

### **Surgeon General's Report on Acquired Immune Deficiency Syndrome**

In February 1986, President Reagan asked me to prepare a report to the American people on AIDS. The report is now completed.

In preparing this document, I consulted with the best medical and scientific experts this country can offer inside and outside the Public Health Service. I met with leaders of organizations concerned with health, education, and other aspects of our society to gain their views of the problems associated with AIDS. The resulting report contains information that I consider vital to the future health of this nation.

Controversial and sensitive issues are inherent in the subject of AIDS, and these issues are addressed in my report. Value judgments are absent. This is an objective health and medical report, which I would like every adult and adolescent to read. The impact of AIDS on our society is and will continue to be devastating. This epidemic has already claimed the lives of almost 15,000 Americans, and that figure is expected to increase 12-fold by the end of 1991—only 4 years from now.

Our best scientists are conducting intensive research into drug therapy and vaccine development for AIDS but, as yet, we have no cure. Clearly this disease, which strikes men and women, children and adults, people of all races, must be stopped. It is estimated that 1.5 million people are now infected with the AIDS virus. These people—the majority of whom are well and have no symptoms of disease—can spread the virus to others.

But new infections can be prevented if we, as individuals, take the responsibility of protecting ourselves and others from exposure to the AIDS virus. AIDS is not spread by casual, nonsexual contact. It is spread by high-risk sexual and drug-related behaviors—behaviors that we can choose to avoid. Every person can reduce the risk of exposure to the AIDS virus through preventive measures that are simple, straightforward, and effective. However, if people are to follow these recommended measures—to act responsibly to pro-

tect themselves and others—they must be informed about them. That is an obvious statement, but not a simple one. Educating people about AIDS has never been easy.

From the start, this disease has evoked highly emotional and often irrational responses. Much of the reaction could be attributed to fear of the many unknowns surrounding a new and very deadly disease. This fear was compounded by personal feelings regarding the groups of people primarily affected—homosexual men and intravenous drug abusers. Rumors and misinformation spread rampantly and became as difficult to combat as the disease itself. It is time to put self-defeating attitudes aside and recognize that we are fighting a disease—not people. We must control the spread of AIDS, and at the same time offer the best we can to care for those who are sick.

We have made some strides in dispelling rumors and educating the public, but until every adult and adolescent is informed and knowledgeable about this disease, our job of educating will not be done. Unfortunately, some people are difficult to reach through traditional education methods, so our efforts must be redoubled. Others erroneously dismiss AIDS as a topic they need not be concerned about. They must be convinced otherwise.

Concerted education efforts must be directed to blacks and Hispanics. While blacks represent only 12 percent of the U.S. population, 25 percent of all people with AIDS are black. Another 12 percent of AIDS patients are Hispanic, while this group comprises only 6 percent of the population. Eighty percent of children with AIDS—8 out of 10—are black or Hispanic. For optimum effectiveness in reaching minority populations, educational programs must be designed specifically for these target groups.

Many people—especially our youth—are not receiving information that is vital to their future health and well-being because of our reticence in dealing with the subjects of sex, sexual practices, and homosexuality. This silence must end. We can no longer afford to sidestep frank, open discussions about sexual practices—homosexual and heterosexual. Education about AIDS should start at an early age so that children can grow up knowing

the behaviors to avoid to protect themselves from exposure to the AIDS virus.

One place to begin this education is in our schools. Every school day, more than 47 million students attend 90,000 elementary and secondary schools in this nation. Our schools could provide AIDS education to 90–95 percent of our young people. As parents, educators, and community leaders we must assume our responsibility to educate our young. The need is critical and the price of neglect is high. AIDS education must start at the lowest grade possible as part of any health and hygiene program. There is now no doubt that we need sex education in schools and that it include information on sexual practices that may put our children at risk for AIDS. Teenagers often think themselves immortal, and these young people may be putting themselves at great risk as they begin to explore their own sexuality and perhaps experiment with drugs. The threat of AIDS should be sufficient to permit a sex education curriculum with a heavy emphasis on prevention of AIDS and other sexually transmitted diseases.

School education on AIDS must be reinforced at home. The role of parents as teachers—both in word and in deed—cannot be overestimated. Parents exert perhaps the strongest influence on their youngsters' developing minds, attitudes, and behaviors. We warn our children early about the dangerous consequences of playing with matches or crossing the street before checking for traffic. We have no less a responsibility to guide them in avoiding behaviors that may expose them to AIDS. The sources of danger differ, but the possible consequences are much more deadly.

Before we can educate our children about AIDS, we must educate ourselves. The first thing we have to understand and acknowledge is that AIDS is no longer the concern of any one segment of society; it is the concern of us all. People who engage in high-risk sexual behavior or who inject illicit drugs are risking infection with the AIDS virus and are endangering their lives and the lives of others, including their unborn children.

The Surgeon General's report describes high-risk sexual practices between men and between men and women. I want to emphasize two points: First, the risk of infection increases with increased numbers of sexual partners—male or female. Couples who engage in freewheeling casual sex these days are playing a dangerous game. What it boils

down to is—unless you know with *absolute certainty* that your sex partner is not infected with the AIDS virus—through sex or through drug use—you're taking a chance on becoming infected. Conversely, unless you are *absolutely certain* that you are not carrying the AIDS virus, you must consider the possibility that you can infect others.

Second, the best protection against infection right now—barring abstinence—is use of a condom. A condom should be used during sexual relations, from start to finish, with anyone who you know or suspect is infected.

I'd like to comment briefly on the issues of mandatory blood testing and of quarantine of infected individuals. Ideas and opinions on how best to control the spread of AIDS vary, and these two issues have generated heated controversy and continuing debate. No one will argue that the AIDS epidemic must be contained, and any public health measure that will effectively help to accomplish this goal should be adopted. Neither quarantine nor mandatory testing for the AIDS antibody will serve that purpose.

Quarantine has no role in the management of AIDS because AIDS is not spread by casual contact. Quarantine should be considered only as a last resort by local authorities and, on a case-by-case basis, in special situations in which someone infected with the AIDS virus knowingly and willingly continues to expose others to infection through sexual contact or sharing drug equipment.

Compulsory blood testing is unnecessary, unfeasible, and cost prohibitive. Furthermore, rather than aiding in prevention, testing could, in some instances, cause irreparable harm. A negative test result for someone who has been recently infected but has not yet developed antibodies might give that person a false sense of security not only for him- or herself, but for that person's sexual partners as well. This could lessen the motivation to adhere to safe sex practices. Voluntary testing is available and useful for people who have engaged in high-risk behaviors and want to learn if they are infected so that they can seek appropriate medical attention and act to protect others from infection.

My report supports and reinforces recommendations by the Public Health Service on AIDS prevention and risk reduction. Although my involvement with AIDS is fairly recent, the Public

Health Service has been deeply involved in the AIDS crisis from the start. In the past 5 years the PHS has made excellent progress in characterizing the disease, delineating the modes of transmission, and protecting our blood supply from contamination with the AIDS virus. Vigorous research into drug therapy and vaccine development continues, and the drug azidothymidine (AZT) is being made available to thousands of people with AIDS who may benefit from this treatment.

Much remains to be done to stop this epidemic, and the Public Health Service will continue to work together with all elements of public and private sectors and use all our joint resources to the fullest to eradicate AIDS.

My report on AIDS is a document that people should read. It provides—in layman's terms—detailed information about AIDS, how the disease is transmitted, the relative risks of infection, and how to prevent infection. Copies of the "Surgeon General's Report on Acquired Immune Deficiency Syndrome" are available from Post Office Box 14252, Washington, DC 20044.

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Surgeon General

### **National Center for Nursing Research Is Ready for Action at NIH**

The National Center for Nursing Research (NCNR) was authorized under the Health Research Extension Act of 1985 (Public Law 99-158), and on April 18, 1986, Secretary Otis R. Bowen of the Department of Health and Human Services announced its establishment at the National Institutes of Health (NIH). The conference report accompanying Public Law 99-158 articulates an anticipation that the programs of the NCNR will be directed primarily toward basic and applied research related to patient care, the promotion of health, the prevention of illness, and the understanding of individual family and community responses to acute and chronic illness and disability. Patient care research may also address ethical and public policy concerns that will have a profound effect on the delivery of patient care.

The organization of the NCNR reflects its mission. There is one Division of Extramural

Programs which is divided into four branches. Three branches are primarily concerned with the conduct of research. The fourth is a review branch responsible for the initial scientific and technical evaluation of applications for research career development and special programs support.

The Health Promotion and Disease Prevention Branch is under the leadership of Deidre M. Blank, RN, DSN. It is responsible for implementing the focus on basic and applied research as it affects the promotion of health and the prevention of illness. Dr. Blank describes research in the area as being designed to decrease the vulnerability of individuals and families to illness or disability across the lifespan. Specifically, health promotion research addresses the general health of the population and is not directed at any particular illness or disability. Studies which promote health, for example, might consider, but not be limited to, nutritional requirements suggested for the various developmental stages or phases of life, the need for optimal human development, and the relationship between biomedical and behavioral dimensions of human health.

Disease prevention research, on the other hand, normally includes measures which are applicable to a particular illness or disability and attempts to intercept their onset. Studies which promote specific protection of individuals and families would include, but not be limited to, the identification of biomedical, behavioral, environmental, and epidemiologic factors and the development or refinement of methods that enhance the abilities of individuals and families to respond to actual or potential problems.

The Acute and Chronic Illness Branch is the responsibility of Patricia McCormick, RN, PhD, who describes research in this area as dealing broadly with responses to acute and chronic illness and disability across the lifespan. The branch considers biomedical, behavioral, environmental, and epidemiologic factors that contribute to the causes, prevalence, amelioration, and remediation of illness and disability. Some examples would include, but not be limited to, adaptation to and functioning in chronic illnesses such as arthritis, diabetes, hypertension, and renal disease; technological developments and rehabilitation therapy; adherence to therapeutic regimens; epidemiologic factors in disability; nursing interventions, including physical, behavioral, and educational interven-