

The Concentric Effects of the Acquired Immune Deficiency Syndrome

Preoccupation with the medical and scientific aspects of the acquired immune deficiency syndrome (AIDS) has caused many in the public health disciplines to neglect the profound social and psychological effects of this disease. For many AIDS patients, their families, and their friends, the psychological impact has been devastating. Two leaders of the American Psychological Association, Stephen Morris and Walter Batchelor, were asked to address these mental health effects and provide a clinical perspective for readers of *Public Health Reports*. Their paper appears on pages 4–9. Its publication is a reflection of the continuing determination of the Public Health Service to confront the many problems of AIDS.

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The PHS is no newcomer to handling sensational threats to the public health. We have taken on Legionnaire's disease, toxic shock syndrome, the Tylenol tamperings, dioxin, and many others. Some of these began as mysteries that were finally unraveled by solid epidemiologic and laboratory science.

Secretary Heckler has called AIDS the "number one" health priority for the Department of Health and Human Services. Support for our work has never been the problem. The key nonscience issues are, first, the public has become frightened out of proportion to the threat of this disease and, second, government has had to relearn some lessons about the nature of public health policy.

The first factor alarming the public about AIDS is medicine's inability to understand it or to protect people against it. People have written and telephoned us to ask if it is really true—that we do not know what this disease is. The public's confidence in American biomedical science is extremely high. It is so high that most people simply have a hard time understanding that we just do not know very much about some immediate things. Without any doubt, the AIDS problem has inserted a serious note of doubt and confusion into the relationship between the public and public health.

The second factor causing alarm has been the need to describe and explore and understand a good deal about gay lifestyle. The statistics tell the story: 93 percent of all AIDS victims have been men and nearly 3 of every 4 AIDS victims are homosexual or bisexual men. Physicians, nurses, and public health administrators suddenly had to learn a great deal about private sex activities between men.

A third complicating factor is the assumption we are making, based on the evidence collected so far, that AIDS may be transmitted from one person to another through blood. Of more than 3,000 cases reported so far, only a possible 3 dozen may have originated from transfused blood. The Centers for Disease Control is still following all of these cases. We must remember also that as many as 10 million blood transfusions have been done since June 1981, when we began tracking the disease. We are not able to say for certain that AIDS is transmitted through blood or blood products. But the presence of those three dozen cases requires us to exercise good judgment and say, as cautiously as we can, that AIDS just might be spread through transfused blood.

These three factors—the public's response to medicine's apparent powerlessness, the need to know a lot about the sexual conduct of homosexual and bisexual men, and the deep fear of any potential danger to one's blood—are intrinsic to the AIDS story.

The second issue has to do with the nature of public health policy. Our best effort, our best hope, and our best defense in public health is its scientific base. The AIDS issue has crowded in with a complex tangle of personal emotions, politics, ethics, religious beliefs and morality, and the scientific mystery.

These are expressed by a variety of interest groups of virtually every persuasion. I decided early on that we would hold to our primary responsibility of protecting the health of the public—all members of the public—with the most appropriate tools that science may make available. Some members of groups who were at risk have accused the PHS of dragging its feet for one reason or another. We could well understand their anxieties, but they were wrong. We took, and we still take, great pains to draw the still hazy picture of this new and complicated puzzle. We are moving toward a solution with as much dispatch as

is humanly possible, but we will not ask for more resources than we can responsibly manage. Nor will we promise more than we can deliver.

We have had face-to-face dialog with those at risk—the AIDS victims and those representing them—because we need to have them understand, for their own well-being and protection, just what the scientific evidence is. PHS people met with leaders of the National Gay Task Force to solicit their help in transmitting helpful, accurate information to the group at highest risk: homosexual and bisexual men. It was important to do this, and also difficult; to repeat, hardly any issues are more volatile in our society than issues of human sexuality and personal privacy. But issues of morality are not the issues of AIDS. It is important that the gay community, the medical profession, and the Public Health Service be clear about that.

I believe that our staffs were tested on their ability to hold to the scientific issues and not be drawn into other matters for which we have no objective data or over which we have no legal authority. We

are learning many things we were never taught in medical school, but most important of all, we are relearning the proper boundaries of our role as public health professionals.

We have met with and still meet with many who oppose our work, who object to the expenditure of public funds to find a cure for AIDS or the relief of its victims. As public servants, we are obligated to receive their grievances and to hear their request for redress of some kind. We cannot slam the door on any public petition. But we are obligated by law and by the ethics of our profession to pursue the scientific basis for this terrible disease and find a cure as quickly as we can. That quest has been, and will remain, the vital center of our policy.

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Excerpted from Dr. Brandt's address to the Annual Roundtable of the U.S. Conference of Local Health Officials, held in Washington, D.C., September 15, 1983.

The GME Quandary: Who Will Pay for the Piper's Lunch?

He who pays the piper calls the tune.—Proverb
There is no such thing as a free lunch.—Common economic wisdom circa 1980

The system of graduate medical education (GME) in the United States is at a critical juncture in its development. The established relationships which have grown up between hospitals, medical schools, payors, and generations of house staff now are being strained.

The stresses come in a variety of forms and from multiple directions. The demand for graduate education continues to increase, not only as graduates of the U.S. medical schools seek training spaces, but also as U.S. citizen graduates of non-U.S. schools and foreign medical graduates compete for available slots. At the same time, the total supply of first year positions is leveling off, or even decreasing somewhat. In a general environment of cost containment and restrictions on hospital inpatient costs, many decisionmakers in inpatient settings are deciding that they will sacrifice a certain number of positions each

year. And if this conflict between supply and demand were not in itself suitably complex, the ongoing issue of specialty "maldistribution"—a struggle to find the right balance in GME offerings between the needs of primary care training and those of the more limited specialties and sub-specialties—adds to the problem. In brief, our system of pluralistic, decentralized decisionmaking that has served us so well for the last 40 years is being sorely tested.

In an area so complex, it is dangerous to oversimplify. Yet, two common themes seem to emerge from the proceedings of the Conference on Graduate Medical Education (from which a selection of papers is published elsewhere in this issue). These themes are cost and control.

The system of graduate medical education that has evolved over the last two decades in the United States has been successful in resisting the vesting of control of GME in the hands of any particular interest or organization. Definite and important roles are played by the profession (accreditation), teaching hospitals (sponsors of training programs), insurers (payment), and house staff (services). Yet a central question which is raised and discussed in these conference papers is the degree to which there should be