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that reveal a growing concern for increasing the breadth of participation in decision making throughout our social structure. This is reflected in such phrases as "grass-roots politics," "consumer participation," "community involvement," "people power," and "women's liberation." Despite the use of the terms there is a lack of understanding. A discussion of political systems should not be concerned with partisan politics or election campaigns. It refers to power relationships and decision-making forces among any group of people composing a social network or system. Political dynamics can be seen in some forms even at the level of the family, although the theories are rarely applied there, and move up through formal and informal organizations to the realm of international relations.

Although each individual nurse belongs to and has a role in many political systems, a professional group such as nursing has a role and identity beyond that of its individual members. Nursing is a profession that draws on a theoretical base to provide service to individuals. The unique activities of nursing are those that assist individuals to maintain as healthy a balance as possible in the face of physical and emotional stress. Nursing is interdependent with medicine and all the allied health sciences. The term *interdependence* is not used to smooth over an acceptance of dependency but reflects an expectation that nurses assume and will be allowed to assume a fully collaborative role as they demonstrate their readiness and capacity to do so. The central focus on meeting the needs of the individual patient that gives direction to nursing in patient care also gives direction to the role of nursing in the political realm. In any apportionment of power, the nurse has the capacity and obligation to allow and assist patients or potential patients to participate in decisions that may affect their ultimate health or illness. This capacity grows out of the knowledge gained through those close relationships with individual patients that form the heart of nursing practice. Within any political system, the role of nursing continues to be caring for and meeting the needs of those whose capacity to meet their own health needs is affected by the functioning of the system. Many people must participate if the idealized American system of decision making is to exist in fact. Simply participating enthusiastically in anything and everything is not enough. Certain lessons must be learned, and if learned in advance, they can save much crushed idealism and many hours of futile energy expenditure. If, however, the work of involving more persons in health care decisions is done and done well, this should ultimately result in more gain for nursing and nurses than vast amounts of efforts expended on promoting "the profession of nursing" as an entity.

We contend that the nature of human interaction is such that involvement in political activity is essential. This does not mean, however, that this book is a statement of our own partisan political viewpoint. We hope that the readers will represent the entire spectrum of political philosophy, from ultraconservatism to extreme liberalism, present in our American society. We are presenting a theoretical framework that should enable a nurse with any partisan conviction to be more effective in any attempts to broaden the participation of individuals in political decision making.

Some readers may doubt the feasibility of such an attempt. One fact may lend credence: after collaborating in the classroom, public forums, and professional writing on this subject for a number of years, neither of us yet knows the full range of the other's partisan political commitments. This has remained true, not because of any dramatic effort to keep secrets or because of nonparticipation in partisan issues, but simply because such knowledge is not necessary to the presentation and comprehension of the subject matter of this book. It remains the responsibility of the readers, as we have left it with our students and colleagues in the past, to utilize the materials within any political context. We believe that they will be stronger and more effective because of it. The plenitude of new material facing the practitioner of nursing who is concerned with remaining abreast of the latest advances in providing patient care might discourage the addition of this whole new world to one's scope of awareness. This may be a real factor or an excuse for avoiding an assuredly stressful encounter. Even if one accepts the potential of such study, it may seem impossible to fit it into any schedule or curriculum, especially with the abundance of basic and advanced scientific data that must be understood for the practice of the profession. If the political context of nursing is ignored, however, the number and scope of opportunities for the practice of nursing may well decrease. Thoughtful engagement in politics will lead to true interdependence of nurses with others in the health professions.

A word of acknowledgment goes to those who stimulated the preparation of this manuscript. These include graduate and undergraduate nursing students who wanted to "get involved," fellow nursing practitioners who "didn't know where to go," and graceful antagonists, nurses and others, who challenged our right and capacity to engage in constructive conflict as nurses. We hope that the material presented here will provide these individuals and others like them with a rationale for activity in political systems and encouragement to begin, as well as an understanding of the reasons for our persistence.

Grace L. Deloughery
Kristine M. Gebbie

CONTENTS

Men could learn a lesson from
The lowly turtles who crawl about;
And note they never get anyplace
Until they stick their necks out!

RUTH M. WALSH[1]

INTRODUCTION

This book is intended to enhance nurses' understanding of those political dynamics that have in the past and will continue to influence nurses as they interact among themselves and with others in the world about them. Once one begins observing life in a social system, one is observing political interactions, some complex, some simple. The movement of many people toward involvement in activities that will either improve their own lives or the overall quality of life necessitates not only their observing but also interacting with one or more aspects of some political system. Nurses, as individuals or groups, are consciously or unconsciously deeply involved in this process. Those who are only unconsciously involved are well described in the following rhyme:

Restrainer

I lead a very stainless life
And have from the beginning.
A pillar, I, of rectitude—
I never think of sinning.

Oh, not for me the wanton sins
That others may parade to.
It's not that I'm a saintly soul
It's just that I'm afraid to.

GEORGIE STARBUCK GALBRAITH[2]

Regardless of the degree of awareness, energy is expended in political interactions. This energy has the potential of contributing to the achievement, or failure to achieve, an improving condition of life, either one's own or that of others. The better understanding one has of political dynamics the greater the opportunity for effective action. In addition to understanding political dynamics it is useful to understand how one's personal and professional identity can inhibit or enhance one's actions. It is then possible to identify problems that are amenable to change by way of the political process and to work toward their resolution.

Following this brief introduction to professionals, professionalism, and politics the content is divided into four major sections:

1. Theoretical presentation of political science and organizational theory. To enhance accuracy, these will be given in the language and structure of the academic disciplines that developed them as much as possible; some accompanying illustrations are presented to facilitate "translation" into the experience of nurses.

2. Presentation of "power" as a theoretical construct and a force in everyday life. This

is focused around practical questions of who has power, how one recognizes powerful people, and what those people do with their power.

3. Description of those dilemmas encountered by the nurse because of issues such as "professionalism," "uniform function," and "ethics in the provision of health care" as well as personal philosophy and beliefs. We do not believe we have created new problems. Rather we hope to articulate those that have existed not just as a statement of fact but with discussion of the dynamics behind them. The sometimes subtle influence of these issues and the lack of awareness thereof have been partially causative of the current state of affairs.

4. Discussion of possible courses of action that might follow the understanding of oneself relative to power and political interaction. No one specific course of action will be prescribed. Rather it is expected that, subsequent to this discussion, each nurse will move politically in directions that seem comfortable and work successfully.

The imposition of rigid definitions is in itself a political act: an expression of power on the part of the definer, and the acceptance of that power by those who use that term as stipulated. The lack of definition is not necessarily a conscientious avoidance of the misuse of power. The conflict generated during communication that is attempted without a common understanding of terms has the potential for more harm than have the limitations of definition. The latitude between anarchy and dictatorship is sufficiently wide that the goal of making distinctions between them seems realistic. Therefore at the risk of sounding extremely pedantic and limiting the reader's scope, we will begin by introducing some basic terminology. *Webster's Seventh New Collegiate Dictionary*[3] points out that the word *politics* refers to the art and science of holding control of a governmental unit, political affairs, or business through artful and often dishonest practices. A secondary meaning given is "the total complex of relations between man and society." Although cognizant of the former, it is more the latter sense of the word that we employ in this book.

The complex of relations being discussed is understood primarily as involving power, the amount of power that each individual has in relation to those around him, and the aggregation of power in a large or small number of institutions, including but not limited to governments. The corresponding adjective, *political*, may be used to refer to any other person, system, or activity that is involved in or related to this network of power relationships. It is unfortunate that for many the negative connotations of the terms *politics* and *political* come most readily to mind.

A politician is usually described as one versed in the art or science of government, engaged in party politics, or primarily interested in political offices from selfish or other narrow, short-run interests. A person will be labeled a *politician* if it is believed that his skill is being used to promote his own selfish advantage. Someone equally skilled in politics or the manipulation of power but believed to be doing so for more altruistic motives is called a *statesman*. The appearance of the individual's motives may be altruistic but, whether by design or not, also promotes some selfish or personal desires. Regardless of whether the motives are either partially or purely selfish or altruistic, the individual is a politician. There is no other word than politics, however, that conveys the necessary concept of man's attempt to deal with his fellows within organized units. The words have further utility because there is so little that occurs in contemporary society that is not related in some way to government or public affairs, and politics implies a public process.

To compound the matter these terms are commonly used in the course of everyday events to describe the activities of persons or groups who are attempting to organize one another to achieve some desired good. They are pertinent to group activities within settings such as health care organizations, and, in fact, groups such as the Medical Committee on Human Rights and the Nurses' Coalition for Action in Politics openly acknowledge their political nature.

The term *political system* refers to any group of persons and their activities as they relate to one another in an organized fashion within any given sphere of action. A speech on health matters given by a city councilman in California and the public health advisory board of a county in Georgia may both be "political" in that they are related to the governing or organization of public affairs, but they are not a political system. Within one city or county the health department, the public health advisory board, and the city or county council as they interact to affect the health of the people compose a political system. Such systems have often been masculine domains, with the inclusion of women being primarily as objects in these domains. Much of the energy expended by the women's liberation and feminist movements is directed toward opening political systems to both sexes. Not only are the politicians changing but the gender of the process seems to have changed. Weinstein[4] differentiates the Pre-Enlightenment Period from the Introspective Period on the basis of separation of emotional and abstract factors. The emotional, internal aspect is equated with the maternal (feminine) role, whereas the abstract external aspect (characterized by rationality, self-discipline, and emotional constraint) is equated with the paternal (masculine) role. The political system, as a result of the political and industrial revolutions, has undergone a differentiation. The modern political system demonstrates a more instrumental role, concerned with achievement of specific goals and exercise of control on the social or interpersonal level rather than the achievement of power over others and doing so as though they were nonhuman objects. Recognition that power may be achieved through factors other than the manipulation of external forces, mastery, rationality, and conscious control facilitated the active participation of many formerly excluded from the political system such as women, nurses, and various legal and ethnic minorities.

As already stated, it is the exercise of power over others, or in relation to others, that makes activity political. Power, meaning the ability or strength to act, in this area of political dynamics usually means not just individual power but delegated power that is present in those who represent some group or viewpoint. The more equal the distribution of power among those with conflicting viewpoints the more likely it is that the resolution or compromise will reflect portions of all the original viewpoints. As will be discussed in Unit I, the American political system is ostensibly founded on the premise that each adult has approximately equal political power, that is, the right to vote and, hence, the right to equal participation in the resolution of conflict throughout the course of public affairs.

Since politics and political systems involve groups of people who are using power, it is inherent that they involve conflict. Conflict refers to the concurrent expression of more than one viewpoint with concurrent goal-directed action. It is both universal and healthy, since little change or progress would be likely to occur without the stimulus of conflicting viewpoints. It becomes unhealthy when the choice between views is made by force or when alternate viewpoints are kept from open expression by disenfranchisement or similar measures. The resolution of conflict usually involves some degree of compromise, a process of interaction that leads to the integration of various portions of the originally conflicting viewpoints. Of course, this can only take place if all conflicting viewpoints become known to those involved in the resolution of conflict and is dependent on the distribution of power among those involved.

An understanding of political systems today is complicated by two phenomena. One phenomenon encompasses those problems in the modern world resulting from population density and the quantity of interaction in which all persons must participate in order to survive. This is stimulated by the almost universal and instantaneous communication media. No issue ever arises or is settled in isolation from ongoing events, even those half a world

away. Indeed, the resolution of one problem often contributes to the conflict related to another problem. The second phenomenon is the rapidity with which change occurs. The advances of modern technology have made "instant obsolescence" a fact of life. This almost implies that teaching adaptation to *specific* changes must be replaced by teaching adaptation to the *process* of change.[5] Social institutions, including political systems, tend to change at an extremely slow rate. The increasing rapidity of change in other aspects of life has left social institutions, at least in the opinion of many, hopelessly out of date. Some critics have even questioned the ability of the political system to adapt to the complexity of problems and the rapidity of change in the modern world.[5a] It may be hopeless to equate social systems with technological systems, and doing so may limit the capability of dealing with those issues that should be foremost in the social and political realms.

Involvement of professions in politics

Among the headings of articles that appeared in newspapers during recent years are the following: "Congressional 'Physicians' Try to Doctor Nation's Health,"[6] "AMA OK's Action on Emotionally Ill Doctors,"[7] "How a Social Worker Helps People Adjust to an 'Unjust System,' "[8] "Small M.D. Group Hit: Health Care for Poor 'Stifled,' "[9] "Surgeons Seek Curbs on Their Numbers,"[10] "State Hospital for Retarded Lack Funds: Children Silently Suffer Perils of Heat, Flies,"[11] and "The Reason Men Go Off the Deep End at 41."[12]

Public policy in the United States is the product of conflict resolution among private interests. Private interests include recipients or potential recipients of direct or indirect benefits from public policy as well as those who must either support (financially or otherwise) and those who personally provide the benefits. Conflict is inherent in the overall process. Whereas professionals as private individuals have been involved in these conflicts, professional organizations often have not. However, in recent years professional organizations more frequently have taken positions by means of formal statements or papers. This seems related to the fact that the issues were of such significance as to threaten the survival of one or more professional groups. Focus on the areas of difference or conflict that might otherwise have been of importance temporarily vanished. An article referred to earlier[10] expresses concern for control of the number of individuals to be allowed to enter the professional ranks, and another[13] sanctions the practice of procedures that, like acupuncture, might have the capacity for threatening medical practitioners.

Law, medicine, and theology are commonly listed as the classical professional groups. Law has been a traditional stepping-stone into public office. Many of the most prominent elected officials have practiced law before election to office or even between terms of office. They are expected to be "politically" knowledgeable. One needs only to read the accounts of recent major scandals associated with those holding public office at federal, state, and local levels in the United States and elsewhere to be aware of those from the field of law who were involved directly or indirectly. Individual physicians are frequently politically active. As with members of other professional groups, the opinions and judgment of physicians are sought out and respected on important issues. Articles or news releases frequently include quotations from individuals, even if in such form as "Doctors in the hospital say a serious health hazard exists." Since the advent of consumerism, various physician, insurance, and health advocate groups have focused on the goal of 50% consumer participation on boards and in decision-making areas. For reasons that will be discussed later in the book the goal is, in fact, seldom or never realized. Although some physicians openly verbalize the need for accountability to the public and respect for consumers' participation, according to 1973 data of the Department of Social and Health Services in the state of Washington, only 40% of all physicians there accepted welfare patients.[14]

Although the American tradition has been one of separating church and state, individual clergymen have played active roles in public life. Recently, for example, the conflict regarding civil rights has brought many individual members of the clergy into political activity. A number of clergy serve actively in elected office. One major issue that has involved not only individuals but organized religious groups is the question as to whether public tax monies should be used to support church-sponsored educational institutions. In the state of New Hampshire a position was taken that the state should not dictate the kind of education a child receives and that all children of school age, whether in private or public schools, are entitled to identical shares of public funds available for education.[15] The number of men and women "of the cloth" in positions of responsibility for policy determination and implementation of public programs at all levels continues to increase. This varies from consultants within divisions that control health, education, and welfare in the federal government, associates of high public officials, assistants to the State Superintendent of Schools, and members of local boards of health.

As we have stated, professionals are often asked for advice regarding public issues. When those issues relate to a field like health, it is certainly possible that the health professionals might have some pertinent knowledge or data. Once they have explained such data, however, the democratic ideal would require that their voice or vote have no more weight than anyone else's. This is not always the case, even though it has been said that many with the distinction of having degrees are academic technicians but lack wisdom.[16] In practice many persons accept the *opinion* of professionals as *fact* rather than as data from which to form their own opinions. This is the heart of the objections raised against professional organizations, as organizations, making public statements concerning political issues. This same objection is raised when professionals become involved in community organization or "grass-roots" projects. Furthermore, if professionals with conflicting sets of data and opinions participate in the same conflict, the effects may be to completely bewilder the population at large and even to paralyze the decision-making process. (A study of the fluoridation decisions in the United States[17] discusses these problems well.)

There is a related problem that arises if one does assume the appropriateness of professional organizations to participate officially in political activities. There are some issues in which the decision made may affect the role, status, or power of the professional organization or its individual members. Other issues may not affect the profession specifically but may have a bearing on the societal need that led to the development of the profession. If one accepts that a profession, by definition, only should exist as long as it fulfills a societal need, one would probably think that professional organizations should be involved only in the latter type of issue. It might be expected to follow that if they contribute to the effective political action regarding pertinent social issues, they will have contributed to the overall social position or standing of their profession. On the other hand, if they are only concerned with the standing of their profession, public support will shift to those groups showing concern for societal needs. The profession may lose its constituency or clients entirely and, in theory, cease to exist. Interesting dynamics come to mind as the number of individual social workers increase with the proliferation of societal needs. It has been labeled a "controversial profession."[17] Figures indicate that in 1940 only 45,000 social workers were employed as contrasted with 116,000 in 1960 and 170,000 in 1970. An additional 100,000 will be added in 1980. They are considered controversial in that their roles and activities in helping troubled people range from helping drug addicts to gluing together marriages that are on the rocks, to helping people get on welfare rolls, and to providing mental health service. Along with such help that provides people with an ability to cope with an "unjust" system, the middle class so-

cial worker may be also advocating certain liberal politicians by passing out literature and assisting with campaigns. This produces a dual role: (1) it goes beyond helping troubled human beings in a system that they want to make work and (2) it directs energy toward the changing of the society that they believe created the problem as they identify with those in despair with whom they deal.

The major official organization of medical practitioners, the American Medical Association (AMA), has openly and actively attempted to influence political decision making. Its endeavors to influence decisions concerning national health insurance are an excellent example. Current changes in the AMA indicate that physicians are reconsidering that involvement. To some the activity of the AMA was an attempt to preserve the profession rather than to aid society. President Wesley W. Hall, in 1971, prescribed less politics as a cure for the organization's slipping membership and ailing finances. He is quoted as telling the AMA policy-making House of Delegates that there was "a serious struggle for power in the ranks of AMA." He called for a reorganization of its entire structure. Following this challenge, former Vice-President Spiro Agnew addressed the group in praise of their interest in politics.[18]

Nursing and politics

Although organized nursing considers itself professional, and many individual nurses would say that nurses constitute a profession in the classical sense, the general public has not acknowledged nursing as such in the same manner as they would, for example, medicine or law. For this reason nurses have never been asked to participate in political activities or have they been consulted on public issues to the same degree as members of other professions. It has been rare for a nurse, for example, to be a requisite member of community advisory boards or boards of directors of worthy groups, whereas such groups almost always include physicians and lawyers. The traditional dominance of men and physicians probably has led to the assumption that nurses, as women and followers, think like physicians and thus have their views represented. The National Commission on Manpower was created without any nurse representation, although nurses are the largest health manpower pool. The fact that most nurses are women probably deserves the most credit for this public ignorance of nursing as a force in decision making. Even in the major women's colleges, given credit for producing many articulate, active women and leading the way toward equality, men hold a majority of the teaching and administrative positions.[19] Thus the persons consulted for decisions and opinions in these "women's centers" are often male.

Hiring practices in almost all areas of the labor market have been discriminatory to women. Women have not only been undersold but also have been kept out of certain areas entirely. A new development is that of entrepreneurship among women. Women are acquiring or founding companies. Although accurate statistics are not available, *The New Woman's Survival Catalog*[20] lists more than 500 such companies. One specialist in small business predicts that this will go through an evolutionary process like that of immigrants. Like immigrants, women first will sell to their own people. It has been observed also that women are more likely to venture into businesses that are not traditionally dominated by males, perhaps indicating their cynicism about the possibility of succeeding there. Women-owned and women-operated businesses include *Ms.* magazine, which promotes jewelry and other items made by women-owned companies. The magazine and the companies have promoted one another. Strong commitments to the philosophy of women's liberation lead feminist businesses to utilize services and products of other women's businesses.

As women leave traditional positions for new opportunities in business, they seem to be venturesome and willing to experiment with new patterns of staffing and operating their organization. Work patterns, when they require attention to avoid mismanagement, are reviewed by outside specialists rather than turning to the usual organization-tightening process. A parallel seems to exist between this evolution and that of nurses going into private practice, nurse-operated clinics, and so on. This will be discussed in more detail later.

Small wonder, then, that nurses remain on the fringe of the health power system. Research reports often perpetuate this oversight. The report *U. S. Health Care: What's Wrong and What's Right*[21] discusses a study of the views of physicians and laymen but no data regarding the opinions of nurses. By contrast, nurses are frequently consulted privately by individuals for advice concerning the resolution of personal or individual problems. One nurse who recently completed a master's degree has articulately described her "backfence" practice. Many nurses report instances in which they were approached for aid by persons stating that they were "afraid to ask the doctor" or thought the nurse would "understand better how it was." Since public issues are the aggregate and composite of individual concerns, this contrast between public and private intimacy is of interest. Perhaps nurses themselves encourage the view that they are not interested in health except as an individual thing by becoming distressed at health approached from an actively political frame of reference. An example of this reaction is the negative response a nurses' group showed when an actively campaigning national politician brought politics into his invited address, and the nurses indicated surprise and concern that theirs was to have been a "nonpartisan" meeting. Few groups have such apparently naive expectations.

Collectively, nurses have not had a long record of success influencing decisions that advanced their profession. Individual nurses have been able to influence many decisions related to health care. Nursing's favorite heroine, Florence Nightingale, was no exception, as demonstrated by her activities during and after the Crimean War. Frances Storlie[22] gives historical data on other individuals in her plea for more involvement by all nurses. The effectiveness of collective action is becoming apparent, and recent examples of group action by nurses are their successful lobbying *for* the New York State Nurse Practice Act and *against* the Massachusetts Institutional Licensure Law. Although it is not possible to determine all of the causes of this change, some factors seem obvious. The women's rights and women's liberation movements have moved many women to become more vociferous on issues of concern. Educated women who were previously silent seem to be especially open to the impact. The increasing numbers of college-educated women entering nursing, particularly as other employment opportunities narrow, adds to the pool of nurses exposed to the activism and involvement of the university campus.

The fact that health is a national, state, and local political issue of great concern, and an issue discussed not only in hospitals but in homes and on street corners, adds to the stimulus. In an approach frequently criticized in current nursing literature the nurse has traditionally utilized personal contact with individual physicians as a means of promoting her viewpoint regarding patient care or health needs. Most nurses, while laughing, acknowledged the truth in a recently published article[23] describing this so-called "doctor-nurse game." Whereas part of the game is the nonrecognition of the nurse's contribution by the physician, there are instances of public acknowledgement. In discussing the treatment of alcoholism a physician states that good nursing care, rather than drugs, seems to be the main factor in improvement.[24]

There are some possible pitfalls in the participation of nurses and nursing in political systems. One danger is that persons who have long kept silent regarding an issue may, when they finally speak, do so with such vehemence that they are not heard by others. A parallel is the sudden transition from silence to riot in some ghetto communities, which succeeded in completely alienating some members of the surrounding community. Nurses may also take on issues that appear helpful yet ultimately defeat the purpose. Nurses who only campaign when their own economic welfare is

at stake may lose their constituency—those patients for whom they should be caring. There is a necessary balance because if nurses are only concerned with abstract altruisms regarding health, they may also lose the platform of a secure profession from which to speak.

Another danger relates to the understandable blurring together of the various health disciplines in the mind of the public. Many nurses have resented the fact that people have assumed nursing to be in agreement with all the formally announced positions of the American Medical Association. Few people know, for example, that the American Nurses' Association backed Medicare as formally as the American Medical Association opposed it, although not as vocally or effectively. Within a few years it will be of interest to consider a retrospective view of the positions taken by the two professional groups in relation to one another regarding the issue of national health insurance. It may be a long time before the voice of nursing is as loud or effective as that of organized American medicine appears to have been, but the potential in manpower (or womanpower) and knowledge is there.

However, in their desire to be recognized as distinct from physicians, nurses should not lose sight of the common ground between the two professions. It must be remembered that all the health disciplines are interdependent as they work to meet the societal need for health care. Nurses will receive public support for doing this and not for fighting among themselves. Although many have criticized the individual bonds with physicians that nurses utilized in the past, it would be regrettable if interprofessional conflict led to the loss of such valuable relationships. Dignified interprofessional conferences in formal settings can never accomplish some of those things for patients that can result from informal colleague contacts.

Need for theoretical understanding

Sex role stereotypes remain much alive not only within the larger society but even among those professional groups where it would be least expected. One survey[25] among specialists in psychiatry of both sexes indicated that an overwhelming and almost equal majority of the respondents indicated that a man's most fulfilling experience would be a career or profession, whereas a woman's most fulfilling experience was marriage. Implicit in achieving a successful career or professional position is the understanding of a significant body of theoretical knowledge in at least one field. The investigator who conducted this study[25] remarked, "Sure, it's a man's world, baby, but you can change it if you want to." Successful change of the status quo, however, brings mixed blessings. It may bring about a more humane society in some respects and more self-actualization for some individuals. On the other hand, a personal confrontation has been described as occurring among successful men who realize that they have reached the peak of their careers (maximized their theoretical understanding).[12] As nurses and women attain the now enviable position of those successful men, it may be expected that a similar phenomenon will confront them.

In their naiveté about politics nurses find that assumptions are easily made about moral and ethical principles being practiced if they are professed. As a result, less "watchdogging" is done to assure compliance with rules and regulations, and efforts to uncover noncompliance are directed only toward those areas with the reputation for various forms of noncompliance. Salt Lake City, a city renowned for its Mormon Church, good works, and moral zeal was found by the Securities Exchange Commission (SEC) and the National Association of Securities Dealers to be involved recently in financial manipulation and securities fraud.[26] The over-the-counter stock manipulations and other frauds were found to be so pervasive that an extensive study was initiated and "new twists to old schemes" were uncovered, including small stock offerings exempted from SEC registration as well as "blatant defrauding of brokers by shady stock promoters and even by some of the customers. The city got the reputation of being the stock-fraud center of the nation, the sewer of the securities industry."[26] It prompted proposals to undertake studies in other cities that are considered problem areas, including Los Angeles, Miami, Minneapolis, and among them a much smaller city, Spokane, the home of many speculative mining issues. There is a speculative trait among Americans that dates back to its beginnings. Speculating in "penny stocks" allows those having only a small amount of money to become involved. Specializing in such small stocks therefore encourages a great deal of business. This, in Salt Lake City, has resulted in a list of fifty-one brokerage firms for its population of 189,000.[26]

It has been said that the doctorate is a racket in American education[27] and that when Ph.D.s which are of marginal worth are granted, their value is deflated and the more competent who might have been convinced to strive for them are discouraged. How many nurses are caught up in a preconscious hope that, having the Ph.D., they will be referred to as "Doctor," and patients as well as colleagues might make the assumption that they are physicians and ascribe to them that power and status? The pressure for equal access for men and women to the halls of ivy and all the departments within them has led to the change in the stereotypes, even of women themselves who graduated from places like Vassar College, which serve as rare sanctuaries for those who study there. They are here provided protection from an awareness of job discrimination against women that they learn if they attend Yale Law School[28] in preparation for top level positions in the professional and political worlds.

With theoretical understanding, increased power, and status come an accountability and responsibility. This includes the evaluation of performance and accepting of merit awards based on the successful attainment of certain specific objectives. A sobering thought occurs to those who would accept only the "privileges" without the responsibility to produce results as an outcome of learning theory and skills. Without the separation of the emotional from the abstract, autonomy cannot be achieved. Moreover, unless this separation is made and unless there is a tolerance for the psychological and social consequences, regression results. Movement in the cycle of change is a step backward on the scale of incremental progression.

The ambivalence that must be expected is a result of a simultaneous desire for autonomy and a continued unconscious desire to maintain dependence upon that which is perceived as nurturing and protective. A current example is that of the lengthy and controversial discussions regarding the "expanded role of the nurse," equated with recent nursing legislation and legislation to increase allied professions. This new role of necessity presents a question of legal responsibility as individuals venture beyond present professional territorial boundaries and move into more independent practice. Nurses express resentment toward physicians' telling them what to do in areas in which they feel competent but are reluctant to accept in toto those areas of responsibility.

The development of progression from the early seed of the ideas leading to the expanded nurse role to actual change or action is not inevitable. The idea or fantasy thought (in freudian terms) may be considered as originating in response to deprivation. The idea is conceived at the emotional level, taking the form of wish fulfillment. Before it can be operationalized it must be consciously thought out and modified. Logic and causality then refine the conscious idea. The refined idea must be congruent with two worlds: (1) the internal structure of morality in the individual's unconscious personality and (2) the demands and pressures of the external world. The idea of the "expanded role" may be congruent with some individual's first world, but the second world is more than those outside the nursing profession; it includes the rest of the nursing group as well.

Implementation of value change is closely related to what is held as "sacred." The more sharing of values, involvement, and responsibility for implementation of values, the greater will be the social stability and sense of reward.

This is true even though, as has been said before, no system will change unless a little conflict or disunity is present. Reward stimulates energy and perpetuates progression of change. When these conditions are not met, hostility may be turned inward and acts as a legitimizing force toward aggressive action. This may be observed at two levels: (1) within the nursing community and (2) within health-related professions.

Society should not prevent women from making free choices about their careers, and at the present time the choices available to women for obtaining the necessary theoretical knowledge and experience are broadening. This is not occurring without some opposition. Although we would not wish to present ourselves as radical women's liberationists, some of the problems we have encountered in our struggle to be wives and mothers in addition to well-educated nurses serve to validate the existence of a male-dominated society. This opposition is not new but has crushed the spirits of women throughout the centuries, although it has undergone gradual, if reluctant, change in the past 140 to 150 years. Resistance to change is a universal phenomenon, but in the case of this change men were confronted not merely with a potential loss of domination but also the loss of something that has been ego building. Without breaking through this resistance nursing will never be able to make its full contribution to society.

While this struggle continues, another simultaneous one takes place in contemporary America. This is the decreasing capacity of institutions to help individuals find a place from which to participate and make meaningful contributions. American society is frequently not perceived as stable, peaceful, and happy. The question is whether this is because of the level of tension that prevails or the inability of people generally to find fulfillment to some degree. (Obviously the two are related.) Economic achievement earlier provided man's life with some sense of meaning; in this area nurses are recently realizing a sense of meaning. However, automation and technology soon diminished the economic meaning because work contributed less to the total society. So with nurses—climbing the economic ladder and achieving more leisure in the midst of the prevailing work ethic is not all to which nurses aspire. Rather, they must find, as do all others in this society, more personal satisfaction in their work and individual fulfillment through the constructive use of leisure time to regain individual identity and finally gain or regain a vision of the future.

Geographical mobility serves as another force that diminishes the individual's potential to feel a sense of belonging. As nurses and women direct their energies toward the achievement of more theoretical knowledge and upward mobility in society and find meaning for themselves as individuals rather than being a number or object, they must be ready to deal with the consequences of the rising expectations that they must face. If not prepared for the challenge, they will be much like the young people of recent years who, searching for meaning in a world that fosters ambivalence and alienation, are unwilling or too paralyzed to act. In the same way that courts and prisons have been charged with an inability to prevent crime and health care systems charged with an inability to heal, nurses and women may be charged with abandoning the use of those abilities that they and they alone can contribute to a functioning society. The question of how this is accomplished is intended for later discussion. The grasping of theoretical materials and their application should not be seen as an alternative to functioning as a feeling and compassionate human being.

There are those who believe that the only proper place of the nurse is at the bedside of the acutely ill patient in the hospital. The scope of health care has changed rapidly during this century, and members of all health disciplines are found in homes, clinics, and communities as well as in hospitals. If health is a right rather than a privilege, if it is more than the mere absence of disease, and if health care must be provided with some equality for all, it will take many health professionals

throughout the political and social system to achieve these goals. So it seems that nurses should have access to that knowledge which will facilitate their effective participation in such political dynamics. Throughout history nursing has been marked by development through trial and error, education by apprenticeship, and practice based on empirical approaches. The rapidity with which change occurs today means that such slow methods will be ineffective. As an applied science, nursing should seek theory from basic disciplines and actively apply it within the framework offered by the role and philosophy of nursing. In regard to political dynamics there is a sound theoretical base from the fields of political science and public administration. Once understood, these theoretical materials can be utilized by nurses in ways that are appropriate to the socially sanctioned goals of the profession. (Units I and II will discuss such theories.)

Before using these new theories the nurse (like any professional) should consider the impact they might have on the usual role of the profession. There are some philosophical assumptions about individuals and the social system into which individual nurses have been "professionalized" to be nurses and which have rarely been consciously considered. One of the "professional" assumptions, which will receive attention later, has to do with the right of the professional to make decisions regarding an individual's destiny without allowing that individual to participate in that decision making. This assumption is made so subtly that examples of nonparticipation in decision making, perhaps obvious to outsiders, go on unrecognized by the professionals responsible. Consider, for example, the public push to make professionals realize that not everyone wants to maintain physical life indefinitely if it must be done with multiple machines at great social and economic cost. In addition to the professional philosophy there may also be personal beliefs that lead various members of a profession to appropriately utilize the same theoretical framework in different ways to strive toward different goals which are still congruent with that profession's socially assigned task. (Unit III covers these issues.)

Once having grasped the concept of political dynamics and considered this knowledge in relation to personal and professional issues, nurses may feel a need for some guidelines for initiating action of a political nature. Assuming that one accepts our premise that the professional nurse practicing today should be participating in the political system with and on behalf of individuals seeking health and health care, one should begin analyzing political systems and problems and actively engage in the process of change. (See Unit IV for discussion.)

Up until now nurses have often been giving nothing but a negative emotional sense and feeling of futility regarding the whole decision-making process. This feeling cannot be replaced by a positive one until nurses have a sound theoretical basis from which to plan and experience positive participation in decision making. That will facilitate the development of positive feelings which then can be shared. Translating this into economic terms, many people believe that professional nurses are an expensive luxury, and indeed, many people believe that professional nurses are not providing a level of service equal to their cost. This ratio of cost to benefit could be increased if the self-image and the role expectation promoted a higher level of nursing practice. This applies not only on an individual patient level but also on the level of the health agency or organization established to meet individual and community needs.

The need for understanding exists not only on the part of nurses but also on the part of those around them. Changes in attitude and increase in understanding on the part of others will not occur without reason to do so. It can occur as others gain respect for nurses as a community of contributing members, including a knowledge of their heritage, a recognition of their achievements to date, and some awareness of their motivations and future aspirations. For some, knowing that nurses are interested in increasing their knowledge

and participation leads to changes in expectation and attitude. It is our goal to provide the reader with support for a philosophy of involvement and some of the theoretical knowledge that they will need to enable them to translate the philosophy they have into practice.

If one observes phenomena that coincide in time and seem to be related, it becomes necessary to ponder whether their simultaneous occurrence is related or coincidental. An example is that of the current moves on the part of both physicians and nurses to provide family-centered, community-based health care. Either of the professions could be striving for a larger sphere of interest and power, each could be responding independently to requests for improved care, or both factors could be operating. Only thorough research, well grounded in the theories of social change, would reveal the casual agents operant in the change.

In contemporary mythology nurses are kind, understanding workers of mercy and mother figures like Florence Nightingale and Clara Barton. Most people forget that the people like Florence Nightingale and Clara Barton did in fact go on to activities far removed from the mother-role stereotype. Nurses are otherwise seen as gruff, insensitive, money hungry, and uncaring. Nurses are not alone in receiving the criticism when people in society think of life, death, and the dollars they spend to obtain the best that is available in health care. In response to criticism and demands on them physicians have enlisted the aid of assistants such as Medex trainees and former military medics. With a few months of on-the-job training these assistants are expected to take the overload off physicians under their supervision, often in rural areas where the physician is not readily at hand to supervise. Charges have been made that training programs to prepare such physician assistants are a waste of taxpayer money because nurses could perform the same tasks but have been neglected or ignored. Whether spoken or written, feelings prevail that the duplication is perpetuated because nursing consists largely of women and is being cast aside as a discriminatory move in favor of men. (Note that physicians' assistants begin at salaries which may overlap with those of nurses only at the highest administrative levels.) As nurses and their professional organizations become more fluent with knowledge and concepts related to political dynamics, they are seeking recognition for their work and articulating their role, that is, pointing out that physicians and physician assistants are oriented to crisis care, whereas nurses' activities center on health promotion, education, and maintenance. They insist on legitimizing the decisions they make independently in everyday practice through changes in the nurse practice acts in the respective states. It has been said that nurses wait for physicians to tell them what to do except when the physicians are absent and patients are dying. Nurses make diagnoses and will do so in the future but will depend more on the physicians to care for the acute phase of illness, which is their major interest. This will not only address the physicians' interests but will also utilize the nurses' skills to the utmost. The old mythologies about roles are no longer acceptable. Nurses and others must be guided by newer models of practice.

Awareness of the existence and impact of minorities, prominority programs, and antiminority feelings is also necessary. The National Association of Social Workers established a fund to assist members who require legal defense to fight against being fired in social service cutbacks or to serve as client advocates in courts of law to protect agency policies.[29] Liability insurance becomes more commonly carried by professionals as lawsuits against them increase. Social workers are sued for alleged negligence in preventing suicides, removing a child from an adoptive home, or encouraging a spouse to break up a marriage by divorce. Some social workers perceive the increase in legal problems as a reflection of increasing government and public dissatisfaction with social service programs.[30] Unemployment rates are higher among college graduates than other groups for the period from 1969 to 1972.[31] The demand for professional workers is slowing. According to the United States Bureau of Labor Statistics, the unemployment rate among workers with only an elementary education is lower than their better educated counterparts, yet the total number of nonhigh-school graduates in the work force has declined greatly in recent years. What are persons to do? Their elders encouraged an education as assuring them better employment opportunities. They often pointed out that education was something like an insurance policy, "something nobody can ever take away." Now in some cases it becomes a liability because fields are closed because of surplus of workers or because the educated person is considered "overqualified" and is excluded from jobs in other areas.

The minority group issue has increased professional involvement in politics. Although some minority and ethnic groups still have inadequate numbers of professionals in proportion to the population, the difficult controversy of "reverse discrimination" arises when nonminority persons who have better qualifications are denied admission to schools or jobs. The DeFunis case, against the University of Washington, is still before the United States Supreme Court and may help to establish future directions.[32] The Constitution and American tradition supports the view that special efforts should be made to overcome the historical effect produced by slavery. However, as the DeFunis case points out, other minorities also can make claims, and the question arises regarding real standards. When standards of merit and equality of opportunity are abandoned, quotas are the natural outcome. The boundaries of what are considered minorities are certain to create hard feelings on the part of some. Granting preference in proportion to the seriousness of past discrimination is an equally impossible undertaking. (Black slavery, to the Japanese-American, is no worse than concentration camps during the Second World War were to them.) Target minority groups have been referred to by the United States Department of Health, Education and Welfare and the Equal Employment Opportunities Commission, but the wording in statutes, the intent of legislation, and Supreme Court decisions all support the position that racial quotas are out of order in America. Equality of opportunity and selection based on merit are congruent with traditions of justice. Additional recruitment efforts in areas where additional minority students or workers are needed would better ensure equality of opportunity and neither lower standards nor give preferential treatment to minorities with lower qualifications. Not least among the results would be increased self-esteem and self-confidence of individuals from minority groups.

Nursing literature has for several years included many statements about the need for change, and individual authors have pleaded with nurses about the absolute necessity of their involvement in the process of change. The question to be raised, then, is why no more nurse participation and *real* change have, in fact, occurred. In our experience with students and nurse practitioners, there is one major factor in common among nurses as a group of professionals that affects and limits them in this area; until nurses individually achieve an understanding of the dynamics and impact these factors have on them, they will continue to act in congruence with traditional ways. This is evidenced in the inability of the nursing profession as a whole to implement the changes that are presently necessary to improve health services. It should result in an increase of public support for incorporating professional nurses as essential members into the health care team.

The size and diversity of the nursing profession and its vocational assistants contribute to the slow rate of change and the problem others have identifying with the newly stated ideal stereotype of the interdependent, decision-making, community-leading, caring nurse. Until most persons coming into contact with a nurse can identify practices that are consistent with that image, blocks will exist. As long as expatients say, "I never *saw* a nurse" or "They just gave pills," the nurse will not be acknowledged as a change-inducing professional.

Individuals who perceive a cause have risen through the years among various groups and have fought lonely battles to right what they saw as wrong. Meanwhile they are thought of by their fellows as altruists or "nuts"; some cheer them on while others jeer at them. Some question the motives even to the extent of charging selfish motives with statements like, "If it wasn't for his own livelihood, he wouldn't give a hoot." Many hours are devoted to lobbying and waging the war. As one searches for reasons for the commitment, it is often because there has been first-hand involvement that brought personal significance to the issue. Some such "causes" for which people devote their energies are of such a nature that their correction or resolution would seemingly affect few people. Such causes as health care, too, may be seen as affecting few if one looks at society only in segments of those who are absolutely indigent and find care of any kind inaccessible to them. In addition, one must add to their number those persons, along with their families and communities, who receive care only when a major crisis occurs. In the city of Seattle, seven hospitals and many private physicians' offices sit on what is known as "Pill Hill." Only a few miles away a free clinic study of one neighborhood found that 65% of the people had no insurance and no private physician and relied only on the hospital emergency room for care.[31] Added are those who receive crisis care and some additional care of such marginal quality as to lead them into a false sense of "being healthy." Much of the latter care may be covered by some type of prepaid health plan through the employer or public assistance. Yet people know little about how the health care system works, except that it does not work well. Much of the care they receive is designed to fill gaps between hospital and home. Nursing home care, subsidized by government funds, may be cheaper but is by no means "free." The next group of people to be added are those who pay cash from the pocket and look for those health providers who charge the least, a process that might be either wise "shopping" or foolish. Getting sick, for these people, can be really frightening. Worrying about how they will pay the bill may be the worst part because everyone has heard shocking stories about families hit by a catastrophic illness that left them with thousands of dollars in unpaid medical bills. As one continues to add to the numbers affected by the health system, one goes up the socioeconomic ladder, and by the time one reaches the top, one encounters persons who may be able to afford care but may have reached their position under such physical and emotional stress that they require large amounts of health care from those having various areas of expertise. Even these persons tend to receive only care for episodes of identifiable illness, and not continuously, in the effort to promote or maintain health.

Health professionals join the public at some point in that they, too, require care from their colleagues with various other kinds of expertise. Whether they receive that care depends on the availability of time, the kind of expertise needed, and their financial resources. Traditionally, physicians have had an exchange policy with their physician friends so they "trade" their expertise with those having other specialties to receive what they need of health care for themselves and their families. When needed, nursing care has been purchased relatively cheaply, but this is beginning to change. Nurses have usually paid full or a partially reduced fee for service from their physician colleagues. To bring all this back into focus the readers are reminded that health care as an issue or "cause" does in some way affect all of us. Those few who have been crusaders for improved health care and a better system of delivery are those who for some reason found it hit them below the belt. Nurses have been among the lonely crusaders but have also been found suspect and have won few friends. Perhaps because nurses are primarily women, related and hidden issues have contributed to the suspicion and loneliness.

For those nurses who believe they are carrying out an unrewarding crusade they might take some mixed consolation in the

fact that they are not alone in their being held in suspicion. Private insurance companies are suspected of graft, proprietary hospitals are considered unsuitable, public hospitals are criticized as inadequate, private physicians are charged with ordering unreasonable numbers of diagnostic tests to increase their fees, and nurses are questioned about wage increases in light of their "doing" less. Examples of accusations are numerous. One person, George Coffee, incurred bills of $110 for 110 days of attention, $8 for two bottles of brandy and six bottles of whiskey, and $25 for burial expenses in 1860. There was little a hospital could do for him then; treatment was simple, billing was simple, and paying the bill was not all that difficult. "Nowadays, the hospital can keep you alive . . . but it's the cost of those 'medical miracles' that catches attention. In the old days there were some patients who died with certain diseases . . . today, they live to stomp their feet and scream about the bill."[32] Indeed, costs have skyrocketed. Only part of the addition (nobody really knows how much) is due to advances in medical technology.

Inequities in billing have also been blamed. Although hospitals charge everyone the same rate, not everyone pays the same amount. Blue Cross, Medicare, Medicaid, and private insurance companies each have their own formula for what they will pay, based on what the hospital claims are its "actual costs" as determined by negotiation. One hospital, for example, reported that Medicare paid 83% of its patients' total bills, Blue Cross paid 90%, and Medicaid paid 85%. Meanwhile, the private patient paid 100% and allegedly subsidized some of the bad bills as well. The result was that the person who pays out of his own pocket shells out more for exactly the same service than the amount that persons on other payment programs pay.[33] One state legislator claimed that $400 million in excess Medicare claims were paid to hospitals in 1967 and that the overpayments were the fault of administration of the program and lack of prescribed and simple regulation by the Department of Health, Education and Welfare rather than the fault of the hospitals. Because of ineffectiveness on the part of the federal administration, he charged that federal funds were used to pay for "private-duty nurses, TV sets and telephone service to Medicare patients," all of which are illegal under the mandate.[33] Health care is considered an enterprise, and funding for health is often based on a method of cost analysis that is applied to any other enterprise. The rationale is given that if 60% to 65% of hospital costs are for labor, to cut cost one must cut the number of personnel and design cheaper hospitals as well as ones which can be more efficiently operated. This is one approach, but to date, it has not satisfied many.

Comprehensive health councils were established with consumer majorities on their boards dictated by law. But who are the "consumers" making up the majority, and what power do they have? Hospitals seeking accountability to the public must have clear signals and priorities from administrators of governmental programs that do not change from day to day. In discussions of large public programs, growing population, and the anonymity that accompanies urbanization, cries are faintly heard that the individual must receive more focus. Early childhood programs are geared toward later individual achievement. Teaching the "fundamental skills" of reading, communication, and mathematics to the underachiever is challenging the creativity of educators through funds available under federal programs. The cause of underachievement may be related to a complex web of health-related circumstances. The amount of learning can be more easily evaluated, however, than can the actual impact of efforts directed toward alleviation of the underlying causes. When funds are allocated, it is easier to justify the classroom program than the supportive health services provided. When only modest or no significant improvement is shown as a result of special education programs, the blame is often placed with the pupils, the teachers, or the school system rather than with the lack of emphasis on the actual root of the problem.

Various approaches to coordinating needs with resources have been taken; one recent development is that of private nonprofit corporations such as the East Los Angeles Health System, Inc.,[34] and the Western Medical Group.[35] The intent of such organizations is to bring about communication among numerous individual providers and/or agencies, thereby cutting costs and improving services. No less important than communication at that level is the need on the part of the citizenry to be concerned and interested in the improvement of their health care. Even though the service is available, it is of no value and the money is wasted if it is not utilized. Health officials often refer to a need to "educate" people so that they will take an interest in their health. Will "spreading the good word" educate people to use a wide range of services, especially preventive services, when their previous orientation was on their obtaining health care during a crisis?

In an effort to reach their publics, health professionals have challenged colleges and universities with the development not only of their clinical skills and healing arts but also their ability to communicate with one another and their clients. As a result, instead of completely eliminating the journalism department in 1972, the administration of the University of California at Los Angeles moved ahead with a plan to open a professional journalism graduate school.[36] It was considered not necessarily to be sensible university politics but, rather, a wise educational policy.

Although government charges the health providers and consumers with abuses, it also charges state and local governments with being recalcitrant and failing to carry out mandates. One example is pollution. Compliance with exhaust emission standards and enforcement, surveillance of industrial waste, and control of litter depends on state and local government. Dissatisfaction with court orders to bus children for purposes of achieving racial balance and concern about the taxpayers' bitter disenchantment with state and local school systems are pervasive and mounting.

Unionism and strikes have been one response of professionals who feel caught among the levels of government and societal pressures. Quarrels over wages, work loads, hours, and services expected contribute to the loss of certain images and intangibles that once had great value—the quiet atmosphere, dedicated workers, "neighborhood" facilities, and confidence which people had that their needs would be met. Are these old ideals and values no longer tangible and must people conceal their bitterness about the fact? For many the search for a sense of identity, recognition, and happy times continues. When will those times come again? Is the community college movement today an indication that people are seeking some understanding and meaning in an otherwise meaningless existence? School and job phobias are present-day diagnoses that are treated by specialists in psychiatry. Is the solution to be found in understanding why one reacts negatively to a school or job situation? Must this society look for alternatives such as medications* to ameliorate the adverse effects of emotion and stress in everyday life?[37] All these issues, not superficially tied to traditional nursing, may jar the reader as being out of place. One goal of this book is to aid nurses in realizing that almost *no* issue is irrelevant to the practice of a health care profession.

Nurses are challenged to provide assistance to many others seeking answers to the same social questions. We would individually and together say what Thomas Jefferson wrote to a black, self-educated scholar and friend[38]: "I can add with truth that nobody wishes more ardently to see a good system commenced for raising the condition both of their mind and body to what it ought to be."

*An example is the drug oxyprenolol, used in the treatment of heart disease and being researched in England because it was found to suppress rapid heartbeat among race-car drivers.

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in the last few years, and in several we have heard someone from the other side of the imaginary fence question the change, react to it, and even fight against it. If the ties of nurses were closer, the chances are greater that they would participate in each other's changes and be much more supportive to them as they are realized. Today nurses are going to hear of changes from all sides of nursing and health. We hope that this discussion of change has provided some insight into the process behind the innovations and into each reader's responses to them. More than that, we hope that the discussion will facilitate the participation of all nurses in change so that all nurses might have a share in the decision making, which by affecting nursing, affects the health care of the individuals for whom the profession of nursing exists.

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Faith is seeing light with your mind when all you see with your eyes is blackness.

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SUMMARY

In this book we hope that we have helped some readers to further develop what we see as healthy attitudes regarding political involvement. Among these are a respect for the dignity of the individual, a respect for the rights and opinions of others, a willingness to cooperate for the common good, a belief in the power of intelligence to solve social problems, an acceptance of social responsibility, and a social and international outlook.

A framework based on a philosophy of democracy was utilized throughout. Certain assumptions or "givens" were presented within that framework. These included the following:

1. Democracy implies not only a form of government but also a way of life.

2. Democracy assumes that a person has integrity, dignity, right to opportunities, rational capacity to solve problems cooperatively with others, and a capacity for self-government.

3. A person's fullest potential can be developed in a climate of freedom. The search for freedom has been a major factor in the progress made by civilizations throughout history. An entire society benefits when its members are relatively free to develop their individual talents.

4. Human beings are creatures of self-interest. For democracy to function, however, a degree of self-interest must be curbed in favor of public interest.

5. The prime goal of democracy is the preservation and extension of human freedoms. Freedom is absolutely useless, however, unless it is coupled with a balanced sense of responsibility. Freedom seems to range from legal to political freedom and from political to genuine economic and social freedom.

Freedom

Several basic factors are necessary for health care to be optimally accessible and utilized by all members of a democratic society. The Bill of Rights must stand, with respect for the individual built uppermost into the laws of the land as opposed to laws favoring the state or crown. A broad moral code is necessary that incorporates individual

responsibility based on the precept that one person's rights end where another's rights begin. Opportunity must be accessible for individual accomplishments and development of self. All citizens must have the basic education and a level of health and well-being so that they can assume the responsibilities of free citizens in a representative form of democratic society.

"Democracy desires the well-being of all men."[1] Individuals must not lack sensitivity and imagination but try to realize the experiences of all people within their scope, being convinced that they are not equal, because their circumference of experiences is different from others. This therefore is equality.

Freedom and equality have been defined in some of the following ways. Legal equality means that before the law every person is judged by the same standards. Moral equality means that individuals have equal ultimate worth and need not anticipate "violation" by others. Spiritual equality implies every person's potential spirituality, which every one earns, or in other terms every person's right to "salvation." Spiritual freedom defines a kind of inner strength, an ability to stand up under extreme adversity. One might question therefore the state of spiritual freedom in the United States today.

Equality, as the Constitution defines it, may be defined as, first stressing the ties that bind humankind and, second, recognizing what makes human beings different. People therefore respect each other so that differences, such as monetary differences, become less and less important. This is not a process of leveling but rather of allowing the individual to develop his potentialities to the fullest and then be able to look at another person's differences with respect.

Freedom does not mean license. Rather, with freedom also come discipline and self-control. In *The Paradoxes of Freedom*[2] Hook says "No one can reasonably make a demand for freedom in an unqualified sense—a freedom to do anything one pleases. For it is morally impossible to approve all freedoms. . . . There are freedoms and freedoms—and we cannot have them all. For each one we pay a price." Freedom may be interpreted as meaning a state of mind, so that a person in physical bondage may have freedom. This means that not only do people living in a democracy have freedom but also that what makes a democracy unique is its stress on individuals and their ultimate value.

Meyers[3] states that "One should be free from the threat of molestation, so as to enjoy the fruits of one's labor." In a democracy the purpose of laws is to protect the rights of the individual. Yet if law goes far enough in a democracy, it becomes an impeding influence rather than a liberating one. Benedict, Rousseau, and others speak of the danger that the more a government watches and protects a minority's equality, the less freedom actually is present.

From the agrarian days of early America to the highly accelerated industrial life of today some of the people's concepts and philosophies have been in conflict with their manner of living; thus there is what anthropologists such as Benedict[4] and Mead[5] call a relative disintegration of American culture. The question arises as to whether a democracy is applicable under industrial conditions, in which everything is specialized and people are so interdependent. This would appear to be possible only as long as individuals participate and have an interest in their destiny. When this is lost, however, minority groups rule and democracy no longer exists. If one defines freedom as a level at which individuals relate to one another, enhance one another, and participate in an exchanging relationship, we agree that this can happen in an industrialized society such as America. It is not a natural outcome, but it is entirely possible.

There is much emphasis in the United States on *success*, which immediately to most people means dollars and cents. If this is what is meant when one says that in a democracy one aims for the individual's attainment of his maximum potential, one is attaining anything but a democratic society. When individuals have achieved this *success*, they may well be hollow and have a feeling of futility. The correction of this situation is a job for all American institutions, including educators and health professionals. American society needs something to be committed to, as an adaptation to this industrial way of life from the earlier agrarian type of life. No doubt the changes will take place in terms of adaptation, but this may occur without democratic ideals and humankind will become a mass.[6]

Because some people have seen the danger of mediocrity and loss of individual identity and creativity, an overcompensation has occurred in terms of valuing strong individualism. The danger here is that the strong individualist may have a lacking of social conscience and social morality, so that destruction may result, according to Maslow.[7] Yet one must not forget that a prerequisite to morality, so defined, is freedom. If individuals harm no one but themselves by their action, this is their choice and they have liberty to do so, but only insofar as they do not endanger others. It may also be their right to be wrong, insofar as they are acting intelligently and not deliberately endangering another's freedom. Here we use *freedom* as a term implying restraint and *liberty* as implying absence of restraint.

First, in a democracy the aim is to treat individuals as "ends" and not "means." To do this, Maslow[7] points out, individuals must know themselves and must realize that they do not *need* to use people as means. Second, pathological authoritarianism is ruled out so that society grants individuals more freedom. Individuals, in terms of ends, are allowed to develop, are trusted, and thereby take more responsibility. Thus they experience more freedom. Granted, this can be a dangerous tool; however, if people practice democracy and create the proper atmosphere, they can rightly take the risk as to where such freedom leads.

Individuals as ends also implies that they are not judged in terms of their contribution to the state but rather in terms of what each may personally achieve under favorable opportunities.[8] It also means that the way in which individuals make their living should hopefully also enrich their personality and give them a sense of satisfaction and reward.[9]

Freedom, equality, and democracy are not absolute terms. They are ideals toward which individuals aim, and as long as individuals are aiming toward these ideals it would seem that relative amounts of these qualities exist. Many lives and horrible events can testify as to what has happened throughout history when people take absolutistic stands, and often for what passed as "democracy." For this reason one wonders whether religious freedom and equality and morality are not at almost opposite ends of the continuum. Dewey and colleagues[8] say that "the idea of forcing man to be free is an old idea, but by nature it is opposed to freedom. Freedom is not something that can be handed to man as a gift from outside. . . ." It is earned and only so through the kinds of relationships that individuals have with one another. It is through this voluntary cooperation that the optimum development of the individual can be made secure and enduring.

Boundaries

It is almost impossible to provide any tidy summary or conclusion to a book such as this. The range of theories, concepts, examples, and comments has been wide. Indeed the task of the book would not be accomplished were it possible to have any sense of closure at this point. The political process is one of constant change and flux. The socialization process in nursing has all too often delivered the message that there is an ideal state to which one can conform—a state defined primarily by appearance, dexterity in tasks, and acknowledgement of organizational superiors. In fact there *are* principles to which one may wish to conform, and we have been suggesting that these include particularly the involvement of all persons in decision making when it affects their destiny. For nurses this means two things. First, they should be involved on all levels when policy is being made regarding health. Second, in achieving that end, nurses must recognize

that the profession should not forget the clients of health care and their need to be a part of decision making as well.

From the study of culture groups Brown[10] has observed that when a new belief, a new tool or invention, or new custom is introduced, one of the following alternative reactions can be expected from the group:

1. It may fit into the pattern and be accepted.
2. It may clash with the existing pattern and be rejected.
3. It may be found unsuitable in its original form but capable of modification or substitution so as to make it acceptable.
4. It may conflict with deep-seated elements in the cultural pattern, and the society may disintegrate or, after a period of disintegration, manage to reorganize itself around the new trait.

As with the introduction of a new custom, invention, or belief into a culture group, so it is with a new policy that is introduced into an organization. Therefore the staff in an organization may be expected to react in any of the four ways Brown describes.

Although the settings in the two following instances are extremely different, the underlying psychological mechanisms remain the same. A tribe of African natives might completely ignore the World Health Organization's construction of sanitary privies in the area and continue their old, unsanitary customs that contaminate the soil and spread typhoid throughout their land. A professional staff, because they believe that they must show professional good manners, may go along with a change in policy but be resentful, frustrated, and generally feel exploited because decisions were made without consulting them.

Among the characteristics required of organizations is that they have boundaries, which may be defined with varying degrees of precision, along with energy, resources, coordination of effort, and channels of distribution for that effort. The boundary of an organization is defined to indicate who is within the organization and who is outside. This may be done by means of uniforms, badges, insignia, names listed on a roster, or as in the field of public health, a directory of certified public health personnel. Membership in an organization may be voluntary, in which the boundary serves to *keep out* individuals who do not bear the marks of identity of the organization, or it may be involuntary, in which the boundary is designed to *keep* members *in* the organization. Public health agencies are an example of voluntary membership, and families, nations, prisons, and armies are examples of involuntary membership.

In public health nursing agencies an extremely apparent boundary can be drawn with uniform policies. The uniform designates to the public health nurse, to other staff in the agency, and to the public that the wearer belongs to the organization known as the health department. Some public health agencies have stringent uniform regulations, up to and including a proper pocket tab and scarf, periodically reinforced with a memorandum from the director's office, whereas other agencies permit the wearing of casual street clothes, sometimes not even excluding such daring features as sleeveless dresses and jewelry.

One might speculate as to what brings about the establishment of certain uniform or dress regulations. We might simply accept an answer that they have been long-standing or traditional with the agency. However, the beginning or establishment of the policies are of interest. Traditions or customs have their beginnings in fulfilling some human need, says Brown.[10]

Determination of uniform policies is done by the administrator of a public health nursing agency, with varying degrees of participation from the staff. As with the introduction of a new belief, new tool or intervention, or new custom in a culture group, one of the group reaction patterns may be expected that Brown describes.[10] It may be speculated that the acceptance of the new policy by the staff will be directly proportional to the amount of their participation in the formulation of policies.[11] From observations in the field of public health we are not aware of any instance in which an entire staff requested that an administrator establish a policy about uniforms. When street clothes are acceptable in an agency, in no known instance is a staff nurse prohibited from wearing a uniform if he or she wishes.

Why therefore does an agency administrator initiate uniform policies when prior to this, there have been less formal dress regulations? In other words, why does the leader decide to draw the organizational boundary with heavier, more visible markings? The verbal reasons which might be given are that the public believes that public health nurses look more "professional" in uniform, that in the long run it is less costly for public health nurses to buy uniforms than street clothes, and so on. Whether the wearing of a uniform makes one a more professional public health nurse is questionable in the same way that a certain manner of dressing is not indicative of a "good" teacher.[12] If these factors are not highly significant, what therefore brings about the change?

When "things are not going so well" in an agency, production of work declines, nurses are spending as little time as possible in the office, even to the point of recording some home visits in their cars, the agency may be described[13] as having a "closed organizational climate." The administrator perpetuates the closed organizational climate by initiating or enforcing uniform regulations, whereby all nurses are reminded that they belong in the organization and every other nurse is reminded of that individual's mark of identity. At the same time those outside the organization are told that these are marked individuals and are expected to behave in certain ways. The situation is now taking on more of the quality of an involuntary membership in that it is actually designed to *keep* individuals *in*, to require their loyalties and energies, rather than being designed to *keep* others *out*, as in the voluntary type of organizational membership.

One might speculate about other administrative decisions that would effect a sharpening of boundary demarcation. However, this one is made universally in public health agencies, and indeed in almost all health facilities, whether in terms of strictly enforced uniform regulations or varying degrees of less formal dress. It appears that strictly enforced uniform policies are introduced during a period of "closed climate" leadership and tend to relax during "open climate" leadership.[13] It may also be speculated that without open climate leadership, nursing will not move from preoccupation with the external form and boundaries of their profession, such as uniforms, to development of the content needed to survive as a vital force in health care.

Like makers of corn brooms, it is essential that nurses be able to provide evidence that they are irreplaceable by anything—other kinds of health personnel or machines. The specialized skill required to turn out good quality corn brooms[14] has not been lost to any competition by synthetics or mechanization. A recent attempt was made to develop a mechanical broom–corn harvester with funds from the government and industry, but it was abandoned. Each boom is made from broom corn fiber, which is hand sorted for length, wound, and wired so that no two are alike, and their sales tag varies accordingly. If nursing is a profession, any attempt to mechanize its membership (through uniforms or other means) should similarly fail.

Consequences

In planning change, serious consideration must be given to unanticipated consequences. It is risky to stimulate change for the sake of change. Not all change is better than no change—in fact it may be worse. An example that comes to mind is California nurses' first attempt at changing the Nurse Practice Act. Instead of accomplishing what nurses intended, it stimulated increased resistance as well as hopelessness among many nurses. Medex practitioners were prepared to augment physician manpower, but no licensure laws were passed to serve as boundaries

within which they would practice. The graduates of Medex programs had difficulty in finding employment; nurses were confused and threatened, and physicians were reluctant to assume responsibility for the actions of Medex practitioners. Assuming personal risk is necessary to attain the power for change to occur, but taking foolish risks may be worse than not risking at all.

As nurses do attain power, will they be able to continue their effectiveness in caring for and serving in the best interest of the powerless? As power is attained, it is frequently accompanied by a change in life-style which more closely resembles that of members within the ranks of wealth, power, and high status. Such individuals then tend to lose their identity with the downtrodden, and they strive toward maintaining the status quo.

During the current tight economy, there are numerous applicants for most jobs, and even college graduates join the ranks of the unemployed. With increased cost of living many more persons are moonlighting to meet expenses. Pressured by inflation, layoffs in industry, and a shortage of skilled job openings, many more workers are migrating to the unskilled labor market. Jobs that previously attracted skid row residents are now filled, for example, by teachers, office workers, or truck drivers who work after hours. Help wanted advertisements are now a thing of the past for many employers; instead, posting a job opening notice or simply word of mouth obtains many more applicants than there are openings. Nurses have had a reputation of working to supplement family incomes rather than as a distinct lifelong career. The current economic changes undoubtedly are affecting nurses in various ways, including alterations in both practice and education patterns.

Any visitor to the 1974 World's Fair (Expo '74) in Spokane heard a bell ring every 10 seconds in the area of the United States pavilion. When the fair closed in November, 1974, the bell had rung more than 1.5 million times.[15] Each ring represented one new birth in the United States. Although a new birth is considered exciting, the impact that each has on the environment and the society may be somewhat less exciting and more thought provoking. The display at the fair shows this impact of each new life as follows. During an average life-span, the earth must provide the individual with 2 tons of textiles, 21,000 gallons of gasoline, 50 tons of food, and 56 million gallons of water. In return he puts back in the earth 165 tons of garbage and in the air 100 tons of air pollution. A Herculean task lies ahead in which nurses should be willing and able to assume a meaningful role in developing a harmony between man and the environment. Pollution control, environmental management, and population control must go hand in hand.

Almost every family in the United States is feeling the effects of skyrocketing consumer prices. For families on welfare it has become an extraordinary situation. An old adage frequently used is "It takes money to make money." There are those in society who for various reasons failed to make the money that would help them make more money. These people frequently find themselves on welfare assistance. There are some who have the know-how and motivation to calculate ways of making the dollars stretch to cover the costs of housing, of nutritious although inexpensive meals, and of clothing. The others join the ranks of the malnourished, depressed, and hopeless. Nurses often find more reward in helping the former type of families, but the challenge remains of finding ways of helping the latter group other than through a simple increase in income level. Income does not ensure good nutrition.

The urgency of national health insurance is supported by many facts including (1) an increase in the average personal yearly health bill by over 100% in twenty-five years, (2) lack of hospitalization insurance to cover nearly 50% of the people in income brackets at or near the subsistence level, (3) hospital expenses of hundreds of dollars a day, and (4) the poor distribution of physicians and the frequent use of foreign medical graduates.[16]

Although most people look on national health insurance as inevitable, the form in which it came about requires considerable concern. Neither the Kennedy-Mills plan to federalize all health insurance under the Social Security program nor the administration's private payroll deduction deals with the problem of cost. Compromise plans have appeared little better at solving the multiple problems. They are designed to make care available to more people, but it is contended[17] that the burden of increasing costs would still be on that 80% of the wage earners who are already subscribing and paying for some health insurance program. The solution seemingly must yet be found.

Stability or the lack of stability in government is not only a current American dilemma. It was a difficult personal dilemma for many citizens to defend Richard Nixon as the man to be President of this United States, but it was equally difficult for many to wholeheartedly support his impeachment. The controversy over the numerous conversations contained in the White House transcripts pointed to what some would call a degree of narrow-mindedness and nit-pickiness toward the executive and his assistants, made possible by technological advances. From other viewpoints, the President's years in the White House were not a total failure but produced some accomplishments. Supposedly it was Madison who once said that the American system of government was designed to work not because of noble men but despite base men. The loss of moral leadership, although it might be cause to remove the executive of other systems of government, is not automatically sufficient in the United States, where the founding fathers spelled out the requirement of "high crimes or misdemeanors" as the only cause for impeachment. Perhaps the founders were all too well aware of emotionalism and its results, therefore limiting threats to enhance a stable government. The syndrome of instability within the United States was seen paralleled across the world, with the resignation of Germany's Chancellor Willy Brandt, the inability of Prime Minister Trudeau to serve his government in spite of his charisma, the narrow margin of support held by France's new leader, and the rarity of a majority party holding the government in Great Britain. Western governments generally seem to be in a state of crisis.

Meanwhile, one must also remember that disfavor with the President is not unique to our time. Thomas Jefferson[18] encountered some of the same during his second term of office, with the precipitating issue being an embargo he placed on foreign trade. Other issues included the treason trial of Aaron Burr, with friction because of it with Chief Justice John Marshall, a feud with fellow politicians, and details of the Lewis and Clark expedition.

The money market and currency conditions can be both economic and psychological. The uncertainty of the value of various national currency systems is partially a result of the inability to make calculations and trade with reasonable certainty that the currencies will in ten or fifteen years hold the same value in relation to others. With deteriorating value of the American dollar, psychological factors begin to play an ever-increasing role, with panic making it even harder to stabilize the economy, stave off recessions, depressions, money crises, and economic movements. People look at past experiences as they look toward the future. During the 1971 slump, many predicted decreasing world trade and ultimately a depression. Many based this on a recall of experiences from the 1930s. Current economics have puzzled many but certainly cheered few. With a recollection of this aspect of human behavior a few banks have developed a system that serves to measure mob psychology to protect their interests.

Finding new areas in which to apply their knowledge and skills, nurses may take example from what may be seemingly "far-out" approaches used by other disciplines. In 1969 the Holiday Inns of America began adding a chaplain to their payroll and began a new type of ministry—that of working with the lonely and suicidal persons who utilize their motel and hotel accommodations. The

founder of the program has estimated that perhaps 1,000 potential suicides have been averted. For persons in trouble and running away a hotel or motel serves as a logical neutral place. It is a refuge for lonely people, including musicians and would-be actors, among other hopefuls or past hopefuls whose bubbles have burst. Cooper[19] writes that room service may include "3 bourbons, 2 scotch—and one chaplain." Avoiding sanctimonious lectures and drab clerical garb, he says, "Most clergymen are such duds. They come in with the starched frocked approach, and it's hard for a frightened person to relate to that. Christ is my business, and Hollywood is my beat; I try to make these people understand that I really care about them, that Christ cares about them."

The impact made by Louis Schweitzer,[20] a wealthy cigarette manufacturer known for his philanthropic, yet eccentric activities, has been described and serves as an example of how his background, creativity, and money power helped bring about changes. When irritated with radio commercials, he ordered programs be run without interruption. He bought a barber shop so that he could obtain haircuts after hours and a taxi so that he need not wait for service when he wanted it. Often he gave sums of money to persons whose lives he considered would be improved because of it. Finally he ran into an employee of Manhattan's Department of Corrections who told him of thousands of people sitting in jail because they were too poor to pay bail. A subsequent jail tour angered him so that he began an extensive reform program called "Vera" (free bail for those eligible). He argued with criminologists, negotiated with the Mayor, and after six years was able to get the free bail policy written into law (supported by former Attorney General Robert Kennedy) in the form of the Bail Reform Act. It was expanded to the issuing of summonslike traffic tickets for offenses such as disorderly conduct and petty thievery rather than making formal arrests. The Director summarizes[20] the basis of success in the program by saying: "If we had created Vera to deal with the whole administration of justice in the U.S., we would have floundered for a few years and just petered out, but we had something very specific to do."

Although those sciences that attempt to explain the past experiences of man have barely been mastered, there has been developed also a science of futurology—the attempt to predict social developments in advance. This can be combined with the movement of futurists, who attempt to engage the minds and energies of highly skilled persons not only to predict but also to plan for the future to ensure its improvement over the present. Certainly the interest of nurses in changing the future of the health care system and their place in it is not a unique, self-generated activity but a part of the total phenomenon in the culture.

Outcomes

The careful reader may have observed how many of the references are from the general press rather than scholarly works. This is particularly true in regard to examples cited. The reader should be directed toward classic works on politics, and we hope that direction is provided. However, appropriate involvement in the broad political sphere necessitates a process of constant self-education with regard to any and all issues related to health. The flow of thought should go on continuously from a headline, to memory of historical precedent, to questions of unstated options, to discussion with affected groups, and eventual translation of opinion and reaction to action.

What should be the outcomes of reading a book such as this? We will attempt not to violate our own philosophy and tell you what you should do. However, if a reader has persevered thus far, it is possible he or she will be open to suggestions or will have begun to change behavior in one of the following ways. Awareness of data sources should be heightened, and the need to take advantage of the available sources may have been stimulated. The first step in effective participatory democracy is an informed electorate. As a

basic student, the reader may have had some exposure to "read the paper and bring in clippings" in a course on community health nursing. That is certainly a good beginning. One should not be afraid of ignorance. A person may read in the paper that a certain bill has passed the legislature and is going to the governor for signature. The importance of the bill to health care is so obvious that the reader assumes he or she is the guilty party who has not paid attention and hesitates to speak to anyone, despite serious reservations about the intent and provisions of the bill. However, that same reader might find, on asking questions, that no significant health professionals know anything about the measure, and it indeed had gone quickly through the legislative process, either by intent of a special interest group or because the lawmakers had failed to appreciate the consequences of their actions.

In knowing to whom one should speak at such a time, the press is again important. After one's own close work associates, a person wishing to enter political processes may not know to whom to turn. Keeping track of those health professionals serving on boards, advisory bodies, or as elected officials of health groups provides a roster of potentially powerful colleagues. One should not further downgrade one's own potential to be heard by those individuals. They sustain themselves by their responsiveness to constituencies. The knowledge that nurses expect representation and might be vocal if not attended to can have a significant impact.

Another group to whom one can always turn are those officials representing one's local area in a city, state, or national legislative body. Surveys have consistently shown that people are largely ignorant regarding such elected officials so that the reader is in good company if unable to name mayor, alderman, state senator, or United States congressman. As with those serving on boards and committees, these representatives depend on constituencies and are aware that they can ill afford to ignore the interests of their populace. They can ignore perhaps one letter or two, but regular correspondence from an informed citizen who shows evidence of being in touch with community groups can scarcely be overlooked. Given the busy life of any professional, it is obvious that one cannot write every official regarding every potentially health-related measure. Each person will probably find time to relate to one level of government broadly or to all levels regarding a narrower range of issues. A network of people who among themselves begin to encompass the whole range of electees and concerns might gradually build up.

Another potential constituency is that of one's patients. If one does a complete assessment of each new patient, one learns something about where and how that person is involved in community affairs. It is certainly not out of line to point out issues of potential significance to health. However, one must certainly do so with great care, providing all individuals with sufficient data on all aspects of the problem so that they can make up their own minds. It is always possible that their decision will be opposite or at least different from that of the nurse. If nurses are not prepared to expect or even foster such a diversity in views, they are violating again those precepts under which this book has been written.

In regard to the partisan political issues, particularly those of election campaigns, it is more difficult to comment on what directions a person might go with additional knowledge. One possibility is to become directly involved with a political party. There are those who feel an urgent need for both women in general and nurses in particular to gain elective office throughout the land. That route is not appropriate for everyone. A possible route, however, is for each nurse, during any campaign, to stimulate questions to candidates that will clarify their stands on health and health-related concerns. This serves the purpose of making the necessary data more in keeping with the philosophy expressed here, rather than proclaiming loudly, "I say vote for X because I'm a nurse and I know."

At a much more personal level each nurse should be more prepared to say "this is where I am" in regard to every health issue. Too many individuals, nurses among them, have followed battles such as that regarding a national health insurance program from a great distance, voicing concern to one another that something potentially bad is in the offing but unable to say what or how or why. In addition to following more knowledgeably the current affairs as reported one might even ask to be placed on the mailing list of one or more legislative committees or administrative bureaus, thus ensuring a steady influx of data and commentary on current issues. Such data might be used entirely for self-education or be shared with others.

On a personal level one should also be in a position to understand more clearly one's own responses and reactions to the organizational structures in which nurses move and the other persons with whom they have contact, especially those from other disciplines. If staff nurses learn about nursing and being a nurse only from within the profession, they may fail completely to understand why male hospital administrators look through them, the rules of the documentation process change around them, and patients remain unhealthy despite them. It takes a good deal more knowledge than an adaptational theory of nursing, complete with basic sciences, to prepare one for the blows the culture continues to deal women—even the professionals' manipulations of power within a bureaucratic structure like hospitals—and the failure of the society to meet the needs of all its members.

In retrospect, this summary has been prepared in a rather hindside-to manner. It is the last-mentioned personal awareness that precedes the search for data, and it is the accumulation of data that precedes useful action at any level. Hopefully the discussion here has started some readers on that long journey.

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GUIDE TO PUBLIC HEALTH PRACTICE:

HTLV-III SCREENING IN THE COMMUNITY

**Recommendations from a Consensus Conference
Convened by the
Association of State and Territorial Health Officials**

March 1-2, 1985
Centers for Disease Control
Atlanta, Georgia

Kristine Gebbie, R.N., Presiding
Administrator
Oregon State Health Division
President, ASTHO

This publication presents the recommendations of a consensus conference convened by the Association of State and Territorial Health Officials. This effort was supported, in part, by the Centers for Disease Control. The content of this publication does not necessarily reflect the views or policies of the Department of Health and Human Services.

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ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS
1311A Dolley Madison Blvd., Suite 3A, McLean, VA 22101
Phone (703) 556-9222

March 20, 1985

Dear Colleague:

As President of the Association of State and Territorial Health Officials (ASTHO), I had the privilege of presiding over the working conference responsible for developing a suggested national policy for HTLV-III testing in the community. The working group represented epidemiologists, blood banks, practicing clinicians, and high risk communities, as well as federal, state and local health agencies.

It is intended to give you clearer answers to critical questions related to the introduction of HTLV-III antibody testing. It is preliminary, and it will not cover all of the questions you will raise in the next six months. Please communicate your concerns, and suggested revisions, clarifications and expansions to me or one of the participants. Those points raised will receive careful consideration at an expected follow-up conference.

I must acknowledge the fine work done by all participants and thank them for their efforts. Particular thanks go to Gary Clarke, Executive Director of the ASTHO Foundation, for synthesizing the recommendations of the working group. I hope you will be aided, as I have been, by the results.

Sincerely,

Kristine Gebbie

INTRODUCTION

ACQUIRED IMMUNODEFICIENCY SYNDROME

Acquired Immunodeficiency Syndrome (AIDS) is the medical term used to describe the set of clinical signs and symptoms caused by a deficit in the functioning of the immune system. The syndrome was first described in 1981, and by January, 1985, more than 8,000 cases had been reported to the Centers for Disease Control.

AIDS has been particularly frightening to the general public and a challenge to public health professionals because its cause has been discovered only recently; it is communicable; and because definitive treatment is not available. The vast majority of patients diagnosed with AIDS according to the CDC's case criteria died within five years of initial diagnosis.

AIDS is transmitted from person to person through the transfer of body fluids, such as blood and semen. There are no documented cases of AIDS resulting from exposures such as sharing meals, coughing or sneezing, or other forms of casual contact. The disease first appeared in the United States in the male homosexual and intravenous drug user communities, and continues to be concentrated in those groups (72.8% of reported cases are male homosexuals). In some areas of the country, AIDS is the leading cause of death for young men aged 35 or less. Other groups which make up a large proportion of reported AIDS cases include intravenous drug users (17.2%), Haitians (3.6%), and persons with hemophilia and other persons who are recipients of blood transfusions or blood products (1.8%). While the proportion of AIDS cases among these groups has remained relatively constant, there is concern that the disease may spread into other population groups and affect far larger numbers of persons.

In 1985, the number of reported AIDS cases is expected to double compared to 1984. The number of AIDS cases reported in 1984 was 74 percent higher than the number reported in 1983. Epidemiologists at the Centers for Disease Control estimate that as many as 250,000 persons in the United States may have been infected with the virus that causes AIDS.

Recent research in both the United States and France has identified a retrovirus (human T-lymphotropic virus type III, or HTLV-III), as the probable cause of AIDS. In addition, numerous research studies have used the ELISA test (enzyme-linked immunosorbent assay) to detect the prevalence of antibodies to HTLV-III virus in patients with AIDS and related conditions. Different studies have found the presence of HTLV-III antibody to range from 68 to 100 percent among persons with AIDS, and from 84 to 100 percent among persons with AIDS-related conditions.

PUBLIC HEALTH SERVICE BLOOD SCREENING RECOMMENDATIONS

The results of these and other studies prompted the U.S. Public Health Service to recommend, in the January 11, 1985 "Morbidity and Mortality Weekly Report" (MMWR), that all blood used for transfusion or the manufacture of blood products be screened for HTLV-III virus. The proposed method of screening was an ELISA test. Shortly thereafter, the Secretary of the Department of Health and Human Services (DHHS), Margaret Heckler, announced the impending licensure by the FDA of the ELISA test to detect antibodies to HTLV-III as a screening test to be used in blood and plasma centers.

Secretary Heckler also announced that in addition to testing at blood banks and plasma centers, alternative testing sites would be established through, or in cooperation with state and local public health departments and agencies, to provide an alternative to blood banks and plasma centers for those persons wishing to know if they had been infected with HTLV-III. Secretary Heckler further announced that the federal government would be providing additional resources to state and local governments, particularly in the form of training, to help them respond to the anticipated demand for this antibody test.

On February 7, 1985, the Association of State and Territorial Health Officials (ASTHO) -- the organization representing heads of the nation's state health departments and agencies -- convened a meeting in New York City to discuss the impact of these developments on state and local public health departments. At least three issues were of major concern:

1. The large number of individuals expected to have an ELISA test falsely positive and the resultant need for additional information and assistance. It has been estimated that the ELISA test may generate as many as 100,000 to 200,000 false positive results in persons who are truly not infected with the HTLV-III virus.

2. The ability of state and local health departments or others to quickly establish high quality alternate testing and counseling sites.

3. The diversion of scarce resources -- particularly laboratory and infectious disease control personnel -- to work on this program.

Of greatest concern to the nation's state health officers was the large number of false positives expected to be found through comprehensive screening of the nation's blood supply. The recently licensed ELISA test performs as accurately or better than many screening tests now in use by the medical community, (e.g., VDRL). However, unlike most of these other tests, currently no other reliable diagnostic tools are available to confirm the test result. In addition, the state of medical knowledge concerning the meaning of a positive result is limited, especially when no other signs, symptoms or risk factors are

present. Simply stated, the long term prognosis for the development of AIDS in a person with antibody to HTLV-III is unknown. Given the very high case fatality rate associated with AIDS and resultant public fear and social stigma, implementation of this test without adequate preparation to respond to the large number of individuals with true and false positives was troubling.

ASTHO CONSENSUS MEETING

In order to prepare themselves and other state and local health departments for the expected reactions to the licensure and widespread use of this test, ASTHO convened a meeting of its executive committee, together with state epidemiologists, private physicians experienced in dealing with AIDS, representatives of city and county health departments, gay rights groups and blood banks to recommend a course of action. The meeting was conducted at the Centers for Disease Control in Atlanta, Georgia, on March 1 and 2, 1985. The CDC also made available its technical staff to assist with the deliberations. ASTHO would like to thank CDC for its assistance and cooperation.

The recommendations in this document are the result of that meeting, and are intended to assist state and local health departments as they develop their own policies in response to licensure of the ELISA test for HTLV-III screening. On March 2, 1985, Secretary Heckler announced the licensure of this test, making these recommendations even more timely and urgent. The actual public demand for counseling and alternative testing in response to licensing of the ELISA test is unknown. Actual experience will dictate the degree of necessary safeguards, and the number of alternate testing programs required. State and local health departments should monitor the situation closely and implement a program that best fits their needs and circumstances.

Additional detailed information on the technical aspects of the ELISA test; clincal evaluation of HTLV-III antibody-positive individuals; advice and requirements for blood banks; and laboratory requirements have been made available by the CDC and FDA to all state health departments. In addition, a "Dear Doctor" letter containing notification of licensure of the ELISA test for HTLV-III screening was mailed to all physicians in the country by the FDA. Copies of these materials are available directly from these agencies.

RECOMMENDATIONS

I. GENERAL PRINCIPLES:

1. The HTLV-III antibody test is not a test to diagnose Acquired Immunodeficiency Syndrome (AIDS).

2. The HTLV-III antibody test is a useful tool that can assist in protecting the nation's blood supply, and is a valuable test to assist research efforts into the AIDS problem.

3. At the present time, the HTLV-III antibody test has extremely limited utility for purposes other than stated above, and is not a useful screening test for AIDS. The test does not have applicability except in specific medical circumstances. The HTLV-III test should not be used for generalized screening or as a precondition for employment, evidence of insurability, or admission to school or the military.

4. Because of the serious potential for harm to the individual resulting from the HTLV-III antibody test results, great care must be taken to inform the public and health care professionals about limitations in current understanding of the test results and of the entire disease process labeled Acquired Immunodeficiency Syndrome.

5. Information gathered from the testing or counseling of individuals should be kept strictly confidential.

6. State and local health departments, working in concert with the private medical and hospital communities, university systems, blood banks and plasma centers should establish a network and referral system (where not previously established) of physicians and other health care providers with expertise in dealing with AIDS.

7. For purposes of this document, persons tested for HTLV-III antibody will be classified in one of two ways prior to a medical assessment:

   - High risk: Persons with known risk of exposure to AIDS. This group includes all men who have had sexual contact with another man, intravenous drug users, persons with hemophilia, and other persons who receive blood or blood products (excluding, at this time, immune globulin and hepatitis B vaccine), Haitian immigrants, and persons who have had sexual contact with a person who has AIDS or an AIDS-related condition or who is at increased risk of exposure to AIDS.

After this medical examination and counseling, patients with repeat ositive HTLV-III tests should be divided into two groups:

- High risk -- those persons felt to be at high risk for developing AIDS based on risk assessment or symptoms.
- Low risk -- those persons with no apparent risk factors, normal laboratory and examination findings, and no symptoms.

Further counseling and medical follow-up is indicated for both roups, but as detailed in Sections V and VI, should be different as a esult of this evaluation.

/. RECOMMENDATIONS FOR ALTERNATIVE TESTING SITES

State and local health departments and agencies are strongly urged o work with blood banks, plasma centers, community groups, aboratories and private providers where alternative testing sites are stablished. The location and assignment of administrative responsibility or alternative sites must be determined within each jurisdiction to best t local needs and circumstances. Where such sites are established, it is ecommended that state and local health departments assure that the llowing conditions are met.

1. Each person tested for HTLV-III antibody at an alternative site should be provided the results in person from a counselor during a scheduled return visit. A personal presentation of the test results (whether positive or negative) is the only method which:
   - Does not involve potentially serious risk to the privacy of the individual;
   - Permits the counselor to assess the individual's emotional reaction and provides an opportunity for a private and sensitive explanation of the implications of the results; and
   - Permits persons in recognized risk groups for AIDS who have a negative test result to understand the limitations of the test, and to be counseled on methods of reducing their personal risk, and the risk to others, of exposure to HTLV-III.
2. Counselors must be trained and experienced in assessing and responding to people about sensitive and potentially life-threatening issues. Such counselors need not be persons with academic credentials. However, referral relationships with trained professionals should be established.

3. Strictest confidentiality must be maintained. This can be done i a number of ways, including use of the procedures followed for research protocols (including an Institutional Review Board protocol); strict adherence to standard procedures for confidentiality in clinical settings; or use of a patient number rather than name to assure complete record anonymity. No information about an individual should be shared with any other organization or individual without the signed permission of the individual who was tested. However, summary statistical information without individual identifiers should be provided to public health authorities if requested.
4. Persons should be fully informed about the limitations and implications of the test prior to providing the test (see Appendix A). In addition, the person should be informed of how the results will be communicated or made available to him/her; how and where the results will be recorded; where the results might be reported; and who may have access to them. Any possible future uses of the person's name for medical follow-up or research should require a signed consent and should be considered separately to avoid confusion.
5. A record of the information provided to the patient, including counseling when applicable, should be maintained in a confidentia patient record containing the results of the HTLV-III testing.
6. All alternative testing sites for antibody to HTLV-III must be medically supervised. In addition, physicians, nurses and mental health professionals with additional specific training should be an integral part of a referral network for any counseling effort.
7. All alternative test sites should have access to a referral list or a system of referral to physicians and other health care providers specializing in treatment of AIDS or AIDS-related conditions, and should establish, to the extent possible, working relationships witl these providers.
8. Referral for medical follow-up for all persons with positive test results must be assured, and all persons at an alternative test site wishing further information should be informed of a referral network of health care providers with expertise in dealing with AIDS.
9. Charges for services provided at alternative sites, especially blood testing and an initial counseling, should not be made if at al possible. (This will be possible where federal funds are provided for these purposes.) Provision of low or preferably no cost services are an important incentive to keep persons from utilizing

blood banks or plasma centers for initial testing and counseling. Costs and charges for the more expensive medical assessment and further counseling recommended in subsection III(3) will have to rely, for the most part, on individual arrangements with private physicians and health care providers. However, consideration should be given to financial assistance for those persons in need of service and without adequate resources.

State and local health departments should compile and maintain a list of alternative testing sites and make this information available to persons wishing access to those sites. State health departments also may consider establishing an "800" number to provide this information, as well as other general advice and referral services. Alternatively, a "900" number, which costs the caller 50 cents, may be considered.

V. FOLLOW-UP RECOMMENDATIONS FOR HIGH RISK INDIVIDUALS WITH REPEAT POSITIVE TEST RESULTS

State and local health departments are urged to work with blood banks, plasma centers, private providers, community organizations and others providing HTLV-III testing to assure that high risk individuals be advised to establish a relationship with a physician who can, by reason of training and experience, continue to evaluate the patient for signs and symptoms of AIDS or related conditions. High risk individuals are defined as persons with known risk of exposure to HTLV-III, or of high risk of acquiring or transmitting the HTLV-III virus. This group includes all men who have had sexual contact with another man, intravenous drug users, hemophiliacs and other persons who have had sexual contact with a person who has had an HTLV-III infection or who is at increased risk of exposure to HTLV-III. It is also recommended that:

1. High risk individuals be advised of the early clinical manifestations of HTLV-III infection, AIDS, and AIDS-related conditions and advised to seek immediate medical attention if any of them occur.

2. High risk individuals be advised that the prognosis for an individual infected with HTLV-III (the probable cause of AIDS) over the long term is not known. However, available studies conducted among homosexual men indicate that most persons will remain infected, but asymptomatic.

3. High risk individuals be advised to seek medical evaluation and followup at least twice annually, and more frequently as indicated for an individual who develops signs or symptoms suggestive of HTLV-III infection, AIDS, or AIDS-related conditions.

4. High risk individuals be advised that although the person may l asymptomatic, there is a risk of infecting others by sexual intercourse, sharing needles, and possibly through saliva or exposure through oral-genital contact or intimate kissing. Th efficacy of condoms in preventing infection with HTLV-III is unproven, but the consistent use of them may reduce transmission.

5. High risk individuals be advised that blood, plasma, body orga other tissue or sperm should not be donated.

6. High risk individuals be advised that toothbrushes, razors, or other implements that could become contaminated with blood should not be shared.

7. High risk individuals be advised that children born since 1979 t women with a positive HTLV-III test should be clinically evaluated.

8. High risk individuals who are women, or women who have a hi risk sexual partner who has a positive test, be advised that th are at increased risk of acquiring AIDS, and that any offsprin is at increased risk of acquiring AIDS.**

9. High risk individuals be advised that in the absence of close o intimate contact, household contacts need not be referred for testing at this time.

10. High risk individuals be advised that after accidents resulting bleeding, contaminated surfaces should be cleaned with household bleach freshly diluted 1:10 in water.

11. High risk individuals be advised that devices that have punctured the skin, such as hypodermic and acupuncture needles, should be steam sterilized by autoclave before reuse safely discarded. Whenever possible, disposable needles and equipment should be used.

12. High risk individuals be advised that when seeking medical or dental care for illness, they should inform those responsible f their care of the positive HTLV-III results so that appropriate evaluation can be undertaken and precautions taken to preven transmission to others.

13. High risk individuals be advised that most persons with positiv HTLV-III test results need not consider a change in employment. However, those persons whose work involves significant potential of exposing others to his or her blood or other body fluids should, at a minimum, be advised to act prudently and take precautions such as wearing gloves.

14. High risk individuals be advised that when they are employed in medical, dental or other health care professions and performing invasive procedures or if they have skin lesions, should take precautions similar to those recommended for hepatitis B to protect their patients from the risk of infection.

15. High risk individuals be advised that any sexual or needle-sharing partner of a person with a positive test should be advised to seek clinical evaluation of potential risk factors, symptom history, and physical findings.**

** Because there was no current consensus on recommendations 8 and 15, these decisions should be left to the discretion of the evaluating physician.

VI. FOLLOW-UP RECOMMENDATIONS FOR LOW RISK INDIVIDUALS WITH REPEAT POSITIVE TEST RESULTS

State and local health departments are urged to work with blood banks, plasma centers, private providers, community organizations and others providing alternative testing and counseling sites to assure that low risk persons with repeat positive HTLV-III antibody tests be provided with counseling. These persons are defined as those with repeat positive results who are not members of known risk groups, have no signs or symptoms of immune deficiency disease, and have a normal physical and laboratory examination. It is recommended that:

1. Low risk individuals be advised about interpretation of these test results. This should include an understanding that the prevalence of false positives in the low risk group may be high, and that the patient's particular result may be of questionable significance. The person should also understand that a positive test -- if it is not a false positive -- measures only antibodies to the virus which may indicate past or present exposure to HTLV-III or a related virus. In addition, the person should be counseled that he/she does not appear to have AIDS, and that the risk of developing AIDS in the future, if the test is not a false positive, is small.

2. Low risk individuals be advised that, as a precautionary measure, they should not donate blood, plasma, sperm or body organs.

3. Low risk individuals be advised that if no known risk factors are present, currently there is insufficient evidence to warrant a broad restriction on sexual relations. However, advice on sexual relations and practices should be individualized.

4. Low risk individuals be advised that until more is known about the status of a positive test in a low risk population, that testing the patient's regular sexual partner may provide better or more information to determine if the test result may be a true or false positive. However, testing of other family members of low risk patients is not advised.

5. Low risk individuals be advised that there is insufficient evidence to warrant advising blanket postponement of pregnancy at this time. However, each circumstance should be carefully evaluated.

6. Low risk individuals be advised that they should notify their personal physicians and dentists that they have had repeat positive HLTV-III screening tests but were considered as having no known risk of exposure to AIDS.

7. Low risk individuals be advised there is no need for any restrictions on employment, education, or other social contacts

8. Low risk individuals be advised that additional counseling or referral is available if they have further questions or concerns.

9. Low risk individuals be advised to seek medical follow-up assessment within six months in order to identify any potential changes in their medical status or recommendations.

The nine recommendations above apply only to individuals who have no abnormal physical or laboratory findings other than repeat positive HLTV-III tests, and are not in a known risk group for acquiring AIDS. All other individuals with repeat positive HTLV-III tests, whether with known risk factors (including being a sexual partner of a person in a high risk group) but otherwise free of findings, or with no known risk but some clinical findings, should be counseled as "high risk" patients. There will be cases where low risk individuals desire to know all recommended precautions concerning the transmission of HTLV-III infection, AIDS, and AIDS-related conditions. In these cases, it is suggested that the recommendations for high risk individuals also be given to the individual. In addition, where the individual clinician is uncertain as to the risk status of the person who has been tested, it is suggested that both sets of recommendations be given to the individual.

now in charge of the Senate Judiciary Committee. They criticized Meese for budget cuts and infighting among agencies in the war on drugs, for watering down protections for accused persons, and for backtracking on civil rights. Senator Edward Kennedy led the attack.

Sen. EDWARD KENNEDY (D) Massachusetts: Tax credits for segregated schools, opposition of the Voting Rights Act, resistance to the Martin Luther King holiday bill, the assault on the Civil Rights Commission, relentless hostility to affirmative action, nomination of racists to the federal courts. I'm not accusing the administration of being responsible for racism in our society, but I am accusing them of creating the climate that encourages discrimination or repudiates opportunity. Howard Beach, Forsyth County, are happening on your watch.

EDWIN MEESE, Attorney General: Most of the things that you've said in your political diatribe, you are just flat wrong. But I don't have the time to go into detail, probably, to answer all of those without unduly infringing on the time for other members, but I will be happy to answer those points specifically in writing for the record, because there were so many inaccuracies and misstatements of fact.

LEHRER: Also in Washington today, a former secret police officer from Chile made an unusual admission. Armando Fernandez Larios pleaded guilty to being an accessory in the 1976 car bombing death of former Chilean Ambassador Orlando Letelier. Fernandez resigned Monday as a major in the Chilean army and a member of its intelligence corps. He then came to Washington to enter his guilty plea, saying he felt remorse over his role in the Letelier killing. Letelier died with a remote controlled bomb exploded in his car as it drove down Washington's embassy row. Ronni Moffit, an associate of Letelier, also died. Fernandez will be sentenced April 6. He could be imprisoned up to ten years.

MacNEIL: The America's Cup will be coming back to the United States after a three year stopover down under. The American yacht Stars and Stripes surged across the finish line in Fremantle, Australia, today in the winning time of one minute and fifty nine seconds. It was the fourth straight victory for the American vessel over Australia's Kookaburra III, and it allowed skipper Dennis Conner to reclaim the 136 year old America's Cup he lost to another Australian contender just over three years ago. The race was beamed to this country at an hour when most landlubbers are asleep. That didn't stop members of the San Diego Yacht Club, home port of the Stars and Stripes, and many other U. S. television watchers from being in at the finish. And the victory had an added finish for Conner's supporters. He was the first American to lose the cup to a foreign challenger after the New York Yacht Club had held onto it for 132 years.

LEHRER: And finally in the news, Liberace, one of America's more flamboyant performers, died today in Palm Springs, California. The 67 year old entertainer had been seriously ill for several weeks with what a spokesman said was anemia, emphysema and heart disease.

MacNEIL: That's the news summary. Coming up, proposed AIDS tests for marriage licenses and life insurance, Iraq's view of the war with Iran, and ambivalent thoughts about surrogate motherhood.

AIDS Test Controversy

LEHRER: There is a new uproar about testing for AIDS, and it is where we go first tonight. The noise is about the suggestion that the use of AIDS blood tests be dramatically expanded -- that they be given to couples seeking

marriage licenses, patients entering hospitals, pregnant women and people seeking treatment for venereal diseases. Officials of the federal government's Centers for Disease Control said in interviews published today, such broad proposals will be discussed at a special two day AIDS meeting later this month. They said they are designed to help find ways to stop the spread of the deadly disease that has already killed more than 15,000 Americans and promises to cause 50,000 or more deaths a year by 1991. But they also emphasized the ideas would be on the table for discussion only, and any CDC action would come only in the form of guidelines recommended to the states for adoption. The discussion has already started, and we pick it up now. First with Kristine Gebbie, health administrator for the state of Oregon and chairman of the AIDS Committee of the Association of State and Territorial Health Officials. She is with us tonight from station KOAP in Portland, Oregon.

Generally, first, what do you think of these proposals?

KRISTINE GEBBIE , Oregon Health Division: Well, I think they deserve very serious consideration. A couple of them have already been recommended in previous documents. The suggestion that persons coming to venereal disease or sexually transmitted disease centers, for example, be tested for the HIV virus; the suggestion that pregnant women, particularly those who have any possibility of previous exposure, be tested has been discussed. The two that are most controversial and that I think a few public health officials are behind right now are those of testing persons when they come to hospitals for routine care and testing persons at marriage license time. That last one is particularly interesting, because many of us have just spent up to ten years changing existing state laws to remove the required test for syphilis, which had been done for many years but was not useful in finding new cases.

LEHRER: Well, what would be the -- excuse me -- what would be the problem in testing -- having premarital tests for AIDS?

Ms. GEBBIE: Well, the issue is, you want to test people who are apt to be positive. You're looking for a cut of people where you expect to find a reasonable level of infection. The test, if widely applied to an uninfected audience, is going to yield a fairly high percentage of positives which are actually false positives, and you will have invested a great deal of time and money in your testing program and your counseling program and your follow up program on persons who are not infected. So most of us in public health are looking for some sort of a funnel, if you will, to identify the likely persons who may have been earlier exposed, persons whose behavior puts them at risk, then use the test with those people to find those who are actually infected.

LEHRER: And hospital admissions would not be a place to do that either? Is that correct? Is that what you're saying?

Ms. GEBBIE: That's correct. Because both of those are simply a cut across the general population. And in most parts of the country, a broad cut of the general population is not going to yield a high percentage of infected people. Infected people are those who have practiced risky behaviors, such as use of IV drugs and sex which is unprotected from the transmission of semen or blood. So persons who are longtime monogamous partners, persons who are not sexually active, persons who have not used IV drugs, persons who have not had blood transfusions or treatment for hemophilia aren't in that pool. And it is not a good use of resources to test them.

LEHRER: Now, you have no objection to testing people who seek treatment for venereal disease. Is that correct?

Ms. GEBBIE: I think that's an excellent place to use the test, but I want to emphasize that in any case where the test is used, it needs to be done with the informed consent of the tested person. This, as with any medical procedure or test, people need to know what they're getting in for. And the opportunity to

do the pretest counseling is a key place for doing education about spread of this disease, even if the person doesn't accept the test.
LEHRER: What are they getting themselves in for?
Ms. GEBBIE: They're getting themselves in for some information they may or may not want. If the test is positive --
LEHRER: Why would they not want it?
Ms. GEBBIE: Some people would rather practice safe sex either way -- that is, they're already informed of the risks. One of the major reasons people don't want to find out about this test is that they don't want records kept about it, because of their fears of the potential discrimination. Other people just say, ''I'm taking my chances. Don't tell me this. '' They don't perceive themselves at risk, and they don't see that the test would be useful.
LEHRER: I think we need to make -- we need to clarify something. This test does not say this person has AIDS. What it says -- it has -- the person may have the AIDS virus, right, that may sometime develop some years down the road into AIDS. Is that correct?
Ms. GEBBIE: That's correct. It only tests for antibodies to the virus. We presume, however, from everything we know, that that means the person is infectious -- that is, capable of transmitting the disease to others and, therefore, needing to practice safer sex practices, make decisions about protecting other people.
LEHRER: Infectious, even though they may not have it themselves. Is that what you mean?
Ms. GEBBIE: That's correct. They're a symptomatic. They may have no clue that they have the disease. But they are a potential of being a danger to others. And some percentage of them -- perhaps as low as 20%, perhaps as high as 50% -- may at some point develop AIDS or AIDS Related Complex.
LEHRER: All right, the other category that's been mentioned is pregnant women. What's your feeling about that?
Ms. GEBBIE: If a pregnant woman has any reason to think she might have been exposed to the virus -- has had sexual partners whose history she does not know, has had -- or some bisexual partners who are infected, or has used IV drugs in the last seven years -- that woman probably should be tested, so that she can enter into delivery knowing the status of her child, because there is a strong possibility that that child may be born infected. Some women, knowing that, might make a decision early in the pregnancy about carrying it to term. I think a more vital group to get to are sexually active women who are not yet pregnant -- those who are at risk of becoming pregnant -- so that, knowing their antibody status, they can make informed decisions about whether or not to bear a child.
LEHRER: And how do you get to them, Ms. Gebbie?
Ms. GEBBIE: That means getting to those women at sexually transmitted disease clinics, at family planning clinics, through gynecologists, through family practitioners who see young women who are sexually active -- anyplace where women who are sexually active come to seek advice, counseling and physical examination. Persons should be prepared to explain about AIDS and HIV infection, to tell them about their potential for infection and, if they're infected, to offer them the test.
LEHRER: All right. Ms. Gebbie, thank you. We'll be back. Robin?
MacNEIL: Now we have the perspective of a man who has written and lectured widely on the ethical implications of the AIDS epidemic. He is Ronald Bayer, co director of the AIDS Project at the Hastings Center, a think tank in Hastings on Hudson, New York.
Mr. Bayer, Ms. Gebbie has been stressing the use of medical resources aspect of how it's appropriate and who it's appropriate to test. What do you think of the kinds of tests that have been discussed from an ethical point of view?

RONALD BAYER, Hastings Center: I think the overriding both public health and ethical consideration facing America today is how to interrupt the spread of this lethal virus, with its untold consequences for the next generations. And it seems to me that the talking proposals that have been put forth by the CDC -- at least those that involve premarital screening, the screening of all hospital admissions -- don't address the issue of heterosexual transmission in an appropriate fashion. They in a way present a posture of being aggressive and effective while, in fact, avoiding the more difficult and more long term tasks which lay ahead of us. And those involve methods of getting to the broad masses of the American people to teach them about how to protect themselves from infection by this virus and how to -- teach them how to protect others if they themselves are infected.

MacNEIL: In other -- do I understand it correctly? So all those people eminently qualified to meet later this month and talk about these things put on the table by the CDC will be talking about proposals that are posturing and not really seriously getting at the issue. Is that what you --

Mr. BAYER: I suspect that in laying out a range of proposals for discussion in Atlanta later this month, the intention of the CDC was to clear the air. Proposals for mandatory premarital screening have appeared in state legislatures across the country over the past couple of years and have been voted down uniformly. I think because it is recognized that focusing on premarital screening, though it appears to be a reasonable and rational and ethically justifiable way of interrupting the spread of this disease, is, in fact, not the way to do it.

MacNEIL: Why is -- let's take that one. Why is it not an ethically justifiable way of trying to control the disease when, for example, it's been commonplace in many states to screen for venereal disease before marriage licenses are issued.

Mr. BAYER: Well, as Kristine pointed out, in fact, many states have begun to reevaluate the use of premarital screening -- especially syphilis screening -- because they turn up so few cases. The misuse of public health resources, which are always in short supply, is, in fact, an ethical concern as well. Furthermore, when you make a decision to intrude upon the privacy of individuals, there has to be a good reason for that intrusion. The good reason in the case of AIDS is that it must bear some relationship to the interruption of the spread of this disease. If, in fact, the intrusion upon the privacy of a couple deciding to be married bears no relationship to the interruption of the spread of this disease, then what we have done is, we have intruded upon them. We've forced them to subject themselves to a test without doing very much for the public health. Furthermore -- and I think this is very important -- it creates the illusion that we are stopping the spread of the virus when, in fact, the virus is being spread not at the point just before marriage, but is, in fact, being spread in the hundreds and thousands -- and in fact, millions -- of sexual liaisons that occur before marriage.

MacNEIL: Okay. This country faces an almost unprecedented plague, if you like, from the AIDS disease -- certainly unprecedented since medical knowledge reached the stage it is. And it is a direct danger to the public health of this country and future generations. There is a test. The test is a clue to who's at risk and who might, as Dr. Gebbie said, spread the disease. Who are the appropriate groups to use that test on to be most effective in stopping the spread of the disease?

Mr. BAYER: The most appropriate use of the test at this point, outside of the context of blood donation centers, is in settings where it is an adjunct to counseling as an adjunct to getting people to alter and modify their behavior in a very profound and in long term ways. The test in and of itself is a technique. The question is, what do individuals do with the information they get as a

result of that test? We hope that those who take the test who are uninfected will double their efforts to remain uninfected. We hope that those who take the test and find out they are infected will use every bit of moral fiber to act in ways which will not result in the transmission of that virus to others. That is our only hope. It sounds like a very weak hope in the face of what everyone is characterizing as a major public health crisis of the last part of the 20th century -- a very kind of slender instrument for protecting American society against a devastating catastrophe. I think that Secretary Bowen may have exaggerated, perhaps for political, perhaps for purposes of appropriately alarming us, when he suggested that AIDS may dwarf the plague, which, after all, wiped out half the population of Europe. I think that appropriate targets of testing -- that is, the appropriate populations who should be encouraged to be tested -- are gay men who have not been able to alter their behavior, women who have been exposed -- who may have been exposed through intravenous drug use who are considering pregnancy. I think there are strong reasons to screen prostitutes, both male and female, who are picked up on prostitution charges. There are reasons for heterosexual couples where both individuals have led very sexually active lives to discuss this matter and undergo screening. But since the critical issue is a modification of behavior, not the result of the test, it is critical to get people to come to the test voluntarily, rather than under conditions of coercion.

MacNEIL: Thank you. Jim?

LEHRER: Ms. Gebbie in Portland, Oregon, do you agree with his list and his prescription?

Ms. GEBBIE: Yes. I think he's outlined very well both the critical problem and the groups of people most appropriate to be tested. I can't emphasize enough that issue of behavior change. But this epidemic is clearly preventable if people stop doing those acts that can spread the virus from one person to another. That takes a very great amount of personal introspection and consideration of how I choose to express my affection for other people or what I do for recreation or what I do to get a high or all of those things. And we have not been terribly successful in this country at getting people to change behavior around many other things that are less deadly than this particular disease. We're going to have to do a lot more exploration of how to use our skills in education, counseling, support, to get those changes to happen.

LEHRER: If those changes do not happen, do you see somewhere down the line that these broad population tests are going to have to be done -- that the public pressure and the political pressure is going to lead right to it?

Ms. GEBBIE: Again, I think there will be a lot of interest in the test. The test looks very good to people. It starts to resemble the magic bullet that we've come to expect for diseases. I think by talking so much about the test, we somehow mislead people into thinking, if we test everybody, that will cause them to change something. Whereas, in fact --

LEHRER: You don't think it will? You don't think it will?

Ms. GEBBIE: I don't think the test in and of itself changes much of anything. And if you talk with people who are involved in the settings where the test is provided, it's very clear that the behavior change is associated with the extensive counseling and support before and after the test and that it's only for a percentage of the people that the actual test result is what makes the magic difference. The lure of the test may be something that gets them in the door. And that's why we need to make sure the test is readily available for those groups at highest risk and not divert our resources into pushing the test where virtually the virus currently isn't, because it won't accomplish that.

LEHRER: Mr. Bayer, is one of the results of a testing -- an extensive testing program going to lead to isolation and quarantine? Is that the next step?

Mr. BAYER: I think that's the grave concern. The grave concern is that the mass use of the test, where there's no real relationship to counseling and the modification of behavior, is the identification of those who are, in the language of some alarmists, the Typhoid Marys of the latter part of the 20th century. Those individuals will be identified and potentially isolated. The calls for isolation and quarantine thus far have really only come from the lunatic fringe of the political spectrum in the United States. There is not a responsible public health official in this country who talks about mass isolation or mass quarantine. Where the issue is raised -- and it's an issue that public health officials talk about privately and where there is enormous concern -- is what to do about individuals who are identified as carrying the virus but who continue to behave publicly in ways that reflect a lack of concern for whether or not the virus is being spread -- male and female prostitutes, for instance, who continue to act as prostitutes, despite the fact that they're infected.

LEHRER: Let me ask you this, though, Mr. Bayer. You mentioned -- you used the word politics a moment ago. Political, you said -- a particular decision, a particular statement. You used the word alarmist, etc. We live in a real world. How many people are going to have to die -- let's say the education programs and things that you and Ms. Gebbie and others support don't work. How many people are going to have to die before something -- whether it's mass testing and quarantine, isolation, or something drastic -- is going to have to be done?

Mr. BAYER: The modification of the course of this epidemic is not going to be affected by Draconian measures like mass quarantine and isolation, even if we could consider undertaking such programs within the norms of a constitutional, liberal democracy. The sheer impracticality of trying to identify and round up close to 2 million people, isolate them, control them -- not for a brief -- you know, people think of isolation and quarantine the way they think about scarlet fever. In the old days, the health officer put a sticker on the door. It was there for two weeks, and that was that. This is a virus that infects an individual and, as far as we know, results in lifelong infection. So when we speak about isolation and quarantine, we have to be very clear. This means lifelong isolation and quarantine -- certainly something that would tear at the fabric of American society, and without, I think, really having a demonstrable impact on slowing the spread of this disease.

LEHRER: Mr. Bayer, thank you. Robin?

AIDS: Coverage ControversyMacNEIL: Another area obviously affected by the AIDS crisis is the insurance industry. Parts of that industry want people tested for AIDS before issuing health and life insurance policies. But that proposal has met with strong opposition. We have a report now about how one state, Wisconsin, is grappling with the issue. It's narrated by David Iverson of public station WHA in Madison.

DAVID IVERSON [voice over]: Sue Dietz is the executive director of the Milwaukee AIDS Project, a place where the numbers of AIDS cases become people instead of statistics and the costs a financial reality.

SUSAN DIETZ, Milwaukee AIDS Project: Insurance or public assistance never pays for all of the cost. It doesn't for anyone -- not just AIDS, but for any kind of illness that's like this.

IVERSON [voice over]: The number of AIDS patients continues to grow, and so do the costs. The average bill now stands at $147,000 per patient. And insurance companies are worried about both the mounting number of cases and the mounting costs of potential AIDS claims. Dr. Robert Gleason is the associate medical director for Northwestern Mutual Life in Milwaukee. The company says it has already paid almost $6 million in AIDS death claims and anticipates more.

Dr. ROBERT GLEASON, Northwestern Mutual Life: Using the 20% figure, you can arrive at a mortality of 2,600% for simply being an a symptomatic, infected carrier of the virus. Now, some companies around the country have tried to price this mortality. They have looked at this and said, ''What would we have to charge somebody who is antibody positive?'' And we can't do it.
IVERSON [voice over]: Northwestern's Gleason is blunt. AIDS patients are simply not a good risk.
Dr. GLEASON: When you think you're going to die, there is a wonderful incentive to buy life insurance. You get a fabulous return on your dollar. Unfortunately, the system can not work if that's the way the game is played.
IVERSON [voice over]: But insurance companies would obviously like to find a new system. The problem is that right now the state won't let them. Wisconsin, along with New York and Washington D. C. , does not allow insurance companies to conduct tests that would screen out potential AIDS claimants and possibly discriminate against those whose lifestyle puts them at risk. The debate over who pays for AIDS has now come to the legislature. The anti discrimination statute is under review. Insurance companies, along with many legislators, believe a compromise is necessary.
BETTY JOE NELSON, state representative: The issue is who's going to pay.
IVERSON [voice over]: State Representative Betty Joe Nelson, the new Republican minority leader in the state assembly.
Ms. NELSON: Do you want to have a hidden tax in your insurance policy to cover the cost of very severe, long term patient care, or do you want it to be up front -- an issue that the state takes care of? And that's the dilemma.
IVERSON [voice over]: Other legislators want to make sure that discrimination against all high risk groups will not occur if insurance companies are allowed to test.
DAVID CLARENBACH, state representative: We would like to see Wisconsin's insurance code specifically prohibit any form of discriminatory application of this HTLB3 antibody test. And I don't think --
IVERSON [voice over]: State Representative David Clarenbach, author of Wisconsin's anti discrimination statute.
Mr. CLARENBACH: We as a society -- certainly we as a state -- are ill prepared to care for these AIDS victims.
IVERSON [voice over]: Clearly, there are problems with public or private support for those who have AIDS. It is only the latest and surely not the last societal question about the spread of this insidious disease. Who will pay?
MacNEIL: Joining us now to discuss the problems of paying for AIDS treatment and the question of AIDS testing for insurance, we have Robert Waldron. He's director of the New York offices of the American Council of Life Insurance and of the Health Insurance Association of America.
Mr. Waldron, first of all, does the insurance industry as a whole think it should not pay for AIDS treatment?
ROBERT WALDRON, insurance industry representative: Oh, not at all. Any of our policy holders who are currently policy holders and who are now putting in claims, we will, of course, pay those claims. The problem with insurance -- especially individual insurance in the private marketplace -- is that you can not sell it to someone after they become ill. If you do that, the system breaks down. And that's been acknowledged all throughout the whole system by politicians who have been dealing with this and by consumerists also. There are other areas in the health insurance and the life insurance system where you do not have to pass a medical examination.
MacNEIL: In fact, most health insurance is group insurance, is it not, and there are no medical tests for group insurance.
Mr. WALDRON: That's exactly so.

MacNEIL: What is the percentage?
Mr. WALDRON: About 85% of all health insurance is group insurance. And I would imagine about 90% of the under 65 population is covered by some form of group insurance.
MacNEIL: Let's go to the personal -- the individual who wants to buy individual insurance, because he isn't part of a group. Does the insurance industry now, in states other than where it's prohibited, require an AIDS test for health insurance?
Mr. WALDRON: Many companies do. We have not surveyed all of the companies, and there are quite a few out there. But many companies do, and most companies feel they have to. Otherwise, they are subject to raids on their funds by people who have already become sick.
MacNEIL: And do they refuse health insurance to the people who test positive?
Mr. WALDRON: Those who are using the tests, yes. They are refusing it.
MacNEIL: Let's move on to life insurance. The industry wants to test people who apply for life insurance -- test them for AIDS. Is that correct?
Mr. WALDRON: They want to test for the antibody.
MacNEIL: Is that an industry wide policy?
Mr. WALDRON: That's the position of the industry. And we've asserted this in any number of settings. Many companies are already testing in those states where it's permitted. The industry feels that if you can not, you are, again, subject to raids by people who are speculating that they're going to die very, very soon. And the test procedure that we're using is not just a simple test. We are using a series of tests. And as has been stated before in the program, if you use a single test on a broad, uninfected, un risked -- or risk free population -- you are going to get a lot of false positives. You can't refuse insurance when --
MacNEIL: So you do three tests to make sure.
Mr. WALDRON: We do three. We do two ELISSA tests. And then to confirm the results of that second ELISSA test, we do a western blot test, which actually weighs the antibody molecularly, and it is very, very specific. It doesn't signal positive for anything but AIDS.
MacNEIL: Does the industry typically now refuse life insurance to people who test positive?
Mr. WALDRON: Those companies that are using the test, they do indeed.
MacNEIL: Does anybody grant life insurance to people who test positive?
Mr. WALDRON: I don't think so. I have not heard of anyone trying to insure or trying to put a price on life insurance for that kind of risk. We can insure people who are ill or have had illnesses, and sometimes very severe illnesses. We can insure probably people who are seven times less healthy than the standard population. But we can't insure people who are more than 50 times less healthy than the standard population. We're talking probabilities now. We never know who's going to live or die, but we do know how many and when when we have appropriate risk groups.
MacNEIL: Are there any places where you are prohibited from testing people for life insurance policies?
Mr. WALDRON: We are prohibited absolutely from testing anybody for the AIDS antibody or even testing the immune system in Washington D. C. Nowhere else is there such a prohibition. In Wisconsin, we can test the immune system. While that is not AIDS specific, it nevertheless will tell us who is very sick. If someone's immune system is impaired, they're open to opportunistic disease. And we can do that also in California. Nowhere else has there been a ban passed.
MacNEIL: Let's bring our other guests in here. Mr. Bayer, as an ethicist, what do you think of the insurance industry's posture on this?
Mr. BAYER: I would like to make a distinction between life and health

insurance. I think it's very important.
MacNEIL: Let's discuss them separately, then.
Mr. BAYER: Let's turn first to the issue of health insurance. The United States and all Western democracies has chosen to insure its population against the cost of illness, to the extent that it does insure its population against the cost of illness, basically through the private sector -- either the blues or other insurance carriers. The insurance industry, therefore, is a private industry serving a social function. It seems to me that to allow health insurance companies to screen individuals for the AIDS antibody as a way of either denying them insurance or of increasing their premiums, perhaps prohibitively, suggests that those who are at risk for developing AIDS must either bear the cost of illness themselves or must become wards of the state -- the welfare system -- after they have depleted all their resources. In a way, that's almost the way we treat the elderly. When they run out of all of their resources in nursing homes, we make them Medicaid eligible. Why is this unfair? Why is this unjust? I believe that all Americans ought to have access to all the health care that they need. And I don't believe that their financial ability should be a barrier to that health care. By allowing insurance companies to discriminate against those who carry --
MacNEIL: But can we bring it to the present? This has been debated a number of times, and so far the political consensus in this country hasn't supported that position. With the situation the way it is now, is the -- what do you think of the insurance industry's posture?
Mr. BAYER: The insurance -- by the way, I will say that the insurance industry often says, ''We don't want to treat AIDS any differently -- or HIV infection -- any differently than the way we treat other medical conditions which place individuals at extremely high risk for very expensive illness. '' And I think the industry is speaking truthfully when it says that. I think what the issue of AIDS forces us to confront is a very fundamental question. Ought individuals at high risk for illness be barred from protection of health insurance?
MacNEIL: Let's get Dr. Gebbie's position on this -- on the health insurance issue.
Ms. GEBBIE: Well, clearly, what AIDS has done is highlight a fundamental problem in our system of paying for illness care. Some way or another, our whole social system pays. And if persons can not pay for it by using a privately purchased health insurance program of some kind, we're going to pay for it through our bills for unpaid hospital bills or through our welfare system. These -- the bills so far run up for AIDS, while they look rather large per patient, are in fact not larger than the individuals run up by very high risk newborns who need multiple surgeries, persons with cancer who have long term therapy. It is the specter of adding somebody new to the groups that are difficult to insure that has forced the discussion and may, in fact, force a change in the social ideas that you rightly point out have not gotten very far in the last 50 years in this country.
MacNEIL: And what you're saying on behalf of the insurance industry is, ''Yes, that's going to be the case. We can't --'' you're saying, ''We can't insure without wrecking our system. ''
Mr. WALDRON: Wrecking a number of individual companies. The weight would fall unevenly. But I would hate to be placed in the position --
MacNEIL: And the cost will have to go onto society is what you're saying.
Mr. WALDRON: No, not necessarily. There are ways of sharing these costs differently. Everyone is going to have to pay, obviously. The insurance business is going to be paying through its group mechanisms and going to be paying very dearly. The life insurance business also has a group system.
MacNEIL: Are people -- excuse me. I keep interrupting you, but thoughts occur

to me. Are people who -- the great majority of Americans -- employed Americans who are part of group health insurance plans -- are those plans and their benefits going to change as a result of AIDS disease? Are the costs of those plans going to go up?
Mr. WALDRON: The costs of those plans are obviously going to go up. Are they going to change? That will be a matter of choice by employers when they start to get pressed up against the wall by these things. But it hasn't happened yet, and we don't expect it will happen in the very near future. Excuse me. I do wish I could finish this point. The point is that there are systems for sewing up the seams in this plural system of health insurance that we have -- government takes care of some of it, the private sector takes care of most of it. And there are other types of plans that can be brought into play. It was mentioned before about the elderly and long term care. Well, we support mechanisms that would make things happen for that very uncovered area. There is talk about risk pools in states that would cover all of the uninsurables, including AIDS patients, provided those risk pools would share the assessments they would need equally among all of the payers. Otherwise, in a competitive society, one of those payers is going to take it in the neck and go down the drain, and we think it might be us. But we'll support risk pools if they can be made --
MacNEIL: Can you make your point briefly?
Mr. BAYER: I think one of the things to point out is about half of the American workers are employed in so called self insured systems. That is, the employer himself pays the full cost of whatever health benefits he provides to his workers. That means that every employer in such a situation has an interest in not hiring an individual who might stress the benefit plan.
MacNEIL: We have to leave this discussion there. We will watch with interest what happens at the conference of the CDC. Dr. Gebbie, thank you for joining us. Mr. Bayer, Mr. Waldron in New York, thank you. We asked the CDC to be with us tonight, and they declined.

Iraq: Nation at War

LEHRER: The Iran Iraq War is still the war that never ends, and information about it is still as hard to come by now as when it started six and a half years ago. But in recent weeks, both Iran and Iraq have allowed Western journalists in to have a look at their respective home fronts. Our update report tonight is from Iraq. You should know it had to be cleared by Iraqi censors. The reporter is Sheila MacVicar of the Canadian Broadcasting Corporation.

SHEILA MacVICAR [voice over]: In the markets of the old city of Baghdad, there are few visible signs of a seven year old war. Soldiers may patrol the street, but here, several kilometers from the main battle zone in the south, they are relaxed. That doesn't mean the war is forgotten. Even men above the age for conscription say they too would go to fight. If his country wants him, he says, he would close his antique shop and join the army. Everywhere, there is talk of the war with Iran -- a war the Iraqis say is a just war.
IRAQI [through translator]: We are thinking about the war, because we don't like the war. But we are part of this country.
MacVICAR [voice over]: The Iraqis know that there are reports of shortages in Iran. But here, the shops are full. There is lots to buy and, most importantly, still plenty of food. Some things aren't available, but the Iraqi government has made sure that even expensive imported goods are still on the shelves. By itself, that's an impressive but necessary feat for a country caught in a

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1. The National Journal, November 28, 1992, HEALTH; Vol. 24, No. 48; Pg. 2723, 2708 words, Attacking AIDS, BY JULIE KOSTERLITZ

2. Copyright (c) 1989 The Times Mirror Company; Los Angeles Times, September 18, 1989, Monday, Home Edition, Part 1; Page 14; Column 1; National Desk, 1095 words AIDS PANEL TO AIM FOR COMPASSION; MYTHS OF SPREADING DISEASE MUST END, CHAIRWOMAN SAYS, By MARLENE CIMONS, Times Staff Writer, WASHINGTON, LEAD: In the fall of 1985, when there were about 14,000 diagnosed cases of AIDS in the nation and most Americans were just beginning to grasp the implications of the growing and deadly scourge, a woman little known outside the public health community delivered a speech that moved many in her audience to the brink of tears., Profile; List

3. Facts on File World News Digest, August 5, 1988, UNITED STATES; AIDS, Pg. 573 A3, 402 words, Reagan Sidesteps Own Commission

4. Copyright (c) 1988 The Times Mirror Company; Los Angeles Times, August 3, 1988, Wednesday, Home Edition, Part 1; Page 1; Column 4; National Desk, 1048 words, REAGAN REJECTS FEDERAL AIDS ANTI-BIAS LAW, By ERIC LICHTBLAU, Times Staff Writer, WASHINGTON, LEAD: President Reagan, putting off judgment on the central recommendation of the presidential AIDS commission, decided Tuesday not to endorse an expansion of federal anti-discrimination laws to offer greater protection to those afflicted by the deadly disease.

5. Copyright (c) 1988 The Washington Post, August 3, 1988, Wednesday, Final Edition, FIRST SECTION; PAGE A1, 830 words, Reagan Turns Aside AIDS Panel Report; More Study of Antibias-Law Proposal Ordered; OPM Rules Adopted, Sandra G. Boodman, Washington Post Staff Writer, LEAD: President Reagan yesterday declined to embrace many of the recommendations contained in the report of his advisory commission on AIDS, including its key proposal for a new federal law barring discrimination against people infected with the virus., NATIONAL NEWS

6. Facts on File World News Digest, June 24, 1988, MISCELLANEOUS; AIDS, Pg. 469 C2, 480 words, U.S. Panel Endorses Ban on Bias

7. Copyright (c) 1988 The New York Times Company; The New York Times, June 18, 1988, Saturday, Late City Final Edition, Section 1; Page 6, Column 1; National Desk, 1104 words, AIDS Panelists Vote to Expand Anti-Bias Law, By PHILIP M. BOFFEY, Special to the New York Times, WASHINGTON, June 17, LEAD: A bitterly divided Presidential AIDS commission today narrowly endorsed an anti-discrimination proposal that its chairman called ''the key issue in the entire report'' to be delivered shortly to President Reagan.

8. Copyright (c) 1988 The Times Mirror Company; Los Angeles Times, June 8, 1988, Wednesday, Home Edition, Part 1; Page 6; Column 1; National Desk, 707 words, SOME AIDS PANELISTS OPPOSE HEALTH EMERGENCY PLAN, By MARLENE CIMONS, Times Staff Writer, WASHINGTON, LEAD: Members of the presidential AIDS commission Tuesday tentatively endorsed the major draft recommendations released last week by their chairman, Adm. James D. Watkins, particularly the proposal to expand anti-discrimination legislation to protect AIDS patients and those infected with the virus.

9. Copyright (c) 1988 The Washington Post, June 7, 1988, Tuesday, Final Edition, HEALTH; PAGE Z14; COVER STORY, 3852 words, SETTING THE COURSE ON AIDS; HOW AN ADMIRAL TURNED AROUND THE PRESIDENT'S AIDS COMMISSION, Sally Squires,

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Washington Post Staff Writer, LEAD: On the surface, this silver-haired retired Chief Naval Officer who helped design Star Wars seems an unlikely warrior against an epidemic -- particularly one as controversial as AIDS. But it's this former member of the Joint Chiefs, this straight-arrow Annapolis graduate, this devout Catholic who joined a senior officer prayer group at the Pentagon and is the father of six children -- a man who has been urged to run for Senator in two states but is so outspoken that he has been nicknamed "Radio Free Watkins" -- this is the one who emerged last week as the newest hero in the battle against, BIOGRAPHY, FEATURE, NATIONAL NEWS

10. Copyright (c) 1988 The Washington Post, June 7, 1988, Tuesday, Final Edition HEALTH; PAGE Z16; COVER STORY, 539 words, Panel Members, Sally Squires, LEAD: Adm. James D. Watkins released his recommendations for the final report of the AIDS commission last week, and now 12 other commissioners will have a crack at offering amendments to the report. The final version goes to the President on June 24., LIST

11. Copyright (c) 1988 The Times Mirror Company; Los Angeles Times, June 3, 1988, Friday, Home Edition, Part 1; Page 1; Column 5; National Desk, 1460 words, AIDS PANELIST URGES STRONGER ANTI-BIAS LAW, By MARLENE CIMONS, Times Staff Writer, WASHINGTON, LEAD: Calling discrimination "the most significant obstacle to controlling the epidemic," the chairman of the presidential AIDS commission Thursday issued an exceptionally strong plea for expanded anti-discrimination legislation to protect those suffering from the deadly disease, as well as those infected with the AI

12. Copyright (c) 1988 The Washington Post, June 3, 1988, Friday, Final Edition, FIRST SECTION; PAGE A1, 1216 words, Commission's Chief Faults AIDS Response; Antibias Laws Urged; Mandatory Testing Hit, Sandra G. Boodman, Washington Post Staff Writer, LEAD: The chairman of the president's AIDS commission yesterday called for sweeping new measures to fight the AIDS epidemic that would cost billions of dollars and repudiate many policies of the Reagan administration., NATIONAL NEWS

13. Copyright (c) 1988 The Times Mirror Company; Los Angeles Times, March 1, 1988, Tuesday, Home Edition, Part 1; Page 19; Column 1; National Desk, 1116 words, FIRST POLICY STATEMENTS CREATE OPTIMISM AIDS PANEL WILL ACHIEVE SOUND STRATEGY, By MARLENE CIMONS, Times Staff Writer, WASHINGTON, LEAD: When the presidential AIDS commission was created last summer, it was immediately dismissed by many in the public health community and elsewhere as a political gesture by the Reagan Administration that would do little, if anything, about the deadly and burgeoning epidemic.

14. Copyright (c) 1988 The Times Mirror Company; Los Angeles Times, February 25, 1988, Thursday, Home Edition, Part 1; Page 1; Column 3; National Desk, 1047 words, AIDS PANELIST URGES $2 BILLION TO FIGHT DRUGS, By MARLENE CIMONS, Times Staff Writer, WASHINGTON, LEAD: In the first of a series of recommendations for creating a national AIDS strategy, the chairman of the presidential AIDS commission Wednesday proposed a dramatic expansion of anti-drug abuse programs to provide treatment for addiction to all intravenous drug users who seek it.

15. Copyright (c) 1988 The Washington Post, February 20, 1988, Saturday, Final Edition, EDITORIAL; PAGE A21; FREE FOR ALL, 691 words, The AIDS Commission: What Secrecy?, LEAD: Over here at the Presidential Commission on the HIV Epidemic (a.k.a. the AIDS Commission) there were belly laughs all around when we read

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Jack Anderson's Feb. 11 column, "AIDS Panel Cloaked in Secrecy." We all ran out to buy trenchcoats at lunchtime., LETTER

16. Copyright (c) 1987 The New York Times Company; The New York Times, November 25, 1987, Wednesday, Late City Final Edition, Section B; Page 11, Column 2; National Desk, 277 words, Leaders Debating AIDS Tests, AP, WASHINGTON, Nov. 24, LEAD: The chairman of the American Medical Association and a member of the President's AIDS commission debated today the wisdom of widespread mandatory testing to determine if people are infected with the AIDS virus.

17. Facts on File World News Digest, November 13, 1987, MISCELLANEOUS; People, Pg. 856 A2, 631 words

18. Copyright (c) 1987 Chicago Tribune Company; Chicago Tribune, November 12, 1987, Thursday, NATIONAL EDITION, NEWS; Pg. 5; ZONE: C Division 1-A independents 354 words, AIDS COMMISSION GETS NEW MEMBERS, LEAD: President Reagan has appointed two well-regarded health-care officials to fill vacancies created by resignations on the Presidential Commission on AIDS, which has been sued for failing to have members who have AIDS or who work directly with the disease.

19. Copyright (c) 1987 The Bureau of National Affairs, Inc.; Daily Report For Executives, November 12, 1987, Thursday, CONGRESSIONAL AND PRESIDENTIAL ACTIVITY; LEGISLATIVE CALENDAR; President; DER No. 217; Pg. A-21, 351 words, 100th Congress, First Session Tuesday, November 10, 1987

20. The Associated Press, November 11, 1987, Wednesday, PM cycle, Domestic News, 380 words, Chairman: Panel Is Revitalized And Ready To Prove Critics Wrong, By A.J. DICKERSON, Associated Press Writer, WEST PALM BEACH, Fla., AIDS Commission, LEAD: The often-criticized presidential AIDS commission has been revitalized and will be able to fulfill its mission of advising the White House on how to cope with the disease, its chairman says.

21. The Associated Press, November 11, 1987, Wednesday, PM cycle, Washington Dateline, 104 words, Vacancies On AIDS Panel Filled, WASHINGTON, Washington in Brief, LEAD: The presidential commission on AIDS is back up to a full complement of 13 members now that President Reagan has filled two vacancies created by resignations.

22. Copyright (c) 1987 Chicago Tribune Company; Chicago Tribune, November 11, 1987, Wednesday, SPORTS FINAL EDITION, NEWS; Pg. 18; ZONE: C, 324 words, AIDS PANEL SUBSTITUTES ANNOUNCED, LEAD: President Reagan Tuesday announced the appointment of two well-regarded health-care officials to fill vacancies created by resignations on the Presidential Commission on AIDS, which has been sued for failing to have members who have AIDS or who work directly with the disease.

23. Copyright (c) 1987 The Times Mirror Company; Los Angeles Times, November 11, 1987, Wednesday, Home Edition, Part 1; Page 13; Column 1; National Desk, 616 words, DRUG, HEALTH EXPERTS PUT ON AIDS PANEL, #NEXE# , By MARLENE CIMONS, Times Staff Writer, WASHINGTON, LEAD: The White House, attempting to bring its beleaguered AIDS commission back to full strength, named two new members Tuesday to fill the vacancies created by the resignations last month of its chairman and vice chairman., #077T910108SEXEA02#

24. Proprietary to the United Press International 1987, November 11, 1987, Wednesday, BC cycle, Regional News, Oregon, 502 words, FORT LAUDERDALE, Fla.,

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Aidspanel-Oregon, LEAD: Oregon Health Division Administrator Kristine Gebbie said she thinks a controversial presidential commission on AIDS to which she was appointed has a commitment to ''getting down to work.''

25. The Associated Press, November 10, 1987, Tuesday, AM cycle, Domestic News, 562 words, Panel Looks at Florida's AIDS Problem, Expects to Meet Deadline, By A.J. DICKERSON, Associated Press Writer, WEST PALM BEACH, Fla., AIDS Commission, LEAD: The chairman of the president's AIDS commission said during a fact-finding trip to Florida on Tuesday the panel has put controversy behind it and will finish an interim report by its Dec. 7 deadline.

26. Proprietary to the United Press International 1987, November 10, 1987, Tuesday, AM cycle, Regional News, Florida, 712 words, By LAURA L. MYERS, BELLE GLADE, Fla., Aids, LEAD: AIDS victims and medical officials told a presidential commission Tuesday that the incurable disease has hit this farming community hard, straining its ability to attract doctors and money.

27. Proprietary to the United Press International 1987, October 8, 1987, Thursday, PM cycle, Washington News, 367 words, Dismay greets two AIDS commission resignations, WASHINGTON, Aidspanel-React, LEAD: Resignations by the two top presidential AIDS commission members are ''disastrous,'' say organizations representing state health officials, business leaders and religious associations.

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**********00672**********

LEVEL 1 - 1 OF 25 STORIES

The Associated Press

June 16, 1988, Thursday, AM cycle

SECTION: Washington Dateline

LENGTH: 510 words

HEADLINE: Panel Recommends that NIH Get Greater Autonomy

BYLINE: By JERRY ESTILL, Associated Press Writer

DATELINE: WASHINGTON

KEYWORD: AIDS Commission

BODY:

The White House AIDS commission recommended Thursday that the National Institutes of Health be given much greater autonomy within the federal health bureaucracy to deal with diseases such as AIDS.

Although adoption of the specific language that will go into the final report to President Reagan was postponed until Friday, the members agreed unanimously with the concept outlined by Dr. Burton James Lee III of the Memorial Sloan-Kettering Cancer Center in New York City.

"As a clinical researcher in cancer medicine, I have worked with the NIH all of my professional life and it is my strong view that NIH has been unable to function as effectively as it could simply because the mechanisms are buried under so much bureaucracy," Lee told his fellow commissioners.

Lee said he would like to see NIH "cut loose" from the Department of Health and Human Services and made an independent agency much like the National Science Foundation.

As a compromise, however, the proposal for which he won approval calls for the president to direct that the NIH director report directly to the HHS secretary, rather than to subordinates in the department, for a two-year trial period and that the NIH chief have broad discretionary budget and personnel authority during the same period.

Lee said if that change in procedure resulted in greater flexibility for NIH to "achieve its scientific mandate, it shall become permanent." Otherwise, he said, Congress should then consider giving NIH a more independent status.

James D. Watkins, chairman of the commission and a strong supporter of Lee's proposal, emphasized that the change would not alter the requirement for the National Institutes of Health to win its allocation from Congress in competition with other government needs.

Nor, he said, would it give the NIH director power to shift funds from one institute to another _ from the National Institute on Aging, for example, to the National Cancer Institute.

Watkins said the main idea was to insulate the NIH director _ now Dr. James B. Wyngaarden _ from having to clear internal personnel and spending priorities with several layers of bureaucrats at HHS and, especially, at the Office of Management and Budget.

Kristine M. Gebbie of Oregon, head of the Association of State and Territorial Health Officials' AIDS Committee, asked whether the object of the Lee proposal was to "bomb the OMB."

"That's not a bad idea," said Watkins, a retired admiral and chief of Navy operations, adding that OMB has been the government's "surrogate health secretary for too long."

"We're saying, 'Get out of the business,"' he continued. "You don't know what you're doing."

Although he supported the proposal in the end, William B. Walsh, president of Project HOPE, expressed concern that the commission had not heard from OMB on the matter.

Watkins shot back that OMB officials had declined to testify before the commission or to allow its employees to answer questions from the commission staff.

"Under those circumstances, we can say what we please," said Watkins.

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LEVEL 1 - 8 OF 30 STORIES

June 18, 1988, Saturday, Late City Final Edition

SECTION: Section 1; Page 6, Column 1; National Desk

LENGTH: 1104 words

HEADLINE: AIDS Panelists Vote to Expand Anti-Bias Law

BYLINE: By PHILIP M. BOFFEY, Special to the New York Times

DATELINE: WASHINGTON, June 17

BODY:

A bitterly divided Presidential AIDS commission today narrowly endorsed an anti-discrimination proposal that its chairman called ''the key issue in the entire report'' to be delivered shortly to President Reagan.

Only 7 of the 12 members present supported the proposal that a Federal law prohibiting Government-supported programs from discriminating against the handicapped, including persons who have AIDS or carry the AIDS virus, be expanded to include the private sector.

The issue was the most contentious debated at today's final deliberations by the 13-member commission on its report. The report, due to be delivered to the President on June 24, contains almost 600 recommendations for coping with the AIDS crisis.

The Arguments, Pro and Con

In a debate that was open to the public, the supporters of the anti-discrimination proposal said it was necessary if individuals were to be persuaded to obtain testing for infection with the AIDS virus, and said the proposal was consistent with existing legislation protecting the handicapped against discriminatory actions.

Opponents of the proposal complained that it would force businesses to hire people who carry the AIDS virus, thus driving up the cost of insurance and exposing both business owners and landlords to possible litigation by infected individuals.

Virus carriers are often healthy for years, but have a high chance of eventually developing acquired immune deficiency syndrome, scientists believe.

Priority Areas Approved

The commission also approved a draft executive summary that highlighted 20 high-priority areas among its recommendations. The list included suggestions that the nation concentrate on dealing with the total spread of the AIDS virus and not simply with the extent of full-fledged AIDS disease.

Other proposals included the following:

* That public health authorities be required to notify the sex partners of infected individuals so that they, too, could obtain AIDS blood tests.

* That the intravenous drug abuse problem become ''a top national priority.''

* That the National Institutes of Health be given greater administrative freedom to conduct and set research priorities to find drug treatments and vaccines to combat AIDS.

* That health education be instituted in kindergarten and extend through the 12th grade.

A potentially controversial proposal approved today recommended that doctors and other health care personnel be required to report to state health officials on a confidential basis the names of all individuals who are found infected with the AIDS virus.

In no case, however, would the names of the infected individuals be released either to the sexual contacts of the infected person or to other Governmental agencies, like the Federal Centers for Disease Control. A few states already require reporting of virus carriers, but most only require reporting of actual AIDS cases and much of the nation's testing for the infection is on an anonymous basis, which would make any reporting of names highly incomplete.

How Members Voted

The commissioners voting in favor of the anti-discrimination proposal included the chairman, James D. Watkins, a retired Admiral; Dr. Colleen Conway-Welch, a nursing dean at Vanderbilt University; John J. Creedon, president and chief executive of Metropolitan Life Insurance; Kristine M. Gebbie, administrator of the Oregon health division;Dr. Burton J. Lee 3d, a physician at Memorial Sloan-Kettering Cancer Center in New York; Dr. Frank Lilly, chairman of genetics at the Albert Einstein College of Medicine, and Dr. Beny Primm, executive director of the Addiction Research and Treatment Corporation in Brooklyn.

Those declining to vote for the proposal included Dr. Theresa L. Crenshaw, a sex therapist from San Diego; Richard M. DeVos, president of the Amway Corporation; Penny Pullen, Republican leader of the Illinois House; Dr. Cory SerVaas, editor and publisher of The Saturday Evening Post, and Dr. William B. Walsh, the head of Project HOPE, a medical relief organization.

The AIDS commission, officially called the Presidential Commission on the Human Immunodeficiency Virus Epidemic, was established by President Reagan last year to advise the nation on measures needed to confront the disease.

The Chairman, Admiral Watkins, had previously presented his own draft report and recommendations. Subsequently, the commissioners have amended some provisions in the chairman's report. Until today, with the outbreak of dissent over the call for a strong Federal anti-discrimination statute, there had been little serious disagreement on major issues being pressed by the Chairman.

John Cardinal O'Connor, Roman Catholic archbishop of New York City, had to leave the meeting early. He left his proxy vote to Admiral Watkins who voted it in favor of the anti-discrimination proposal, making the final vote 8 to 5 in

favor.

Proposal Tied to Disability Bill

The supporters of the anti-discrimination proposal stressed that it is similar to a bill proposed by the Presidentially appointed National Council on the Handicapped in a report last January to Mr. Reagan. The Handicap Council proposal was recently introduced into the Congress and has been co-sponsored by Republican Senator Bob Dole.

The commission in essence is proposing to broaden and extend Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against persons with disabilities by any institution receiving Federal financial assistance.

That law has been interpreted to cover individuals suffering from AIDS or who carry the AIDS virus.

Supporters of the anti-discrimination proposal stressed that they were not seeking special privileges for those who carry the AIDS virus, but rather to provide protection against discrimination to all handicapped people.

The opposition to extending Section 504 to cover the private sector was led initially by Dr. Walsh. He said that he was not in favor of discrimination but preferred a proposal that would simply urge the President as well as state leaders to speak out in favor of protecting the civil rights of infected individuals, while leaving legislative remedies to the local level.

Commissioner SerVaas suggested that the provision ''might be hurting the very people we're trying to help'' because small businesses such as hairdressing salons might be bankrupted if a significant fraction of their employees became infected.'' Other commissioners noted, however, that as with all civil rights laws, small businesses with fewer than 15 employees were exempted from provisions of Section 504.

GRAPHIC: Photo of Adm. James D. Watkins, chairman of the Presidential AIDS commission (AP)

SUBJECT: ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS); LAW AND LEGISLATION; FEDERAL AID (US); HANDICAPPED

ORGANIZATION: AIDS, PRESIDENTIAL COMMISSION ON

NAME: BOFFEY, PHILIP M

GEOGRAPHIC: UNITED STATES; UNITED STATES

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LEVEL 1 - 2 OF 3 STORIES

June 2, 1988, Thursday, Late City Final Edition

SECTION: Section A; Page 1, Column 2; National Desk

LENGTH: 1443 words

HEADLINE: EXPERT PANEL SEES POOR LEADERSHIP IN U.S. AIDS BATTLE

BYLINE: By PHILIP M. BOFFEY, Special to the New York Times

DATELINE: WASHINGTON, June 1

BODY:

A committee of experts appointed by the National Academy of Sciences today strongly criticized ''the absence of strong Federal leadership'' in the fight against the AIDS epidemic, which was first recognized seven years ago.

The panel predicted that well over $1 billion a year might soon be needed to finance public health and education measures to curb the epidemic.

In a reflection of the growing sense of urgency over the still unchecked spread of the deadly disease among intravenous drug users, their sex partners and babies, the committee charged that ''the most serious deficiency'' in current efforts to control the epidemic was ''the gross inadequacy of Federal efforts'' to combat drug-related AIDS.

New Programs Are Urged

Drug addicts frequently spread the AIDS virus from one to another by sharing contaminated needles, and they often spread the virus to their sex partners, providing a route by which the virus is spreading into the heterosexual population.

The committee's report acknowledged that substantial progress had been made over the past two years in research and public education about acquired immune deficiency syndrome. [Excerpts from the report are on page B13.] But it called for a wide range of new or expanded programs, including a new national commission to oversee the fragmented AIDS effort, new treatment programs for intravenous drug addicts and expanded research and drug-testing programs. It also called for educational programs aimed at minority groups that are at high risk of developing AIDS, a Federal statute to prohibit discrimination against victims of the disease, and a Federal grant program to assist states in financing health care for AIDS victims.

Potential Impact of Report

The strong comments by the academy, the nation's most prestigious scientific organization, could exert strong influence on the widening national debate over how best to deal with the epidemic. A previous report from the academy, ''Confronting AIDS,'' issued in October 1986, provided a benchmark by which many members of Congress and analysts judged the effectiveness of the nation's efforts to combat AIDS.

The latest academy report, ''Confronting AIDS: Update 1988,'' adds its weight to similar recent recommendations by the President's AIDS Commission, calling for a major increase in treatment facilities for drug users and in financing AIDS programs.

Today's report from the academy is the opening salvo in an unusually busy week for appraising the AIDS epidemic. On Thursday the chairman of the President's AIDS Commission, James D. Watkins, will issue a major report presenting his final conclusions and recommendations for consideration by the full commission before the final report is forwarded to the White House.

Charting Scope of Epidemic

A large group of experts from the Federal Public Health Service will open a three-day meeting in Charlottesville, Va., on Thursday to update official estimates of the scope of the epidemic and to develop new strategies for dealing with the disease, which cripples the immune system.

The latest academy report was prepared by a committee of eight experts appointed jointly by the organization and its subunit, the Institute of Medicine. The panel was headed by Dr. Theodore Cooper, chairman and chief executive officer of the Upjohn Company, who was a former top Federal health official.

The other members were Dr. Stuart Altman, health policy professor at Brandeis University; Dr. David Baltimore, a Nobel Prize-winning biologist at the Massachusetts Institute of Technology; Kristine Gebbie, head of the Oregon Health Division, who is also a member of the President's AIDS Commission; Dr. Donald R. Hopkins, a former top Federal health official who is now at the Carter Presidential Center in Atlanta; Dr. Kenneth Prewitt, vice president of the Rockefeller Foundation; Dr. Howard M. Temin, a Nobel Prize-winning biologist at the University of Wisconsin, and Dr. Paul Volberding, director of AIDS activities at San Francisco General Hospital. The committee's staff was headed by Dr. Robin Weiss, director for AIDS activities at the Institute of Medicine.

Quest for Vaccine

At a news conference at the academy today, Dr. Cooper praised Surgeon General C. Everett Koop's educational efforts and cited ''substantial progress'' in developing AIDS education programs in the schools and in research to understand the AIDS virus. But he said researchers were ''no closer'' to having an AIDS vaccine today ''than we were two years ago,'' and he foresaw ''no breakthrough on the immediate horizon'' in developing drugs to treat AIDS. He called for wider access to clinical trials of AIDS drugs by extending them to include more women, intravenous drug users, children and new geographic areas.

The panel complained that the Federal Government had failed to provide ''overarching direction'' to unite ''all components of the Government and private sector'' in a coordinated attack on AIDS. As a result, the panelists said, various agencies sometimes appear to be in conflict and many important programs languish for lack of direction.

The academy's report complained of inadequacies in financing adequate health care for AIDS victims and in setting standards to determine who should be tested for the AIDS virus. It said the Government had also failed to formulate an

antidiscrimination statute to protect those infected with the virus from retribution, a step the panel considered crucial if efforts to encourage widespread testing are to succeed.

Dr. Cooper said the panel considered but rejected the notion of an ''AIDS czar'' or a separate AIDS agency to provide more coherent leadership on the ground that it would needlessly disrupt established programs.

New Commission Proposed

Instead, the panel called for a new national commission to succeed the existing President's AIDS Commission, whose mandate is about to expire with completion of its final report. The commission would have a five-year, renewable term and would report directly to the President.

The academy's earlier report had called for total national expenditures, including Federal, state and private contributions, to reach $1 billion a year by 1990 for public health and educational measures to control AIDS, and another $1 billion a year for research.

Today the academy panel said Federal research expenditures would probably reach the recommended $1 billion level by 1990, when a further assessment would be needed.

But in the areas of public health and education, the panel said that the earlier estimate appeared to be insufficient and that ''a substantial sum'' of money, ''well beyond the $1 billion originally proposed,'' would be needed, mainly to provide new treatment and education programs for intravenous drug abusers. Only about $250 million of the $1 billion originally proposed was intended for drug abuse treatment and education, academy officials say.

The panel said it had not had time to develop a new estimate but members noted that the AIDS commission had recently called for additional expenditures of $1.5 billion a year for drug treatment alone. That was roughly six times the amount the academy estimated in 1986 and suggested that the academy's original estimate could have been off by $1 billion or more.

Although the panel did not officially endorse the commission's estimate, Dr. Weiss said it had been derived in a reasonable way and was ''going in the right direction.''

Call for Voluntary Testing

The panel suggested that the Federal Government use paid advertising to provide information to the public about AIDS instead of relying on little-watched public service announcements. It also said that mandatory screening for the AIDS virus was appropriate only for donations of blood, tissue and organs. Otherwise, it recommended greatly expanded voluntary testing.

The committee suggested that infection with the AIDS virus should be considered a disease, even if the victim has not yet developed any AIDS symptoms. The committee called the evidence ''scientifically conclusive'' that the human immunodeficiency virus, HIV, is the cause of AIDS, despite assertions by a few scientists that the case is not proved.

The panel also warned that the small group of health-care workers caring for AIDS victims ''may soon exceed its physical and emotional capacities.'' It called for adequate psychological support, training and guidance about risk for all health-care workers.

In rare cases, the panel said, it may be necessary to restrict the personal liberties of people who are infected but who continue to put others at risk.

GRAPHIC: Photo of Dr. Theodore Cooper and Dr. Sam Thier (pg. B13) (NYT/Paul Hosefros)

SUBJECT: ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS); EPIDEMICS; FEDERAL AID (US); FORECASTS; DRUG ADDICTION AND ABUSE; MINORITIES (ETHNIC, RACIAL, RELIGIOUS); RESEARCH; PUBLIC OPINION

ORGANIZATION: SCIENCES, NATIONAL ACADEMY OF, AND NATIONAL RESEARCH COUNCIL

NAME: BOFFEY, PHILIP M

GEOGRAPHIC: UNITED STATES

LEVEL 1 - 13 OF 25 STORIES

June 1, 1986, Sunday, AM cycle

SECTION: Regional News

DISTRIBUTION: California

LENGTH: 472 words

HEADLINE: Identifying people on edge of AIDS infection

DATELINE: PORTLAND, Ore.

KEYWORD: Aids

BODY:

A national committee attempting to stop the acquired immune deficiency syndrome (AIDS) epidemic has drafted guidelines recommending that sex or drug partners of victims be counseled and tested.

''We want to identify people who are at the edge of AIDS infection, who might not know it,'' said Kristine Gebbie, Oregon Health Division administrator and head of the committee of the Association of State and Territorial Health Officials.

The organization, which completed a draft of the guidelines, is made up of the top health officers of every state. It is an advisory group, but its members have the power to implement such recommendations in their states.

National health authorities suspect that the number of people infected with the AIDS virus is much greater than the actual number of AIDS cases. It is estimated that 500,000 to 2 million people in the United States may be infected with the virus.

More than 20,300 AIDS cases have been reported in the country since 1981 and more than 10,933 people have died of the as-yet incurable disease.

A positive result on the AIDS antibody test only tells a person they have been exposed to the virus and does not predict whether that person will ever get complications of infection or AIDS.

Gebbie said public health efforts have primarily been directed at homosexuals and intravenous drug abusers, groups hardest hit by the AIDs infection, ''but people at the edge of the infection may only be reached if someone is willing to say, 'I may have infected you.'''

''The ignorantly infected person is the dangerous person, if you will, in continuing to spread the infection,'' Gebbie said.

Some gay leaders, however, are concerned by the prospect of AIDs-antibody testing and notification of contacts. They warn that contacts can become frightened if not properly counseled and educated about the test and what it means.

Brown McDonald, executive director of the Cascade AIDs project in Portland, said he is worried that notification of contacts and testing could lead to the infected person's loss of anonymity and subject them to civil rights discrimination.

''Until there are guarantees that people will not be discriminated against, I can't recommend they take the test at all,'' McDonald said. ''That is particularly true of people who are not in the identified risk groups.''

He said uninformed people may consent to the test without realizing that a positive result could mean the loss of employment, insurance and housing, as well as emotional well-being.

Gebbie said critics are overreacting and that her committee's draft recommendations take into consideration their concerns. Instead of coercion, the recommendations urge health authorities to work closely with the high-risk community in forming guidelines that allow voluntary compliance and confidentiality.

LEVEL 1 - 25 OF 25 STORIES

April 27, 1984, Friday, BC cycle

SECTION: Regional News

DISTRIBUTION: Arkansas

LENGTH: 121 words

DATELINE: LITTLE ROCK, Ark.

KEYWORD: Health

BODY:

Kristine Gebbie, administrator of the Oregon State Health Division, has been installed as president of the Association of State and Territorial Health Officials.

Ms. Gebbie is the only woman and non-physician ever elected president of the organization, Oregon health officials said. The Thursday ceremony also marked the first time an Oregon resident has been elected to head ASTHO.

ASTHO provides health officials with information regarding petinent national activities, including bills before Congress and executive agency decisions.

Ms. Gebbie has served as administrator of the Oregon agency for six years. She is a former assistant director and professor of nursing studies at St. Louis University in Missouri.

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