The AIDS Epidemic and the Danger of Contagion

Good News and Bad

Medical journals continue to publish reports on scientific studies undertaken to unravel the mystery of the Acquired Immuno-Deficiency Syndrome (AIDS) epidemic and to halt the spread of this dreaded disease. There is good news and bad news. The good news is that hopefully within five years, a vaccine will be developed to protect high-risk groups from contracting AIDS (now that Dr. Robert Gallo and associates, as of May, 1984, have isolated the virus that causes the disease). Also, the danger of contagion in caring for AIDS victims is not as great as formerly imagined. The bad news is that AIDS continues to claim new victims beyond the original four high-risk groups. In an editorial in the Jan. 11, 1985, issue of the Journal of the American Medical Association (p. 247), Thomas C. Quinn, MD, of the National Institute of Allergy and Infectious Diseases, National Institutes of Health, Bethesda, Md., writes:

"In the relatively short span of three years, over 7,000 cases of the acquired immunodeficiency syndrome (AIDS) have been diagnosed in the United States. Preliminary surveillance reports also estimate over 500 cases in the rest of the Americas, 600 in Europe, and several thousand cases in Central Africa. With a mortality rate that exceeds 80% two years from diagnosis, this illness now ranks as one of the most serious epidemics confronting man in modern times."

Extension of the High Risk Groups from Four to Six

The original high-risk groups for contracting AIDS as discussed in the same issue of the Journal of the American Medical Association (pp. 216-220) are the following: 1) Single men (formerly listed as homosexual or bisexual men), so listed primarily because 86% of AIDS cases among homosexuals or bisexuals were single men; 2) Intra-venous drug users (approximately 70% of the reported IV drug users are from New Jersey and New York City); 3) Haitian entrants to the United States (87% of the Haitians with AIDS have been recent entrants); 4) persons with hemophilia. Two more categories or groups have been added. The fifth group are persons who received blood transfusions. Between June, 1983, and May, 1984, 44 adults over 20 years of age and 6 infants under one year of age became AIDS victims as a result of blood transfusions (p. 218, table 8).

Considering that the median time from exposure to a diagnosis of AIDS in transfusion-associated cases is over two years, it follows that the number of such victims will rise.

The sixth group of possible AIDS victims introduces a whole new and frightful dimension to the epidemic — heterosexuals are contracting AIDS by having sexual relations with female partners of male intra-venous drug users. There were 13 cases of this type reported between June, 1983, and May, 1984 (p. 218, table 7). Most of the victims were New York City residents. It was known previously that heterosexual women contracted AIDS from sexual contacts with intra-venous male drug users. Indications are that AIDS is more readily transmitted by men to their female partners than by women to their male partners (p. 219). The shocking discovery is that not only female partners of male IV drug users, but also prostitutes throughout the world may transmit AIDS to heterosexual men. The AIDS virus isolated by Dr. Gallo (cf. Newsweek, May 7, 1984) is called HTLV-3, or Human T-cell Lymphotrophic RetroVirus. It is an invading virus which destroys the cells (called "T-cells," or "thymic lymphoid cells") which stimulate the body's immune system to fight disease. If antibodies (which fight the virus) are found in an individual who is suspected of having been infected by the virus (HTLV-3), it means, in the words of one member of Dr. Gallo's team, that "the potential is there of the virus being activated, your getting the disease and passing it on." He added that a study of prostitutes in Zaire showed that about 80 percent (continued on page 2)
Dec. 11, 1984, 12 A).

Danger of Contagion in the Six Groups

Starting with the last-mentioned group (heterosexual transmission), it would be misleading to infer that "catching" AIDS female-to-male is going to become as major a source of transmitting AIDS in the U.S.A. as it is in African countries such as Zaire and Rwanda. In those countries, where there are almost as many female AIDS victims as there are male victims, a pattern of promiscuous heterosexual activity is a heavy contributing factor. In his editorial (opening paragraph), Dr. Quinn refers to that African factor, and speculates on the spread of heterosexual transmission of AIDS in the U.S.A. by saying: "... women, including female prostitutes, can become exposed to HTLV-III through sexual contact, IV drug abuse, or transfusion ... the potential for extension of AIDS outside the present high-risk groups remains a real possibility" (p. 248). Only vastly-improved collaborative efforts to strengthen Christian values of chastity, marital fidelity, and personal dignity and integrity can prevent that "potential" from becoming a national nightmare.

There are definite reasons for anticipating a much lower incidence of contracting AIDS through blood transfusions. The main dividend to date of Dr. Gallo’s isolation of the AIDS virus is the ongoing success in developing a blood test which will unmask the culprit (HTLV-III virus) in blood donations and in the handling of plasma derivatives. The Dec. 22/29, 1984, issue of Lancet reveals that five American commercial firms are already competing to provide test kits and that there are confident predictions of success “despite a high rate of false positives at present” (p. 1433). The article in the Jan. 11, 1985, issue of the Journal of the American Medical Association reports that blood transfusion recipients between the ages of 1 year and 20 years “apparently to have a very small risk of AIDS developing.” Another encouraging conclusion is that, for both children and adults, those who received less units of blood (less than 10 units) have significantly lower incidence of AIDS than those who have received 10 units or more (p. 220).

With regard to the high risk group known as hemophiliacs, a distinction is made between hemophilia “A” (marked by a severe clotting-factor deficiency) and hemophilia “B” (less probability of viral infection in treatment). The number of reported cases of AIDS in hemophiliacs (between June, 1983, and May, 1984) was relatively small; 23 of the “A” variety and only 1 of the “B” variety (p. 218, table 6). The article in The Lancet made a special point of noting that “by far the commonest cause of hemophiliac death is bleeding” (p. 1435). In the high risk group known as the Haitians, two reports issued in 1983 revealed that 53 of 70 AIDS cases were in heterosexual males (p. 219). This increases concern over the AIDS potential of the heterosexual connection (group six, above). Due to the large number of recent emigrants, Miami has the highest incidence rate of the Haitian group.

Contagion Through Singles and IV Drug Users

It is estimated that 71% of AIDS victims are homosexual or bisexual (mostly single men), and 17% are users of intra-venous drugs (Public Health Reports, Jan.-Feb., 1984, p. 5). Apparently the article in the Jan. 11, 1985, issue of the Journal of the American Medical Association was referring to these two high-risk groups in particular when it stated that the rate of AIDS in “certain groups” is similar to population mortality rates for two leading causes of death, heart disease and cancer — and higher than the mortality rate for motor vehicle accidents (p. 219). The disease is spread among such individuals by sexual contact, by dirty needles, and by transfusions. Without doubt, this is above all a moral problem of the first magnitude. Considering the relaxed if not non-existent moral standards as advanced and championed by certain liberal elements throughout modern society, it would be illogical to predict a significant decrease in AIDS victims among the “single” and “IV users” within the near future. Predictions by those “in the know” leave little room for optimism. Last November (1984), the head of the AIDS research center in San Francisco made the statement that if cases increased at the current rate, California would have 17,000 AIDS sufferers by 1987 (St. Louis Post-Dispatch, Nov. 12, 1984, p. 6 B).

Danger of Contagion in Caring for AIDS Victims

There have been reports of extreme precautions taken in some hospitals with regard to the care of AIDS victims... even to the extent of wearing double gloves, head and shoe coverings and masks. The effect was depressing for both patients and hospital personnel. Gowns and gloves are necessary only when in direct contact with a AIDS patient’s blood or body fluids (excretions and secretions). The guidelines for treating AIDS patients as issued by the American Hospital Association include the following specifics: extraordinary precautions to isolate AIDS patients are not necessary (no need of segregated examination rooms; private rooms recommended only for patients whose hygiene is poor); hospital workers should not be excused from treating AIDS patients; direct contact between AIDS and other patients susceptible to infections should be minimized in outpatient clinics or emergency departments (cf. Hospitals, Feb. 1, 1984, p. 43).

According to the New England Journal of Medicine (Jan. 3, 1985, p. 3), AIDS has developed in four health-care workers without known risk factors — but none of them were known to have had contact with AIDS patients. A recent study of hospital employees considered at high risk after accidental inoculation (needle-stick) or repeated exposure to specimens from AIDS patients (blood, excretions, secretions) over a three year period in two medical centers in Massachusetts and New York, revealed encouraging results. The conclusion stated that “none of the 85 employees with nosocomial exposure to specimens from patients with AIDS were positive for HTLV-III antibody” (Ibid., p. 1). The 85 hospital employees included 30 who had been exposed to one or more needle-sticks, 20 research scientists and technicians, 8 pathologists who had performed autopsies on AIDS victims, 7 gastroenterologists, etc. Many of them had been exposed repeatedly to handling AIDS specimens, including urine, semen, throat washes and biopsy and autopsy tissue. The final paragraph of the report included the following statement: “Our results do suggest that the isolated procedures
Sterilizing the Severely Retarded Woman

Is it Morally Different from Contraceptive Sterilization?

Over the past three years, theologians who take their lead from the Church's official teaching have begun again to raise some healthy discussion about a subject they had not treated for some time: the sterilization of the severely retarded woman as a last and desperate resort to protect her from criminal impregnation. One of the most eminent American moralists prior to the Second Vatican Council, the late Francis Connell, CSSR, of Catholic University, for all the conservatism alleged of him, wrote in 1966 in favor of such sterilization. After that article, however, we find silence on the issue, at least in the United States and among moralists who defended the Church's doctrine on sexuality as found in Humanae Vitae. It might be argued that circumstances after 1968 were forcing them to expend their energies in defense of numerous well-established moral positions—even the most fundamental ones—to which her official teaching commits the Church.

At any rate, during and after 1982, the issue appeared again, notably in the pages of Dr. Frank Ayd's Medical Moral Newsletter. The reader is referred to that periodical for both sides of what showed itself as still a somewhat controverted matter. Here it might be pointed out in a rather summary way that the case for such sterilization is based on two moral principles.

First, what one might call the Principle of Defensive Sterilization: in an extreme case, where there is no other way for a woman to avoid basically unjust impregnation, she may, in light of the Principle of Totality consent even to physical sterilization. This fundamentally defensive (as distinguished from contraceptive) sterilization has been defended by a number of eminent theologians who base their arguments on the Church's teaching as enunciated by Pope Pius XII. In 1975 when the Holy See condemned contraceptive sterilizations in Catholic hospitals, the Congregation for the Doctrine of the Faith spoke only of sterilizations to avoid pregnancy from "deliberate sexual actions of the person sterilized." Thus the Congregation with deliberate care avoided condemning some theologians' teaching on "defensive sterilization", that is, in cases where a woman was not allowing sexual actions, but being forced into them.

Second, what one might call the Principle of the Medical Rights of the Handicapped: the handicapped have a right to seriously needed surgery, even though some legitimate proxy must give consent for them. This right is the foundation of our insistence that "Infant Doe" and other handicapped neo-nates be given surgery any normal baby would be given, but it applies also to the handicapped who have reached puberty.

A Last Resort

It is important to stress here, contrary to the tendencies of some powerful secular humanistic movements of yesteryear (e.g., the Nazi sterilization programs) and perhaps also of these, our years, that defensive sterilization must clearly be a last resort. It applies only in what we can hope will be extreme cases where other, humanly preferable lines of defense are not possible against the sexual exploitation and criminal impregnation of women or girls who cannot in any basic way comprehend or consent to sexual actions into which they are forced or enticed. The first line of defense is always education in self-governance. Too easily do we write off the limited powers of the mentally, but mildly handicapped to appreciate their own beauty and worth, and to say no to "sexual" actions which are mere and miserable caricatures of what human beings are made for.

A second line of defense, if self-governance is not possible in a given case, is adequate custodial care. Society has an obligation to support and, if necessary, to take over the responsibility of parents to guard effectively against the sexual degradation of a retarded child, whatever his or her age. Such custodial care requires strong legal sanctions against the seduction of the mentally handicapped adult—a neglected area, I am told, when compared to the legal protection afforded minors. It requires also a truly humane expenditure of adequate public and private funds which a highly materialist society chooses to spend on more "glamorous" causes. It requires, in other words, the personal witness and even the political weight of Christians and...