Interview: Prof. Dr. Hans-Philipp Pöhn

Is a change in AIDS policy coming for West Germany?

Dr. Pöhn was interviewed in Wiesbaden, West Germany, on July 18, 1988, by Gabriele Liebig and Jutta Dinkermann. The interview has been translated from the German by John Chambless.

EIR: AIDS, or acquired immunodeficiency syndrome, has come to be described by serious people as not only an epidemic but as a "worldwide pandemic." Many millions of human beings are already infected with the human immunodeficiency virus (HIV). You, Professor Pöhn, were the leader for the Special Department for Infectious Diseases at the Federal Office of Health in West Berlin until the end of April. How great is the AIDS danger in the Federal Republic? How many citizens are already suffering from AIDS, and how many are infected?

Pöhn: That, of course, is not known, since everything is done not to determine those numbers. By our estimates, we have arrived at approximately 3,000-5,000 sick and 300,000-500,000 infected in the Federal Republic. That is arrived at if the American proportion between those sick and those infected is used and—as Mr. Steinbach of the Health Ministry recommends—the present number of the sick who are registered is multiplied by two because of the large number of unknown cases.

EIR: How reliable are existing AIDS tests? We are continually hearing about "false positive" or "false negative" test results.

Pöhn: The HIV antibody tests used currently have a relatively high reliability. A positive test result, which comes first from an exploratory test and then from a specific confirmatory test, means, however, with over 99% probability, that the individual tested has HIV antibodies in the blood. The stories about many "false-positive" test results, which came up in connection with stored blood being tested, have only to do with the exploratory test. Stored blood, which reacts positively to the very sensitive exploratory test, previously was not used and was also not subjected to any confirmatory test, but was rather thrown away. But in connection with the confirmation test, a sero-positive result is over 99% reliable.

It is quite different with sero-negative results: A negative HIV-antibody test merely means that no HIV antibodies have been found in the blood tested. The individual tested, however, can nonetheless be infected, but not yet have formed antibodies. The true incubation time, that is, the time between incubation and the formation of antibodies, can last from a few weeks up to three years.

Only an antigen test that can detect the presence of HIV itself could exclude an HIV infection. Such an antigen test is under development, but not yet made available, because it does not yet satisfy reliability demands.

EIR: So it can take three years until antibodies are formed against the HIV?

Pöhn: Yes, and during that entire time, the one infected is already infectious. The antibody formation can be so long delayed because AIDS is a weakness of the immune system, and the formation of antibodies is also an immune reaction that can be disturbed. Additionally with AIDS, the antibodies are unfortunately useless against the infection, so that it is not a matter, as with other infectious diseases (for example, hepatitis B), of administering such HIV antibodies to someone as protection against HIV.

EIR: Are there already procedures with which the AIDS virus can be directly detected?

Pöhn: Yes, for example, at the Paul Ehrlich Institute in Frankfurt, such a procedure is used, but it is connected with a considerable expenditure that demands trained specialized personnel. The method consists in isolating the virus on a nutrient medium. For that, the blood to be tested is first frozen and then thawed, to destroy the cells; then it is ultra-centrifuged and the appropriate bands are put onto a suitable cell culture. Much equipment is needed, but principally people who manage the procedure. That is not so simple as with the AIDS test, which can be bought today in ready-made kits and can be carried out by any careful technician.

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EIR: Will the antigen test function that way?

Pöhn: No, the antigen test will be made with specific antibodies, so-called gene probes, that attach themselves to the antigen—if any are present—and produce a definite reaction. It functions something like the ELISA test in reverse, in which an antigen is brought into action on which any antibodies that might be present attach and produce a definite reaction. But test methods can still change, and perhaps it will be said in a few weeks, "We have now developed an even better method."

EIR: You spoke of an alarming 300,000-500,000 individuals infected with AIDS in the Federal Republic. In your opinion, what measures are necessary in order to control the further spread of the epidemic?

Pöhn: For the protection of the uninfected, the measures that have always been taken in control of epidemics should be used, that is, to find the sources of infection and block them appropriately. With the mode of transmission of AIDS, it would be necessary that the infected follow certain behavioral directives: The infected must above all not give blood and should refrain from sexual intercourse, or, if they can't manage that, only with a condom in conjunction with a spermicide that is effective on viruses—but that is, naturally, never as reliable. The infected are already told this at counseling offices in the Office of Health, but, of course, only in anonymous counseling talks.

To this extent, the federal epidemic law now applies, since it applies in large part to all human infectious diseases, and these are defined in Paragraph 1 as all "diseases caused by a pathogenic agent that can be communicated directly or indirectly to human beings." This doubtlessly fits AIDS, and, additionally, in the official explanation of 1962, there is the following: "This definition shall assure that, with the appearance of a previously unknown . . . communicable disease, measures for protection and control can be introduced under the conditions more closely specified in the law."

Isolation of the unreasonable, who do not follow the behavioral directives, is included in the now-prescribed measures.

As long as the infected remain anonymous, observation of them by the public health office is, of course, hardly possible.

EIR: How do you explain the tremendous resistance against use of the federal epidemic law from the "AIDS lobby," which is continually spreading new horror stories about terrible compulsory measures?

Pöhn: That probably comes, first, from the accusations of guilt against those infected by HIV and against those who are sick conveyed in such phrases as, "AIDS is not easy to catch; you have to work to get it." The infected feel discriminated against by that, and want to remain anonymous. The chickens of "informative self-determination" have been brought home to roost for us by the federal constitutional court with its census judgment. But today, more and more people are becoming infected without there being anything that can be done about it. Measures for care of the ill and for protection of the uninfected have, in modern control of epidemics, never yet led to discrimination.

What also plays a role, of course, may be the fact that, with the exception of Bavaria, Berlin, and Schleswig-Holstein, the third measure for implementation of the law for standardization of public health services of 1934 continues to exist, which is certainly suitable to produce rejection. For that reason, in Bavaria the first thing done, before any other measures, was that the third measure for implementation was abolished, and was replaced by a new modern health service law. I recommend that for the other federal states.

A really large problem is the drug addicts. The Office of Health, and, within it, the drug treatment office, must concern itself with drug addicts. How they get off the drugs is another question; for the control of AIDS, the principal problem is to wean junkies away from using needles in common. The distribution of single-use needles is certainly no solution, since the problem is not that these people have too few needles. Rather, it's a ritual to pass the needle around, like, previously, the circulation of mugs at feasts or the peace pipes by Indians or even the communion chalice among Protestants. Even if a junky had only one needle for himself, which he uses over and over, then he could very well get a severe sepsis—but not AIDS.

The conversion of addicts to a substitute drug such as methadone, which is not a narcotic and is not injected, but which lessens the withdrawal symptoms, is controversial. The unanswered question is, whether the addicts, in the medium term, get off this drug more easily than from other narcotic substances.

EIR: The majority of those more than 100,000 infected today, however, no longer belong to high-risk groups, but rather are completely normal, predominantly young men, women, and children. What effect would the application of the federal epidemic law have on them?

Pöhn: If the responsible health agency receives information that certain persons have very probably contracted AIDS, then the public health officer will summon them or even go to their houses. He will ask them how they are, what sorts of questions they have, and he will advise them on what they have to do or refrain from doing, in order not to pass the infection on. Such conversations will supposedly take place within a period of a couple of weeks. The public health officer must see how the infected is now dealing, for example, with his sexuality. Such conversations are already being done today; what would be changed with compulsory reporting would be that the public health doctor would know the name of his counterpart and not have to address him as "Mr. 364." So much on the "observation" provided for in the federal

epidemic law.

Second, there is also the "environmental investigation": The medical AIDS adviser at the public health office asks the one infected with HIV: "With whom have you had intercourse, whom could you have infected?" And if he is cooperative, he will say, and then these people can be investigated, informed, etc.

Third, there is the possibility of "isolation": If the behavior of one who is infected does not give a guarantee that he will not pass the disease on, if he does not follow the directives, then he must be isolated in a hospital or other appropriate institution. Earlier, there were quarantine wards in hospitals, but not any longer, because diseases such as smallpox and cholera have died out among us. But perhaps tuberculosis sanatoria could be reactivated, since they are for the most part very beautifully located and are internally equipped appropriately. Also, the isolation does not have to be lifelong, as is often said. The unreasonable could, after a while, come to listen to reason; additionally, there will perhaps be a cure in a few years. At a conference of the Club of Life in Munich, there was discussion of the possibility recently of developing a method within the foreseeable future for marking the cells carrying viruses with conjugated antibodies and then selectively destroying them. . . .

As said, all these prescriptions are in force today. If the Office of Health receives information of an infection, it is obligated to do exactly this.

EIR: What will be changed by the obligation to report names?
Pöhn: The most important change is that the office of public health will receive far more information and can, for that reason, be active on a much greater scale. Every doctor, every laboratory will be under the obligation to report every HIV infection to the responsible public health office so that this office can care for the one infected.

Additionally, a series of other things go along with compulsory reporting, for example, that reportable diseases may be treated only by doctors—and not, for example, by nonmedical healers; additionally, the prohibition against transmitting a reportable disease is backed by a more severe penalty.

The names of those infected will, incidentally, be kept strictly confidential, and not merely because of the confidentiality of personal records: The public health official is first subject to the duty of medical confidentiality and has additionally to maintain official silence. This is a greater difference to the rather rude customs in the previous century when, for example, the names of those sick with cholera were published.

EIR: Let's assume that in the Federal Republic environmental and random tests were to reveal that there are 500,000 citizens infected with AIDS, and the compulsory reporting of names were to be introduced. Would the public health offices, even with increased personnel, in general be capable of the tremendous task of advising them all and keeping them all under observation?

In Chicago, mothers protested against AIDS-sick children in school. I thought, the wrong mother protested, because the one most endangered in school is the child with AIDS. The WHO says AIDS-sick must be integrated. That is the best way of getting rid of them as quickly as possible.

Pöhn: Earlier, in the control of tuberculosis, we managed to do it! In 1950, we had more than 130,000 new cases of TB, and earlier there were still more. So, as there were then TB care centers, we now need AIDS care centers. TB patients were subpoenaed every half-year, till the end. The older TB patients who were still not subjected to modern chemotherapy and with whom it is not clear whether their TB will flare up again, had to be regularly tested.

The public health offices must likewise be put in the position of dealing with the AIDS problem. For example, supporting the public health doctors, who have to be concerned additionally about drinking water, hospital hygiene, burials, and much else, by putting doctors into service who would only be concerned, as specialists, with AIDS counseling. But what earlier worked will also work today.

EIR: Should those infected with AIDS be allowed to go into swimming pools? Do they have to avoid mass gatherings of people?
Pöhn: If someone infected with HIV goes to a swimming pool or to a mass meeting, then he must expect that he will pick up an infection from some commonplace antigen that will be much harder on him than with other people. For the other people, I see as yet no danger, with the known modes of transmission, at least here in Germany—in Africa, it is quite different. But the one infected himself is endangered.

That is my greatest objection against Mr. [Jonathan] Mann of the World Health Organization (WHO), who always says, "AIDS victims must be integrated." No, they must, first of all, be protected from others. How many commonplace in-

fections are going around that can be dangerous to someone infected with AIDS? For that reason, AIDS patients belong in a private room, and should have no contact with anyone who has a cold, who has a runny nose or a cough. In no case should those sick with AIDS be put together in one room since an AIDS victim probably brings an opportunistic infection with him that he has picked up somewhere.

Recently, on a North German Radio talk show, an apparently still completely healthy AIDS patient appeared who repeatedly emphasized that he simply wanted "to live," he did not want to be isolated, he wanted to do everything and go everywhere like other people. Fourteen days later, the same station reported that the man had in the meantime died. He had caught some infection or other, and now it was all over.

EIR: That mentality is still promoted by those who help AIDS patients, who are consequently the actual representatives of the interests of AIDS patients. Isn't that nonsense?
Pöhn: Yes, it is. The WHO says that those sick with AIDS must be "integrated." That is the best way of getting rid of them as quickly as possible! I want to deliberately say that, just that bluntly!

EIR: In the United States, the question is very passionately discussed whether AIDS-infected children should be allowed to go to kindergarten or school.
Pöhn: Here, the same is true with swimming pools or mass meetings. As I read in *Neue Solidarität* about the uprising in Chicago when mothers protested against AIDS-sick children being in the schools, I thought, actually the wrong mother protested, because the one most endangered in the school is the child sick with AIDS.

On the other hand, the protest of the mothers was also justified, since there are possibilities for AIDS transmission and blood exchanges in school, through biting, for example, in connection with which it must be asked, whether biting is still a "normal social contact" among children.

Additionally, the difficulty is that not all HIV carriers can be discovered with the antibody test. That means, basically, all strangers must be considered to be possibly infected. For that reason, it was prescribed legally on Oct. 1 that every automobile first aid kit must contain two pair of disposable gloves: With every action in which blood flows, protective gloves should be worn; with application of a bandage, with withdrawal of blood, and so forth. And it must also be considered that the AIDS virus in spilled blood remains infectious for quite some time, even if it is otherwise easy to kill.

EIR: For the protection of patients and personnel, the public health office issued guidelines in spring 1988 for hygienic measures to guard against transmission of HIV in hospitals. Can you briefly outline those?
Pöhn: Yes, the setting up of these guidelines took, unfortunately, a year longer than planned. The principle of these guidelines for protecting against infection in hospitals is this: It must be assumed that each patient can be infectious. For that reason, personnel must protect themselves with all patients, that is, wear gloves and protective clothing in dealing with blood and other bodily fluids. Objects contaminated with blood and other bodily fluids must be disinfected. Used disposable tubes should not be put back into the box but disposed of in special cans. Additionally, there are prescriptions for instrument sterilization. Disinfection with AIDS is relatively uncomplicated because the HIV virus is rather delicate, and any normal means of disinfection is easily sufficient of HIV.

The federal public health office recommends, of course, routine HIV tests for all hospital patients. It is of great importance that the doctor knows what can be expected with patients in the contemplated treatment or operation. Additionally, surgeons or an operating room nurse cannot be blamed if they want to know before an operation whether the given patient has an HIV infection or not.

On the other hand, doctors who are HIV positive are no longer allowed to operate, since it is quite pointless to say that they should operate with rubber gloves on. In our discussion, a surgeon took part who said, "Do you know how often in operations a finger of one of the assistants is sewed to the peritoneum through a glove?" They work there with surgeon's needles, forceps, and scalpels, and he bleeds.

If, on the other hand, a surgeon injures himself during an operation on an HIV positive patient, there is always the possibility of a preventive AZT treatment that may neutralize the invading viruses before they have attacked any cells. If AZT is given 96 hours after a possible infection and is taken for up to four weeks, an HIV infection can possibly be prevented. AZT has, however, serious side effects that, if taken over the long run, can themselves be the cause of death.

EIR: It is striking with these guidelines for the prevention of HIV infections in the hospital that they relate to all bodily fluids and not just blood.
Pöhn: We do know that all bodily fluids can be infectious, even urine, if, that is, infectious blood cells are contained in it. The virus has been detected in tears, even if there are no cells, and sweat also contains no cells. There can be cells in saliva, and also in the stool. In order, therefore, to exclude all possibilities of infection, we recommend the same protective measures with all bodily fluids. In contact with the deadly AIDS antigen, the greatest caution is enjoined. One certainly doesn't say: "Why do we need fireproof doors, there are fires only very rarely?" In connection with nuclear reactor safety, the most improbable risks are taken into account.

EIR: In Frankfurt, the AIDS wards are already overcrowd-

ed; in other densely populated areas, it is similar. If we assume that an AIDS victim has a right to optimal treatment just like any other severely ill patient, what must be done in preparation for the treatment of those many, many thousands of AIDS victims who are in store for us?

Pöhn: First, sufficient hospital beds must be created. At this time, we actually have an excess of hospital beds, but these beds should be maintained, or, at most, put into mothballs so that they are available again, anytime there is the need.

Also, it should be borne in mind that AIDS victims cannot be put into just any arbitrary hospital. That can be done with those with circulatory disturbances who do need an elevator, a tidy bed, and decent personnel, but are neither infectious nor in danger of being infected, as are AIDS victims.

AIDS victims are in great danger of infection, and require isolation for their protection. Not strict isolation but rather protective isolation: Each AIDS victim must be put in a private room. If I put an AIDS victim in with someone sick with typhus, then the person with typhus will not get AIDS but the AIDS victim will possibly get typhus. In no case should an AIDS patient be put in the same room with another AIDS patient, since these patients can no longer, of course, infect one another with AIDS but with all possible opportunistic infections. AIDS patients may, of course, go walking together, but not in places where there are uncontrolled crowds of people, and they should not be visited by people with runny noses, coughs, or other infections.

The standards at AIDS clinics must correspond to the standard of today's most modern infection clinics, equipped with the appropriate care personnel who are trained to protect patients from secondary infections. Such clinics should have available the high-quality equipment that is used with others whose immune systems are weakened, as, for example, arises in connection with cortisone treatment or organ transplants—before an organ transplant, the patient's immune system is deliberately weakened, so that the organ is not rejected. We need similar equipment with AIDS victims.

EIR: What progress has been made recently in the treatment of AIDS?

Pöhn: AIDS is, up to this point, incurable, but most opportunistic secondary infections are not only preventable and treatable, but are curable. Among these infections is tuberculosis. We now have an increase of TB cases—in the United States it is statistically obvious, but not with us—for, among others, the following reason, that an old TB infection is reactivated in older AIDS victims. But TB, just like other secondary infections, can be cured.

Unfortunately, the patient frequently dies later of encephalitis, that is, of a brain disease. Americans provided the proof back in 1985, that HIV not only attacks the cells of the immune system but also nerve cells. The first cases of encephalitis were detected in Berlin in the isolation hospital, where they had been successful in protecting patients from infections or in successfully treating them. So the profile of the disease has changed, with the patients developing encephalitis, while in earlier years they died from some infection or other.

EIR: Because there is, so far, no cure for AIDS, the euthanasia lobby makes the ghastly argument: Why is so much money spent on AIDS victims who will die sooner or later, no matter what? Which ignores that there are many diseases that are not curable, but are quite treatable.

Pöhn: If you want to be consistent with the thought, "Why should I treat AIDS victims, who are certainly going to die?" then I can also ask, "Why should I treat a human being in general—he'll certainly die?" A doctor simply treats a human being as long as he can and as long as it is somehow possible. And, obviously, I can manage the opportunistic infections with an AIDS patient, while the encephalitis is not presently curable. If one had a tool like AZT without the side effects, then that would be a gain since a life-long therapy would then be possible. But, nevertheless, the patient would always remain infectious.

EIR: What is to be expected of Bonn? Will it—with or without [Health Minister] Rita Süssmuth—make a change in direction on AIDS policy in time?

Pöhn: There is, probably, a change coming sooner or later. Bavaria has set a clear example. The German Society for Internal Medicine has issued a memorandum that quite clearly says: We have to do something! A member of the Board of Directors of the German Society for Infectious Diseases, who said to me a few years ago, "For God's sake, no compulsory reporting and no federal epidemic law, that'll put us all under!" now says "We need that." In my opinion, physicians have come to a kind of consensus that something must be done.

I expect very little from Mrs. Süssmuth because, in any case, she treats public health like a step-child, showing more interest in the integration of her fringe groups. She is, of course, a sociologist and pedagogue. But she cannot be blamed for a policy that the WHO explicitly recommends. Why the WHO makes such a devastating policy, I don't know. Perhaps that will change suddenly, just as so much so very suddenly changes with WHO.

Another question is, whether the department of public health is best placed with Mrs. Süssmuth. Perhaps it would help her and the public health service if it were put somewhere else. I would like it where it was until 1961, with the minister of the interior—before Adenauer absolutely needed a ministry for "Miss" Schwarzhaupt but did not want to saddle her, as an unmarried woman, with the ministry of the family. But even being with the minister of the environment would better preserve the department of health than with Rita Süssmuth. That is, of course, entirely my personal opinion, but I think that many colleagues think that way.