its institutional biases, as does any constituency. Gay rights representatives may fear

discrimination on the basis of sexual orientation and may feel a need for confidentiality in AIDS-related information that is not shared by the majority of heterosexuals.

Public health officials may disfavor a wider approach to antibody testing because of the immense burden that it will involve. I am talking about fiscal, bureaucratic and psychological burdens, to name a few. For this reason, there has tended to be a consensus at the Centers for Disease Control and in the public health profession that testing is generally a bad thing. This is a consensus that I do not believe is shared, or ought to be shared by the majority of Americans.

I conclude with the observation that there are enormous political and institutional biases that are operating in this area, and I think we ought to identify these problems and move the debate into the general public.

CHAIRMAN WASHINGTON: I would now like to introduce Paul Cushing, Regional Director, Region Three, Office for Civil Rights, U.S. Department of Health and Human Services.

PRESENTATION OF
PAUL CUSHING
MANAGER, REGION THREE
OFFICE FOR CIVIL RIGHTS, HHS

MR. CUSHING: Thank you, Mr. Chairman.

I serve as Regional Manager for the Department of Health and Human Services' Office for Civil Rights in Region Three. Our geographic jurisdiction includes five mid-Atlantic States, plus the District of Columbia. We are responsible for ensuring compliance with Federal civil rights statutes by recipients of Federal dollars from the Department.

As an employee of Health and Human Services, I feel somewhat compelled to defend some of my coworkers in the Centers for Disease Control and Public Health Service. AIDS is both a public health issue and civil rights issue.

I think some of the comments and the ideas of leading us to quarantining individuals has not been a traditional way of dealing with

sexually transmitted diseases in the field of public health. I think we can reasonably classify AIDS and its transmissibility in that kind of category. Quarantining is not the way that we would approach it, either historically or currently, under current public health control practice.

Secondly, CDC will not come out tomorrow or next year and say to us, "Golly, folks, we were wrong. AIDS can be transmitted casually." There is just too much evidence up to this point to demonstrate that it has not been. There have been intensive studies done both in New York City and in San Francisco, in homes and in settings where people live who have AIDS, who share common utensils, toothbrushes and bathrooms, and there has been no evidence of transmission in that area.

People are looking for 100 percent certainty. No medical professional is going to stand up and give you that kind of certainty. But you have a far greater risk of death or injury to yourselves by getting into your cars this afternoon and driving yourselves home than you will ever have from getting AIDS through casual transmission.

Let me address some of the civil rights aspects. There has been some question, discussed by previous speakers, concerning that AIDS is a handicapping condition and that persons who have AIDS are covered by the Rehabilitation Act of 1973.

By way of a little bit of background, in March of 1986 the Department requested some guidance from the Department of Justice (DOJ) on whether a person suffering from AIDS, which is a syndrome and not a disease unto itself, whether a person suffering from the debilitating effects of AIDS, was protected by the law.

Justice responded by saying that section 504 would offer protection to persons suffering from the debilitating effects of the syndrome, but those who were contagious would not be afforded the same protection. DOJ went on to state that individuals, out of fear of contagion, could discriminate against persons who are HIV-positive. In essence, section 504 would not apply where an individual is excluded from a program or an activity based on either a real or perceived ability of the individual to spread contagion.

In March of 1987, the Supreme Court ruled, in School Board of Nassau County v. Arline, that an individual with a physical impairment, resulting

from a contagious disease or tuberculosis, may be considered handicapped under section 504.

While the Court noted specifically that it was not deciding the issue of a person carrying the HIV virus, I think some of the Court's statements in its ruling are illustrative. For example, the Court said, "Congress acknowledged that society has accumulated myths and fears, about disability and disease that are as handicapping as are the physical limitations that flow from actual impairment. Few aspects of a handicap give rise to the same level of public fear and misapprehension as contagiousness. The Act is carefully structured to replace such reflexive actions to actual or perceived handicaps to actions that are based on reason and medically sound judgments."

By excluding individuals who would be perceived as being contagious or a threat to others, as was suggested by the DOJ opinion, there would be no opportunity to have that individual's condition evaluated. Thus, the Court states, "They would be vulnerable to discrimination on the basis of mythology," precisely the type of injury Congress sought to prevent.

The Arline opinion renders the DOJ memorandum at this point inoperable. It now becomes a major point of reference in discussing the civil rights protection that are afforded to persons with AIDS under Federal statutes. Of course, the implications of this ruling can be overwhelming for our Department.

In view of the public health projection of 1.5 million persons infected with the virus, we are beginning to brace ourselves for what we expect to be dramatic increases in the number of complaints that are filed both by individuals and organizations. Already, the number of cases in our Department nationwide, is 50. While most of these cases fall into the area of denial of services, we can reasonably expect that, over time, we will branch heavily into the area of employment.

In consideration of what are really life and death circumstances around some of these cases, the Director of our agency, Audrey Morton, has ordered the staff to develop and implement an expedited complaint process that will reduce the administrative time involved in investigating these complaints. I expect this process to be in place by September 1st.

The Department, as a whole, is endeavoring to develop a comprehensive policy on AIDS that will incorporate all aspects of our activities: education, prevention, treatment, research, and civil rights protection. There has been a variety of drafts prepared by the Public Health Service and the Assistant Secretary for Health that are circulating through the Department for comment at this time.

Presently, OCR is accepting and investigating complaints filed by persons or groups who believe they have been discriminated against because of AIDS. In addition, under certain circumstances, we will also investigate complaints where there is a denial of emergency treatment in hospital settings, based on the Community Service Provisions in the Hill-Burton Act. These are found at 42 CFR, Section 124.

There are a couple of assumptions here. One, the hospital in question has to be a recipient of Hill-Burton funds and, secondly, the individual, in order to have standing in such a case, must be a resident or work in the service area of a hospital.

We have not yet assessed the Title VI implications of the AIDS issue. Looming large before us is the fact that while blacks represent 12 percent of our nation's population, they account for 25 percent of individuals within the AIDS group.

One last note I would like to present to the Committee as a challenge, if nothing else. The real cause of discrimination in the arena that we call AIDS is fear, and we have to begin to dispel that fear. We have to join with our coworkers in the public health field to educate the public about AIDS.

Education, as we all know, at the present time is the only weapon that we have to combat the disease. It is the only weapon that we have to combat the spread of discrimination. If we allow the misinformation and the rumors that persist about the syndrome to continue and spread throughout our communities, we are doing a great disservice to ourselves and a great disservice in an attempt to control this dreaded syndrome.

SAC MEMBER TOPPING: This is a factual question for any of the panel members who might be familiar with this. I think the witnesses here and Congressman Dannemeyer as well referred essentially to three gradations of potential conditions.

One would be that of someone who has tested sero-positive for the virus. Another one would be someone having essentially, a kind of AIDS-related complex, and the third would be the actual AIDS itself.

Now, in any of the work that CDC has done in trying to trace both through sexual transmissibility and also through drugs and I presume also passage through the blood stream, has there been any ability to establish statistically where the actual transmission of AIDS has actually come?

Has it come primarily from people in the sero-positive category, or in the ARC category, or in the AIDS category? Where is the actual transmissibility primarily within the process? I have not seen that in public discussion, and that is going to be an important factual situation, at least as far as public health, if not as far as the civil rights, strategies are concerned.

MR. McDONALD: Maybe I could just mention that one thing they have been able to explain is that intravenous drug users who contract the disease seem to exhibit a certain form of pneumonia whereas gay males who contract the disease seem to have a predilection towards Kaposi sarcoma.

As far as whether a person who is sero-positive is more or less contagious than a person who has full-blown AIDS or ARC, I would think we would all be kind of shooting from the hip. The virus is contained in the T-4 lymphocyte, and a person with full-blown AIDS is pretty much out of those.

So you could actually make a good argument that a person with full-blown AIDS is less contagious than a person who is merely sero-positive, although the virus probably has not multiplied sufficiently to fell the person who is merely sero-positive but asymptomatic. So it is possible that the person who is somewhere in between there, on kind of a bell curve, may be the most infectious. But nobody knows.

MR. CUSHING: There are so many variables. If you had full-blown AIDS, you would get a negative blood test because your immune system is totally destroyed, and you are not going to pick up the antibodies.

I agree with Bruce, and I think if there was anyone here from CDC, they would also agree that the point of transition from a sero-positive to ARC to AIDS, the point where they are most contagious would be very difficult to tell.

I think you even have to look at individuals, once they have tested sero-positive, what their extended life becomes. Some individuals die within 6 months; some individuals last 5 years. There are so many variables in each individual's physical makeup including how well they take care of themselves and many other factors that it is very difficult to say where it happens.

There is also an element of the efficiency of the transfer. Certain types of intimate contact are more efficient than others, regardless of the person's ability to transmit the disease.

Needle-sticks. There have been a couple of studies done of health-care workers, the number is about 600 now through a CDC-sponsored study, who have volunteered to be stuck with needles that contain the virus, or contain blood that is carrying the virus, and have not become infected. A figure of 1 or 2 out of that 600 have been affected.

When you get a needle-stick, it may go into the top of the skin or into the vein. If you go into the top of the skin, it is not an efficient way to transmit the disease. When you mainline it into the vein, you are getting right into the blood system.

When people ingest it, the hydrochloric acid in their stomach will kill it, if they do not have any other open sores within the tract or within their mouth. So there is a whole question of the efficiency of the transmission, which they just do not have a good handle on yet, aside from knowing that there are some ways that are more efficient than others.

CHAIRMAN WASHINGTON: I am now going to open up the questioning to everyone. If you have a question, please go ahead and ask it.

PARTICIPANT: I would like to ask a question, if I might. I have been noticing more and more that AIDS is considered a lethal weapon. I would like to know what your comments are on that. Anyone.

MR. CONNELLY: There is an article that I am aware of, or actually a case in San Francisco, involving a charge, a criminal charge of assault with a deadly weapon on an individual who bit a policeman upon arrest and also screamed, "I have AIDS, you had better watch out." I think the charges were eventually dropped.

MR. McDONALD: There are many criminal charges pending in this area. If you know that you have an HIV infection and you have unprotected sex

with a person that you do not disclose this to, the prevailing thought is that you are guilty of intent to murder. There are a number of prosecutions pending.

PARTICIPANT: So it actually can go to court for attempted murder. Thank you.

PARTICIPANT: To what extent does the Federal Government have an obligation to provide general safe working conditions?

My name is Don Short from the Red Cross. But I am not asking for the Red Cross.

If a person has the syndrome, he can die from a common cold. Is there any obligation from the Federal Government, under OSHA or any other regulation, to provide a safe environment because this person has the ability to die from something that is that common?

MR. CUSHING: I am not well versed in OSHA regulations or the law. From our own Department's position, the Secretary has issued a letter to all employees. The letter was issued from the standpoint of the transmissibility of the disease in the workplace. But you are addressing more the issue of the individual's protection, is that it?

MR. SHORT: Exactly. If you have the majority population employed who have AIDS, either the syndrome or full-blown AIDS, or whatever, which makes them vulnerable to anything that comes along, is there any extraordinary responsibility of the Government to provide a safe environment for those people?

MR. CUSHING: I cannot give you an OSHA perspective. From a 504 perspective, there would be a requirement to provide some accommodations so that the person could perform the essential functions of the job. Now, what that would constitute, I guess, would depend on the certain set of facts. I think you have to view that those vulnerable individuals have a responsibility to take care of themselves.

Conceivably, they could be working in a setting that could be as germ-free as possible, although that probably is somewhat unrealistic to achieve given the quality of the air in Federal buildings. But from an OSHA standpoint, I cannot address that.

MR. SHORT: The reason I brought it up is this backlash from cases

where there have been some problems with asbestos. Could there be anything connected with the syndrome which could be brought up in discussions?

MR. McDONALD: The sword cuts two ways. For example, a person who has AIDS may be a threat in the workplace to pregnant women or other people who have a low immune function because the person with AIDS or HIV infection may be shedding certain kinds of viruses like cytomegala virus which is harmful to certain individuals with a suppressed immune system. So that kind of phenomenon is typically referred to as secondary infection, and it can be a threat either to the AIDS patient or to others in the environment; how much of a threat, I do not really know.

MR. SHORT: Locally, there was a controversy. A doctor claimed that the CDC, in its reporting, did not necessarily include the effects of oral medication as depressing the immune system. You were talking about IV drug users as a way of depressing the immune system and creating an opportunity for AIDS to enter the body. He mentioned that perhaps oral medication, which may do the same thing, was not included in the reports. Do you recall that?

MR. CUSHING: I do not recall it, but I do not see how it could happen. In the intravenous drug user, what is happening is that you are sharing a needle and one person's blood is being passed on to another individual. His infected blood is then introduced into another blood stream, and that is what causes the syndrome or the virus to take hold in the immune system and begin the process. For someone who would ingest a drug or a medication orally -- I am somewhat confused by the statement.

MR. SHORT: Would it make you more vulnerable? That was his point.

MR. CUSHING: I do not know how it would make you more vulnerable.

MR. SHORT: He feels that perhaps people with depressed immune systems are more vulnerable to sexual transmission as opposed to directly with the blood.

MR. CONNELLY: I would just add, and I am no expert on the innumerable studies that are being done around the country, but there is the whole issue of cofactors. You might have a situation where an intravenous drug abuser might have, let's say, poor nutrition, who we know does not eat properly in general. He might have an immune system that is more vulnerable.

Then you have the density question which Paul brought up earlier. It is those type of things, I think, that in an individual case would make the difference between getting infected or not.

MR. SHORT: My only question is that I think it is somewhat like the Belgrade Mosquito case: some are going to start coming in out of left field.

PARTICIPANT: If God is the beginning of wisdom, fear of AIDS is going to be the beginning of death. It seems like fear is the killer. I had a sixth-grade girl who came for tutoring with me and she was doing research on AIDS. I asked her, "Why are you interested in AIDS? You are only in sixth grade." She is panicked. Somebody told her it was a deadly disease.

I want to point out to this Committee that AIDS is not the only epidemic which was in this world. There was cholera; where is it? There was plague; where is it? There was malaria; where is it?

In my own lifetime, in my own village in India, I have seen tens and twenties of people killed in one village because of cholera. I go there in 1985, there is no cholera.

What I am trying to say is that there is a hope that this will be eradicated. This is one of the timely diseases or timely epidemics which is sweeping the world. Maybe we can call it punishment of God. It is just like any other epidemic.

But again, raising the question of who causes it has created this fear in people. If cholera was caused by bad water or insects, now this disease is between human beings. That may be the reason for the intensive fear that people have.

I think that kind of fear must be taken out of children, first of all, and the adults. What are you really doing on it? What agency is really working on this fear?

MS. LETTIERI: My name is Kathy Lettieri, and I have the honor of being the executive director of the AIDS Education Bureau, working in different areas. This particular AIDS Education Bureau is directed primarily towards the adult heterosexual community, going on the premise that we no longer have high risk groups, but a high risk behavior. Our premise recognizes that it is a human-to-human transmitted disease, and a

basic blood-to-blood transmitted disease, basically by sexual contact, over which we humans have control.

One does not have to get the disease AIDS. You can take precautions or you can not have sex at all. One is responsible for one's own behavior and one's own effect with the disease. Education is that which teaches you how to handle it, what to do or, more yet, what not to do, thus eliminating fear.

MS. GALIBER: I have been sitting here wanting to comment after Paul spoke because he spoke about the great incidence of AIDS in the black community and other ethnic minority communities in this country.

My great concern is the perception that this is a white male homosexual disease, and many of the clients that we know of just do not realize this can happen to them in other ways. I want to know if the Office for Civil Rights or any other Government agencies are developing educational material that will, in fact, get another kind of message out to persons who are really the ones that are suffering right now.

MR. CUSHING: I know the CDC is investigating getting materials printed that will be in other languages, bilingual. How far away they are from that yet, I do not know. They are also encouraging local health departments, particularly where there are large minority populations, to begin to get out to the minority communities, to get the information out to people through the public health workers. What you have had happen is that a lot of the educational efforts about AIDS has come out through the gay community itself. They had the first start.

But the social structure of a gay community in large metropolitan areas is predominately white so that even black gay men are not going to be going into the bars, the gay bars, of Philadelphia, Washington, or New York. Whatever instruction or information and education is going out through that system is still not getting to the black population.

The gay community is taking on the responsibility to try to reach out to the black population among gay organizations throughout some of the large metropolitan areas. To get to the drug abusers, those who are substance abusers, at least at this point, they are trying to build on the public health system that is already out there and rely on our public health workers. CDC has a number of people in these large areas who, along

with their other functions, are tracking down communicable diseases, which they still do day-to-day, to begin to get into those communities and inform people about what the risks are.

CHAIRMAN WASHINGTON: We will now proceed with Topic B, we call Mr. Marvin Hart, representing the Director of the D.C. Office of Human Rights, to lead off the forum this afternoon.

PRESENTATION OF MARVIN HART, REPRESENTING THE DIRECTOR, D.C. OFFICE OF HUMAN RIGHTS

MR HART: I am Marvin Hart, an attorney at the D.C. Office of Human Rights and Minority Business Opportunity Commission. I am also a member of the D.C. Commission on Public Health AIDS Advisory Committee, office liaison to the District of Columbia Interagency Task Force on AIDS, a member of the Commission on Public Health AIDS Educators Committee, a member of the Family Services Subcommittee on Pediatric AIDS, and our office's AIDS coordinator.

I am here today representing Maudine Cooper, the Director of the Office of Human Rights and Minority Business Opportunity Commission. I wish to thank you, Mr. Chairman, and this Committee for the opportunity to appear before you to address AIDS handicap protection.

First, our office is pleased to be able to share with you the efforts we have made to date to address the needs of the District constituency as regards AIDS handicap protection. I will briefly outline our office's work interests and policies in this area.

In 1983 we received a telephone call from a young woman who did not wish to file a complaint but felt that our office should be aware that a new condition existed in the medical community which might give rise to discrimination.

As you know, though the virus which caused Acquired Immune Deficiency Syndrome had been isolated in 1981, very little was known or could have been predicted about the impact that AIDS would have on various aspects of

our society, and particularly about how it would impact on opportunities in employment, housing, education, and other community services.

Our office began to monitor the development of both medical and legal information concerning AIDS after that telephone inquiry. The development of legal information was very slow and there was really no place to turn for specific guidance. The medical community had, however, defined AIDS as a bodily condition in which the immune system destroys itself through the virus' reproductive process.

We reviewed the handicap provisions of the D.C. Human Rights Act of 1977, in light of the medical information available, to determine how we should process a complaint that raised AIDS as an issue. Upon review, we noted that a physical handicap is defined as a "bodily or mental disablement which may be a result of injury, illness or congenital condition for which reasonable accommodation can be made."

We determined, in 1984, after a review of comparable legislation on both the Federal and State levels, that AIDS should be a protected illness, requiring accommodation. Our office received numerous inquiries throughout 1984, 1985, and 1986, primarily from lawyers, employers, and concerned citizen groups regarding what our policy would be regarding AIDS. We informed each inquirer equally that our policy would be that AIDS is a physical handicap under the Human Rights Act, and that we were continuing to monitor the activity of the courts around the country for further direction.

As the number of inquiries increased, it became apparent that we would need to issue a formal policy statement to ensure that employers, service providers, and District residents would know their rights and obligation under the D.C. Human Rights Act.

Since we were drafting our employment guidelines at the time, we seized the opportunity to further clarify the statutory definition of "physical handicap" by adopting, in part, the definition found in regulations to the Federal Rehabilitation Act of 1973, which prohibits physical handicap discrimination by Federal contractors. We also specifically included Acquired Immune Deficiency Syndrome in the list of conditions which could be considered physical handicaps for purposes of the act. The regulations were formally published in August of 1986.

We then prepared our policy statement, our office's policy statement, and circulated it throughout the community for comments and recommendations. During this time, we were also working with the District Interagency Task Force to ensure that this policy would be considered and included in the citywide plan.

In October 1986, our office cosponsored a conference with the Interagency Task Force on AIDS, entitled "AIDS, District Government, and You," at which we formally outlined the protection which the D.C. Human Rights Act provides for persons with AIDS. We mailed our employment guidelines to the top 200 employers in the District, and placed our AIDS brochures in various public locations. We began to send speakers, on request, to various conferences on AIDS, and we incorporated a section on AIDS discrimination in our Equal Employment Opportunity Counselors Training Program.

It is noteworthy that during this period, the Supreme Court had agreed to hear the case School Board of Nassau County v. Arline to determine if a contagious disease, such as AIDS, but specifically in that case tuberculosis, could be considered a physical handicap for purposes of coverage under the Rehabilitation Act of 1973.

The Court did hold that a contagious disease may require the physical handicap protection of the Rehabilitation Act and, in so doing, set the tone for comparable interpretations for local statutes. We are pleased that the Supreme Court and our office were of the same mind on this definition issue.

Currently, we continue to work with the Commission on Public Health, specifically with the Office of AIDS Activities, to help spread the word about the discrimination protection available for persons who have AIDS, AIDS-Related Complex, or persons perceived to have AIDS.

The protection of the Human Rights Act extends to persons who are unlawfully discriminated against because they test positive for the presence of Human Immuno-Deficiency Virus or because they are otherwise wrongfully perceived to have AIDS merely because they live, work, or care for a person with AIDS.

I will now turn to a few specific areas of interest. To date, our office has received five complaints alleging discrimination on the basis

of AIDS. We attribute this low number of cases to our early efforts to inform persons who inquired with us about our policy. In conversations with attorneys and employers, we found that once people became aware of our policies, they acted accordingly. This is not to say that discrimination is not occurring; it says that with the policy of nondiscrimination, it has been easier for the parties to settle their cases before formally filing a complaint.

When cases are filed, they are processed through an accelerated case processing system. We bring the investigator in early and we begin processing immediately. We are constantly evaluating our system to make it as effective as possible.

Of the cases filed, four are currently under investigation and one resulted in a settlement. Because of the confidential nature of these complaints, we cannot reveal the specifics of the allegations. However, we can say that four of the cases are employment related and one is a public accommodations case.

Our experience has been that whites are more likely to file a complaint than nonwhites. We are working with the AIDS Educators Office to better assess the means of assisting nonwhite persons who have been discriminated against because of AIDS, using available resources to seek redress.

Finally, we realize that AIDS will provide us with new challenges over the next few years and, though our progress in both the medical and legal communities is moving slower than many of us would hope, we stand ready to meet those challenges.

PRESENTATION OF INSPECTOR GARY ABRECHT REPRESENTING MAURICE TURNER, THE CHIEF OF THE D.C. METROPOLITAN POLICE DEPARTMENT

INSPECTOR ABRECHT: I am the Director of Planning for the D.C. Metropolitan Police Department and have been assigned by the Chief of Police to fulfill the function of AIDS coordinator for the Department. Thank you for the opportunity to discuss our police department's response to the AIDS handicapped individuals.

Like most large police departments throughout the country, the D.C. Metropolitan Police Department has been dealing with the impact of AIDS on our operations for some time. The primary concern has been to protect our personnel from the possibility of contracting the disease through contact with the blood or body fluids of infected individuals.

As we developed policy in this area, the overriding principle Chief Turner enunciated was that we would not discriminate in providing police service to any person on account of his having this disease. This guiding principle grew out of the long history of this Department as the leader in the field of civil rights and community relations.

Sensitivity and responsiveness to community concerns have been important values to this agency for many years, and it has been in that context that our policy has evolved. We have been greatly helped in this regard by our active community relations effort with the city's large gay community over the last 6 years.

Starting in 1981, well ahead of practically any other department in the country, when Chief Turner first appointed a liaison to the gay community, our outreach efforts have continually expanded, so that we now have a captain in each of our seven police districts designated as a liaison with the gay community. In addition, a gay community representative sits on the Chief of Police's Advisory Council, and the Department actively recruits openly gay and lesbian persons as officers.

This previously established reservoir of good will and trust proved to be very valuable to us when the fear of AIDS among our officers caused them to offend the organized gay community by wearing gloves and masks in two incidents involving gay persons. We were able to work, through our existing channels of communication, to assure the community of our continuing support and to obtain their cooperation in the preparation of a comprehensive policy on the wearing of protective equipment, which will be published very shortly.

The police department of this city will continue its long history of nondiscrimination and aggressive community relations under the challenge of responding to the needs of persons with AIDS. No one will be denied police service on account of his having AIDS.

When persons with AIDS come into our custody, they are treated as any other person with a serious illness would be. If they require medical care, it will be provided for them; if they do not, they are treated as any other arrestee.

I will be glad to amplify on any aspect of our policy that may be of interest to the Committee.

CHAIRMAN WASHINGTON: Very well. You're not using gloves?

INSPECTOR ABRECHT: No, not any more.

CHAIRMAN WASHINGTON: All right.

I would like to call on Mr. Reginald Jenkins, representing Hallen H. Williams, Director of the D.C. Department of Corrections.

PRESENTATION OF
DR. REGINALD JENKINS,
CHIEF MEDICAL OFFICER,
D.C. DEPARTMENT OF CORRECTIONS

DR. JENKINS: I am Dr. Reginald Jenkins, the Chief Medical Officer for the D.C. Department of Corrections. The D.C. Department of Corrections, like many correctional facilities across the Nation, has had to meet the many challenges that AIDS presents to every facet of government. In 1986 our department formulated its first departmental order on AIDS. This departmental order addresses two main areas of concern, testing and housing, and is consistent with AIDS policies of the majority of correctional facilities across the United States. In addition, education for residents and staff has become of paramount importance in stemming the rising tide of hysteria surrounding this disease.

Our policy on testing prohibits mass screening of inmates for the HIV virus. Testing is done within the established risk groups and at the discretion of the attending physician. This policy developed secondary to concerns with the difficulty of maintaining the confidentiality of the test results in a small prison community, as well as concerns with discrimination and other detrimental effects on individuals' lives if results are divulged.

Our policy on housing states that persons who are asymptomatic sero-positive will be housed in the general population. Inmates who are

symptomatic sero-positive, that is those residents with AIDS-Related Complex, are housed in the infirmary where they can receive more intense medical attention, but are returned to the general population after their acute medical problem is corrected.

Residents who meet the Centers for Disease Control definition of AIDS are housed in the locked ward of D.C. General Hospital where they can receive the level of medical attention required.

With the exception of AIDS patients at D.C. General Hospital, our policy protects residents from being identified as would occur if they were to be segregated. It also recognizes the fact that small correctional facilities are unable to adequately provide separate but equal programming for inmates who are identified as having AIDS.

Many new problems have been presented since the original departmental order was written, and the Department is currently engaged in exchange with other governmental agencies to resolve them. The Department is committed to refinement of its policies on AIDS and will continue to address issues affecting our resident population.

CHAIRMAN WASHINGTON: We now have Dr. Reed Tuckson, the distinguished Commissioner of D.C. Public Health Service, who is appearing for himself.

PRESENTATION OF DR. REED TUCKSON, COMMISSIONER, D.C. PUBLIC HEALTH SERVICE

DR. TUCKSON: I am convinced that if we are ever able to get a handle on this epidemic, this unprecedented plague of ours in this community and around the country, one of its major aspects will hinge around how we solve, handle, debate, and explore the problems of civil rights and human rights in those issues.

I believe it is important to stress that how this society is judged during this time, in this era of our development in history as a people, as a city, and as a nation, will ultimately hinge on how we handle the issues of AIDS. There is no other issue, no other health issue, no other social

issue that presents more challenges in more areas of how we can conduct ourselves not only as individual human beings, but also as social human beings, as political human beings, and as an organized community of civilized persons.

Unfortunately, there is a contradiction between making sure we do all we can to treat an unprecedented disaster and making sure that we preserve and maintain all those things that this society holds dear and sacred from a humane perspective. There should not be a contradiction, but there is. Ultimately the most difficult part of my job as a Commissioner of Public Health is how to do all that we should do but not destroy the society in the process of doing it.

Let me just remind you that there are 744 persons in our city that have come down with this disease, and over 60 percent of them are now dead. And the numbers continue to grow.

CHAIRMAN WASHINGTON: What were those figures again?

DR. TUCKSON: Seven hundred and forty-four of our friends, neighbors, and relatives have had this disease; 434 of them have died.

There is a very important set of data I want to mention. A recent study of military recruits in the District of Columbia suggested 1 out of 100 of our military recruits, ages 18 to 30, from this city alone, are positive for the virus. That is not as frightening as New York and Manhattan and Brooklyn, where the numbers are like 1 in 50, but still 1 out of 100 says to us that this virus, unfortunately, is quite prevalent among our young people as well.

The issues for me are simple; the most fundamental one is for us to educate, educate, and educate. We live in a pluralistic society that has many religious communities who have very strongly-held religious beliefs about the role of sex education to our young people. While respecting that, I think my job, as a Commissioner of Health, is to advocate strongly even down to the third or fourth grade level. We must talk to our young people with vigor and intensity about what this disease is and how it is spread and transmitted. In the course of education, we have been confronted with the challenge of whether we talk about condoms in the public air space on the radio and television. But that is something that a free society has to have an open debate about. As a Commissioner of

Health, my responsibility is to advocate that we demystify and deenergize the issue of condoms.

I think it ought to be as common a practice as we can possibly make it for those that are old enough and rational enough to make an intelligent decision to have sexual activity. I do not suggest that young people have access to this. Rather, I strongly suggest that the message to young people is to abstain. But the point is that those who are adults ought to have access to condoms, and it ought not be a mystical or difficult issue. Otherwise, we are headed down the road of disaster. But that is something that a pluralistic community must debate.

The second issue for us is the question of testing. Clearly, we need to know from an epidemiological and scientific base whether this disease is spreading and, if it is, to what parts or subsegments of our community. While we understand this is not a disease of high risk groups but a disease of high risk behavior, we understand that sero-prevalence testing is one good way of finding that out.

I think the prison system is one place where we will have to conduct well-designed, confidential sero-prevalence studies to see what the extent of the virus is. It does not require, in my opinion, mandatory testing of the entire population of the city.

The question of testing, though, does get into the issue of whether or not we want to engage in mandatory testing and how we protect the confidentiality of the result of such testing. That is the central theme I wanted to spend my last few minutes on.

It is impossible for us to encourage the people who are engaged in the high risk behavior to come in for testing. It would be impossible for us to convince them to do so if it occurs in an arena of discrimination, in an arena of potential abuse.

A person who is known to be a drug abuser already is trying his very best to stay underground, and so he does not want to confront society in an organized way. A person who is a prostitute, a person who is engaging in homosexual activity or bisexual activity, or a person who is heterosexually promiscuous, quite often will not want to come forward for testing. Those persons will not come forward for testing if, number one, they think that their life style will be exposed and, number two, they think that if they

have a positive test, they may lose their homes, or their jobs, or their children will be denied access to the public schools.

For me as a public health official, it is impossible to have a testing program for those that really need it so long as there is the specter of the possibility of discrimination. I think this is as fundamental a part of my job as any that I can imagine. We are convinced that at this point in time, given the state of the treatment art, we ought to advocate for voluntary, anonymous testing for those individuals for whom it would be appropriate.

I end my presentation with the suggestion that no matter what the issue is, whether it is condoms given out in the prisons, whether it is how we decide to treat and deal with prostitutes, whether we should do sex education in the schools, that it should be specific about AIDS. The ultimate issue has to do with how we, as a society, are going to organize ourselves and what kinds of messages and signals we are going to send.

This disease presents no black and white, but only subtle shades of gray. I would suggest that it is of fundamental importance that the open debate be, number one, an informed debate but, number two, that it be a well-reasoned and active debate.

CHAIRMAN WASHINGTON: You have given the Committee and the people assembled here a very good perspective in terms of education -- I remember one citizen who was right on target with you, she was talking about education and training, and you glorify the two dimensions and initiatives.

We appreciate the words of all of the panelists that came representing different programs and efforts of the District government. We are pleased to know that the District government is not only aware but is moving in a positive way to develop a program that will treat the very difficult problems presented by AIDS.

MR. TOPPING: The concern I have is how the resources, that will be designated for combatting this serious problem, will and should be distributed, and what forces will determine distribution.

In the early stages of the civil rights movement, our main task was to educate -- it was very general. We had to educate, everybody had to be educated. Then it began to narrow down, and the question became who would

be responsible? How do we get to focus the resources to get the biggest return for the buck?

That then led to such things as getting civil rights enforcement machinery. We got to the place where we actually began to set up case files and to give money to send people out to see what was happening. Finally, we got to affirmative action, which gave some active rather than passive impetus from the managers, like yourselves.

You aptly identified the dilemma in this area of the public health aspect, the aspect of protecting and ensuring the civil rights of all citizens. I see the discrepancies and gaps, the varying rates of prevalence among different groups in the community, but I see no indication of where the funds were going, except the claim that we have got to have more funds. Everybody has got to have a bigger budget.

Somebody mentioned this morning that in developing educational materials now, it is greatly biased in the direction of a gay community problem, primarily because they were the most articulate in the early stages, the most affluent, and the most educated, so that you got a tremendous amount of very good material on that part of the problem from a private source. Later statistics, however, show the huge preponderance of this problem among minorities, among women, and you go down the usual line of victimization. My question is this. Could you give us any indication on how you see these developments and how in your program you are going to go from the general to the specifics?

DR. TUCKSON: We are caught in a very difficult Catch-22 here. When we first noticed the beginning of this disease, persons from Haiti were singled out as being a major source of plague in this community. There was a very real and very dangerous sort of discrimination against persons of Haitian descent. This initial suspicion turned out to be incorrect and unfounded.

I think that people of color are particularly concerned about being labeled as the cause of this disease. People of color, we have noticed, have been very, very sensitive about some of these issues, especially as the focus, from an epidemiological perspective, seem to indicate some origins on the Continent of Africa. People of color are particularly sensitive about being labeled in a negative way about this disease. So we

find that the black community, in particular, has been concerned about how this issue is addressed, and would prefer that it go away.

We also understand that when this disease was first noted, it was so overwhelmingly manifested in the homosexual and gay community, it was not thought to be a problem for the black community. It was thought to be a problem of gay white males, in particular. For that reason, it probably did not involve the black community. Unfortunately, that is not the case, and this disease is spread tantamount throughout our society.

It is only recently that the major leadership in the black community has focused in on the issue. In my opinion, we have not had, until recently, the kind of demonstration of interest and concern by the major leadership in the black community about this disease. We have not focused in on it as an issue for the major civil rights leaders in this country.

Now I am happy to say that it is, in fact, on the agenda of the NAACP, the Southern Christian Leadership Conference, and the National Urban Coalition. We are happy about that.

As regards how public funds are expended, you are right that the gay community was a much better organized political community, at least in this town, regarding this disease. They certainly were very thoughtful about their approach and willing to organize themselves into voluntary public/private partnership efforts. They raised a lot of money, and were thoughtful about systems of care delivery and how they could supplement what the government was doing.

It is clear that IV drug abusers are not well-organized in the sense of being able to provide and advocate for their constituency. They may be well-organized in terms of distribution systems for illegal contraband, but that is about as far as it goes.

It seems that black clergy is reluctant to speak about this issue from the pulpit and in the environment of the church. Probably for this reason, some of the traditional institutions available to the black community have not come forward, heretofore, to organize themselves.

The final answer to your question, then, is in terms of our education efforts. From a marketing perspective, we are sophisticated enough to know that you market anything by understanding the importance of the subsegments of markets. You do not speak to the Hispanic community without

understanding the importance of the image of the macho male as a role model.

You do not market to the black community with the same message that you would have for the gay community because we know that the black community is an overwhelmingly religious community and they don't want to hear certain things presented unless it is presented very, very carefully and in certain ways.

Given the demographics of D.C. being 75 percent black and minority, I think that the money that we spend for education for the city ultimately becomes, by definition, education to the black community. The gay community, I think, has done a fantastic job on its own and with the government's support. Our efforts are going to be targeted much more directly now towards the larger community, and also be very specific.

Although I appreciate the role of advocacy, the city government does not feel that it needs to be reminded of the need to watch the distribution of money and to make sure that it goes to all the segments of the community that need it. Since the numbers of people that are going to have this disease are people who are from the IV drug abuse community and the underground of our city, it becomes just so hard to organize that system.

CHAIRMAN WASHINGTON: Let me ask you, Doctor, have you had occasion to make this speech in any of the churches?

DR. TUCKSON: I have been encouraged. We have spoken to, and had the opportunity to address several hundred clergy.

CHAIRMAN WASHINGTON: Baptist churches and clergy?

DR. TUCKSON: Yes, Baptist ministers. Not within the pulpit, but in the back room. I am encouraged by the response.

CHAIRMAN WASHINGTON: I mean on Sunday morning at 11:00 o'clock.

DR. TUCKSON: We are at the stage where the clergy have been spoken with, and are convinced of the need to have this happen. I have not personally spoken at 11:00 o'clock, but I do see that coming, and I do see that the ministers are feeling their responsibility now. I want to be clear; I am extremely encouraged by the responsiveness of the black church, in particular.

SAC MEMBER BANKS: Inspector, how does an officer determine, when he or she is making an arrest, whether the arrestee has AIDS.

INSPECTOR ABRECHT: Generally, the officer does not know unless the person tells the officer. Normally, we come to know when an individual, for whatever reason, thinking perhaps that we would release the person or for whatever reason, tells the officer. That is about the only way that an officer comes to know.

MR. BANKS: In the incidents that occurred with regard to the use of gloves and masks, were those persons identified as AIDS victims before the arrests were made?

INSPECTOR ABRECHT: There really were two incidents, as you are probably aware. There was an incident where we were conducting a raid on an illegal after-hours ABC establishment, Alcoholic Beverage Control establishment, where there was no knowledge on the part of the officers involved that there were any AIDS patients there. They essentially acted because they knew that the place was patronized primarily by members of the gay community.

The second incident, of course, was in front of the White House when there was a demonstration during the National Conference on AIDS at the Hilton. We were told that some of the demonstrators, who were asking to be arrested, did have AIDS, not a large percentage of them, but some of them. We were not told which ones; so that was the dilemma that the officers felt that they were confronted with at that time.

MR. BANKS: Dr. Jenkins, you indicated that there were three, I think, categories given to persons with AIDS in the Corrections Department, one for those who are identified as AIDS victims in the hospital, one for those who are suspected of having the virus, and one for those that obviously have the virus but have some illness that is treated in the infirmary.

DR. JENKINS: Yes.

MR. BANKS: You did not indicate how many of your population fall within those categories. Is that information available?

DR. JENKINS: The Department of Corrections has a total population of about 7,000 inmates. At present, we have two AIDS patients who are housed at D.C. General Hospital. Since 1985, we have had a total, to date, of 12 deaths secondary to AIDS. We keep a running count on the number of people per year who are sero-positive, and for the current year, of about 100

people tested, approximately 48 of them are sero-positive, or are carrying the virus. To date, most of those people are healthy.

MR. BANKS: How do you determine risk groups?

DR. JENKINS: If they give a history of IV drug abuse, homosexual activity or having been transfused, if they have a sexual contact who is known to be sero-positive or known to have AIDS.

MR. BANKS: Dr. Tuckson, my question to you is somewhat general. You made a strong point that discrimination against a person with AIDS would deter persons who had the possibility or had symptoms from identifying themselves or even taking tests because they would be fearful of being discriminated against. In terms of public policy, a position against discrimination carries with it, I presume, either a medically defined limit or some information that is generally accepted in the medical community that there are no dangers or few dangers to the general population in the normal contact with AIDS patients.

DR. TUCKSON: Yes. Basic scientific evidence that underlies the answer to your question is that, again, this disease is transmitted only in very direct and extremely intimate ways. While this is a very lethal virus, it is one that you have to go out of your way to an extraordinary way to encounter. So a person who is a positive for the virus or who has the disease is not a threat to his fellow human beings unless one is intimate with them.

The only caveat to that is a special kind of intimacy that comes with the work of persons who are in contact with blood and bodily fluid such as our emergency ambulance workers or, in some cases, the police department and, of course, hospital personnel. Even there, it is only if they are in extreme direct contact, have contact with the blood of that individual. Thus, it is extraordinarily rare, almost unheard of, for a health care worker to be exposed to this virus in the course of what they do. Therefore, the point is that -- you are right -- it is inappropriate to discriminate against a person with the virus, even with the disease, in the general population.

MR. BANKS: That, of course, means that the education challenge is more difficult, because if the disease is transmitted only through the most

intimate contact, it is the description of the intimate contacts that is controversial and some wish to avoid to talk about in public.

DR. TUCKSON: Precisely one element of the dilemma. Our survival hinges on our ability not to be queasy about real life.

MS. GALIBER: Dr. Jenkins, I have been reading a paper given by Mr. Williams, the head of the Department of Corrections. He mentioned that at the D.C. Detention Facility, 375 tests were performed and 187 out 375 were positive. I am just wondering if your figures might be drastically off since you had a captive audience and did not conduct similar studies at other facilities.

The other thing I wanted to ask you is, "what is the position of the Department now, as it relates to what Dr. Tuckson said, in giving out condoms?"

DR. JENKINS: That sounds like a loaded question. As for the first part, the total number of people tested in the Department since the test was licensed is roughly 300 and some people. We have that documented by records. I am not aware that 187 of those are positive; I am not sure.

CHAIRMAN WASHINGTON: She is reading it.

MS. GALIBER: It is right here.

DR. JENKINS: The figures that I gave were the testing statistics for 1987. Those are probably cumulative numbers for the department.

MS. GALIBER: This is May 1987, "Status of Prevention of Acquired Immune Deficiency Syndrome in the District of Columbia," Department of Corrections.

DR. JENKINS: I will have to check the data.

MS. GALIBER: But these are shocking statistics, right, if that is accurate?

CHAIRMAN WASHINGTON: Could they be cumulative?

DR. JENKINS: They are probably cumulative totals since 1985, when we started doing the testing. A lot of those people are not still in the system. The statistics I am reporting are people that are still in the system, people that have not been paroled and are still in the custody of the Department of Corrections. These are the statistics for Lorton; I have not included statistics for the D.C. Detention Facility, which we are still gathering.

As for the question of condoms, that is a very controversial issue. What I would like to state is that the D.C. Department of Corrections is an institution and, as all institutions, we have rules for the safe operation of that institution.

One of the rules is that homosexual activity is prohibited. So it sort of puts us in a bind: on the other hand, we have rules and laws, but on the other hand, we end up in effect saying, "Well, we know we have those laws and regulations that you are supposed to follow, but here are the condoms for you to use for whatever you are going to use them for."

CHAIRMAN WASHINGTON: Though it be prohibited.

DR. JENKINS: Though it be prohibited.

I think, as a correctional facility, we have a problem with that aspect of it. I can understand, as a physician. I understand the need for condoms as a means of protection, but there are other ways that people can protect themselves. For instance, abstinence is one. We are trying to educate the residents as to risks, "you have to keep in mind that what places you at risk is behavior, and if you can modify the behavior, it lessens your risks." Condoms are not the total answer to the correctional part of that problem.

MR. TOPPING: I have a question for both Dr. Jenkins and Commissioner Tuckson here.

First, has the D.C. Corrections Department ever attempted, through any kind of confidential survey or anything, to get any indication as to the percentage or the likelihood of involuntary sexual relations within the Corrections Department? What is the actual instance, is there any kind of handle?

Obviously, all of us have seen various stories in the papers about situations that have happened. The question is just how prevalent is this? To what extent, if any, are these numbers even remotely close to what you have been talking about here that roughly 50 percent of those tested have been exposed to the virus? To what extent is there risk to the general prison population as a result essentially of involuntary sexual relations?

Do we have any handle on that? Is there 1 chance in 2, in the course

of a year, or 1 chance in 100 that someone is likely to be subject to that?

DR. JENKINS: From the medical aspect, the reporting of sexual assaults is a tricky matter to document. Most assaults are reported by inmates as being a basketball injury, or "I fell down the steps," or something like that. A lot of them are probably underreported.

We see very few documentable cases of rape that we can document medically in the department of corrections. That does not say that it does not occur; it does occur. The point I am trying to make is that because of the nature of the correctional community, these things are usually not reported.

MR. TOPPING: Is there any way, short of reporting, to find out -- I mean focus group activity, or maybe it is people after they have been out. Is there a way of getting any kind of a handle as to the severity of the problem?

DR. JENKINS: It has been very difficult. I have tried to survey some of the residents to get a handle on how much homosexual activity there is. It is known that homosexuality is a reality for the correctional system. Getting a handle on to what degree it is a part of the correctional system is difficult, because it is sort of an underground society. Number one, they are doing something illegal and, number two, I am part of the official system; so it is going to be difficult for me to get that information.

We have had anecdotal data from people who have been in the correctional system, and their reports state that there is little to none, or you may run into someone who may say that it is rampant. So you really cannot get a reliable, scientific type of evaluation of that type of activity. We do not have a lot of sexual assaults that are documented medically.

Commissioner Tuckson, I wondered, based on your assessment of the situation generally, to what extent is there, in fact, safe sex? Assuming the use of condoms, do you have any kind of statistics over a period of time as to what the effectiveness of the proper use is likely to be?

In the heterosexual situations where you might have two sex partners, one having the virus and one not, there actually would be a chance to be

able to observe the effectiveness over a period of time. Can we draw any conclusions from that?

DR. TUCKSON: The best data are actual data involving members of the gay community. Those data strongly suggest to us a couple of things; first, that the incidence of rectal gonorrhea has markedly decreased in the country. That tends to tell us that there is certainly some change in behavior in that community, in a very significant and meaningful way. So that is very helpful.

In terms of the heterosexual community, I do not have similar data. I have not seen any, at least in this city, good trends of sexually transmitted disease yet. But we certainly would hope that we would start to see it. So I cannot answer that question quite yet.

In public health there has always been the issue of trying to equate knowledge and attitude with the change of behavior. It is very difficult to demonstrate. The bottom line for us, the scorecard, is going to be simply the curve of the number of cases, that is, whether we can actually see the curve starting to change.

It still is true the heterosexual community represents 1 percent of the number of cases in our community. I could emphasize the adjective "only 1 percent" but still, that 1 percent is too much. I do not know if that is 1 percent going to 15 percent in the next 2 years; it is too early to tell.

The problem with all of this is that from the time of onset of the virus until the diagnosis of the disease can be as long as 5 years. So we are really playing with tips of icebergs here, and it is too early to tell. But at least the encouraging thing, the good news out of all of it, is that if the gay community can decrease their rate of rectal gonorrhea, then that tells us that people, with knowledge and incentive, will change their behavior.

SAC MEMBER CASTELLANOS: Does the Department of Corrections have a different policy for dealing with parolees that have tested sero-positive, whether it is symptomatic or asymptomatic? Is there a different policy for a parolee who has tested sero-positive? I understand you would offer assistance in terms of getting them employment as part of the parole process, and checking up to see if they are getting employment, housing,

and education. Obviously, someone who has tested positive is going to run into additional problems after leaving. Is there a special sort of policy to ease that transition?

DR. JENKINS: No, not to date. The original departmental policy -- we are in the process of revising our departmental order -- was presented in the early part of 1986, and it has not been changed since. For instance, it does not include females who are detained at the detention facility. It does not include the parolees, to a great extent. It is a general type of policy which covers inmates in general, and mostly those who are held in confinement.

The health care of residents who are in halfway houses is provided by D.C. General Hospital, mostly. They report to the public system, as would any other person. But as far as developing special procedures for finding them employment, that kind of thing, there is no policy.

MS. CASTELLANOS: You are saying that it would not be so much the policy of the corrections department to develop it, but the Public Health Service?

DR. JENKINS: I am saying -- we are looking at some of the problems that are coming up with parolees. For instance, there are problems with some of our sero-positives getting into drug treatment programs, because they are sero-positive. Part of the condition for them to apply for these programs is that they have to be sero-negative or they do not qualify. So that is one of the problems that we are running into. We are looking at that, and we are going to change some of our policies accordingly when we redo the departmental order on AIDS.

I would just like to comment on the numbers. These are cumulative; 375 with 187 positives are cumulative numbers since we started testing, and that is both at Lorton and at D.C. Detention Facility.

MS. GALIBER: I want to ask you this, based on your belief that you will not be able to give out condoms, are you all providing some kind of ongoing educational services to the residents to prevent some of these things?

DR. JENKINS: The idea of education has become of paramount importance, especially, for the Department of Corrections. As I stated before, behavior plays a great role in disease transmission here. What we

need to do is educate residents as to how this disease is spread, and how modifying their behavior can decrease their risks.

We also are concerned with staff, because staff react--sometimes in a discriminatory manner--to residents that are identified as sero-positive. For a small correctional system, keeping the sero data about someone confidential is sometimes difficult.

CHAIRMAN WASHINGTON: Has anyone made any effort to relate overcrowding to the problem of this or any disease factor? It just occurred to me, as you were talking, that is your big problem.

DR. JENKINS: Overcrowding is going to tax all of the systems, including the medical system, including the medical surveillance. So my answer to that would be yes, it does impact on this disease as well.

COMMISSION REGIONAL DIRECTOR BINKLEY: All of you seem to represent agencies or organizations that have given support for the job you have to do in connection with AIDS. If you had the authority to do so and more money, what would you, based upon your experience, do to improve or change what you are presently doing, if anything. Any of you. Mr. Hart.

MR. HART: What I would do is what we have all been talking about, it is to educate. Spend the money on finding whatever mechanisms to reach the specific cultural groups which we are missing currently. I would focus the funding on that, education, because it is education that will lead to a change of behavior, the behavior as opposed to the groups.

Unfortunately, in the beginning, we were focusing on this group and that group and the other group, and that has placed, I think, a primary barrier to our education, because now we have got to educate people beyond the group thinking to behavior thinking, and then we have got to educate them further on trying to change that behavior. That is the focus that I would take.

CHAIRMAN WASHINGTON: I take it that is something that all three of you would relate to, education and training. If you had more money, more resources, you would have more education, more trained people to deal with the problem.

INSPECTOR ABRECHT: Certainly, education is very important in the police department. Part of the problem that we do have is officers who have great fear of the possibility of contracting this disease from the

many kinds of often difficult people that we deal with, and the officers are very fearful of that, and legitimately so.

I think providing them with good education is necessary, which the Commission on Public Health has been doing for us. But they have a very small staff and they are not able to do it as much as we would like or they would like. Providing good education to our officers is certainly a very important part of this, and that would be one thing we would have to spend money on.

The other thing, of course, would be protective equipment for the officers when they do encounter blood or body fluids at the scenes of accidents and things of that nature. The Chief has made money available for that, so we really do not need any additional funds for that, to my knowledge.

DR. JENKINS: At the Department of Corrections, we have been doing our own AIDS education in the medical field initially, and the need to have an expanded educational program, involving government contractors such as KOBA Associates and the Whitman-Walker Clinic, became important. They have been giving seminars to the residents and have conducted AIDS training courses with our staff members. I cannot stress enough the importance of educating both residents and staff about this disease, so that there is more rational thinking about it and less hysteria.

MS. GALIBER: Is that training going on behind the walls, too?

DR. JENKINS: Yes, and we are presently moving to augment that program, because we want to get the message out to everyone.

MR. CONNELLY: I want to supplement what was said before relating to the incidence of the occurrence of AIDS in hospitals. Besides the underreporting and the fact that it is illegal behavior, the fact that prisoners come and go further complicates the matter. There is no real handle on to what extent, within prison walls, AIDS is spread.

There is only one study that I know of, and only one, that was done by the State of Maryland, involving 137 long-term inmates, longer term than the AIDS crisis has been. I believe out of the 137 individuals, under 10 became sero-positive which is, admittedly, a small population but, nevertheless, is a disturbing result.

To return to condoms, as you probably know, Dr. Jenkins, the city of New York and the State of Vermont have policies supporting the dissemination of condoms in prisons. The city of New York makes the condom available to, I guess, individuals in high risk groups who seek it or are advised to use it through the medical counseling process.

I am wondering if that type of mechanism, like the one instituted by the city of New York, might be the way to go. That is to say, it is made available to those individuals in high risk groups who asked for or were given the option to use rather than to each and every prisoner who wants to pick up a few. Is that possibility a way out of this dilemma?

DR. JENKINS: When the issue of condoms came up, I discussed the issue of condoms with both Vermont and New York City. Their demographics are different. Their population is just different from our population. The size of the facilities are different. For instance, I think Vermont had 600 inmates, we have 7,000. They have something like three or four sero-positives in their population. So the populations are really different.

In these jurisdictions, they have laws which prohibit homosexual activities in the prisons, and I asked them, "How do you reconcile having laws on the books and being a correctional facility, whose purpose is to prepare people for the outside, and give them condoms? There would be no other reason for condoms other than sexual activity."

The only thing they could come up with is that it was the best medical judgment. I agree; it is the best medical judgment, but you have to keep in mind that there are other ways to prevent contracting this virus than giving out condoms. I think the inmate population have changed their behavior because they know that there is a risk of contracting this disease by engaging in sexual activity. I have seen this reflected in their behavior, so there is behavioral change.

Whether we give out condoms or not, we should still ask the question, "Are they going to be used?" The other thing to consider is that there are other ways to practice safe sex than using condoms, and we could go into the concept of frottage and sexual practices other than penetration, which do not place them at high risk.

I think that is a point that hinges around whether or not we give out condoms. But there are other ways to avoid getting AIDS and follow the laws that we have set down.

SAC MEMBER COOKE: I think we have been immeasurably aided today by the panel and the earlier panel in getting a broad picture of the AIDS question. It has helped us, I think, to separate out that which is very significant, very grave in the whole AIDS picture: what is a responsibility of the civil rights community which is our responsibility; that AIDS education is important, but it is not our direct responsibility; that medical treatment, health prevention, and other aspects of handling the AIDS question can and should be identified, though they are not our responsibility.

I think it will help us, in the long run, to be able to focus on when is it that a person who suffers from AIDS is deprived of his rights or her rights. I think we have to, sooner or later, come to determine what our responsibility is as an Advisory Committee to the United States Commission on Civil Rights: not public health education, not any other education, but civil rights and the deprivation of rights.

CHAIRMAN WASHINGTON: There were varying points of view here, varying approaches. I think the thing that stands out is that education and training appeared to be the great area for the solution of the problem, generally. Obviously, it has a medical base, as well. But in terms of approaching it and controlling it, the educational feature seemed to come through from both panels as prevailing and as a point of view that must be disseminated throughout the entire community.

Thank you very much, gentlemen and ladies. We appreciate your contributions.

Appendix A—D.C. Code Ann. § 6-121, (Supp. 1987) Persons believed to be carriers of communicable diseases - Examination; diagnosis; detention for quarantine; discharge; public hearing.

§ 6-121. Same — Examination; diagnosis; detention for quarantine; discharge; public hearing.

It shall be the duty of the Director of the Department of Human Services to make or cause to be made by a physician such examination or examinations of such person as may be necessary to determine the existence or nonexistence of such communicable disease in such person or whether such person is a carrier of communicable disease. The diagnosis resulting from such examination or examinations shall be reduced to writing and signed by such examining physician within 10 days after the removal of such person to such place or institution and a copy thereof shall be filed in the office of the person in charge of such place or institution and a copy in the office of the Director of the Department of Human Services. If such diagnosis does not disclose that such person is affected with such communicable disease or that such person is a carrier of communicable disease, such person shall be discharged from such place or institution forthwith. If the diagnosis does disclose that such person is affected with such communicable disease or that such person is a carrier of communicable disease, the person in charge of the place or institution to which the infected person has been removed shall, subject to the provisions of § 6-120 detain such person for such reasonable time as may be fixed by rule or regulation under the authority of §§ 6-117 to 6-130 as is deemed necessary in the interest of public health and safety for the isolation, quarantine, and restriction of movement of persons affected by the particular communicable disease or of persons found to be carriers of the particular communicable disease, unless sooner discharged by the Director of the Department of Human Services or the Superior Court of the District of Columbia. A person so detained, however, may apply at any time to the person in charge of such place or institution for his discharge, and the person in charge of such place or institution shall deliver the application for discharge to the Director of the Department of Human Services, who shall give to such person an opportunity to be heard before the Director of the Department of Human Services. If after hearing held by the Director of the Department of Human Services, the Director of the Department of Human Services be of the opinion that such person is not affected with such communicable disease and that such person is not a carrier of communicable disease, then such person shall be discharged. If denied his discharge such detained person may apply to the Superior Court of the District of Columbia for such discharge and the hearing on such application shall be in or out of the presence of the detained person, in the discretion of the Court. Only such persons as have a direct interest in the case and their representatives shall be admitted to any hearing held pursuant to this section or § 6-120: Provided, that if the detained person shall request a public hearing then the general public shall be admitted thereto. (Aug. 11, 1939, ch. 691, § 5; Aug. 8, 1946, 60 Stat. 920, ch. 871, § 2; Aug. 1, 1950, 64 Stat. 393, ch. 513, § 1; July 8, 1963, 77 Stat. 77, Pub. L. 88-60, § 1; July 29, 1970, 84 Stat. 570, Pub. L. 91-358, title I, § 155(a); 1973 Ed., § 6-119c; Feb. 21, 1986, D.C. Law 6-83, § 3(c), 32 DCR 7276.)

Section references.

This section is referred to in §§ 6-117, 6-118, 6-126 and 31-2406.

Effect of amendment. — D.C. Law 6-83 inserted "rule or" near the middle of the fourth sentence.

Legislative history of Law 6-83 — See note to § 6-117.

Appendix B—D.C. Code Ann. §§ 6-2801 to 6-2806 (Supp. 1987), AIDS Health Care.

CHAPTER 28. AIDS HEALTH CARE.

§ 6-2801. Definitions.

For the purpose of this chapter, the term:

(1) "AIDS" means acquired immune deficiency syndrome or any AIDS-related condition.

(2) "Council" means the Council of the District of Columbia.

(3) "Director" means the Director of the Department of Human Services, established by Reorganization Plan No. 2 of 1979, approved February 21, 1980.

(4) "Families" means persons who are related by blood, legal custody, marriage, having a child in common, or who share or have shared for at least 1 year a mutual residence and who maintain or have maintained an intimate relationship rendering the application of this chapter appropriate.

(5) "Mayor" means the Mayor of the District of Columbia. (Mar. 25, 1986, D.C. Law 6-102, § 2, 33 DCR 796; June 10, 1986, D.C. Law 6-121, § 2, 33 DCR 2451.)

Temporary addition of chapter. — D.C. Law 6-102 enacted §§ 6-2801 through 6-2806, comprising chapter 28 of Title 6. Section 8(b) of D.C. Law 6-102 provided that the act shall expire on the 180th day after its having taken effect.

Emergency act amendment. — For temporary addition of section, see § 2 of the AIDS Health-Care Response Emergency Act of 1985 (D.C. Act 6-123, December 30, 1985, 33 D.C.R. 320).

Legislative history of Law 6-102. — Law 6-102 was introduced in Council and assigned Bill No. 6-358, which was retained by council. The Bill was adopted on first and second readings on December 17, 1985, and January 14, 1986, respectively. Signed by the Mayor on January 28, 1986, it was assigned Act No. 6-130 and transmitted to both Houses of Congress for its review.

Legislative history of Law 6-121. — Law 6-121 was introduced in Council and assigned Bill No. 6-306, which was referred to the Committee on Human Services. The Bill was adopted on first and second readings on March 11, 1986 and March 25, 1986, respectively. Signed by the Mayor on April 15, 1986, it was assigned Act No. 6-156 and transmitted to both Houses of Congress for its review.

Short title. — The first section of D.C. Law 6-121 provided: "That this act may be cited as the 'AIDS Health-Care Response Act of 1986'."

Supersedure of Law 6-102. — Section 8 of D.C. Law 6-121 provided that the act shall supersede the AIDS Health-Care Response Temporary Act of 1985.

§ 6-2802. Comprehensive AIDS Health-Care Response Plan.

(a) Within 6 months of December 30, 1985, the Mayor shall develop and present to the Council for its review and comment a comprehensive AIDS Health-Care Response Plan for the District of Columbia. The plan shall include, but not be limited to, the development of short-term and long-term goals and schemes for administrative coordination by District government agencies, educational programs, prevention methods and programs, a compilation of private sector services available to AIDS patients, medical research and information gathering, outpatient and inpatient health-care services delivery, social services delivery, exploration of the feasibility of establishing a separate compensation rate for District employees working in the health-care treatment facility or facilities contemplated in § 6-2803, housing, and identifying other general services needs.

(b) The Mayor shall update annually the comprehensive plan mandated by subsection (a) of this section. (Mar. 25, 1986, D.C. Law 6-102, § 3, 33 DCR 796; June 10, 1986, D.C. Law 6-121, § 3, 33 DCR 2451.)

Cross reference. — As to Mayor's issuance of executive order in public health emergencies, see § 6-1504.

Section references. — This section is referred to in §§ 6-2803 and 6-2804.

Temporary addition of chapter. — See note to § 6-2801.

Emergency act amendment. — For temporary addition of section, see § 3 of the AIDS Health-Care Response Emergency Act of 1985 (D.C. Act 6-123, December 30, 1985, 33 D.C.R. 320).

Legislative history of Law 6-102. — See note to § 6-2801.

Legislative history of Law 6-121. — See note to § 6-2801.

Short title. — See note to § 6-2801.

Supersedure of Law 6-102. — See note to § 6-2801.

§ 6-2803. Residential health-care facility.

(a) In preparing the comprehensive plan mandated in § 6-2802, the Mayor shall investigate the need for a residential health-care facility or facilities which shall provide a program of medical, nursing, counseling, palliative, social, recreational, and supportive services to AIDS patients and their families.

(b) If, following an investigation, the Mayor identifies a need for a residential health-care facility or facilities in the District of Columbia, the Mayor shall establish the facility or facilities.

(c) In order to establish the facility or facilities, the Mayor may acquire, by purchase, rehabilitation, condemnation, rental, or otherwise, a building or buildings suitable for use as a residential health-care facility or facilities, including furniture, medical equipment, and other necessary accessories.

(d) The Mayor may enter into contractual arrangements with any agency or organization qualified to provide the services enumerated in subsection (a) of this section. (Mar. 25, 1986, D.C. Law 6-102, § 4, 33 DCR 796; June 10, 1986, D.C. Law 6-121, § 4, 33 DCR 2451.)

Cross reference. — As to day care generally, see Chapter 3 of Title 3.

Section reference. — This section is referred to in § 6-2802.

Temporary addition of chapter. — See note to § 6-2801.

Emergency act amendment. — For temporary addition of section, see § 4 of the AIDS Health-Care Response Emergency Act of 1985 (D.C. Act 6-123, December 30, 1985, 33 D.C.R. 320).

Legislative history of Law 6-102. — See note to § 6-2801.

Legislative history of Law 6-121. — See note to § 6-2801.

Short title. — See note to § 6-2801.

Supersedure of Law 6-102. — See note to § 6-2801.

§ 6-2804. AIDS Program Coordination Office.

(a) The Mayor shall establish, within the Department of Human Services, an AIDS Program Coordination Office.

(b) The AIDS Program Coordination Office shall be supervised by the AIDS Program Coordination Officer who shall, at the direction of the Director of the Department of Human Services, be responsible for the coordination of and serving as the point of contact for the District of Columbia's comprehensive AIDS Health-Care Response Plan established by § 6-2802.

(c) The AIDS Program Coordination Officer shall:

(1) Analyze medical data, reports, and information to determine the effectiveness with which the AIDS program is meeting the needs of the residents of the District of Columbia;

(2) Coordinate and assist in the development of grant proposals to obtain funds from both the federal government and the private sector for AIDS and AIDS-related activities;

(3) Develop and coordinate, with other agencies of the District government, a program of health-care services delivery and other supportive services for persons with AIDS living at home;

(4) Disseminate information on AIDS to the public;

(5) Assist officials from the federal government, community groups, nursing homes, hospitals, and others in the coordination of AIDS plans, programs, and services delivery for persons with AIDS living in the District of Columbia;

(6) Serve as the liaison officer for the District's AIDS program to other District government agencies and monitor their compliance with the District's comprehensive AIDS program;

(7) Conduct community outreach and education programs; and

(8) Perform other duties appropriate to accomplish the objectives of this chapter. (Mar. 25, 1986, D.C. Law 6-102, § 5, 33 DCR 796; June 10, 1986, D.C. Law 6-121, § 5, 33 DCR 2451.)

Temporary addition of chapter. — See note to § 6-2801.

Emergency act amendment. — For temporary addition of section, see § 5 of the AIDS Health-Care Response Emergency Act of 1985 (D.C. Act 6-123, December 30, 1985, 33 D.C.R. 320).

Legislative history of Law 6-102. — See note to § 6-2801.

Legislative history of Law 6-121. — See note to § 6-2801.

Short title. — See note to § 6-2801.

Supersedure of Law 6-102. — See note to § 6-2801.

§ 6-2805. Confidentiality of medical records and information.

The provisions of the Preventive Health Services Amendments Act of 1985 (D.C. Law 6-83), pertaining to the confidentiality of medical records and information on persons with AIDS, shall be applicable to this chapter. (Mar. 25, 1986, D.C. Law 6-102, § 7; 33 DCR 796; June 10, 1986, D.C. Law 6-121, § 6, 33 DCR 2451.)

Temporary addition of chapter. — See note to § 6-2801.

Emergency act amendment. — For temporary addition of section, see § 6 of the AIDS Health-Care Response Emergency Act of 1985 (D.C. Act 6-123, December 30, 1985, 33 D.C.R. 320).

Legislative history of Law 6-102. — See note to § 6-2801.

Legislative history of Law 6-121. — See note to § 6-2801.

Short title. — See note to § 6-2801.

Supersedure of Law 6-102. — See note to § 6-2801.

Delegation of authority pursuant to Law 6-121. — See Mayor's Order 86-171, September 30, 1986.

§ 6-2806. Rules.

The Mayor may issue rules necessary to implement this chapter pursuant to subchapter I of Chapter 15 of Title 1. (Mar. 25, 1986, D.C. Law 6-102, § 7; 33 DCR 796; June 10, 1986, D.C. Law 6-121, § 7, 33 DCR 2451.)

Temporary addition of subchapter. — See note to § 6-2801.

Emergency act amendment. — For temporary addition of section, see § 7 of the AIDS Health-Care Response Emergency Act of 1985 (D.C. Act 6-123, December 30, 1985, 33 D.C.R. 320).

Legislative history of Law 6-102. — See note to § 6-2801.

Legislative history of Law 6-121. — See note to § 6-2801.

Short title. — See note to § 6-2801.

Supersedure of Law 6-102. — See note to § 6-2801.