Food service workers known to be infected with the AIDS virus need not be restricted from work unless they show evidence of another infection, condition, or illness for which there should be such a restriction.

Other Workers

The guidelines for other workers emphasize that AIDS is not spread by the kind of nonsexual, person-to-person contact that occurs among workers, clients, and consumers in such settings as offices, schools, factories, and construction sites. Workers known to be infected with the AIDS virus should not be restricted from work on this account, nor should they be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains. In the case of accidents in the work setting, equipment that is contaminated with blood or other body fluids from any worker, known to be infected or not, should be cleaned with soap and water or a detergent. A disinfectant or a fresh solution of household bleach, as described in the guidelines, should be used to wipe the area after cleaning.

Individual Choice Is the Key

We ask the help of the public health community in dispelling unwarranted public fears by continuing to emphasize that AIDS is not easy to catch and is not spread by casual contact. Personal choices made by each individual with respect to responsible sexual behavior and nonuse of intravenous drugs are the best guarantees of protection from the AIDS virus.

Many organizations and consultants helped the Agencies of the Public Health Service to compile and develop them. The following organizations were represented in the formulation of the guidelines: Association of State and Territorial Health Officers, Conference of State and Territorial Epidemiologists, Association of State and Territorial Public Health Laboratory Directors, National Association of County Health Officials, American Hospital Association, United States Conference of Local Health Officers, Association for Practitioners in Infection Control, Society for Hospital Epidemiologists of America, American Dental Association, American Medical Association, American Nurses' Association, American Association of Medical Colleges, American Association of Dental Schools, Food Research Institute, National Restaurant Association, National Hairdressers and Cosmetology Association, National Gay Task Force, National Funeral Directors and Morticians Association, American Association of Physicians for Human Rights, and National Association of Emergency Medical Technicians. The consultants also included a labor union representative, an attorney, a corporate medical director, and a pathologist.

Reference

1. Recommendations for preventing transmission of infection with human T-lymphotropic virus type III lymphadenopathy-associated virus in the workplace. MMWR 34: 682–695, Nov. 15, 1985.

The Surgeon General's Workshop on Violence and Public Health: Review of the Recommendations

TED CRON

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FOR 2½ DAYS LAST FALL, 175 NATIONALLY known experts in medicine, nursing, public health, law, and social service met in Leesburg, VA, to wrestle with the idea that interpersonal violence—and family violence in particular—was a public health problem. They had been personally invited

by Dr. C. Everett Koop to attend the first-ever "Surgeon General's Workshop on Violence and Public Health."

At the opening session, the evening of October 27, 1985, Dr. Koop presented his charge to the participants. He asked that they focus "squarely on how the health professions might provide better care for victims of violence and also how they might contribute to the prevention of violence." At the closing session on October 29 the participants were to present their recommendations to him and—through him—to the country at large. He asked that they be "framed in such clear, direct language that our colleagues in medicine, nursing, psychology, and social service anywhere in the country can absorb them, understand them, and put them into practice."

The participants worked in 10 groups that dealt with either the prevention of, or the evaluation and treatment of, victims of assault and homicide, child abuse, spouse abuse, rape and sexual assault, and child sexual abuse. An 11th work group dealt with elder abuse. The individuals in each work group represented a range of disciplines and interests (medical practice, behavioral research, the law, and so forth) and a variety of viewpoints, such as those of the health professional, the military service, private foundations, State government, and so on. Each participant brought a personal storehouse of knowledge and experience to the deliberations, and all were enthusiastic about the multidisciplinary process.

What follows is a capsule review of the 156 recommendations generated by that extraordinary assembly. (A complete document is being published separately and will be available from the Office of the Surgeon General, Public Health Service, Washington, DC 20201.)

Generic Issues

A number of issues apply across-the-board to many different aspects of interpersonal violence and were dealt with by several or all of the work groups. For example, the participants recommended that everything possible be done to "reduce the public acceptance of violence" in general. Interpersonal violence, they said, is "behavior learned from various sources," from parents and teachers who use corporal punishment at home and in school and from the government, which permits the sale of handguns and exacts the death penalty.

But special words were reserved for the communications media, where "there continues to be an overrepresentation of violence." Despite a high degree of sensitivity to civil liberties elsewhere in their recommendations, some participants nevertheless urged "the development of realistic standards" to help "reduce the level of violence in all media," and television in particular. Others asked that some leadership group "establish policies" and "set limits" on the "sexualization of children in the media/advertising industries."

Although recognizing that some issues went far beyond the purview of the Surgeon General, participants nevertheless wished to go "on the record" as identifying ageism, racism, unemployment, and sexism as other causes of violence in our society. In several areas, sexism was specifically cited for its effects on both sexes: "Traditional male socialization often limits men's ability to express tenderness," said one work group, while "traditional female socialization often supports passive and submissive behavior." Another referred to research which "has shown that where women's status is high, rape rates are low."

Finally, one idea was expressed as an absolute, the only one carrying no careful modifiers in its wake: "All people—male and female—have the right to control access to their bodies;" women and children, in particular, have a right to say no. Hence, acts of violence—and especially acts of sexual violence—are criminal acts for which the perpetrators (or abusers) must be punished as criminals. Medical treatment of any kind must be *in addition to,* not in place of, punishment.

Services, Research, Education

As a beginning point, all work groups were asked to make recommendations for improved services, additional research, and professional and public education related to their focal area. From all the work groups, these recurring recommendations emerged.

Services. We need to improve greatly our ability to identify high-risk populations and individuals not only as potential victims needing help but as potential perpetrators needing re-direction or restraint.

We also need to do a better job at coordinating the efforts of medicine and health, social services, and law enforcement at all levels—national, State, and local—if we wish to conduct more effective, multidisciplinary campaigns against violence in our families and communities.

At the point of service delivery, we need to develop new model protocols for early identification of, and aid to, victims of violence.

The participants also recommended the development of regional centers which could provide a variety of technical assistance to those communities torn by interpersonal violence but lacking the skills to confront it.

Research. Most participants had responded to a Delphi survey during the summer months prior to the workshop. One of the clear outcomes was consensus around the idea that the research results we already had on hand were probably adequate to help society take direct, effective action to aid victims of interpersonal violence or to prevent it from occurring. However, all work groups expressed the frustration of not being able to find or identify the experimental programs that have worked. The most frequent call, therefore, was not for new research but for "a national search" of the studies done, in order to speed the application of that knowledge.

There were, of course, several specific areas where new research was recommended, but a theme expressed by several work groups was the need for "prospective, longitudinal studies" in order to do for the field of interpersonal violence what the Framingham study, for example, did for the field of cardiovascular disease.

Education. Among the recommendations expressed most frequently was to "enlist the media, schools, and community agencies in educating the public" about all forms of interpersonal violence.

Education for care providers was another matter, however. The workshop participants recommended that information on interpersonal violence "should be incorporated into the core curriculum for undergraduate, graduate, and continuing education" of all health professionals. Again, the groups emphasized the need for multidisciplinary educational materials and experiences.

But they took the next logical step and urged that "certifying, licensing, and State board examinations and credentialing procedures should include questions" on interpersonal violence, in order to "assure minimum knowledge . . . among health professionals and teachers." Similarly, they recommended that academicians and professional societies develop national "standards of practice for the various disciplines," including ways to identify victims and abusers and appropriate methods of intervention and prevention.

Those were among the generic recommendations that appeared in most of the working groups' reports. Most discussions, however, centered on what should be done in each of the six areas of violence that were the particular concern of this workshop. What follows, again, is a sampling of the recommendations; the complete report of the Surgeon General's Workshop on Violence and Public Health will be published.

Child Abuse

- Services must be provided to the children *at highest risk,* such as developmentally disabled children, runaways, and the children of prison inmates, teenage mothers, substance abusers, and of disabled or homeless parents. The services ought to be linguistically and culturally appropriate and should also include those kinds of family services that promote the health and well-being of vulnerable children.
- The starting point for effective child abuse programming is pregnancy planning; hence, education for parenthood ("parenting") should be widely promoted and supported. In addition, quality child care should be available to any parent wanting or needing that service.
- Suggesting that State child protective services may become over-burdened by the rise in mandated reporting, the child abuse work groups recommended that visiting nurses, physicians, and other providers of family and child services also be regarded as alternative points of entry into the system of health and social services for abused children.
- Every hospital should have an interdisciplinary child protection team in order to understand the complexity of both the etiology and the outcomes of violence against children. In addition, these work groups recommended that every community establish a multi-professional "commission" to assess the potential harm or benefit to the child when criminal prosecution is recommended for the perpetrator of the abuse.

Spouse Abuse

- The spouse abuse work groups re-asserted that spouse abuse is a crime, that it is *not* a private matter, and that the perpetrator must be held accountable, regardless of gender or marital status or whether the spouses are or were living together when the crime occurred. They further recommended that the remaining States and Territories follow the lead of 28 States, where husbands may be prosecuted for raping their wives.

• Service professionals working with pregnant women should routinely ask if they have been physically or sexually abused by their partners. Any who have should be considered at high risk and be given the type of prenatal health care appropriate for high-risk pregnancies.
• Spouse abuse protocols should be routinely available to personnel dealing with substance abuse, suicide, child abuse, the homeless, and medical emergencies.
• More attention must be paid to the link between spouse abuse and child abuse, since the evidence thus far suggests that the prevention of spouse abuse and woman battering would have a major impact on the prevention of child abuse.
• The first priority must be to provide safe shelter for victims and their children. Therefore, the shelter movement should be encouraged, supported, and extended.
• Among the research still to be done are studies of the long-term effects on providers who work with spouse abuse and on children who witnessed it.
• All existing and proposed typologies should be examined to eliminate victim blaming. (Several participants specifically singled out a new diagnosis proposed for the next edition of the psychiatry profession's "Diagnostic and Statistical Manual of Mental Disorders." Number 301.89 Masochistic Personality Disorder, they said, was pejorative and sexist and ought not to appear in the manual.)

Rape and Sexual Assault

• The "working definition" used by the participants was "Sexual assault is nonconsensual sexual behavior that includes stranger, acquaintance, and spousal assaults and male or female victims."
• Since sex offenders frequently are repeaters, the spouse abuse work groups recommended early identification, evaluation, and treatment of all sexual offenders, especially adolescents and preadolescents showing any deviant, potentially violent sexual behavior. Prison sentences for offenders should incorporate treatment aimed at preventing them from committing further offenses.
• A number of areas are ripe for further research. These include victim and bystander strategies for rapes in progress, the constraining effects of the fear of rape, some effective deterrents of rape and sexual assault, the pattern over time of a rape victim's recovery, and the way others—friends and loved ones—respond to the victim.

Assault and Homicide

• We need to take a comprehensive, community-based approach to the needs of both direct and indirect victims of assault and homicide. Hence, we need to improve communications and collaboration among the victim service agencies, religious institutions, the criminal justice system, and all relevant providers of health care.
• Hospitals should clearly articulate their policies for identifying, evaluating, treating, and referring the victims of assault and homicide and for staff training.
• Because they are at greatest risk for repeated victimization and insensitive treatment, young and poor minority men should receive special attention from health care providers. Every examination should include the history of the event, risk profiles, and attention to the total health needs of the victim and, if possible the perpetrator of the violence.
• Research opportunities exist in such areas as hospital and police reporting, the risk of subsequent homicide among assault victims, and how the health care system is actually used by assault victims.

Child Sexual Abuse

• A major national education program is needed for all children and it should start in the elementary grades. Such a program should (*a*) teach children that sexual abuse is a harmful, criminal act, (*b*) explain appropriate sexual terminology, (*c*) talk about inappropriate touching (and a child's right to say no), and (*d*) emphasize the importance of telling someone when sexual abuse occurs.
• Programs to serve runaway and homeless youth should be strengthened because these young people are at high risk of sexual exploitation.
• The primary goal of victim assessment (by trained multidisciplinary teams) should be to plan treatment and intervention for both the child and his or her family. The assessment process should consider the possibility that other members of the child's household have also experienced child sexual abuse or other forms of family violence.
• Treatment for a sexually abused child should begin immediately and continue according to a plan that is rewritten as the child's needs evolve. The goals of treatment and intervention should be the reductions of symptoms, the enhancement of positive, adaptive mechanisms for individual and family functioning, and the promotion of adequate growth and development of the child.

The child sexual abuse work groups listed many areas for more research, such as appropriate check-

lists and other instruments for victim assessment; the effects upon the child victim of involvement in the criminal justice system and of disclosure of having been sexually abused; and research into the effectiveness of different treatment strategies for both the child and the child's family.

Elder Abuse

- Services to victims of elder abuse should include legal assistance, victim advocacy, and emergency or long-term housing, services which also recognize and ensure the right of the elderly to live free from abuse.
- Families who want to take care of older members should have available such services as respite care and adult day care.
- Because it is a relatively new area of serious concern, we need to mount special educational programs about elder abuse directed toward personnel in the criminal justice system and in social services, as well as in medicine and health care.

Challenge for Public Health

Rather than re-digest or re-phrase what the participants felt at the Surgeon General's Workshop, let me quote directly from the report prepared by the work group on the evaluation and treatment of victims of homicide:

"Violence in the United States has become so pervasive that it can no longer be usefully viewed as only a problem of disparate acts by individual offenders. Violence is a public health problem because of the toll it exacts in injuries and deaths, especially among younger people. Too many victims are victimized again and again.

"The solution to the problem of violence requires a total community effort, but health care providers can play a special role . . . The health care system must help to make victims whole emotionally as well as physically, and help to prevent further violence. Providers must be alert to the special needs of those most at risk of becoming repeat victims . . .

"Public health has continually redefined its role so as to address more effectively the changing needs of a changing nation. It is for public health to accept the challenge presented to our country by violence and its consequences.

"Our call is for a spirit in America that rejoices in our ethnic variety, a spirit that protects all of our people as our most important resource and legacy, and finally, a spirit that will no longer tolerate violence."

Dr. Koop's Response to the Recommendations

(The following is a shortened version of his response on October 29, 1985, to the recommendations put forth by the participants at the workshop.)

This workshop may be a new departure, but the sheer number of victims—some 4 million—who cry out for help each year demands a public health response. If prevention is the business of public health, where better to focus attention than on this scourge of violence that permeates every level of our society—where victims live not only in fear and dread, but they also desperately try to sort out the shame and the guilt and the fear that competes with their feelings of love and loyalty to their families. While our attention has been directed primarily at interpersonal violence within the family, we seek to address the causes and effects of such violence outside the family as well.

Because this is the first Surgeon General's meeting on the subject of violence, the scope may be more diffuse than some would have wished. We have focused on public health, with additional participants representing the law, the criminal justice system, and social services. I would want the next workshop to focus more directly on the partnership of health and justice.

Your recommendations are just what I had hoped for. It should be possible for individual health professionals as well as the leaders of major health institutions and associations to understand and act on them. Several themes do recur in the recommendations from among the 11 work groups: education of the public on the causes and effects of violence, education of health professionals as to better care for victims and better approaches to violence prevention, improved reporting and data-gathering, some additional research, and increased cooperation and coordination—networking if you will—among health and health-related professions and institutions.

I will begin carrying out that first recommendation of public education tomorrow when I lead off the witnesses at a special public hearing before Senator Paula Hawkins' Subcommittee on Children, Families, Drugs, and Alcoholism. I will also send your recommendations to the Secretary of Education and will indicate your willingness to work with his Department to get something accomplished in our public and private schools, colleges, and universities.

As for professional education, in addition to a report in *Public Health Reports,* I will post your recommendations on the Surgeon General's electronic bulletin board as soon as possible. The bulletin board, which is part of the American Medical Association's computerized Medical Information Network, or MINET, reaches about 26,000 physician subscribers.

I will also convey your concerns to many other professional groups, such as the American Nurses Association, National Board of Medical Examiners, Association of State and Territorial Health Officers, American Academy of Pediatrics, and the National Association of Social Workers.

As for the recommendations for research, I will convey them to the Assistant Secretary for Health and to the heads of the five PHS agencies who have the legal authority and the funds to conduct research. Several work groups have suggested new prospective, longitudinal studies of victims and families. Such studies are complicated and costly to mount. I honestly do not know how my colleagues will react to that, but I will certainly give them the suggestions.

I would also like to respond to some specific recommendations.

- You asked that the Surgeon General undertake an informational campaign about spouse abuse—something that I can and will do. I will transmit to the American College of Obstetricians and Gynecologists the recommendation for more sensitive evaluation and care for battered spouses who are pregnant. That also has my strong support.
- Both work groups on rape were concerned about the need for additional research and recommended that a conference be held specifically to sort out what needs to be done. I endorse that suggestion and convey it to the Alcohol, Drug Abuse, and Mental Health Administration. You also called for greater interdisciplinary cooperation in the field of rape, and I agree that it is absolutely essential.
- In reference to assault and homicide, I understand your emphasis on paying special attention to the impact upon minorities. Rather than responding now, I would first like to see how the recommendations dovetail with those recently made by the Secretary's Task Force on Black and Minority Health.
- A number of recommendations concerning child abuse and child sexual abuse might well receive a more appropriate response from the Department's Office of Human Development Services, a co-sponsor of this workshop. I intend to stay in close touch with that Office, as you clearly imply I should. I can say, however, that I agree completely with the recommendation that the abused child be treated promptly according to an evolving plan. The victim should not be seen merely as a pawn in some legal chess game.

Meanwhile, the PHS's Division of Maternal and Child Health is beginning an aggressive public education campaign on child abuse and child sexual abuse and in May 1986 will co-sponsor a conference on child sexual abuse. The Division will also be disseminating materials related to these problems; I will ask them to include the recommendations in their mailings.

I'd like to add that I will carry the recommendations to certain other groups, such as the American Red Cross, the Boy Scouts and Girl Scouts, and the 4-H Clubs of America.

- From the day I was appointed in 1981, I've chosen the role of advocate for vulnerable, threatened older people in our society. I assure you that I will speak to this issue of elder abuse as well. I will deliver the recommendations on elder abuse to the Administration on Aging in the Department of Health and Human Services. The AoA interacts with about 1,200 centers on aging, so it is an important ally for getting broad exposure to the recommendations in this area. I will also discuss research in elder abuse with Dr. T. Franklin Williams, Director of the National Institute on Aging.

One work group recommended, in effect, that the Federal Government practice what it preaches, and I agree completely. Hence, I'm pleased that we've had a strong delegation from the Department of Defense at the workshop. They represent not only the policy function but also the line function, the people who actually deliver health care to servicemen and women and their dependents.

Let me share what the Public Health Service itself can do, is doing, or will do in respect to interpersonal violence. The National Health Service Corps, for example, is a PHS organization of health care professionals working in medically underserved areas, most of them remote rural areas or distressed inner city neighborhoods. The Corps will be absorbing as many of the recommendations as possible into its continuing medical education program for the 3,100 NHSC officers in the field. And we have agreement from the Indian Health Service that the same actions would be useful for their personnel, too.

The 60,000 PHS employees are a cross-section of American society; they also have their share of personal problems, for which we have an employee counseling service. I understand that domestic vio-

lence will be receiving more attention by that counseling service during the coming year, including the establishment of a support group for battered women within PHS.

I believe the recommendations will be especially significant for the National Institute of Mental Health which supports research in violence and anti-social behavior. I'm sure your thoughts regarding trends and emphases will be carefully studied by NIMH personnel and by the PHS people who work with migrant health centers, community health and mental health centers, State and local health agencies, and so on. I'd like them to have a heightened awareness of interpersonal violence in the conduct of the important grass-roots programs in public health.

Some of the participants are thinking ahead to followup activities to this workshop. Regional meetings and some educational programs are being discussed. I hope that you will drop me a note about subsequent developments in this campaign against interpersonal violence. For my part, I pledge that my Office will put that information together for a 6-month followup report and a 12-month report. I agree with the strong recommendation of greater coordination and information-sharing within—and among—the health professions.

A final word. The causes of interpersonal violence, especially family violence, are complex, multi-faceted, and extend into the social and cultural fabric of society. Sometimes the etiologic agent may be far removed from the narrower realm of health care. However, any remedies undertaken by a health official, including—and especially—the Surgeon General, must be consistent with his actual sphere of responsibility and influence and moral suasion. Several recommendations—thoughtfully conceived and vigorously presented—are nevertheless well outside that public health sphere. But I want to assure you that, when and where feasible, I will transmit those recommendations as the sincere concerns of participants of this workshop, even though they address social and political problems well beyond the influence of our colleagues in medicine, nursing, public health, psychology, and health-related social services and of the Surgeon General and the Public Health Service.

As long as I am Surgeon General, those who are victims of violence in this country will have a strong advocate in my Office.

This Office Tobacco Smoke Free

Poster to designate as smoke-free areas clinics and other facilities of the Indian Health Service was designed by James Justice, MD, Preventive Medicine, IHS, and Maurice Wilson, Dakota artist, both of Tucson, AZ. A series of four-color posters is available from the Tucson Program Area, Division of Health Systems Development, 7900 S. J. Stock Rd., Tucson, AZ 85746-9352, telephone AC 602-629-6675 while the supply lasts.