nesses, especially those of an infectious nature. Although AIDS is clearly an infectious disease, attempts to isolate the AIDS virus by inoculating a wide variety of laboratory animals with AIDS materials have not yet been fruitful.

Identification of the probable cause of AIDS by other methodology has increased rather than diminished the search for an animal model that could be successfully inoculated with the AIDS virus and subsequently used to test the AIDS vaccine. Accordingly, collaborative efforts have been initiated with the Yerkes Primate Center and the New England Primate Center for inoculation in various primate species. Because of the concern regarding the use of primates in AIDS research, the animals will only be used in well-designed, carefully planned studies.

4. *Studies of therapeutic intervention, especially in the early phases of the disease, as identified in the epidemiologic studies. Bioethical and biosafety issues will also be explored.* Despite the wealth of new data now available on AIDS, it has not been possible to translate this into help for people who already have the disease. Ameliorating the suffering of AIDS victims, especially those in the early stages, is a continuing challenge. Based on the discovery of the AIDS virus and test, discussions have begun within the Public Health Service Executive Task Force on what might be done immediately in terms of treating the disease, *even in the absence of positive efficacy of animal model vaccines or treatment*. These discussions are by no means complete, and many issues relating to potential therapies need to be further defined, developed, debated, and evaluated within the Task Force and the scientific community at large.

Scientists are optimistic that isolation of HTLV-III will enhance opportunities for evaluation of chemotherapeutic agents and antiviral or immunologically active biological substances such as the lymphokines and toxin-tagged monoclonal antibodies. Public Health Service agencies will be working with each other and with potential manufacturers to speed the development and licensure of promising therapeutic substances.

By its nature, AIDS is a disease with many and complex bioethical and biosafety issues that must be thoughtfully addressed. At a recent workshop sponsored by Public Health Service agencies, these issues were explored with representatives of the nation's major blood banks and bioethicists from the Hastings Center and the Kennedy Institute of Ethics.

Discussions focused on the ethical, legal, and psychological implications involved in projected clinical studies of AIDS and in the application of the blood test. Workshop participants agreed on the urgency of establishing mechanisms whereby appropriate studies can be done with due consideration for the sensitive issues involved. They also explored a number of approaches that would provide adequately for patient safety while protecting everyone's right to privacy. Followup meetings will be required to develop precise guidelines to ensure that individual rights, including confidentiality of research results, will be respected in all AIDS projects involving the use of human subjects.

The AIDS battle is far from won. As in all things scientific, a few answers raise a thousand new questions. Yet I think that all who have taken part in the fight against AIDS can take some satisfaction from having reached the end of the beginning of the struggle, and can enter the next phase with confidence of final victory. It is important to emphasize that at no time in the history of medicine has so much progress been made, in so short a time, in understanding a complex illness. The Public Health Service and the scientific community should take great pride in their accomplishments.

Edward N. Brandt, Jr., MD, PhD
Assistant Secretary for Health

LETTERS TO THE EDITOR

Outcome of Out-of-Hospital Births Should Not Be Measured by Birth Weight

We take issue with Declercq's conclusions regarding the safety of out-of-hospital births in the United States (*Public Health Reports, January–February 1984*). On the basis of his observations that the proportion of low birth weight deliveries is slightly higher in hospital births (7.1 percent) than in out-of-hospital births (6.9 percent), Declercq concludes that public policy and attitudes toward home births should be liberalized. This suggests that Declercq has mistakenly treated a confounding variable, namely birth weight, as a measure of outcome. Although women choosing to bear their offspring out of the hospital may indeed be at different risk for low birth weight offspring than women delivering in hospitals, it does not follow that birth weight is directly influenced by where a woman chooses to give birth. Birth weight, therefore, is an inappropriate outcome variable for a study attempting to compare the safety of hospital births with out-of-hospital births. As Declercq points out, the most likely explanation for the birth weight differential in favor of out-of-hospital births is referral of high-risk patients to hospitals.

We join Dr. Declercq in looking forward to the availability of national linked birth-death infant data. When such data become available, birth-weight-specific analysis of neonatal mortality may provide us with some more meaningful information on the safety of out-of-hospital births.

Andrew Kaunitz, MD
Pregnancy Epidemiology Branch
Division of Reproductive Health
Center for Health Promotion and Education
Centers for Disease Control
Atlanta, Ga. 30333

Carol J. R. Hogue, PhD
Chief
Pregnancy Epidemiology Branch
Division of Reproductive Health
Center for Health Promotion and Education
Centers for Disease Control
Atlanta, Ga. 30333

Birth Weight Is Not Causally Related to Place of Birth, but It Is Useful

I can hardly disagree with Kaunitz and Hogue's contention that birth weight is not a direct result of place of birth, since I made precisely that point on page 64 of my article (*1*): "No suggestion is made that (birth weight) is causally related to the place of birth."

I would suggest, as I did in the article, that the fact that birth weight is very highly correlated to a variety of outcome measures renders it a useful, albeit not perfect, surrogate (*2*). To follow Kaunitz and Hogue's logic, not even linked birth and mortality-morbidity studies would be appropriate unless specific analysis of each case was done to determine that site caused outcome. Such studies would also presumably not encompass cases where behavior at a setting might have prevented a negative outcome. Awaiting a "perfect study," debate over out-of-hospital births continues, based on little data at all. My study never claimed to resolve the issue, but it did clarify some of the questions that need to be asked concerning matters like self-selection by parents, the nature of midwifery care, and impact of prenatal visits.

Kaunitz and Hogue are also inaccurate when they suggest that, in an article with seven tables and a graph, I based my conclusions on a single comparison (low birth weight in and out of hospitals). Incidentally, the relationships noted for 1978 have generally appeared in data from more recent years. Like Kaunitz and Hogue, I await more complete studies, based on a variety of sources, to shed more light on this health policy area.

Eugene Declercq, PhD
Department of Political Science
Merrimack College
North Andover, Mass. 01845

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2. National Center for Health Statistics: Factors associated with low birth weight, United States, 1976. Vital and Health Statistics, Series 21, No. 37. DHEW Publication No. (PHS) 80–1915. U.S. Government Printing Office, Washington, D.C., April 1980.

Clear Away Barriers to Prenatal Care and Worry about Payment Later

Having just finished reading the March–April 1984 issue with its special section on the Natality and Fetal Mortality Surveys, I feel compelled to add a note from an oldtimer in the field.

All the information contained in the learned articles is only applicable if the pregnant woman presents herself early enough in her pregnancy for someone to do something, either educational or physical.

Frequently our American system makes this very difficult. A quick call to a local hospital brought the reply "Prenatal, Wednesday morning—bring $250 cash—husband's pay stub—any insurance—come in front door—report first to cashier's window." Most of our prenatal patients are Hispanic and probably don't understand that response; certainly they don't have $250 in cash.

Nature being what it is, time goes by and eventually labor sets in, and those in the obstetrical department swear at these stupid women who wait until the last minute and don't get prenatal care.

Let's make sure that every woman who thinks she's pregnant has immediate access to care and worry about payment later.

Every obstetrician (or his wife or nurse) should call, possibly with an accent, the local hospital and try to make a prenatal clinic appointment. When the barriers are cleared away, we can implement the recommendations implied by the surveys.

Robert C. Milligan, MPH
Health Officer
Division of Health
Department of Human Resources
Passaic, N.J. 07055