PLAY FAIR!
MOTHER SUPERIOR'S RECOMMENDATIONS TO HELP CREATE A DISEASE-FREE CONVENT AND COMMUNITY

PLAY FAIR! If you know—or even suspect—that you have a Sexually Transmitted Disease, don't put other people at risk. If you have sex, make sure you know that you are disease-free before you engage in any sexual activity. Remember: you can be treated, but you can't be cured. Use condoms always.

LUBRICANTS. Oil-based free of perfumes, scents, or MSG. The chemicals can irritate your skin.

COCK SOAP. Avoid. It takes off your manhood in true. Some boys can wash it all off, but it can make the penis raw and cause cirrhosis in the baby.

CONDOMS. Condoms do prevent the spread of some diseases. If you have sex on anything or on your contraceptive solutions of your own accord, whatever you do, don't have sex. You might have sex today with the person you love, but you might have sex tomorrow with a new person.

SORE-ASS SYNDROME. If one of your partners discovers an infection after you've been together (and you haven't exchanged names), he probably won't be able to tell you. Try to keep your sex partners as short as possible. Remember: this is the most dangerous sexual behavior. We like red meat, and together we like to have our meat and our gums, and sometimes we like to have our meat and our gums and our ears.

This pamphlet is produced and distributed by the Sisters of Perpetual Indulgence. A non-profit organization created by Sister Anonymous in 1979, the Sisters have been fighting for LGBTQIQ rights since their inception. If you have an STD or asymptomatic infection, the following is a list of gay serosensitive activities to get diagnosed and treated. For further information about these diseases, consult the appropriate pamphlets. See the list of pamphlets at the back of this pamphlet:

1. 1,5, 13
2. 10, 11, 14, 15
3. 1, 3, 5, 6, 7, 9, 13
4. 1, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14
5. 1, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15
6. 1, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16

This pamphlet is intended for educational and entertainment purposes only. For comprehensive medical advice, please consult your healthcare provider.

MOTHER SUPERIOR'S RECOMMENDATIONS TO HELP CREATE A DISEASE-FREE CONVENT AND COMMUNITY

PLAY FAIR! If you know—or even suspect—that you have a Sexually Transmitted Disease, don't put other people at risk. If you have sex, make sure you know that you are disease-free before you engage in any sexual activity. Remember: you can be treated, but you can't be cured. Use condoms always.

LUBRICANTS. Oil-based free of perfumes, scents, or MSG. The chemicals can irritate your skin.

COCK SOAP. Avoid. It takes off your manhood in true. Some boys can wash it all off, but it can make the penis raw and cause cirrhosis in the baby.

CONDOMS. Condoms do prevent the spread of some diseases. If you have sex on anything or on your contraceptive solutions of your own accord, whatever you do, don't have sex. You might have sex today with the person you love, but you might have sex tomorrow with a new person.

SORE-ASS SYNDROME. If one of your partners discovers an infection after you've been together (and you haven't exchanged names), he probably won't be able to tell you. Try to keep your sex partners as short as possible. Remember: this is the most dangerous sexual behavior. We like red meat, and together we like to have our meat and our gums, and sometimes we like to have our meat and our gums and our ears.

This pamphlet is produced and distributed by the Sisters of Perpetual Indulgence. A non-profit organization created by Sister Anonymous in 1979, the Sisters have been fighting for LGBTQIQ rights since their inception. If you have an STD or asymptomatic infection, the following is a list of gay serosensitive activities to get diagnosed and treated. For further information about these diseases, consult the appropriate pamphlets. See the list of pamphlets at the back of this pamphlet:

1. 1, 5, 13
2. 10, 11, 14, 15
3. 1, 3, 5, 6, 7, 9, 13
4. 1, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14
5. 1, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15
6. 1, 3, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16

This pamphlet is intended for educational and entertainment purposes only. For comprehensive medical advice, please consult your healthcare provider.
Q: What can STDs cause?
A: STDs can cause a wide range of symptoms and complications, and they can be dangerous if left untreated. Some of the common symptoms and complications include:

- Painful or itchy sores or rashes
- Discharge from the penis or vagina
- Pain during urination
- swollen, red, or tender lymph nodes
- Rectal pain or bleeding
- Abdominal pain or tenderness
- Fever

However, not all people with STDs experience symptoms, and some symptoms can be mild or resemble other conditions. It's important to get tested and treated for STDs to prevent complications and spread to others.

Q: How does an STD spread?
A: STDs can be spread through sexual contact, including vaginal, anal, or oral sex. Some STDs can also be spread through skin-to-skin contact or sharing items that come into contact with infected skin, such as towels or clothing.

Q: What are the risks of untreated STDs?
A: Untreated STDs can lead to serious health problems, including:

- Infections that spread to other parts of the body
- Pregnancy complications, such as ectopic pregnancy
- Infertility
- Increased risk of contracting HIV
- Cancer, such as cervical, rectal, or anal cancer
- Repeated infections

Q: How are STDs treated?
A: STDs are usually treatable with antibiotics, but it's important to finish the entire course of medication, even if symptoms go away before the treatment is complete. If you have an STD, it's important to notify all sexual partners so they can get tested and treated.

Q: Is it possible to get an STD without having sex?
A: Yes, some STDs can be spread through skin-to-skin contact or sharing items that come into contact with infected skin, such as towels or clothing. It's important to practice safe sex and use condoms to prevent the spread of STDs.

Q: Can you have more than one STD at a time?
A: Yes, it's possible to have more than one STD at a time. It's important to get tested for multiple STDs if you have multiple sexual partners or engage in risky sexual behavior.

Q: How can you prevent STDs?
A: The best way to prevent STDs is to practice safe sex, which means using condoms during sexual activity. It's also important to get tested regularly for STDs, even if you don't have symptoms, and to notify all sexual partners if you have an STD.

Q: What are the symptoms of common STDs?
A: The symptoms of common STDs can vary depending on the infection. Some common symptoms include:

- Gonorrhea:
  - Painful or frequent urination
  - Pain or burning during urination
  - Yellow or green discharge
  - Painful or itchy sores or rashes

- Chlamydia:
  - A burning sensation when urinating
  - A watery or white discharge
  - Lower abdominal pain

- HIV:
  - Fatigue
  - Fever
  - Night sweats

- Herpes:
  - Ulcers or blisters on the genitals, anus, or mouth
  - Painful urination

- Syphilis:
  - Painful ulcers on the penis or vagina
  - A hard, painless bump (chancre) at the site of infection

- Hepatitis B:
  - Fatigue
  - Nausea
  - Jaundice

- Hepatitis C:
  - Fatigue
  - Nausea
  - Itchy skin

- HPV:
  - Warts on the genitals, anus, or mouth

- Trichomoniasis:
  - A yellow, foamy discharge
  - Urinary symptoms

- Fungal infections:
  - Itchy, red, or sore skin

Q: What are the consequences of untreated STDs?
A: Untreated STDs can lead to serious health problems, including:

- Infertility
- Pregnancy complications
- Cancer
- Increased risk of contracting HIV

Q: What factors increase the risk of contracting an STD?
A: Factors that increase the risk of contracting an STD include:

- Multiple sexual partners
- Age younger than 25
- Recurrent STDs
- Not using condoms

Q: How can you get tested for STDs?
A: You can get tested for STDs at a doctor's office, clinic, or other health care provider. Many health care providers offer free or low-cost testing. It's important to get tested regularly, even if you don't have symptoms.

Q: What is the most common STD in the United States?
A: The most common STD in the United States is chlamydia, followed by gonorrhea and trichomoniasis.

Q: How can you prevent the spread of STDs?
A: The best way to prevent the spread of STDs is to practice safe sex, which means using condoms during sexual activity. It's also important to get tested regularly for STDs, even if you don't have symptoms, and to notify all sexual partners if you have an STD.

Q: What are the long-term effects of untreated STDs?
A: Untreated STDs can lead to serious health problems, including:

- Infertility
- Pregnancy complications
- Cancer
- Increased risk of contracting HIV

Q: Can STDs cause infertility?
A: Yes, some STDs, such as chlamydia and gonorrhea, can cause infertility if left untreated. Infertility from STDs can be prevented by getting tested regularly and treating infections early.

Q: Can STDs be cured?
A: Yes, many STDs can be cured with antibiotics. It's important to finish the entire course of medication, even if symptoms go away before the treatment is complete. If you have an STD, it's important to notify all sexual partners so they can get tested and treated.

Q: What are the symptoms of late-stage syphilis?
A: Late-stage syphilis can cause a variety of symptoms, including:

- Neurological problems
- Arthritis
- Cardiac problems
- Eye problems

Q: What are the risks of untreated chlamydia and gonorrhea?
A: Untreated chlamydia and gonorrhea can lead to serious health problems, including infertility, pelvic inflammatory disease, and, in women, increased risk of miscarriage and premature birth.

Q: What is the most common cause of PID (pelvic inflammatory disease)?
A: The most common cause of PID is untreated chlamydia or gonorrhea. Other causes include the use of intrauterine devices and the use of birth control.
THE PHYSICIAN IN THE AIDS CRISIS

An Educational Symposium sponsored by The Bay Area Physicians for Human Rights, and co-sponsored by The University of California at San Francisco Department of Psychiatry, and The American Association of Physicians for Human Rights

Location
San Francisco Medical Society Auditorium
250 Masonic Avenue
San Francisco, California

June 24 - 25, 1983 (Friday and Saturday)

Symposium Objectives
To increase the physician's understanding of the medical and psychological aspects of AIDS.
To stimulate critical discussion of the psychological, social, and political implications of the AIDS crisis for the physician and for the gay and lesbian community at large.
To formulate guidelines for physicians seeking to define their role in the evolving crisis.

Audience
The choice of topics is designed to be of interest to the complete range of medical specialists who provide health care to gay men and women. Health care providers in allied professions may also find the program of interest.

Fees

<table>
<thead>
<tr>
<th>Before June 15</th>
<th>After June 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>M.D.'s &amp; other doctorate</td>
<td>$195.00 *</td>
</tr>
<tr>
<td>House Staff</td>
<td>$100.00 **</td>
</tr>
<tr>
<td>Medical Students</td>
<td>$ 60.00</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

* $20.00 discount for BAPHR members in good standing for registration before June 15.
** $10.00 discount for BAPHR student and house staff members for registration before June 15.

Refund Policy
In the event of cancellation an administrative fee of $30 will be withheld from the refund. Refund requests must be in writing. No refunds will be given after the Symposium begins.

Meals
Coffee and rolls served each day.

FACULTY

James W. Curran, M.D., M.P.H.
Director AIDS Activity Center for Infectious Diseases,
Atlanta, Georgia

Roger W. Enlow, M.D.
Associate Attending Physician,
Hospital for Joint Disease
New York, New York

Stephen E. Follansbee, M.D.
Assistant Physician in Medicine
University of California, San Francisco

James Geary
Executive Director, Shanti Project

Stephen M. Goldfinger, M.D.
Director of Out Patient Services,
Department of Psychiatry, S.F. General Hospital
Assistant Professor of Psychiatry
University of California, San Francisco

Evelyn Hooker, Ph.D.
Professor, Department of Psychiatry
University of California, Los Angeles

David Kessler, M.D.
Clinical Professor of Psychiatry
University of California, San Francisco
Past President BAPHR
Past President of Caucus of Gay, Lesbian
Bisexual Members of American Psychiatric Association
Board of Directors, National Gay Task Force

Stuart E. Nichols, M.D.
Associate Chief Medical and Psychiatric Service
Beth Israel Medical Center
New York, New York

Pat Norman
Coordinator for Gay and Lesbian Health Services
City of San Francisco

Herbert Perkins, M.D.
Medical Director, Irwin Memorial Blood Bank

Bruce Voeller, Ph.D.
President Mariposa Foundation
Los Angeles, California

Paul Volberding, M.D.
Assistant Professor of Medicine
University of California, San Francisco
Chief of Oncology
San Francisco General Hospital
Board of Directors, Kaposi Sarcoma Foundation

THE PHYSICIAN IN THE AIDS CRISIS

THIRD ANNUAL SYMPOSIUM

BAY AREA PHYSICIANS FOR HUMAN RIGHTS

JUNE 24 - 25, 1983 • SAN FRANCISCO, CA

Co-Sponsored by The University of California at San Francisco Department of Psychiatry and the American Association of Physicians for Human Rights
# Symposium Program

**Friday, June 24, 1983**

<table>
<thead>
<tr>
<th>AM</th>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:45</td>
<td>Registration</td>
<td></td>
</tr>
<tr>
<td>8:45-9:00</td>
<td>Welcome and Introduction</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ian Barlow, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symposium Chair</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Opening Remarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Richard L. Andrews, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>President, BAPHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John T. Hopkin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vice Chair, Dept. of Psychiatry, UCSF</td>
<td></td>
</tr>
<tr>
<td>9:00-10:00</td>
<td>Epidemiology of AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>James Curran, M.D.</td>
<td></td>
</tr>
<tr>
<td>10:00-11:00</td>
<td>Clinical Treatment of AIDS Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paul Volberding, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Roger Enlow, M.D.</td>
<td></td>
</tr>
<tr>
<td>11:00-12:00</td>
<td>Small Group Discussions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PM</th>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00-1:30</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1:30-2:30</td>
<td>Support and Counseling of AIDS Patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stuart Nichols, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>James Geary</td>
<td></td>
</tr>
<tr>
<td>2:30-3:30</td>
<td>The Worried Well and the Walking Wounded</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stephen Goldfinger, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Closing Remarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denny McShane, M.D.</td>
<td></td>
</tr>
<tr>
<td>3:30-5:00</td>
<td>Small Group Discussions</td>
<td></td>
</tr>
</tbody>
</table>

### Cocktail Party

Time and Place to be announced.

---

**Saturday, June 25, 1983**

<table>
<thead>
<tr>
<th>AM</th>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:15</td>
<td>Opening Remarks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Denny McShane, M.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>President, AAPHR</td>
<td></td>
</tr>
<tr>
<td>9:30-10:00</td>
<td>Risk Reduction Factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stephen E. Follansbee, M.D.</td>
<td></td>
</tr>
<tr>
<td>10:00-10:15</td>
<td>Safety of Blood Products</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Herbert Perkins, M.D.</td>
<td></td>
</tr>
<tr>
<td>10:15-11:00</td>
<td>The Physician and AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>John D. Rouse, M.D.</td>
<td></td>
</tr>
<tr>
<td>11:00-12:00</td>
<td>Panel Discussion: Social and Political Issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bruce Voeller, Ph.D.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pat Norman</td>
<td></td>
</tr>
<tr>
<td></td>
<td>David Kessler, M.D.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PM</th>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00-1:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>1:00-2:00</td>
<td>Small Group Discussions</td>
<td></td>
</tr>
<tr>
<td>2:00-3:00</td>
<td>Challenge and Opportunity in the Health Crisis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evelyn Hooker, Ph.D.</td>
<td></td>
</tr>
</tbody>
</table>

Sequence of Presentations Subject to Change

This is an approved program of continuing medical education. Physicians attending this course may report up to 10 hours of Category I credit toward the California Medical Association Certificate in Continuing Medical Education.

National CME Credit Pending

Symposium Chairperson: Ian D. Barlow, M.D.
Associate Chairperson: John D. Rouse, M.D.
HOW CAN I JOIN BAPHR? BAPHR membership is available to individual physicians, house staff, and students in training (in an accredited medical or osteopathic school) who support the goals of BAPHR. An individual or organization not professionally eligible or not wanting full membership but wishing to further the goals of BAPHR may become an affiliate.

Membership fees are paid once a year and are tax deductible. Membership in BAPHR is strictly confidential. BAPHR is a tax exempt organization under section 501 (C)3 of the Internal Revenue code and as such is in a position to accept grants and bequests.

Structural organization of BAPHR — the general membership (exclusive of affiliates) elect the officers for a term of one year. The officers are President, President Elect, Vice-President, Secretary and Treasurer.

All members are urged to join and be active in the standing committee of their choice. These include:

1. Membership/Support
2. Education
3. Scientific Affairs/Journal Club
4. Social Concerns/Community Outreach
5. Publications/Media
6. Finance
7. Administration

BAY AREA PHYSICIANS FOR HUMAN RIGHTS
P.O. Box 14546
San Francisco, CA 94114
(415) 558-9353
**WHAT IS BAPHR?**

Bay Area Physicians for Human Rights is an organization of physicians, medical students, residents, and professionally affiliated health personnel dedicated to promoting human rights and quality medical care for lesbians and gay men.

During the anti-gay campaigns of 1977 the "Gay People in Medicine Committee" of the American Medical Student Association began to form support groups for the lesbian and gay medical students in the U.S. Inspired by this concept of mutual support, the Bay Area Physicians for Human Rights (BAPHR) was founded in July, 1977. This was the first formal association of lesbian and gay physicians in the U.S. Other regional organizations have since emerged across the country, and in June, 1981, a national organization, the American Association of Physicians for Human Rights (AAPHR) was formed.

**WHAT ARE OUR GOALS?**

BAPHR’s major goal is to provide an organization in which the lesbian or gay physician can find a source of professional and personal support and affiliation. We hold social functions for our members and their partners. We provide opportunities to grow through involvement in our service projects and in the administration of the organization.

BAPHR is also dedicated to the improvement of the quality and accessibility of medical care for lesbian and gay patients. To further this goal, BAPHR seeks to educate both physicians and the public about the special health care needs of the homosexual, sponsors research into medical problems relating to the homosexual, and forms liaisons with professional associations and public officials concerning lesbian and gay health issues.

Community Service — BAPHR provides a telephone referral service for gay patients and sponsors an annual health screening fair for the public. BAPHR distributes health education materials at major public events, and provides speakers on lesbian and gay health issues. We work closely with government leaders to promote the health and protection of lesbian and gay people.

Communication — BAPHR publishes a monthly newsletter (The BAPHRON) which includes articles of social, political, and medical interest to the membership. All members and affiliates receive the publication. To insure confidentiality, it is mailed in an envelope bearing only the BAPHR logo and return address. A non-member edition is read by influential physicians throughout the United States and by public policymakers on local, state, and national levels.

**HOW DO WE ACHIEVE OUR GOALS?**

Meetings — General meetings are usually held on the second Sunday evening of each month for members to meet each other and provide mutual support. The meeting includes a guest speaker, committee reports, and a social hour with small group discussions.

Professional Education — BAPHR sponsors an annual symposium on lesbian and gay health issues for both gay and non-gay physicians. We maintain useful educational liaisons with mainstream regional and national medical associations. BAPHR has sponsored research on gay issues which has been published in major medical journals. We are approved to grant Category I CME credit for the annual symposium and for the monthly general meetings.
MEMBERSHIP RENEWAL: Please indicate any changes.

Name ___________________________________________ Degree _______________________

Mailing Address ________________________________________________________________

City ______________________ State ________ Zip _________

Telephone: Residence (______) __________________________ Office (______) ______________

Please renew my affiliation with BAPHR for six months as:

☐ Physician member ($50.00)       ☐ Housestaff member ($25.00)
☐ Medical student ($10.00)        ☐ Affiliate ($25.00)

Please make checks payable to BAPHR.
I would like to join the following Committee(s):

- Membership/Internal Support
- Education
- Scientific Affairs/Journal Club
- Social Concerns/Community Outreach
- Publications/Media
- Finance
- Administration

I would like to recommend for membership in BAPHR:

Name: ___________________________ Degree/Specialty: ___________________________

Address: _________________________________________________________________

City: ___________________________ State: ___________ Zip: ___________

Telephone: Residence (____) ___________ Office (____) ___________
MEDICAL ASPECTS OF SEXUAL ORIENTATION II

An Educational Symposium sponsored by
The Bay Area Physicians for Human Rights

Location
San Francisco Medical Society Auditorium
250 Masonic Avenue
San Francisco, California

June 25 - 26, 1982
(Friday and Saturday)

Symposium Objectives
To increase the physician's understanding of the psychological and social functioning of gay men and lesbians.
To increase the physician's knowledge of the treatment of medical and psychological problems encountered by gay men and lesbians.

Audience
The choice of topics is designed to be of interest to the complete range of medical specialists who provide health care to gay men and women.
Health care providers in allied professions may also find the program of interest.

Fees

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 15</td>
<td>June 15</td>
</tr>
<tr>
<td>Physician/Ph.D.</td>
<td>$150.00</td>
</tr>
<tr>
<td>House Staff/Allied Professional</td>
<td>$75.00</td>
</tr>
<tr>
<td>Medical Student</td>
<td>$30.00</td>
</tr>
</tbody>
</table>

Refund Policy:
In the event of cancellation an administrative fee of $30 will be withheld from the refund. Refund requests must be in writing. No refunds will be given after the Symposium begins.

Meals
The registration fee includes coffee and rolls each morning. Lunch will be served both days.

Travel Arrangements
Transportation, accommodations may be made through Passport to Leisure
4111 18th Street San Francisco, CA 94114
(415) 621-8300

FACULTY

Donald Abrams, M.D.
Fellow in Hematology-Oncology
Cancer Research Institute
University of California, San Francisco

Bronwyn D. Anthony, Ph.D.
Private Practice, Clinical Psychology
West Hollywood

Robert K. Bolton, M.D.
Clinical Instructor
Department of Family and Community Medicine
University of California, San Francisco

Steven P. Borkovik, M.D.
Resident in Dermatology
University of California, San Francisco

Robert A. Bush, Jr., M.D.
Assistant Clinical Professor, Department of Surgery
University of California, San Francisco

Michael J. Catanzaro, M.S.
Director of Staff Development
Naval Regional Medical Center, Alcohol Recovery Service
Long Beach

William J. Kapla, M.D.
Clinical Instructor
Department of Family and Community Medicine
University of California, San Francisco

Douglas C. Kimmel, Ph.D.
Professor of Psychology
City University of New York

Dale McGhee, M.D.
Clinical Instructor, Urology
Stanford University

Patrick J. McGraw, M.D.
Clinical Instructor in Family, Community and Preventive Medicine
Stanford University

Dennis J. McShane, M.D.
Assistant Clinical Professor of Medicine in Rheumatology
Stanford University

David P. McWhirter, M.D.
Assistant Clinical Professor of Psychiatry
University of California, San Diego

Andrew Mattison, M.S.W., Ph.D.
Assistant Clinical Professor of Community and Family Medicine
University of California, San Diego

William F. Owen, Jr., M.D.
Private Practice, Internal Medicine
San Francisco

Patty Robertson, M.D.
Private Practice, Obstetrics and Gynecology
Santa Monica
SYMPOSIUM PROGRAM
Friday, June 25, 1982

AM
8:00-8:45 Registration
8:45-9:00 Opening Remarks
9:00-10:00 Research and the Gay Community
   Robert K. Bolan, M.D.
   Dennis J. McShane, M.D.
10:00-11:00 The Aging Gay
   Douglas C. Kimmel, Ph.D.
11:00-12:00 Lesbian Relationships
   Bronwyn D. Anthony, Ph.D.

PM
12:00-1:00 Lunch
1:00-2:00 Proctology
   Robert A. Bush, Jr., M.D.
2:00-3:00 Health Issues of Lesbians
   Patty Robertson, M.D.
3:00-3:10 Break
3:10-4:10 Alcoholism in the Gay Relationship
   Michael Catanzaro, M.S.
4:10-5:10 Kaposi's Sarcoma Update
   Donald Abrams, M.D.
   Steven P. Borkovic, M.D.

SYMPOSIUM PROGRAM
Saturday, June 26, 1982

AM
9:00-10:30 More on Coupling-Gay Male Relationships
   Andrew Mattison, M.S.W., Ph.D.
   David P. McWhirter, M.D.
10:30-11:00 Break
10:45-12:15 Clinical Updates Hepatitis, Prostatic Disease, Sexually Transmitted Diseases
   Robert K. Bolan, M.D.
   William J. Kapla, M.D.
   Dale McGhee, M.D.
   Patrick J. McGraw, M.D.
   William F. Owen, Jr., M.D.
12:15 Lunch

Sequence of Presentations Subject to Change

This is an approved program of continuing medical education. Physicians attending this course may report up to 10 hours of Category I credit toward the California Medical Association Certificate in Continuing Medical Education.

Symposium Chairperson: James P. Krameski, M.D.
Associate Chairpersons: Richard L. Andrews, M.D.
                      William J. Kapla, M.D.

Optional: The First Annual Meeting of the American Association of Physicians for Human Rights (AAPHR) will convene Saturday after lunch.
I would like more information regarding:
- ☐ other ways to contribute to the BAPHR Foundation
- ☐ active participation in fundraising projects as a volunteer
- ☐ membership information on BAPHR (services, dues, goals, etc.)

All donor names are kept confidential to the maximum extent allowed by law unless donor authorizes usage.

☐ Please keep my name confidential.
☐ You may use my name in support of your fundraising efforts.
☐ No, I cannot contribute at this time. Please keep me advised of future fundraising projects.

DONOR INFORMATION (please print)

NAME ____________________________

MAILING ADDRESS ____________________________

CITY ____________________________ STATE _______ ZIP ________

TELEPHONE ( ) _______ DAYS ☐ EVENINGS ☐

SIGNATURE ____________________________ DATE ________

MAIL TO: BAPHR Foundation
Post Office Box 14546
San Francisco, CA 94114-0546

"THE HEALTH OF THE PEOPLE IS REALLY THE FOUNDATION UPON WHICH ALL THEIR HAPPINESS AND ALL THEIR POWERS AS A STATE DEPEND."

These words, spoken in 1877 by Britain's Prime Minister Benjamin Disraeli, carry an important message for people interested in improving the health of the Bay Area's gay and lesbian community. If you share this interest, we hope that you will read further to learn more about the BAPHR Foundation.
The BAPHR Foundation was created in 1981 in response to the need for a philanthropic organization dedicated to improving gay and lesbian health care.

The Foundation is an autonomous part of Bay Area Physicians for Human Rights, Inc. (BAPHR) which was founded in 1976. At present, BAPHR has some 300 members and has inspired the formation of similar groups across the nation, Canada, and Europe. The organization is an acknowledged leader in AIDS education, known most notably for its nationally-respected publications on the prevention of this syndrome.

Locally, BAPHR continues to sponsor an annual health symposium and an annual health fair, and forms liaisons with professional associations and public officials concerning lesbian and gay health issues.

**FOUNDATION PURPOSE**

The purpose of the BAPHR Foundation is to fund health-related education and direct service projects which impact the gay and lesbian community of the Bay Area. This unique mission distinguishes the BAPHR Foundation.

The BAPHR Foundation operates with its own Board of Directors who are selected from BAPHR and from the community at large. Directors are sought from various medical, business, and community interests representing the cultural diversity of Bay Area life. The Board is responsible for all fundraising efforts, fund management, and project grants.

**SCOPE OF GRANTS**

- The BAPHR Foundation makes grants based upon applications which document needs consistent with the Foundation's purpose. Grants may be made to non-profit direct health service projects, medically-related social projects, and educational programs for both the medical community and the general public. Research, other than in the specific areas of history and anthropology, is not funded.

**SUPPORTING OUR WORK**

The BAPHR Foundation is supported by contributions from BAPHR members and the general public. Donations are tax deductible under BAPHR's 501-c3 (tax exempt/non-profit) status and may be made to either the General or Endowment Fund.

- GENERAL FUND—a portion of contributions to this fund is granted in the same fiscal year as donated.
- ENDOWMENT FUND—only the earned income derived from contributions held permanently in this fund is granted.

Deferred contributions to either fund can be accomplished through bequests of estate funds or property, or by designation of the BAPHR Foundation as beneficiary of an insurance policy. Significant contributions of restricted purpose or "donor-advised" gifts can be made to either fund, provided the donor's designation is within Foundation guidelines.

United Way donations may be directed to the Foundation through their donor option plan.

For more information or to make your contribution to the BAPHR Foundation, please send the attached response card to:

BAPHR Foundation
Post Office Box 14546
San Francisco, CA 94114-0546
Telephone: (415) 558-9353

**RESPONSE CARD**

- The BAPHR Foundation, with your assistance, can improve the health of gay men and lesbians in the Bay Area. Please help us now by completing this response card and returning it today.

Enclosed is my tax-deductible contribution in the amount of $ ____________________.

I would like to pledge the total sum of $ ____________________ in the following manner:

- monthly donation of $ ____________________
- quarterly donation of $ ____________________
- semi-annual donation of $ ____________________
- annual donation of $ ____________________
- other ____________________

Please send pledge reminders.

Please apply my contribution to:

- General Fund for granting
- Endowment Fund to help secure the BAPHR Foundation's financial future

Please contact me regarding:

- my deferred contribution
- my donor-advised contribution

(continued on other side)
The following items are important factors for spread of sexually transmitted diseases in general; their possible connection with AIDS is based on the increased likelihood of acquiring a theoretical AIDS germ.

- Anonymity: Anonymity in reference to sex is a relative term which includes those sexual encounters where you know nothing or almost nothing about your partner's health, frequency of different sex partners, and sex or health practices. In other words, you have no chance of knowing how likely it might be for that person to harbor an infection that you might acquire. This is obviously varying degrees of anonymity: the encounter where you know even one area of your partner's anatomy, the "one night stand" with whom you have spent some time and have established some rapport, and so on. Although far from foolproof, knowing a person's habits and self-care will give you a much more accurate estimate of his health.

- Bathhouses, back rooms, bookstores and part-time sex workers where one is quite likely to have sexual contact with more than one partner at a visit or more than one partner at a time represent increased opportunities for transmission. Sex work is particularly true when facilities for hygiene are either absent or inadequate.

- Drugs: Although no studies to date have singled out any drug as a significant risk for AIDS we think that the use of mind altering drugs can affect many aspects of overall health by impairing sleep, causing a "drugged" or non-natural sleep, affecting decisions about the kind of sex one has, the number of partners one has, and altering one's appreciation so that injury may occur.

- Sexually, our sexual practices will be both fun and healthy if you determine that some changes are needed, additional things worth considering follow:
  - If you choose not to eliminate something that may be risky, consider modification. For example, if you wish to continue bathhouse partners, consider not having rectal sex with them.
  - Recognize that some of the advised changes may go against current subculture sexual customs so that peers may not readily accept your decisions.
  - The freedom to discuss sexual preferences openly with partners provides the needed opportunity to include communication about sexual limits.
  - Fantasy will always be a central feature in human sexuality, so if it is a usual component to a particularly favored but risky activity, fantasize about it.
  - Take good care of your body and general health (adequate fast, good nutrition, physical exercise, reduction of stress, reduction of toxic substances like alcohol, cigarettes, marijuana, poppers, non-prescription drugs).
  - Consider showering before sex and inspect your partner.

**Bloodstream.** The use of condoms for intercourse would provide the logical barrier to reduce the likelihood of this happening. If a condom is not used, withdrawal prior to ejaculation would be a "next best" precaution. Since inanimate objects not only can induce tissue injury but can carry germs, using only your own douche equipment or toys is prudent.

- Anal intercourse: Insensitive (fucking). It is not certain whether significant trauma regularly occurs to the penis during anal intercourse so that infections can enter and create ulcerative infections in the bowel and can protect the wearer against many of the sexually transmitted infections.

- Note: Lubrication for anal intercourse is important. Saliva, though ever present, is a poor lubricant. If it is used, friction can cause tearing of the rectal lining. The best lubricant should be non-perfumed and in closed containers which can be contaminated with fecal germs to be transmitted to the next partner.

- Oral-genital insertive (being sucked). If there are no cuts or abrasions on your penis to be infected by mouth germs, probably no extra precautions need to be taken except to avoid trauma done by the teeth.

- Oral-genital receptive (sucking). With the intact barriers of unbroken skin on your partner's penis and your unbroken oral mucous membrane, this probably presents minimal risk. Remember that semen is a bodily secretion that may contain germs or other material foreign to your body. Either not having your partner cum in your mouth or not swallowing the cum are ways to minimize your exposure. If there is uncertainty about the recent whereabouts of your partner's penis, requesting a shower never hurts.

- Water sports: Urine on intact skin probably represents little risk but when it enters the body it becomes the exchange of an excretion.

- Kissing: Providing neither partner has open cuts or sores of the mouth, lips or tongue, kissing probably represents little risk. Although the degree of infectivity of the mouth has not been determined, the kissing partners mentioned above are not known, it is unlikely that an AIDS agent could be transmitted easily through kissing.

- Hugging, cuddling, sensual massage, mutual masturbation. Since no bodily fluids are exchanged, these activities are sexual, after no risks for AIDS transmission and could easily be encouraged.

**SECTION AND COMMUNITY RESPONSIBILITY**

The uncertainty about AIDS will be overcome in this health crisis there are the seeds for positive social growth. We think that thoughtful consideration of the facts will help achieve:

- Recognition of our fear through a sharing of feelings with partners, friends and strangers in discussion groups and other organized efforts and hopefully the channeling of some of the effective action.

- Emotional and financial support for those who have or who are suspected of having AIDS.

- A community network that provides a supportive atmosphere in which the principles in these guidelines can be accomplished.

- A community that assists anyone affected by AIDS or AIDS-like conditions to maintain intimacy and sexual contacts without risking their health or the health of their partners.

- A knowledge of AIDS based on fact and not on rumor.

- Continued development of gay-influenced support, education, referral services, and research (SHANTI and AIDS KS Foundation).

The facts we offer are actively working to make the energy of AIDS found necessary to solve this health crisis as soon as possible.

---

**GUIDELINES FOR AIDS RISK REDUCTION**

**What is AIDS?**

- AIDS is shorthand for Acquired Immune Deficiency Syndrome.
- AIDS is a disease that damages the immune system of otherwise healthy persons.
- AIDS is a life-threatening disease.
- AIDS may be a sexually transmitted disease.

**The message is clear:**

**AVOID THE DIRECT EXCHANGE OF BODILY FLUIDS**

**Strong evidence indicates that AIDS is transmitted by direct contact with the blood or semen of someone who is infectious.** The most common way in which bodily fluids (semen, saliva, urine, and even stool) are exchanged is through intimate sexual contact.

As with other sexually-transmitted diseases like gonorrhea, syphilis, hepatitis, herpes, etc., it may take only ONE contact to acquire AIDS.

As health care professionals we recognize the importance of physical and emotional intimacy for overall health. We believe that knowing the health and disease implications of specific risk sexual practices is essential for the safe and satisfying expression of that intimacy.

The aims of this brochure are:

1. To present a framework for the understanding of Acquired Immune Deficiency Syndrome (AIDS) as a transmissible disease -- a concept which we think best fits the available data;
2. To suggest risk reduction guidelines.

As research progresses we expect our understanding of AIDS to improve and our recommendations to be more specific. Presently, since the cause (or causes) of AIDS is unknown, we cannot be certain that following these guidelines will protect you from AIDS. We do know that the longstanding health crisis of multiple sexually transmitted diseases in the gay community can be reduced if everyone were to heed the suggestions outlined in this brochure. If repeated infections also weaken the immune system as many believe, these suggestions should help you lead a healthier and safer life! If our comments seem too judgmental or directive, understand that we, too, have experienced these diseases and are trying to follow our own recommendations. We would rather be safe than sorry.

---

This brochure was prepared by the BALD-65 Scientific Affairs Committee with invaluable counsel of many gay community leaders.

For further service, call:

**BAPHE — (415) 673-3189**

**AIDS KS Foundation — (415) 864-4376**

For reprint requests, contact:

**AIDS/KS Foundation**

P.O. Box 14227, San Francisco, CA 94114
ENCLOSED IS MY TAX-DEDUCTIBLE DONATION *

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$10</td>
<td>$20</td>
<td>$25</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| I'd like to volunteer to help. Please contact me.

NAME

ADDRESS

PHONE

Make check payable to: AIDS/KS Foundation and return it, with this form to: P.O. Box 14227 San Francisco, CA 94114

* Your regular United Way donations can be channeled to the AIDS/KS Foundation by requesting a donor option card and specifying the AIDS/KS Foundation.

WHAT HAPPENS TO PEOPLE WITH AIDS?

They are susceptible to a wide variety of illnesses which are neither "new" illnesses nor unique for AIDS patients. These include serious infections caused by some microscopically parasitic agents (e.g., pneumonia caused by Pneumocystis carinii), some bacteria (including one related to the agent of tuberculosi,s), some fungi (e.g., cryptococcal meningitis), and some viruses (e.g., prolonged herpes zoster infections). Certain cancers, particularly Kaposi's sarcoma, have been the major manifestation of AIDS in many individuals. Not all people with AIDS get all these illnesses. Many symptoms associated with AIDS are nonspecific and can with benign ailments such as a cold, bronchitis, or stomach flu. What characterizes many AIDS symptoms are their duration (much longer than harmless, self-limited conditions), their unrelenting waxing and waning, their severity, and their coexistence with an increasing debility or failure to thrive.

General symptoms of AIDS may include the following:

- Unexplained increased and persistent fatigue.
- Periodic or regular fevers, shaking chills, drenching night sweats not accompanied by a known illness and lasting longer than several weeks.
- Weight loss that is unexpected and greater than approximately 10 lbs. in less than 2 months.
- Otherwise unexplained swollen glands (enlarging lymph nodes with or without pain, usually in the neck, armpits, or groin) lasting for more than two weeks.
- Pink to purple flat or raised blotches or bumps, usually painless, occurring on or under the skin, inside the mouth, nose, eyelids, or rectum. Initially they may look like bruises that do not go away and they usually are harder than the skin around them.
- Persistent white spots or unusual blemishes in the mouth.
- Persistent or often dry cough that is not from smoking and has lasted too long to be from a usual respiratory infection.
- Persistent diarrhea.

IF YOU ARE UNCERTAIN ABOUT YOUR HEALTH, PLEASE SEE A HEALTH CARE PROVIDER KNOWLEDGABLE ABOUT AIDS AND ITS MANIFESTATIONS.

HOW IS AIDS CONTAGIOUS?

This answer requires some understanding of general principles that apply to all contagious diseases. In general, disease transmission requires a vehicle carrying a significant number of germs into or on to the person. A vehicle can be microscopic amounts of blood such as in the case of some types of hepatitis, it can be urine or semen in the case of syphilis (virus). It can be pus or stool or the objects contaminated with these. Not all germs are present in all body fluids or secretions.

HOW ARE WE SUSCEPTIBLE TO INFECTIONS?

We are susceptible either by 1) exposure to germs that are active and that respect none of the natural barriers most people have, or 2) damage to natural barriers allowing invasion of germs that otherwise might not have a chance to cause infection.

WHAT ARE THESE NATURAL BARRIERS?

They include intact skin and mucous membranes of the nose, throat, urethra, and rectum. They include stomach which kills many swallowed germs. They include healthy cells of the nose and lungs which can filter and expel invaded germs. They include normal mucus and saliva production which can coat and "neutralize" many germs.

ARE THERE ANY OTHER BARRIERS BEHIND THESE NATURAL ONES?

A hand can be held over the mouth when coughing, a tissue or handkerchief can be held over the mouth when sneezing, a condom can be used when having sexual intercourse with a man. These and other means of avoiding direct contact with the excretions and secretions (urine, stool, blood, semen, saliva) of other persons represent barriers that limit the chance for you to acquire germs those people may harbor—even if they don't appear ill.

DO YOU KNOW IF I CAN CATCH AN INFECTION FROM SOMEONE WHO DOES NOT APPEAR ILL?

Yes. Many infections are contagious even during the "incubation period." This means that during that time an infection has been acquired but the symptoms have not yet developed. In the case of many infections, the germs may be transmitted to other people. It is presumed that the incubation period for AIDS may be 7-24 months or longer. Thus, there may be two or more years before the time the person is infected and the feels sick with AIDS. It is therefore possible and probable (but not proven) that the AIDS agent may be spread during this time.

WHAT DOES ALL THIS HAVE TO DO WITH AIDS?

As stated earlier, no one knows if AIDS is caused by a germ. If it is, we do not know (1) what the vehicle(s) is/are that enter the disease, (2) what other persons are infected and how they are infected by AIDS, (3) whether all persons who come into contact with these persons are equally susceptible to its consequences, (4) how long the period may be, and (5) whether all germ are present in all body fluids or secretions.

REDDUCING RISK

Reducing risk for AIDS may mean making changes in sexual practices but it does not mean denying the sexual part of one's life. Fear of AIDS can and probably will stir homophobic responses in many of us.

Gay sex and intimacy with gay men may be seen as bad and to be avoided at a time when we need more intimacy and self-affirmation. We may need to create a kind and rational "gay parent" in our heads that counteracts such negative thoughts and guides us toward a healthy regard for our bodies and the bodies of those we love. However, we urge careful consideration of the following points and their implied suggestions.

There are general factors agreed upon by virtually all researchers as representing significant risk.

1) Sexual activity in which bodily secretions are exchanged;
2) The more partners with whom sexual activity includes secretion exchange, the greater the risk.
3) The injection of illicit drugs or the shared use of needles for such injections. By logical extension, sexual contact with those known to use intravenous drugs would represent significant risk.

Certain sexual practices are known to be associated with an increased risk of sexually transmitted diseases. Unless you and your partner have been monogamous for two years or more, eliminating, reducing, or modifying these practices may decrease your risk for AIDS. Remember the principles of protective barriers and blocking the spread of germs in blood, secretions, and excreta from person to person.

- Biting (both giving and receiving); with the microscopic and frequently visible injury to the rectal tissues, germs may penetrate into the bowel and bloodstream; also the inserting partner's fingers or hand is exposed to all the bowel germs and with the tissue injury involved, is exposed to his partner's blood. This is a principle for which correlation with AIDS has been demonstrated.
- Oral-anal contact (rimming). The "active" partner is at risk of ingesting multiple infectious agents in feces. The receptive partner may absorb his partner's semen into his bloodstream through small tears or fissures in the anal skin.
- Anal intercourse receptive (being fucked). This is a known risk for which correlation with AIDS has been shown. Because the rectal lining can be easily injured during anal intercourse, foreign material or germs in your partner's semen can gain direct access into your body.
Reducing Risk

Reducing risk for AIDS may mean making changes in sexual practices but it does not mean denying the sexual part of one's life. Fear of AIDS can and probably will stir homophobic responses in many of us.

Gay sex and intimacy with gay men may be seen as bad and to be avoided at a time when we need more intimacy and self-affirmation. We may need to create a kind and rational "gay parent" in our heads that counteracts such negative thoughts and guides us toward a healthy regard for our bodies and the bodies of those we love.

Reducing risk may mean that you may need to change your sexual activities, and this may mean exploration of new enterprises. What is this exploration? It is simply the process of becoming aware of the contents of your body and how to use them to the mutual advantage.

When we examine our own bodies, we find that they are full of potential for harm and for potential for self-affirmation. They are also capable of self-healing; for example, if a scratch is made on the body or if the body is injured, the body healing process will begin immediately.

AIDS-KSFS is committed to working to reduce the risk of AIDS for everyone. We have developed the following principles to help guide all of us in reducing our risk.

1. Avoid all direct body-to-body contact.
2. Avoid any kind of sexual behavior.
3. Avoid any kind of intimate contact.

Further Reading


As health-care professionals we recognize the importance of physical and emotional intimacy for overall health. We believe that knowing the health-related implications of specific gay male sexual practices is essential for the safe and satisfying expression of that intimacy.

The aims of this brochure are:
1) to present a framework for the understanding of Acquired Immunodeficiency Syndrome (AIDS) as a transmissible disease—a concept which we think best fits the available data;
2) to suggest risk reduction guidelines.

As research progresses we expect our understanding of AIDS to improve and our recommendations to be more specific. Presently, since the cause (or causes) of AIDS is unknown, we cannot be certain if these guidelines will protect you from AIDS. We do know that the longstanding health crisis of multiple sexually transmitted diseases in the gay community can be reduced if everyone makes an effort to heed the suggestions in this brochure. If repeated infections also weaken the immune system as many believe, these suggestions should help you lead a healthier and safer life. If our comments seem too judgmental or directive, understand that we, too, have experienced these diseases and are trying to follow our own recommendations. We would rather be safe than sorry.

WHAT HAPPENS TO PEOPLE WITH AIDS?

They are susceptible to a wide variety of illnesses which are neither "new" illnesses nor unique for AIDS patients. These include serious infections caused by some microscopic parasites (e.g., pneumocystis carinii), some bacteria (including one related to the agent of tuberculosis), some fungi (e.g., cryptococcal meningitis), and some viruses (e.g., prolonged herpes rectal ulcers). Certain cancers, particularly Kaposi's sarcoma, have been the major manifestation of AIDS in many individuals. Not all people with AIDS get all these diseases.

BUT WHAT ARE THE SYMPTOMS OR SIGNS OF AIDS?

Many symptoms associated with AIDS are nonspecific and can occur with benign ailments such as a cold, bronchitis, or stomach flu. What characterizes many AIDS symptoms are their duration (much longer than harmless, self-limited conditions), their unrelenting waxing and waning, their severity, and their frequency: co-existence with an increasing debility or failure to thrive.

General symptoms of AIDS may include the following:

- Unexplained increasing and persistent fatigue.
- Periodic or regular fevers, shaking chills, drenching night sweats not accompanied by a known illness and lasting longer than several weeks.
- Weight loss that is unexpected and greater than approximately 10 lbs. in less than 2 months.
- Otherwise unexplained swollen glands (enlarging lymph nodes with or without pain), ulceration in the neck, armpits, or groin) lasting for more than two weeks.
- Pink to purple flat or raised blotches or bumps, usually painless, occurring on or under the skin, inside the mouth, nose, eyelids, or rectum. Initially they may look like bruses that do not go away and they usually are harder than the skin around them.
- Persistent white spots or unusual blemishes in the mouth.
- Persistent or often dry cough that is not from smoking and has lasted too long to be from a usual respiratory infection.
- Persistent diarrhea.

If you are uncertain about your health, please see a health care provider knowledgeable about AIDS and its manifestations.

HOW IS AIDS CONTRACTED?

This answer requires some understanding of general principles that apply to all contagious diseases. In general, disease transmission requires a vehicle carrying a significant number of germs into a susceptible person. A vehicle might be saliva, menstrual blood, or genital fluids. Some microorganisms (e.g., syphilis, gonorrhea, human papilloma virus) enter the body through cuts or breaks in the skin, the respiratory tract, or the digestive tract. Some organisms (e.g., tuberculosis) enter through the lungs. Some organisms (e.g., viruses causing hepatitis, cytomegalovirus) can be passed from the affected organs to others. Not all germs are present in all body fluids or secretions.

HOW ARE WE SUSCEPTIBLE TO INFECTIONS?

We are susceptible either by (1) exposure to germs that are very invasive and that respect none of the natural barriers most people have, or (2) damage to natural barriers allowing invasion of germs that otherwise might not have a chance to cause infection.

WHAT ARE THESE NATURAL BARRIERS?

They include intact skin and mucous membranes of the nose, throat, urethra, and rectum. They include stomach acid, intestines, and saliva. They include healthy cells of the nose and lungs which can filter and expel ingested germs. They include normal mucus and saliva production which can coat and "neutralize" many germs.

ARE THERE ANY OTHER BARRIERS BEHIND THESE NATURAL ONES?

A hand can be held over the mouth when coughing, a tissue or handkerchief can be held over the mouth when sneezing, a condom can be used when having sexual intercourse with a man. These and other means of avoiding direct contact with the excretions and secretions (urtis, stool, blood, semen, saliva) of other persons represent barriers that limit the chance for you to acquire germs those people may harbor—even if they don't appear ill. YOU MAY I CAN CATCH AN INFECTION FROM SOMEONE WHO DOES NOT APPEAR ILL?

Yes. Many infections are contagious even during the "incubation period." This means that during that time after a person is infected but before he or she feels sick; the germ for that illness may be transmitted to other people. It is proposed that the incubation period for AIDS may be 7-24 months or longer. Thus, there may be two years or more between the time the person is infected and he feels sick with AIDS. This makes prevention and the probable (but not proven) that the AIDS agent may be spread during this time.

WHAT DOES ALL THIS HAVE TO DO WITH AIDS?

As stated earlier, no one knows if AIDS is caused by a germ. If it is, we do not know (1) what the vehicle(s) are that carries it; (2) how many germs it takes to cause disease. We do not know whether all AIDS germs come into contact with the germ are equally susceptible to its consequences, or (3) how long the infectious period may be. We also do not know if there are other factors that make an individual particularly susceptible to the disease.

The following items are important factors for spread of sexually-transmitted diseases. In general, their possible correlation with AIDS is based on the increased likelihood of acquiring a theoretical AIDS germ.

- Anonymity: Anonymity in reference to sex is a relative term which includes those sexual encounters where you know nothing or almost nothing about your partner's health, frequency of different sex partners, or sex or health practices. In other words, you have no chance of knowing how likely it might be for that person to harbor an infection that you might acquire. There are obviously varying degrees of anonymity. The person you know only very generally about (e.g., a member of your partner's anatomy, the "one night stand" with whom you have spent some time and have established some rapport and so on. Although far from footsteps, knowing a person's habits and self care will give you a much more accurate estimate of his health.
- Bathhouses, back rooms, bookstores and bars: Places where people would likely come in contact with someone other than one partner at a visit or more than one partner at a time represent increased opportunity for transmitting infections. This is particularly so if the local hygiene facilities for hygiene are either absent or inadequate.
- Drugs: Although no studies to date have singled out any drug as a significant risk for AIDS we think that the use of mind altering drugs can affect many aspects of overall health by impairing sleep, causing a "drugged" or non-sleep natural sleep, affecting decisions about the kind of sex one has, the number of partners one has, and offering pain alleviation so that injury may occur.
- Ideally, our sexual practices will be both fun and healthy. If you determine that changes are needed, additional things worth considering follow:
  - If you choose not to eliminate something that may be risky, consider modification. For example, if you want to continue both tongue partners, consider not having rectal sex with them.
  - Recognize that some of the advised changes may go against your personal values or behaviors (and probably so that peers may not readily accept your decisions.
- The freedom to discuss sexual preferences openly with partners provides the needed opportunity to include comments about disease transmission. The freedom to discuss sexual preferences with each other may lead to modification of risky behaviors and downplaying of potentially harmful behaviors.
- Fantasy will always be a central feature in human sexuality, so that if you choose to eliminate a particularly favored behavior but not specific fantasy.
- Take good care of your body and general health (adequate rest, good nutrition, physical exercise, reduction of stress, reduction of toxic substances—alcohol, cigarettes, marijuana, poppers, non-prescription drugs).
- Consider洗澡 beforehand and see your partner.

GUIDELINES FOR AIDS RISK REDUCTION

• Recognize that some of the advised changes may go against your personal values or behaviors (and probably so that peers may not readily accept your decisions.

- The freedom to discuss sexual preferences openly with partners provides the needed opportunity to include comments about disease transmission. The freedom to discuss sexual preferences with each other may lead to modification of risky behaviors and downplaying of potentially harmful behaviors.
Receptive anal intercourse without condom (being fucked). AIDS seems to be transmitted through semen as well as blood, and perhaps feces. During anal intercourse, injury occurs to rectal tissue, allowing direct access of semen or pre-ejaculate fluid to the bloodstream. Studies have indicated that this practice has high correlation with acquisition of Kaposi’s sarcoma and immunological defects.

Insertive anal intercourse without condom (fucking). The risk of acquisition of AIDS agent through this practice is unknown, but some studies indicate that it is less risky to the insertive partner (top man) than the receptive partner (bottom man) since no semen is received by the top man. However, the risk of exposure to blood and feces is high, and it is well known that other sexually transmitted diseases can be acquired in this manner.

Manual-anal intercourse (fisting). An early study indicated a direct correlation between fisting and AIDS for both active and passive partners. The rectal tissue can be damaged during this activity, which would allow direct access for semen to the bloodstream if fisting were preceded or followed by anal intercourse. The insertive partner’s hand is exposed to blood or blood-contaminated feces and infectious agents may enter through breaks in the skin. The risk may be reduced by use of a glove and the absence of semen.

Fellatio (sucking). If semen is ingested, risk is increased as AIDS agent may be present in the semen. There is a possibility of absorption of the agent through membranes of the mouth, especially if sores are present. Risk is reduced by withdrawal before climax.

Oral-anal contact (rimming). AIDS may be transmitted by blood-contaminated feces. This act will certainly transmit parasites, hepatitis, and various forms of dysentery. It is unknown whether saliva transmits AIDS. Consequently there may be risk to the receptive partner. If open fissures or sores are present, risk is increased.

Vaginal intercourse without condom. There are case reports of transmission of AIDS to women whose sex partners had AIDS or were in high risk groups.

GENERAL FACTORS
Since sexual compatibility is important, it is best to discuss your concerns about health before taking the step with a new partner, and learn his or her attitudes as well. Denial of the problem bodes ill for the relationship and possibly your health. Fantasies are frequently an important element, and sharing fantasies can substitute at times for high-risk behavior. It is generally conceded that sex with anonymous partners carries a higher risk because these initial steps cannot be taken.

Sex in groups may expose you to risks carried over from encounters with others in the group. Adherence to only the safe practices reduces the risk in group situations.

Cleanliness is important in disease prevention. Showering with your partner before sex can be erotic as well as cleansing, and also affords the opportunity to find lesions or other problems beforehand. Another shower after sex is also advisable. Encounters in situations where such facilities are not available (parks, restrooms, backrooms) are unsatisfactory from this standpoint.

There are no studies indicating direct correlation between AIDS and recreational drugs. However, reduction of rational thinking by drugs can impair your resolve to “play safe” and lead to high risk activity. Perception of pain may also be diminished, leading to trauma and increased risk of exposure to the AIDS agent.

Take good care of your body and general health. Recommendations include adequate rest, good nutrition, physical exercise, reduction of stress, and avoidance of alcohol, tobacco, and drug abuse.

SOCIAL AND COMMUNITY ISSUES
In this health crisis there are seeds for positive social growth. Sharing our fears and concerns with partners, friends, and discussion groups can convert frustrations into effective community action. We must give emotional and financial support to those who have or are suspected to have AIDS, and foster a community network to provide a supportive atmosphere. We need to maintain intimacy while avoiding sexual contacts which increase risk to ourselves and our partners. We must be committed to continued development of gay-sensitive support, education, and referral services by organizations like the Shanti Project, the San Francisco AIDS Foundation, and the Bay Area Physicians for Human Rights.

This brochure was written by the Scientific Affairs Committee of the Bay Area Physicians for Human Rights.

For gay-sensitive health care referral, contact the BAPHR referral service: (415) 673-3189

For AIDS-related information and referrals, call the San Francisco AIDS Foundation hotline: In San Francisco Toll Free in Northern California
863-AIDS 800-FOR-AIDS

GUIDELINES FOR AIDS RISK REDUCTION

What is AIDS?

- AIDS is shorthand for Acquired Immune Deficiency Syndrome
- AIDS is a disease that damages the immune system of otherwise healthy persons
- AIDS is a life-threatening disease
- AIDS is a sexually transmissible disease

AIDS is probably transmitted through certain kinds of sexual contact, receiving certain contaminated blood products, and sharing unsterile needles. Despite certain risks, physical intimacy (as well as emotional intimacy) is important for overall health. Knowing that specific risks are related to certain sexual practices is related to those who have or are suspected to have AIDS, and foster a community network to provide a supportive atmosphere. We need to maintain intimacy while avoiding sexual contacts which increase risk to ourselves and our partners. We must be committed to continued development of gay-sensitive support, education, and referral services by organizations like the Shanti Project, the San Francisco AIDS Foundation, and the Bay Area Physicians for Human Rights.

This brochure was written by the Scientific Affairs Committee of the Bay Area Physicians for Human Rights.

For gay-sensitive health care referral, contact the BAPHR referral service: (415) 673-3189

For AIDS-related information and referrals, call the San Francisco AIDS Foundation hotline: In San Francisco Toll Free in Northern California
863-AIDS 800-FOR-AIDS

© July, 1984, BAPHR. All Rights Reserved.
WHAT HAPPENS TO PEOPLE WITH AIDS?

Researchers believe that AIDS is caused by a virus which infects and damages the immune system. Persons at risk of AIDS include gay and bisexual males, IV drug users, recipients of certain blood products, sexual partners of these groups, and infants born of mothers at risk for AIDS. Studies indicate that the disease may not become manifest until several months or years after exposure to the agent. This delay is termed the incubation period.

Persons with AIDS are susceptible to a wide variety of illnesses which are neither “new” nor “unique” for AIDS patients. These include infections caused by certain microscopic parasites (e.g. Pneumocystis carinii pneumonia), certain bacteria, certain fungi (e.g. Cryptococcal meningitis), and certain viruses (e.g. extensive cytomegalovirus infections). Certain rare malignancies, particularly Kaposi's sarcoma, have been the major manifestation of AIDS in many individuals. Not all people with AIDS have all these diseases. Since the immune system is not working properly, people with AIDS are susceptible to many diseases which healthy people with intact immune systems can ward off. So far no one has recovered normal immunity but many of the above diseases can be treated.

WHAT ARE THE SYMPTOMS AND SIGNS OF AIDS?

Many symptoms associated with AIDS are present in minor illnesses, such as colds, bronchitis, and stomach flu. However, in AIDS these symptoms are usually persistent or recurrent. The general symptoms of AIDS may include the following:

- Unexplained, persistent fatigue.
- Unexplained fever, shaking chills, or drenching night sweats lasting longer than several weeks.
- Unexplained weight loss greater than 10 pounds.
- Swollen glands (enlarged lymph nodes usually in the neck, arm pits, or groin) which are otherwise unexplained and last more than 2 weeks.
- Pink to purple flat or raised blotches or bumps occurring on or under the skin, inside the mouth, nose, eyelids, or rectum. Initially they may resemble bruises but do not disappear. They are usually harder than the skin around them.
- Persistent white spots or unusual blemishes in the mouth.
- Persistent diarrhea.
- Persistent dry cough which has lasted too long to be caused by a common respiratory infection, especially if accompanied by shortness of breath.

If you have any of the above symptoms, have your health evaluated by a health care provider familiar with AIDS. A referral in Northern California can be obtained by calling the San Francisco AIDS Foundation. General gay-sensitive health care provider referrals are also available through the Bay Area Physicians for Human Rights.

REDUCING RISK THROUGH SAFE SEX PRACTICES

Reducing risk for AIDS may mean making changes in sexual practices but it does not mean denying the sexual part of one's life. We believe that intimacy, both sexual and emotional, is necessary as we move toward a more healthy regard for our own bodies and those we love. If you or your partner are a member of a high-risk group, we recommend following the SAFE-SEX guidelines as outlined below, unless both you and your partner have been in a monogamous relationship for five years or more. Sexual practices are classified in three categories: SAFE, POSSIBLY SAFE, and UNSAFE.

-- SAFE --

Most of these activities involve only skin-to-skin contact, where transfer of virus is unlikely from one person to another unless there are breaks in the skin.

- Mutual masturbation (male or female)
- Social kissing (dry)
- Body massage, hugging
- Body-to-body rubbing (frottage)
- Light S & M activities (without bruising or bleeding)
- Using one's own sex toys

-- POSSIBLY SAFE --

In these activities small amounts of certain body fluids may be exchanged causing some risk. This risk is increased in proportion to the number of contacts.

- Anal intercourse with condom (fucking with condom). There should be minimal chance for transfer of virus from one person to another if the condom does not break and spillage of semen into the rectum is prevented. The risk is further reduced if one withdraws before climax.
- Fellatio interruptus (sucking - stop before climax). Since it is unknown whether pre-ejaculate fluid contains an AIDS agent, there is some risk in this practice. The insertive partner should warn the receptive partner before he climaxes to prevent exposure to a large volume of semen. If mouth or genital sores are present, risk is increased. Likewise, overzealous action which causes mouth or genital trauma will increase risk.
- Mouth-to-mouth kissing (French kissing, wet kissing). It is unknown whether saliva contains an AIDS agent. Moreover, since less than one-half percent of persons with AIDS in San Francisco fall outside the risk groups (gay or bisexual men, IV drug users, blood product recipients), it seems unlikely that AIDS is transmitted in saliva. If either partner has open mouth or lip sores, risk may be increased.
- Urine contact (watersports). If urine contacts only the unbroken skin, risk may be low. Urine should not be taken by mouth or rectum.
- Vaginal intercourse with condom. The same precautions should be observed as with anal intercourse with condom.
- Oral-vaginal contact (cunnilingus). Since it is unknown whether vaginal secretions and saliva may contain an AIDS agent, there may be some risk. If menstruation is occurring, risk is probably enhanced.

-- UNSAFE --

These activities involve tissue trauma and/or exchange of body fluids which may transmit an AIDS agent or other microbes. They carry high risk unless the sex partners have been monogamous and healthy for five years or more.
Membership to BAPHR is open to students and graduates of approved schools of medicine and osteopathy who support the organization’s goals. Two non-voting categories of affiliation are also available: patron-for physicians, and friends of BAPHR - for non-physicians who wish to support the organization.

BAPHR has four major activities:

- **Meetings.** General meetings are usually held on the third Sunday evening of each month to allow gay physicians to meet and support each other. They generally include a social hour, committee reports, and a guest speaker. In addition, there are periodic social events such as parties, cookouts, and an annual awards banquet.

- **Communication.** The newsletter, the BAPHRON, includes articles of special interest and announcements. All members, patrons, and friends of BAPHR receive this publication. For the sake of confidentiality it is mailed in an envelope bearing only the BAPHR logo and the return address.

- **Professional Education.** BAPHR sponsors an annual national symposium on lesbian and gay health and social issues for the lesbian and gay physician. We maintain useful educational liaisons to mainstream regional and national medical associations. BAPHR has sponsored research on gay issues which has been published in leading medical journals and is approved to grant category 1 CME credit.

- **Community Service.** BAPHR provides a telephone referral service for gay patients and sponsors an annual health screening fair for the public. BAPHR distributes health education materials at major public events and provides speakers on lesbian and gay health issues. In addition, we work closely with government leaders to promote the health and protection of lesbian and gay people.

All members are urged to join and become active in one or more committees.

These include:

- **Membership.** Acts to sustain and increase the membership in BAPHR and advises the officers on membership matters.

- **Publications.** Publishes the BAPHRON. The chairperson acts as the editor in chief of this official newsletter.

- **Finance.** Develops sources of income including dues and contributions, and prepares the annual budget.

- **Education.** Arranges speakers for the meetings and other educational activities.

- **Psychiatric Issues.** Conducts consciousness raising experiences on issues surrounding the nature of homosexuality and the problem of homophobia.

- **Research.** Follows current research activities and encourages investigation into areas which are of special interest to sexual minorities.

- **Social Concerns.** Seeks to improve the quality of medical care of lesbian and gay patients through liaison with other organizations in the health care field and with public officials.

- **Support.** Encourages peer support by organizing meetings, social functions, and discussion groups.

- **Women’s Issues.** Deals with issues of special interest to the lesbian physician and medical student.

- **Bylaws.** Proposes bylaws and rules by which BAPHR is governed and advises the President on parliamentary procedure.

Grants and Bequests

Bay Area Physicians for Human Rights has been approved as a tax exempt organization under Section 501 (c) 3 of the Internal Revenue Code.

---

MEMBERSHIP APPLICATION

**BAY AREA PHYSICIANS FOR HUMAN RIGHTS**
Post Office Box 14546
San Francisco, California 94114

- **Dues and contributions are tax deductible.** Please make checks payable to BAPHR
- **Patron (Contribution at least equal to membership dues)**
- **Friend of BAPHR ($25)**
- **Medical Student member ($12.50)**

Name ____________________________
Address __________________________
City ____________________________
State ____________________________
Zip Code __________________________

Mail to: BAPHR, P.O. Box 14546, San Francisco, California 94114

I would like to join BAPHR as a:

- [ ] New Member
- [ ] Renewal
- [ ] New Member
- [ ] Dues and contributions are tax deductible. Please make checks payable to BAPHR

Do you wish to receive the BAPHRON newsletter:

- [ ] Yes
- [ ] No

Please indicate your area of specialty:

- [ ] General
- [ ] Pediatrics
- [ ] Surgery
- [ ] Psychiatry

---
What is BAPHR?
Bay Area Physicians for Human Rights is an organization of students and doctors of medicine and osteopathy who support human rights and quality medical care for lesbian and gay people.

BAPHR accomplishes this through:
- education
- research
- social action
- peer support

Goals of BAPHR
- To improve the quality of medical care for lesbian and gay patients by educating physicians and the public about the special health care needs of the homosexual.
- To sponsor research into medical problems which especially relate to the homosexual.
- To maintain liaison with public officials about matters relating to lesbian and gay health.
- To offer the lesbian and gay physician support through social functions and consciousness raising experiences.

History of the Organization
In 1977, the Gay People in Medicine committee of the American Medical Student Association initiated the formation of support groups for lesbian and gay medical students in the United States. Inspired by this concept, a group of physicians in San Francisco founded the Bay Area Physicians for Human Rights in July of that year.

Although BAPHR was the first formal and independent association of lesbian and gay physicians in the United States, other regional organizations have emerged in Los Angeles, San Diego, Philadelphia, New York, and other cities. In addition, a national organization has been formed, the American Association of Physicians for Human Rights.

Categories of Affiliation
BAPHR presently consists of over 300 physicians and medical students in all specialties of medicine. Although most members reside in the San Francisco Bay area, physicians and medical students from all over the world are invited to join.
A. MEMBERSHIP
1. Please indicate your status:
   - Physician
   - Podiatrist
   - House Staff

2. Your interests or reasons for membership include:
   - Social Events
   - Representation of gay/lesbian interests in medical and/or community decision making
   - Referral Panel inclusion
   - Educational opportunities (Symposium, Scientific Discussions)
   - Medical Practice Networking
   - Community activities (Health Fair, AIDS work, etc.)
   - Improving gay/lesbian health care environment
   - Other: ____________________________

3. a) The voting membership now consists of physicians and medical students only. Dentists and podiatrists are currently Professional Affiliates.
   - Should they become full voting members? YES [O] [NO] [X]
   - Should BAPHR membership be extended to:
     - Physicians Assistants
     - Psychologists
     - Nurses
     - Chiropractors
     - Other allied Health Professionals
   - Should BAPHR more actively recruit lesbian physicians/health care workers? [O] [X]
   - Should a women's issues committee be created? [doesn't work] [O] [X]

B. DUES
   - Present annual dues are: TOO LOW [O] JUST RIGHT [X] TOO HIGH [O]
   - If not about right, how much would you suggest? $__________

C. BAPHR OFFICE AND STAFF
   - Have you dealt with the BAPHR office? [O] [X]
   - Has the office and staff been helpful to you? [O] [X]
   - The office is staffed by one paid lay person working 1/2 time. Should this be increased to full time? [O] [X]
   - What is the top salary you would deem proper? $__________ / year
   - Comments ____________________________
D. BAPHRON

1) Do you regularly read The BAPHRON? .................................................. YES NO
   O ........................................ O ........................................
2) The BAPHRON should be published:
   monthly .................................. O .................................. bi-monthly ............... O .................................. never ................. O ..................................
3) Please rate the content of The BAPHRON:
   excellent ................................ O .................................. good .................................... O .................................. fair .................................... O .................................. poor .................................... O .................................. worthless ................. O ..................................
4) If it is not OK now, what would you like to see more of?
   Organization News ............... O .................................. General Medical Information .......... O ..................................
   Editorial Opinion ............... O .................................. Discussion of G/L medical issues .......... O ..................................

5) Do you feel free to express your views in The BAPHRON? ......................... YES NO
   O ........................................ O ..................................
6) Have you written a "Letter To The Editor"? ............................................. YES NO
   O ........................................ O ..................................
7) Would you pay higher dues for larger or more frequent BAPHRON's? ............. YES NO
   O ........................................ O ..................................
8) Comments: Would depend on what else was happening, the Baphron by itself, will not keep the organizational interest, but it can be a major interest to members.

E. REFERRAL PANEL

1) Are you familiar with the Referral Panel? ............................................... YES NO
   O ........................................ O ..................................
2) Are you a member of the Referral Panel? ............................................... YES NO
   O ........................................ O ..................................
3) Do you feel the Referral Panel serves an important function? .................... YES NO
   O ........................................ O ..................................
4) Do you benefit professionally from the Referral Panel? ............................ YES NO
   O ........................................ O ..................................
5) Should BAPHR continue to operate the Referral Panel? ............................ YES NO
   O ........................................ O ..................................
6) For Panel members: a) Is your contribution worthwhile? ............................ YES NO
   O ........................................ O ..................................
   b) Would you contribute more if advertising were increased? ...................... YES NO
   O ........................................ O ..................................
7) Comments.

F. SOCIAL AND MEMBERSHIP ACTIVITIES

1) The number of BAPHR social functions is:
   TOO FEW ............... O .................................. ABOUT RIGHT ............... O .................................. TOO MANY ............... O ..................................
2) In the past year you have attended how many social functions?
   NONE ............... O .................................. ONE ............... O .................................. TWO ............... O .................................. THREE OR MORE ............... O ..................................
3) Please rate the following:

   a) New Year's Day Brunch ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   b) Annual Banquet ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   c) Annual Picnic ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   d) Dinner at El Drisco ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   e) Annual Retreat at Wildwood Ranch ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   f) BAPHR Foundation Cocktail Party ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   g) Annual Symposium (Conference) ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   h) General Meetings ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................
   i) Dental Dinner ........................................ GOOD FAIR POOR
      ........................................ O ........................................ O ........................................ O ........................................

4) Your comments and suggestions for BAHR activities:
G. COMMUNITY ACTIVITIES

1) Should BAPHR continue to participate in the annual Health Fair? YES ? NO
   O . . . O
2) Should BAPHR continue to sponsor an annual Symposium/Conference? . . . . O
   O . . . O
3) Should BAPHR be active in state and local health advisory committees? . . . . O
   O . . . O
4) Other desirable activities

H. BAPHR’S POSITIONS AND ROLES

1) Should BAPHR assume a health leadership position in the community? . . . . O
   O . . . O
2) Should BAPHR speak out on issues concerning:
   a) Medicine and the gay/lesbian community? . . . . O
       I don’t like this wording . . . . O
   b) Gay/Lesbian civil rights? . . . . O
   c) Specifically medical issues of AIDS? . . . . O
3) Are you familiar with BAPHR’s positions on:
   a) Bathhouse closure? . . . . O
   b) HTLV-III antibody testing? . . . . O
   c) Quarantine of AIDS and ARC patients? . . . . O
4) In your opinion, should the bathhouses have been closed? . . . . O
   O . . . O
5) At this time, HTLV testing is appropriate for:
   EVERYONE . . O
   MANY . . O
   FEW . . O
   NO ONE . . O
   ONLY “STRAIGHTS” . . O
6) Quarantine is appropriate for:
   PERSONS WITH AIDS . . O
   PERSONS WITH ARC . . O
   NO ONE . . O
   SOME INDIVIDUALS . . O
   WHO?
7) In your opinion, BAPHR’s positions have generally been:
   TOO LIBERAL . . O
   ABOUT RIGHT . . O
   TOO CONSERVATIVE . . O
   too polarizing; too much street rhetoric; not enough appreciation of issues.

I. BAPHR FOUNDATION

1) Are you familiar with the BAPHR Foundation? . . . . O
   O . . . O
2) Do you understand the relationship between BAPHR and the BAPHR Foundation? . . . . O
   O . . . O
3) Are you familiar with the Foundation’s purpose and goals? . . . . O
   O . . . O
4) Do you support the concept of the BAPHR Foundation? . . . . O
   O . . . O
5) Are you considering donating to the BAPHR Foundation? . . . . O
   O . . . O
6) Comments
   Although the gap has done a great job organizing the structure of the Found.

J. GENERAL SUGGESTIONS

1) BAPHR would be of more personal benefit to you if:
   a) There were more chances for interaction with peer groups . . . . O
   b) There were more medical functions other than general meetings and Symposia . . . . O
   c) You were left alone and merely kept informed . . . . O
2) BAPHR would improve if it:
   a) Continues its present role . . . . O
   b) Were more SOCIAL and less MEDICAL . . . . O
   c) Were more MEDICAL and less SOCIAL . . . . O
   d) Were LESS “activist” . . . . O
   e) Were MORE “activist” . . . . O
   f) Were silent on political (civil rights) issues . . . . O
   "activist" is not the issue . . . . O
   "more activist in a positive way" . . . . O
3) What changes would you like to see that have not been mentioned, in terms of long range goals? __________

________________________________________

________________________________________

________________________________________

4) What do you think of this questionnaire approach? It is a good step. It can help us to reevaluate, hopefully, reevaluate.

5) Comments or suggestions: Baphr should focus less on money/finances and more on positive community involvement and leadership. More on creative ways for members to interact.
Cardiologists remain divided over meaning of thrombolytic trials

Chronic fatigue needs a revised definition

Congress targets regs at Medigap insurers

Hyped 'fat pill' stirs up a storm of doubt

Institute of Medicine proposes a major overhaul of PROs

Some goals for STD control won't be met

Medicine's losses to AIDS
In 1977, seventeen physicians met to form the Bay Area Physicians for Human Rights, with the goal to “promote the health and well being of gay men and lesbians.” The next year, 125 members strong, BAPHR was public and visible as the first openly gay physician’s organization in the world—bringing doctors “out of the closet” through press coverage in the United States and Europe. Since then, a national organization and sibling entities have been formed in many cities.

In 1983, as a “new virus” began to strike gay men, BAPHR proposed the first safe sex guidelines and pioneered recommendations for voluntary withdrawal of gay men from the pool of blood donors. Today, we continue to work with organized medicine and community groups on HIV and other health-related issues.

The BAPHR Foundation was created in 1981 in response to the need for a philanthropic source dedicated to improving gay and lesbian health care. Last year it granted more than $25,000 to worthwhile projects in the San Francisco Bay Area.

As BAPHR has become part of the fabric of gay and lesbian community, it also is part of its loss. As a result, BAPHR members are sewing quilts for more than 35 of its members who have died of AIDS. This also underscores BAPHR’s unique and crucial role: to support its members, many of whom have been on the frontlines since the beginning of the HIV epidemic.

BAPHR continues to support its members and advocate for quality health care for gay men and lesbians throughout the San Francisco Bay Area. Its nearly 200 members have played a significant role in carrying the message which reflects our humanity and draws the link between AIDS, Science, and Technology. We are sharing this article with you as a further example of how AIDS affects us all as human beings.
Cover Story: Medicine's Losses to AIDS
The medical profession has lost dozens of young physicians to AIDS—perhaps as many as 350, by the CDC's count. Their deaths often bring promising research and treatment protocols to a premature end, and rob the AIDS arena of political leadership and scientific knowledge. Physicians living and practicing with the disease face incredible challenges. Page 24

Clinical Medicine

Thrombolytic Debate
Cardiologists are divided over the significance of two European trials in which researchers found no survival benefits for tPA over streptokinase in myocardial infarction patients. 12

Chronic Fatigue
The CDC's criteria for CFS exclude too many patients, according to a camp of researchers who call for a revision of the case definition. But even the critics fail to agree on the combination of symptoms that make up the syndrome. 13

‘Fat Pill’
A report that bromocriptine in a "secret regimen" melts fat made a splash in the news. But concerned researchers noted that the drug had never been shown to reduce body fat or serum cholesterol levels. 16

Estrogen Labeling
The FDA is adding warnings regarding potential breast cancer risk to labeling for estrogen replacement therapy. The action comes in response to evidence of increased risk with long-term ERT use. 19

Cystic Fibrosis
An NIH consensus panel sanctioned CF screening on a limited, pilot basis only because the current test can't provide adequately definitive results. 36

Silent Ischemia
Routine exercise testing may be a reliable and economical alternative to 24-hour Holter monitoring for risk assessment of angina patients. 41

Holter monitoring may prove to be more useful for assessing treatment efficacy.
AIDS' toll: These MDs and some 300 more

L. Bud Boucher, M.D.
Family practice
San Francisco
Coauthored first publication on sexually transmitted giardiasis

D. Alan Bouffard, M.D.
Neurology
Chicago
Reinstated by hospital after AIDS discrimination lawsuit

Don Brown, M.D.
Psychiatry
San Francisco
Conducted group therapy sessions for people with HIV

Ralph D. Clark, M.D.
Cardiology
San Francisco
Founded and directed an echocardiography lab

Leigh J. Harris, M.D.
Ophthalmology
New York
Imported AL-721 to distribute to people with AIDS

Peter H. Hollinger, M.D.
Psychiatry
New York
Awarded APA research fellowship for residents

James Holloran, M.D.
Emergency medicine
San Francisco
Produced AIDS educational video for U. of California

Paul A. Paroski, M.D.
Pediactrics
New York
Founded two national gay medical groups

George Riley, M.D.
Psychiatry
Oakland, Calif.
Worked with indigent patients in county clinic

John R. Royer, M.D.
Internal medicine
Hollywood, Calif.
Practiced in Los Angeles for 30 years, had large HIV practice

Harvey Thompson, M.D.
Hematology-Oncology
Sacramento, Calif.
Cofounded Sacramento AIDS Foundation

Tom Waddell, M.D.
Family practice
San Francisco
Olympic medalist who organized Gay Games

Stephen R. Walters, M.D.
Psychiatry
San Francisco
Chaired medical school alumni fund-raising effort

Philip Wood, M.D.
Psychiatry
San Francisco
Had family practice, then trained in psychiatry

Stephen Yarnell, M.D.
Psychiatry
San Francisco
Led voter drive to legalize physician-assisted euthanasia
Depleting the front lines

Medicine's Loss

The AIDS epidemic is claiming a lion's share of some cities' resources, and some of medicine's young lions as well. As many of the specialists who've been treating AIDS patients succumb to the disease, promising careers are cut short, research is slowed, and patients are left looking for doctors.

Four years ago, two Sacramento, Calif. physicians took care of the majority of the patients with HIV-related medical problems in the city. Now, one of those doctors is dead and the other retired—both felled by the disease they fought professionally and personally.

Oncologist Harvey Thompson died suddenly in late 1986, three weeks after his first episode of Pneumocystis carinii pneumonia. He was 45. Less than two years later, internist Sanford E. Pomerantz retired at age 39, suffering from severe AIDS-related complex.

The closing of their practices, both centered largely on patients infected with the human immunodeficiency virus, left a void for hundreds of patients. Similar voids have appeared across the country as AIDS claimed the lives of countless physicians, often bringing promising research and treatment protocols to a premature end.

In Sacramento, finding an experienced HIV practitioner "is really hit or miss," said psychiatrist Elizabeth Harrison. Most of the city's AIDS practitioners "are still beginners" in treating patients with HIV infections, she told MWN.

Although insured patients can usually find a physician "if they are really persistent," those who have no private insurance or who require home care now find it next to impossible to get care in the private sector, she said.

"Many AIDS patients here have lost not one, but two physicians," noted Dr. Harrison, who cofounded the Sacramento AIDS Foundation with Dr. Thompson. "AIDS patients often look to their physician as a pillar of strength, someone whom they can count on, who will be there for them till the very end. When they lose [that person], it can be really frightening."

Work left undone. Few other communities have felt the loss of physicians to AIDS as acutely as Sacramento. Nationwide, however, the medical profession has lost dozens of promising young physicians to AIDS. Many of them were leaders in the AIDS arena—in primary care, policy-making, community research, and advocacy—where they helped to shape the way the epidemic has been fought.

The first generation of medicine's AIDS activists targeted many goals: speedier release of drugs, increased government funding, safe sex education programs, and physician-assisted euthanasia. Their progress has been significant, but the goals are far from reached. And in many cities, just finding physicians who will care for patients who are HIV antibody-positive is increasingly difficult.

The extent of medicine's loss is difficult to measure, in large part because the stigma of homosexuality within the profession has fueled a strong level of denial. Spokesmen for a number of specialty societies—among them the American Psychiatric Association, the American Society of Internal Medicine, and the American Academy of Family Physicians—said their organizations have no information on physician deaths from AIDS.

Continued
An informal count by physicians’ groups in just New York and California put the number of AIDS-related physician deaths at well over 100. The CDC estimates the toll to be about 350.

Secrecy muddies count. Outside of San Francisco and New York, where gay physicians’ groups are strongest, few doctors have publicly acknowledged having an HIV-related illness. In Atlanta, physicians with AIDS “seem to just disappear from practice,” said family physician Stosh Ostrow. “They just go away and we never find out what has happened.” He thinks that at least a half-dozen Atlanta physicians have been diagnosed with AIDS, but that because of a “tremendous stigma [there], no one is willing to talk about [having] AIDS, even with colleagues.”

Even in the epicenters, secrecy remains, particularly among ethnic minorities and married men. In New York, the family of a Hispanic psychiatrist who established a grass-roots AIDS education program has denied that his death was AIDS-related. His colleagues say it was. And in San Francisco, the widow of a physician who put in hundreds of hours on an AIDS crisis line has asked that the cause of his death not be discussed, although he had acknowledged his AIDS diagnosis.

More and more, observers can read between the lines of obituaries to draw their own conclusions. A New York Times obituary of infectious diseases specialist Jack B. Weissman, for example, said his “long-time companion . . . declined to give the cause of death.” A spokesman for Gay Men’s Health Crisis in New York, however, told MWN that it’s “well known” that AIDS-related causes led to the death of Dr. Weissman, who cared for hundreds of AIDS patients at Columbia University College of Physicians and Surgeons.

Rare memorials. A few physicians who died of AIDS have been honored by some of their colleagues.

In Boston, a clinic was renamed for its chief of ambulatory care soon after he died of AIDS.

And in San Francisco, members of the Bay Area Physicians for Human Rights sewed a quilt to memorialize the 32 practitioners lost to the disease.

“When a physician gets sick, he or she finds it an embarrassment or a failure. And when the illness is AIDS, then you have to add the stigma of being part of a despised minority,” said orthopedist Leonard Simpson, who organized the quilt project. “For many physicians, even those who have been openly gay, a diagnosis of AIDS has put them right back in the closet, hiding. A number have died without even a memorial service. If we don’t remember our own, who will?”

Activists lost. Within the past year, three of medicine’s high-profile AIDS activists succumbed to the disease.

Until 10 days before his death, New York internist Nathaniel Pier managed one of the largest solo HIV practices in the city. Dr. Pier, 37, was one of the most vocal advocates for faster development of AIDS treatments. In 1988, he testified before the presidential AIDS commission about his four-year effort to spark research on lentinan, an immune modulator derived from the shiitake mushroom and widely used in Japan for treating cancer.

Dr. Pier was also one of the founders of New York’s Community Research Initiative (CRI), a grass-roots organization that conducts clinical trials in private physicians’ offices. He was “single-handedly responsible” for convincing a Japanese pharmaceutical company, Ajinimoto, to set up an American affiliate that would allow clinical trials of lentinan to be conducted in the U.S., said internist Bernard Bihari, executive director of CRI.

Internist Barry Gingell, who died of AIDS last May at age 34, had left private practice in 1987 to become the top medical expert for Gay Men’s Health Crisis, a New York service and education organization that serves the city’s entire HIV-infected community. He launched Treatment Issues, a widely read newsletter about HIV therapies.

Dr. Gingell, who served on advisory panels for the National Academy of Sciences and the Society for Infectious Diseases, repeatedly assailed restrictions put on trimetrexate (Parke-Davis), an experimental drug that appeared effective against PCP. Following his protests, the government announced a new protocol to enable more people to receive the drug. continued
When the FDA sought expert advice from health care professionals knowledgeable about AIDS, “we called Barry,” said Dr. Stuart Nightingale, associate commissioner for health affairs. He credited Dr. Gingell with being among the first to publish regional data based on clinical trials.

A third New York AIDS activist, pediatrician Paul A. Paroski, died last month at age 37. As director of ambulatory care at the Woodhull Medical and Mental Health Center in Brooklyn, he established the first New York municipal hospital HIV clinic, which has since become a national prototype for providing family-oriented HIV services to an inner-city minority population.

Before the clinic opened, Dr. Paroski developed a 30-hour educational program to teach staff about the needs of black and Hispanic gay men and drug abusers infected with HIV. He lectured widely on the program and chaired the New York State AIDS Institute Ambulatory Care Medical Criteria Committee.

Education advocate. In California, Dr. A. Bradley Truax, a family physician with a large HIV private practice, died in 1988 at age 42. As chairman of the San Diego Regional Task Force on AIDS, Dr. Truax had been “the champion” for safe-sex education, recalled Dr. Chris Matthews. At Dr. Truax’s urging, the county government eventually adopted such programs and okayed his five-year plan to fight the epidemic.

Dr. Truax had also cofounded a university-based clinic to care for gay men and lesbians. And as a member of the county’s human relations commission, he was “very courageous in taking a controversial stand backing closure of bath houses,” said Dr. Matthews, noting that the county eventually approved legislation regulating such facilities.

Fought for euthanasia. After San Francisco psychiatrist Stephen Yarnell was diagnosed with AIDS in 1986, he spent hundreds of hours campaigning for a ballot initiative to give dying people the right to voluntary euthanasia with the help of a physician.

When Dr. Yarnell died in 1988 at age 45, the voluntary euthanasia movement lost “one of its most important spokespersons,” said Derek Humphry, founder of the Hemlock Society, the leading proponent of active voluntary euthanasia in North America.

Combined careers. Neonatologist Robert F. Frederickson, who died last year at age 54, was also an attorney and the author of the American Bar Association book, *Specialization in the American Medical and Legal Professions*.

Clinically, Dr. Frederickson was known for establishing the first neonatal nursery in Marin County, Calif. “I can’t imagine anyone being more loved by parents, including the many families with premature babies who credit Bob with saving their infant,” said pediatrician Bert Jolly, a partner of Dr. Frederickson for 18 years.

Politically, Dr. Frederickson was the Marin County Medical Society’s delegate to the California Medical Association, where he testified about AIDS issues. In 1987 he was president of the county society, which named him “Physician of the Year” in 1988. He was also honored by the California Senate for his work, which included cofounding the Marin AIDS Task Force and serving on the county’s pediatric AIDS committee.

Agency founder. In 1980, New York psychiatrist Emery Hetrick donated $1,500 to launch a volunteer group to help gay and lesbian youth. Today, almost three years after Dr. Hetrick’s death from AIDS at age 58, the group, now known as the Hetrick-Martin Institute, has a paid, full-time staff of 37 and a budget of $1.6 million.

The institute runs an alternative high school in Greenwich Village, sponsors safe-sex outreach programs for runaways and homeless youth, and educates social service agencies about the needs of lesbian and gay youth, said Dr. Damien Martin, a cofounder.

Much of the agency’s success stems continued
How Six MDs Are Coping as HIV Patients

For four months, Dr. Don Hagen delayed seeking medical treatment for his excruciating headaches. The Irvine, Calif. family physician was certain that the headaches were HIV-related, but he preferred to withstand the pain rather than risk jeopardizing his career.

A member of a large group practice, he feared that if his partners learned he was infected with the human immunodeficiency virus, he’d be forced to quit. When he finally sought treatment, he was diagnosed with HIV-related aseptic meningitis.

Dr. Hagen, now retired from practice at age 44, suffered the fears and isolation common to many physicians who’ve had to come to terms with HIV infection. Often afraid to share the news with colleagues for fear of professional repercussions, the doctors struggle with decisions about if, when, how, and what to disclose.

In interviews with MWN, Dr. Hagen and five other HIV-infected physicians—a psychiatrist, an orthopedic surgeon, an obstetrician-gynecologist, a pediatrician, and an internist—discussed the problems they faced and the solutions they devised.

They found little help in the guidelines issued by medical groups or the government.

The AMA, in a policy approved last December, encourages HIV-infected physicians to continue their careers “without engaging in activities that pose an identifiable risk of HIV transmission to patients.”

Whether HIV-infected workers, especially those who perform invasive procedures, “can adequately and safely be allowed to perform patient care duties” is a question that must be answered “on an individual basis,” say the published CDC guidelines.

Despite respected medical opinion that the virus is not transmitted casually, fears about contact with infected physicians persist, survey results show.

The physicians interviewed by MWN agonized that such fears—among patients and colleagues—could jeopardize their medical careers, as has happened to several doctors whose illnesses became public knowledge. But after disclosing their status, the interviewees found that their worst fears never materialized.

When Dr. Hagen finally sought medical care, treatment with zidovudine (Retrovir, Burroughs Wellcome; AZT) ended his headaches. But his fears of a backlash of public opinion didn’t disappear overnight, he told MWN. After an infectious diseases specialist prescribed zidovudine, Dr. Hagen hesitated to fill the prescription. He then tried to fill it in a community 40 miles from his home, only to find that the three pharmacies there did not stock the drug. Finally, he filled it locally.

Eventually, Dr. Hagen told the administrator of his medical group that he planned to retire because of HIV-related problems. Although very supportive about Dr. Hagen’s departure, the administrator asked him not to divulge his HIV status formally to patients. Dr. Hagen agreed, but said, “If I’m asked, I’m not going to lie.”

After retiring, Dr. Hagen continued in a number of volunteer positions, among them his gubernatorial appointment to the California AIDS Leadership Committee.

“My fears about ceasing to be a doctor have abated because I’ve been able to practice medicine through these groups,” he said.

Although he speaks publicly about having HIV, Dr. Hagen said, he doesn’t mention the name of the medical group he left.

“Unfortunately, the stigma surrounds AIDS because people with the disease are still not willing to be up-front about it. It’s something I fight against every day.”

Being up-front didn’t hurt San Francisco psychiatrist Jeff Cohen, who decided to curtail some of his responsibilities as associate director of residency training at Langley Porter Psychiatric Institute when he developed AIDS-related symptoms.

When he divulged his medical problems to his supervisor, who was involved in a research project on the immunologic effects of stress in people with AIDS, he was “immensely supportive,” said Dr. Cohen, who was offered a leave of absence and a lightened work load when he returned. He continued to see his private patients while he was on leave.

Disclosing to his patients came later, when Dr. Cohen was hospitalized with his first bout of Pneumocystis carinii pneumonia. The majority of patients either terminated therapy or asked for referrals. Five patients decided to wait for him. Three months later, following additional hospitalizations for adverse drug reactions, he resumed their therapy in an office in his home. In order not to
jeopardize his disability income, he sees the patients at no charge, asking them to donate the fee to an AIDS charity.

For help in getting through the struggle, Dr. Cohen attends a support group for HIV-infected psychotherapists and is assisted by a volunteer from a local service agency.

Recently diagnosed with Kaposi's sarcoma in the lungs and throat, he underwent irradiation followed by weekly chemotherapy, which have left him very weak. As he lives alone, friends and neighbors prepare many of his meals.

Dr. Cohen said he has always been "very open about being gay" and finds a parallel in revealing his AIDS diagnosis.

"I feel that this is a political cause, like a little banner that I carry. It has been very therapeutic to try to live with AIDS and use it as an asset and a cause and to give it meaning and not just be victimized or stigmatized by it," Dr. Cohen said.

The stigma of AIDS is reflected in the stipulation by three of the physicians interviewed that their names not be used.

A Chicago orthopedic surgeon said he stopped performing major invasive procedures after learning he was HIV antibody-positive. He no longer performs total hip replacements or spinal surgery with instrumentation, for example, but continues to do arthroscopy and closed reduction of fractures.

"Although it is possible that a seropositive surgeon might present an infinitesimal risk to a patient undergoing surgery, the actual risk of a physician cutting himself and bleeding into a wound is more theoretical than real," he said. Nonetheless, he "felt safer opting out" of major procedures.

The orthopedic surgeon revealed his condition to a few colleagues, who were friends as well as practitioners whom he assisted in the operating room. All were supportive. He decided not to tell patients or hospital officials about his HIV infection.

"If surgeons announced their HIV status, I'm certain there would be [previously infected] patients who would come forward and sue, claiming they got infected during an operation," he commented. "It would be enormously difficult for any surgeon or any hospital to defend against that sort of allegation."

When a Washington obstetrician-gynecologist told his hospital employer about his AIDS diagnosis, he was assigned to a position where he doesn't have to scrub.

"Patients are more of a risk to me than I am to them," he said. "If I thought I was any risk at all to patients, I wouldn't be doing the job.

He has lived with AIDS for some time. His lover, a medical resident, died of the disease last year. Despite setbacks, he has carried on.

After irradiation and chemotherapy left him bald, he "bought a $2,000 wig and went back to work."

A pediatrician went public with news of his HIV infection during a panel discussion at an AIDS conference in Los Angeles, where he was an administrator in a government clinic.

But when he moved to the East Coast for a consulting job with an organization doing AIDS education, he decided he'd entered "a conservative environment where it might be better not to disclose" his illness.

He regrets the secrecy.

"I'm afraid I am buying into some of society's views that people with HIV are pariahs," he told MWN.

People who go through 12-step self-help drug recovery programs know the power of self-disclosure, he noted. "It is important for people who are HIV-positive to acknowledge it, if they can. The world has got to see that there are successful, happy, coping people who are seropositive."

When internist Sanford E. Pomerantz, of Sacramento, Calif. learned he was seropositive, he left solo practice to join a multispecialty group, he said, "so I knew my patients would be taken care of when I retired."

In negotiating with his future medical partners, Dr. Pomerantz "matter-of-factly told them" of his condition. The negotiations "didn't stall for a second" after his disclosure.

After telling his medical partners, Dr. Pomerantz decided to share the news with some of his HIV-infected patients, many of whom "had become like family" over the years. Often, the topic came up when a patient asked for advice in handling an HIV-related issue.

"I'd tell them how I handled it myself, and people seemed to find the advice very reassuring," he said.

In late 1988, Dr. Pomerantz developed severe AIDS-related complex and retired.

"I resolved that I valued my life more than my practice. That was a very difficult decision. Some physicians think that if they can't practice, they don't want to live. I thought, 'If I continue, I'm not going to live long.' I knew I needed the rest."

After several months in which he grew a garden that he said became a symbol of his life, Dr. Pomerantz felt strong enough to work part-time as an AIDS policy analyst for the state. In February, he became medical director of the Shanti Project in Phoenix, Ariz.

"My focus has been to teach people about AIDS," he said. "Ironically, it will some day help me, too, since I hope people will be there to give me the kind of care I will need."
Two MDs Apparently Got HIV from Patients

Suits filed separately by two physicians with AIDS were among the most publicized cases in which health care workers said they were infected with the human immunodeficiency virus on the job.

The CDC has compiled a worldwide list of 27 “HIV-infected health workers with no reported nonoccupational risk factors and for whom case histories have been published in the scientific literature.” In 19 of the cases, seroconversion after the point of exposure was documented. The agency is investigating 34 more cases of alleged transmission in the health care setting.

In New York last month, Dr. Veronica Prego, who attributed her AIDS to a 1983 needlestick at King’s County Hospital in New York, settled out of court for $1.35 million. She had sued the hospital and two other physicians, charging negligence and breach of confidentiality.

In Baltimore, Dr. Hacib Aoun attributed his AIDS to a cut he received in 1983. A capillary tube that he was sealing broke in his hand, covering it with the contents, blood from a leukemia patient who’d received at least 100 units of blood and blood products. The patient’s stored serum later tested antibody-positive for HIV.

As Dr. Aoun wrote in the Sept. 7, ’89 issue of The New England Journal of Medicine, he sued Johns Hopkins “to defend my reputation and obtain appropriate benefits.” The suit was settled three weeks before the trial date.

Needlesticks and punctures were the type of exposure cited for the majority of the cases on the CDC list. But two others involved cuts; four involved nonintact skin; three, mucous membrane; and one, cutaneous exposure.

—M.A.S.

from Dr. Hetrick’s efforts as a volunteer psychiatrist and a member of the governing board, said Dr. Martin, a retired professor of communication at New York University.

“Emery was a great strategist,” said psychiatrist Stuart Nichols, a colleague who worked with Dr. Hetrick. “I’ve never seen anyone else who could see the need, create the organization, and help it flourish.”

Public health practitioner. Early in the epidemic, Boston internist Jay Goldfarb, chief of ambulatory care at Lemuel Shattuck Hospital, helped the state hospital begin its AIDS program, co-chairing the committee that established the facility’s dedicated AIDS unit. After he retired on disability in 1987, he served as a volunteer, counseling HIV-infected patients at Shattuck and caring for AIDS patients at the Fenway Memorial Clinic.

After his death last year at age 37, the Shattuck clinic was renamed the Jay Goldfarb, M.D., Ambulatory Care Center. “We really grieved when Jay died,” said Dr. Joseph L. Cohen, the hospital’s medical director.

Civil rights advocate. In 1987, neurologist D. Alan Bouffard was told by his employer, Cook County Hospital in Chicago, that his patient care duties were being suspended because of his HIV infection. Dr. Bouffard decided to fight the system.

As he was in compliance with CDC regulations about HIV-infected health care workers, he filed suit, contending that the county was discriminating against him. The day before a hearing was scheduled, the county agreed to allow Dr. Bouffard to return to work. He died in 1988 at age 43.

The case arose at a time when there were “virtually no court decisions” about the ability of HIV-infected physicians to practice, said Harvey Grossman, legal director of the Illinois division of the American Civil Liberties Union, which represented Dr. Bouffard. The federal consent decree “has become a model” recognizing HIV disease as a handicap under the federal rehabilitation act, he added.

“Alan believed the county officials were bashing him because they thought it was acceptable and popular,” said Dr. Bindu Desai, a neurologist at Cook County Hospital. “As his colleagues, we all supported his very courageous decision to fight against this very discriminatory action.”

The physicians lost to the medical profession because of AIDS may be just the tip of an iceberg when it comes to the total impact of the epidemic. Given the estimate that for every death there are as many as 10 other Americans infected with HIV, the loss of physicians is certain to intensify.

—SARI STAVER
The American Association of Physicians for Human Rights is an organization of physicians, residents, medical students, and professionally affiliated health professionals, from the U.S. and Canada, dedicated to promoting quality medical care for lesbians and gay men.

AAPHR's goal is to provide an organization through which its members can find a source of professional and personal support and affiliation. Yearly symposia are held to educate our members and other interested persons on the health care issues affecting gay men and lesbians, and ongoing information is provided through a quarterly newsletter and timely action alerts on medical practice important to the physician treating our population.

As an organization and through its individual members, AAPHR has played a leadership role in addressing the health care issues created by the AIDS epidemic and is committed to continuing an emphasis to this issue.

If you are interested in membership information, please write or call us at:
• 2940 16th Street, # 105 • San Francisco, CA • 94103 • 415-255-4547 •
or return the membership form below with your dues

AAPHR's MAILING LIST IS STRICTLY CONFIDENTIAL

NAME.................................................................................................................................
ADDRESS...........................................................................................................................
CITY........................................... STATE/PROVINCE ...................................................
ZIP/Mailcode.....................................................................................................................
PHONES office.............................. home.................................................................
SPECIALTY......................................................................................................................
DUES: Physicians-$160
House officers-$65
Medical students-$20
Individual sponsors-$100
Organizational sponsors-$200
Retired persons-$50
Disabled persons-$25

CANADIAN MEMBERSHIP: PLEASE SEND A MONEY ORDER IN U.S. DOLLARS
THANK YOU FOR THIS EXTRA TROUBLE
GALA RECEPTION FOR GAY AND LESBIAN
HEALTH CARE WORKERS IN THE FIGHT AGAINST AIDS

BAPHR INVITES YOU TO JOIN US ON
FRIDAY, JUNE 22, 1990
6:00 to 8:00 pm

at

THE GREEN ROOM
2nd FLOOR, VETERAN’S BUILDING
VAN NESS & McALLISTER (across from City Hall)

Hours d’oeuvres, wine, and sparkling water

Entertainment and Surprises!

Donation $20

SUNDAY, JUNE 24th
IS LESBIAN/GAY FREEDOM DAY

JOIN BAPHR AND AAPHR
FOR THE WORLD’S LARGEST PARADE AND CELEBRATION
FOR LESBIANS, GAY MEN, AND THEIR SUPPORTERS

All health care workers and their friends are invited to march with BAPHR and AAPHR in the parade. Look for our banners at the end of Market Street, near the Ferry Building and the Hyatt Regency Hotel. The parade starts at 11:00 am. We will be near the beginning of the lineup, but you can join us anywhere along the parade route.

DON’T MISS THIS UNIQUE EXPERIENCE!
BAY AREA PHYSICIANS FOR HUMAN RIGHTS

Presents

MEDICAL ASPECTS IN SEXUAL ORIENTATION

A Continuing Medical Educational Symposium

June 26 - 27, 1981

San Francisco Medical Society
250 Masonic Avenue
San Francisco, California

President
R. Dale McGhee, M.D.

Vice-President
James Krajeski, M.D.

Secretary
Robert K. Bolan, M.D.

Treasurer
Richard L. Andrews, M.D.
June 26, 1981

Dear Colleagues,

Welcome to this symposium on Medical Aspects of Sexual Orientation, and welcome to the "Emerald City" of San Francisco on this gala weekend of our annual Gay Freedom Day Celebration.

This symposium has been designed to provide you with up-to-date information about a variety of health care issues of special interest to Lesbian and Gay men, including sexually transmitted diseases, lifestyles, psychological problems and sexual response.

Additionally, we invite you to join us on Saturday afternoon in an historic congress to establish a national wide coalition of Gay and Lesbian physicians. Let me emphasize that Bay Area Physicians for Human Rights will not be creating this coalition. You will be creating it along with us, and I urge you to be prepared to share with us your own ideas and goals for such an organization.

I hope that you will find your experience here educationally nourishing, historically inspiring, and personally rewarding.

Sincerely,

Dale McGhee, M.D.
President
BAPHR

Symposium Chairpersons

Wm J. Kapra, M.D.
Richard L. Andrews, M.D.
PROGRAM OUTLINE

Friday June 26, 1981

8:15 AM Registration

8:45 AM Welcoming Comments: Dale McGhee, M.D., President BAPHR

9:00 AM Sexually Transmitted Diseases (STD's)
Robert K. Bolan, M.D., William Owen, M.D.
Lawrence Drew, M.D., Alvin Friedman-Kien, M.D.

10:00 AM STD's (Continued)

11:00 AM STD's (Continued)

12 Noon Catered Lunch - foyer San Francisco Medical Society
Informal Showing - Movie: The Word is Out

1:00 PM Approaching the Lesbian and Gay Patient
Lisa Capaldini, Medical Student UCSF, Wm J. Kapla, M.D.

2:00 PM Lifestyles and Relationships
David Kessler, M.D., Carol J. Cohen, M.D.

3:00 PM The Lesbian and Gay Doctor in a Straight World
Michael Rankin, M.D.

4:00 PM Adjourn to Cocktail Party
Home: Dale McGhee, M.D. - President BAPHR
198 Gold Mine Dirve
San Francisco

Saturday June 27, 1981

9:00 AM Sexual Dysfunction: Medical and Psychological Aspects
Dale McGhee, M.D., Richard Long, Ph.D., Marny Hall, Ph.D.

10:30 AM Practical Proctology
Robert Bush, M.D.

11:15 AM "Coming OUT" - The patient as well as the Physician
James Kraseski, M.D.

12 Noon Catered Lunch - foyer San Francisco Medical Society

1:00 PM Begin Planning for a National Organization of Gay and
Lesbian Physicians
Moderators: Dennis McShane, M.D.
Richard Andrews, M.D.
Michael Rankin, M.D.
FACULTY PARTICIPANTS

Richard L. Andrews, M.D.  
Private Practice - Child and Adult psychiatry  
Teaching Faculty - McAuley Neuro-psychiatric Institute, San Francisco.  
V.P. elect and current treasurer of BAPHR

Robert K. Bolan, M.D. FAAFP  
Clinical Instructor, Dept. Family and Community Medicine - University of California, San Francisco  
Member National Coalition of Gay STD Services  
Secretary - BAPHR

Robert A Bush, Jr., M.D., FACS  
Private Practice - General Surgery and Proctology  
Clinical Instructor, Dept. of Surgery, UCSF  
Attending Faculty, Proctology Clinic, San Francisco General Hospital

Lisa Capaldini, M.S. UCSF  
Co-Coordinator: The Lesbian and Gay People in Medicine Task Force of the American Medical Students' Association.

Carol J. Cohen, M.D.  
Certified, American Board of Psychiatry.  
Private Practice of Psychiatry, Berkeley, California  
Active in Feminist and Gay Communities

W. Lawrence Drew, M.D, Ph.D.  
Private Practice and Research, San Francisco

Alvin Friedman-Kien, M.D.  
Private Practice, New York City, New York

Marny Hall, Ph.D.  
Psychologist, Associate staff, UCSF.  
Human Sexuality Program UCSF  
Private Practice - Predominately lesbians and lesbian couples.

Wm J. Kapla, M.D.  
Private Practice, Family Practice, San Francisco  
Clinical Instructor, Dept. Family and Community Medicine, UCSF  
Treasurer elect - BAPHR

David Kessler, M.D., FAPA  
Associate Professor of Psychiatry, UCSF  
President of Caucus of Gay, Lesbian and Bisexual members of the American Psychiatric Association.  
Past President, BAPHR

James Krameski, M.D.  
Private Practice of Psychiatry, San Francisco  
Pres. elect, Caucus of Gay, Lesbian and Bisexual members of the American Psychiatric Association  
Visce President, BAPHR

Richard Long, Ph.D.  
Clinical Psychologist and Sex Therapist in Private Practice, San Francisco.  
Former Director of Training, Human Sexuality, UCSF
FACULTY PARTICIPANTS
Continued - Page 2

Dale McGhee, M.D.                                      Private Practice of Urology, Santa Clara, CA
Clinical Instructor, Stanford University
Lecturer UCSF
President, BAPHR

Dennis J. McShane, M.D.                                  Clinical Assistant Professor of Medicine in
Rheumatology, Stanford University

William F. Owen, Jr., M.D.                               Board Certified in Internal Medicine
Private Practice, San Francisco
Former Coordinator of Emergency Medicine
Education, UCSF.
Founder, BAPHR
Past Secretary, BAPHR

Michael Rankin, M.D.                                    Psychiatrist, San Francisco
MEDICAL ISSUES IN SEXUAL ORIENTATION

SEXUALLY TRANSMITTED DISEASES SESSIONS PROGRAM

June 26, 1981

9:00 AM  STD INTRODUCTION  Bill Owen, M.D.

9:05 AM  Neisseria gonorrhoea

Neisseria meningitidis  Bob Bolan, M.D.

Chlamydia trachomatis?lymphogranuloma venereum

9:20 AM  Syphilis

Granuloma inguinale, chancroid, molluscum contagiosum, Streptococcal Disease  Bill Owen, M.D.

9:35 AM  Herpes simplex virus II

Condylomata accuminata  Bill Bolan, M.D.

9:55 AM  Discussion

10:05 AM  15 minute break

10:20 AM  Enteric infections: Shigella, Salmonella, Campylobacter, Amebiasis, Giardiasis, Hepatitis A, Ectoparasites  Bill F. Owen, M.D.

10:50 AM  Hepatitis B  Bob Bolan, M.D.

11:10 AM  Cytomegalovirus, Pneumocystis carinii,  Larry Drew, M.D.

11:20 AM  Kaposi's sarcoma  Alvin Friedman-Kien, M.D.

11:30 AM  Panel Discussion

12 NOON  Lunch
APPROACHING THE GAY AND LESBIAN PATIENT

I. General Comments
   A. The Gay and Lesbian Community
      1. Size
      2. Diversity
   B. Health Care Expectations

II. Family Structure and Support Systems
    A. Nuclear
    B. Expanded
    C. Encompassing

III. Sexual History
    A. Content
       1. What is primary sexual activity
       2. Who are the primary sexual partners
       3. When and how often is sexual activity
       4. Where does primary sexual activity occur
       5. How is most of sexual activity done
    B. Attitude of physician
       1. Acceptance with open-ended approach
       2. Body Language

IV. EDUCATE YOUR PATIENT
    A. Preventive Health
       1. Disease avoidance
       2. Disease recognition
       3. Routine-self-administered rectal exams
    B. Lifestyle techniques
       1. How to perform sexual activity with less risk
       2. General body maintenance
OUTLINE

THE ANORECTUM
ITS CARE, NURTURING AND PRESERVATION

I General
A. Functions
   1. Anal continence
   2. Erotic pleasure
B. Source/Site of disease

II Anorectal Problems
A. Traumatic
   1. Mechanical
   2. Chemical
   3. Surgical
B. Infectious
   1. Endogenous
   2. Exogenous
   3. Communicable
C. Tumors
   1. Benign
   2. Condylomata acuminata
   3. Cancer
D. Psychological

III The anorectum is a significant source of morbidity to the gay patient as well as his community of sexual partners.

IV Keys to Anorectal Health
A. Minimize trauma
B. Avoid infection
C. Prevention
   1. Education
   2. VD Screen
   3. Anoscopy (Proctoscopy)
V Common Surgical Problems of the Anorectum

A. Anatomy

1. Ectoderm vs Endoderm
2. Anal Crypts/Glands
3. Sphincters
4. Spaces
5. Lymphatics

B. Fissure in Ano

Source - Trauma
Pathology - Incomplete drained abscess
Complications - ? 1° Syphilis
Rx - Relieve sphincter spasm

C. Abscess

Source - Trauma/Infection
Pathology - Anal gland
Complications - Fistula
Rx - Drainage

D. Fistula

Source - Abscess
Pathology - Crypt/Goodall's Rule
Complications - Abscess/Continence
Rx - Excise, drain source

E. Thrombosed External Hemorrhoid

Source - ?
Pathology - Perianal Hematoma
Complications - Abscess/Fissure
Rx - Thrombectomy/Expectant

F. Internal Hemorrhoids

1. Acute, Thrombosed

Source - ?
Pathology - Thrombosed vein/Prolapse
Complications - Abscess/Fissure/Bleeding
Rx - Medical/Surgical
2. Chronic

S/S - Bleeding/Prolapse
Types - 1°, 2°, 3°
Complications - Anemia/Fissure/Pruritis/Soilage
Rx - Injection/Dilation/Banding
- Cryotherapy/Surgery

G. Condylomata Acuminata

Source - Venereal Transmission
Pathology - Papilloma Virus
Complications - Bleeding/Fissure/Abscess-Fistula
- Pruritis/?Cancer
Rx - Multiple

H. Cancer

Adeno carcinoma
Squamous cell carcinoma
? anal warts

I. Pruritis Ani

Keep skin of anal area clean, dry, slightly acid
Avoid injury from excessive wiping or abrasion
<table>
<thead>
<tr>
<th>NAME</th>
<th>ADDRESS</th>
<th>CITY, STATE</th>
<th>SPECIALTY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HARRINGTON, David, M.D.</td>
<td></td>
<td></td>
<td>EM</td>
</tr>
<tr>
<td>2. PEREZ, Michael</td>
<td></td>
<td></td>
<td>Psy</td>
</tr>
<tr>
<td>3. GOODWIN, Lawrence, M.D.</td>
<td></td>
<td></td>
<td>IM</td>
</tr>
<tr>
<td>4. THAL, Sam, M.D.</td>
<td></td>
<td></td>
<td>IM</td>
</tr>
<tr>
<td>5. SEITZMAN, Peter, M.D.</td>
<td></td>
<td></td>
<td>Surg</td>
</tr>
<tr>
<td>6. PLUCINSKI, Theodore, M.D.</td>
<td></td>
<td></td>
<td>FP</td>
</tr>
<tr>
<td>7. GARSON, Richard, M.D.</td>
<td></td>
<td></td>
<td>GP</td>
</tr>
<tr>
<td>8. LINGOUSKY, Arthur, M.D.</td>
<td></td>
<td></td>
<td>Urol.</td>
</tr>
<tr>
<td>9. GUNASEGAR, Jay, M.D.</td>
<td></td>
<td></td>
<td>Psy</td>
</tr>
<tr>
<td>10. VALGEMAE, Allan, M.D.</td>
<td></td>
<td></td>
<td>FP</td>
</tr>
<tr>
<td>11. MARMER, Jeffrey, M.D.</td>
<td></td>
<td></td>
<td>Psy</td>
</tr>
<tr>
<td>12. LYMAN, David, M.D.</td>
<td></td>
<td></td>
<td>FP</td>
</tr>
<tr>
<td>13. NEARING, Joseph, M.D.</td>
<td></td>
<td></td>
<td>EM</td>
</tr>
<tr>
<td>14. SEALY, John M.D.</td>
<td></td>
<td></td>
<td>EM</td>
</tr>
<tr>
<td>15. AKELEY, Robert, M.D.</td>
<td></td>
<td></td>
<td>Psy</td>
</tr>
<tr>
<td>16. FONVILL, T. W., M.D.</td>
<td></td>
<td></td>
<td>IM</td>
</tr>
<tr>
<td>17. HARRIS, Steven, M.D.</td>
<td></td>
<td></td>
<td>EM</td>
</tr>
<tr>
<td>18. GREEN, Steven, M.D.</td>
<td></td>
<td></td>
<td>CA</td>
</tr>
<tr>
<td>19. BRUCE, Frank, M.D.</td>
<td></td>
<td></td>
<td>IM</td>
</tr>
<tr>
<td>20. ROSSI, Toni, M.D.</td>
<td></td>
<td></td>
<td>IM (Res)</td>
</tr>
<tr>
<td>21. BICKELHAUPT, Ethan, M.D.</td>
<td></td>
<td></td>
<td>Psy/ER</td>
</tr>
<tr>
<td>23. SMITH, Jaime, M.D.</td>
<td></td>
<td></td>
<td>Psy</td>
</tr>
<tr>
<td>24. WILLOUGHBY, Brian, M.D.</td>
<td></td>
<td></td>
<td>FP</td>
</tr>
<tr>
<td></td>
<td>Name</td>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------</td>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>SCHRAM, Neil, M.D.</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>BRAUDE, James, M.D.</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>RILEY, George, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>GORMAN, Michael, Ph.D.</td>
<td>Med. Anthropology</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>THOMPSON, Harvey, M.D.</td>
<td>IM.</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>JOHNSON, James D., M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>SCHAFFNER, Bertram, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>NICHOLS, STUART, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>MORGAN, James, M.D.</td>
<td>Anesth.</td>
<td></td>
</tr>
<tr>
<td>35</td>
<td>WEABER, George, M.D.</td>
<td>Anesth</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>SCHWARTZ, Robert, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>DIMAIO, Christopher, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>PAIBOON, Isra, M.D.</td>
<td>IM/Allergy</td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>PASSER, Dennis, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>JOHNSON, George, M.D.</td>
<td>Anesth.</td>
<td></td>
</tr>
<tr>
<td>41</td>
<td>LEWIS, Angie, R.N., M.S.</td>
<td>Nursing Ed</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>TRUAX, A. Brad, M.D.</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>BLAKEWOOD, Robert, M.D.</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>PECKHAM, Mike</td>
<td>Med Stu</td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>DIAZ, David, M.D.</td>
<td>GYN</td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>CANTWELL, A., Jr., M.D.</td>
<td>Derm</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>HEFFNER, Leland, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>TELLER, Benjamin, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>WEDVED, John, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>BLACK, Richard</td>
<td>Med. Stu</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>OEHLER, Ron</td>
<td>Med. Stu</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Name</td>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Krampf, Walter, M.D.</td>
<td>GP/Pub Health</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Estes, Milton, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Diodata, James, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Carfagni, Arthur, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Paulson, James, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Schneider, Max A., M.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>Goodwin, Lawrance, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Morrison, Charles, M.D.</td>
<td>Plastic Surg</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Ivans, Michael</td>
<td>Med Stu</td>
<td></td>
</tr>
<tr>
<td>61</td>
<td>Solomon, Les, M.D.</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Lutrin, Harry, M.D.</td>
<td>OB/GYN</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>McGraw, Patrick, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Keith, Paul, III, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>Strickland, Scott, M.D.</td>
<td>IM</td>
<td></td>
</tr>
<tr>
<td>66</td>
<td>Wade, Bill, D.O.</td>
<td>Psy/EM</td>
<td></td>
</tr>
<tr>
<td>67</td>
<td>Burton, Mike, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
<tr>
<td>68</td>
<td>Neger, Robert, M.D.</td>
<td>Ophth.</td>
<td></td>
</tr>
<tr>
<td>69</td>
<td>Merworth, Roy, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>Shafer, James, III</td>
<td>PA</td>
<td></td>
</tr>
<tr>
<td>71</td>
<td>Sack, Kent, M.D.</td>
<td>EM</td>
<td></td>
</tr>
<tr>
<td>72</td>
<td>Goldstein, Henry, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>73</td>
<td>Graham, S. Robert, M.D.</td>
<td>FP</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Trefelner, Eric</td>
<td>Med. Stu</td>
<td></td>
</tr>
<tr>
<td>75</td>
<td>Mahan, George, M.D.</td>
<td>Ped</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Hartmeyer, James</td>
<td>Med. Stu</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Matheus, Chris, M.D.</td>
<td>PA</td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>Beaulieu, Maurice, M.D.</td>
<td>Psy</td>
<td></td>
</tr>
</tbody>
</table>
SYMPOSIUM PARTICIPANTS
Continued - Page 4

79. SAMPSELL, J. B., M.D.  
80. WOFSY, Connie, M.D.  
81. DEFACIO, Les  
82. ANDERSON, Robert, M.D.  

[Redacted]  
[Redacted]  
[Redacted]  
[Redacted]  

Pys  
IM  
PA  
Path/Lab Med
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Patient complaints</th>
<th>Signs and clues</th>
<th>Laboratory findings</th>
<th>Treatment</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cellulitis, penile</td>
<td>Pain and redness over penis; penile drainage</td>
<td>Erythema over penis with warmth; occasional purulent or serous drainage; history of fellatio</td>
<td>Culture of any exudate may show staphylococci, streptococci, or anaerobes.</td>
<td>Dicloxacillin sodium (Dyna-pen, Pathocil, Veracillin, etc.) or erythromycin, 250 mg po q6h for 7-10 days.</td>
<td></td>
</tr>
<tr>
<td>Anal</td>
<td>Rectal pain and/or discharge; may be asymptomatic</td>
<td>Rectal inflammation.</td>
<td>Positive culture for gonorrhea.</td>
<td>Aqueous procaine penicillin G (Crysticillin A.S, Pfizerpen-AS, Wyccin, etc.), 4.8 million units IM, plus 1 gm probenecid (Benemid) po just before injection, or spectinomycin HCl (Trobicin), 2 gm IM for penicillin-allergic patients.</td>
<td>Do anal cultures every 3-6 months in sexually active patients: instruct patients to abstain from all sexual activity until cure is confirmed by culture. Ampicillin/probenecid (Benemid), amoxicillin (Amoxil, Larotid, Polymox, etc) probenecid; and tetracycline [see treatment, urethral gonorrhea] are not as effective for anal gonorrhea as are the other recommended regimens.</td>
</tr>
<tr>
<td>Oral</td>
<td>Sore throat</td>
<td>Inflamed pharyngeal area.</td>
<td>Positive culture for gonorrhea.</td>
<td>Aqueous procaine penicillin G (Crysticillin A.S, Pfizerpen-AS, Wyccin, etc.), 4.8 million units IM, plus 1 gm probenecid (Benemid) po just before injection, or oral tetracycline HCl, 500 mg qid for 5 days.</td>
<td>Do cultures on oropharynx every 3-6 months in sexually active patients: Avoid treatment with ampicillin and spectinomycin HCl (Trobicin). They are ineffective for treatment of pharyngeal gonorrhea. Urge patients to refrain from sexual activity until test of cure is positive.</td>
</tr>
<tr>
<td>Urethral</td>
<td>Dysuria, penile drip; may be asymptomatic</td>
<td>Urethral discharge.</td>
<td>Positive Gram's stain containing gram-negative intracellular diplococci; positive culture for gonorrhea.</td>
<td>Aqueous procaine penicillin G (Crysticillin A.S, Pfizerpen-AS, Wyccin, etc.), 4.8 million units IM, plus 1 gm of probenecid (Benemid) po just before injection, ampicillin, 3.5 gm with 1 gm of probenecid po; amoxicillin (Amoxil, Larotid, Polymox, etc.), 3 gm with 1 gm of probenecid po; or oral tetracycline HCl, 500 mg qid for 5 days. Patients who are allergic to penicillin and who cannot tolerate tetracycline may be treated with spectinomycin HCl (Trobicin), 2 gm IM.</td>
<td>Do urethral cultures every 3-6 months in sexually active patients: instruct patients to abstain from all sexual activity until cure is confirmed by culture.</td>
</tr>
</tbody>
</table>

*Because of space limitations: not all medical problems in this chart are included in the accompanying article.

*Infectious medical problems are less prevalent in patients in strictly monogamous relationships.

PATIENT CARE / OCTOBER 30, 1980
### Treating infections common in the homosexual community*  

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Patient complaints</th>
<th>Signs and clues</th>
<th>Laboratory findings</th>
<th>Treatment</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis</strong>&lt;br&gt;Hepatitis B</td>
<td>Fatigue, loss of appetite, indigestion, right upper quadrant pain, fever</td>
<td>Generalized jaundice may follow dark urine, light-colored stools, and scleral icterus.</td>
<td>Positive test for hepatitis B surface antigen. Antibody to hepatitis B surface antigen will become positive several months after infection.</td>
<td>Bed rest; proscribe alcohol and all sexual activity for symptomatic period. Some patients find a high-protein, low-fat diet easier to tolerate.</td>
<td>Advise patients to refer all sexual contacts for hepatitis B surface antigen test. Do a hepatitis B surface antigen test every 3 months in patients with multiple sexual contacts.</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Fatigue, loss of appetite, indigestion, right upper quadrant pain, fever</td>
<td>Generalized jaundice may follow dark urine, light-colored stools, and scleral icterus.</td>
<td>Antibody to hepatitis A will become positive after symptoms resolve.</td>
<td>Bed rest; proscribe alcohol and all sexual activity for symptomatic period. Some patients find a high-protein, low-fat diet easier to tolerate.</td>
<td></td>
</tr>
<tr>
<td><strong>Herpes simplex, genital</strong></td>
<td>Genital, anal, or oral lesions; pain or itch</td>
<td>Cluster of small vesicles.</td>
<td>Cowdry type A cells observed upon Tzanck test. Other confirmatory tests include viral culture, immuno-fluorescence, and serology.</td>
<td>Keep area clean and dry.</td>
<td>Counsel patients to avoid sexual contact during symptomatic period; explain to patients that they are extremely contagious while lesions are present. Sitz baths may cause maceration. Complications of anorectal herpes include lumbosacral radiculomyelopathy or sacral meningomyelitis manifested by local signs or urologic complaints.</td>
</tr>
<tr>
<td><strong>Lice and mites</strong>&lt;br&gt;Pediculosis pubis (crab or pubic lice)</td>
<td>Itching of pubic area</td>
<td>Tiny adult forms are visible, nits (eggs) attached to pubic hair may be seen under a magnifying glass.</td>
<td>None.</td>
<td>Apply gamma benzene hexachloride (Kwell) to affected areas of trunk, thighs, and axillae. Wash off thoroughly after 12 hours (overnight). Repeat in 4-7 days.</td>
<td>Advise patients to clean all clothes and linens thoroughly and to wear fresh clothing and use clean linens the first day after treatment.</td>
</tr>
<tr>
<td>Scabies (itch mites)</td>
<td>Itching, especially at night, between fingers, on extensor surfaces, on genitalia or groin</td>
<td>Linear burrows, 1-10 mm long, are visible; note marked dermatitis representing an allergic reaction to the mite.</td>
<td>Wet mount of scrapings from unroofed burrows may reveal the mite.</td>
<td>Apply gamma benzene hexachloride (Kwell) to all areas of the body except the face, eyes, eyelashes, and mucous membranes. Wash off thoroughly after 12 hours (overnight). Repeat in 4-7 days.</td>
<td>Advise patients to clean all clothes and linens thoroughly and to wear fresh clothing and use clean linens the first day after treatment.</td>
</tr>
</tbody>
</table>

*Because of space limitations, not all medical problems in this chart are included in the accompanying article.*
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Patient complaints</th>
<th>Signs and clues</th>
<th>Laboratory findings</th>
<th>Treatment</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphogranuloma venereum (LGV)</td>
<td>Papule, blister, or ulcer on penis; pain or mass in anorectum</td>
<td>Primary papule or ulcer on genitalia; enlargement of nodes on both sides of inguinal ligament; abscess resulting in groove; granuloma in anorectum or fistulas, fibrosis, and strictures.</td>
<td>Complement-fixing antibodies develop earliest; biopsy may be necessary to exclude carcinoma, TB, especially in anorectal granulomas. Frei test becomes positive in 6 weeks in many patients.</td>
<td>Tetracycline, 500 mg qid for 21 days, or sulfisoxazole (Gantrexin, SK-Soxazoline), 1 gm qid for 21 days.</td>
<td>Suppurative of inguinal nodes and multiple fistulous tracts may develop; negative Frei test does not exclude the diagnosis.</td>
</tr>
<tr>
<td>Parasitic Infestation</td>
<td>Acute abdominal pain, fever, or diarrhea</td>
<td>Dehydration, purulent or bloody diarrhea, rapid onset of symptoms.</td>
<td>Fecal leukocytes on methylene blue smear. Do a stool culture and sensitivity test for Shigella.</td>
<td>Hydration, bed rest, clear liquids as tolerated. Recommend ampicillin, 7.5 mg/kg qid for 5-7 days. Use trimethoprim and sulfamethoxazole (Bactrim, Septra)—160 mg/800 mg po every 12 hours for 5-7 days—for patients who are allergic to penicillin.</td>
<td>Concurrent infection by other parasites is common. Purpose of treatment is to abort development of the carrier state.</td>
</tr>
<tr>
<td>Amebiasis</td>
<td>Diarrhea, hepatic abscess may develop, flatulence, cramps, bloating; chronic symptoms of several weeks' duration or intermittent symptoms</td>
<td>Cutaneous amebiasis (ameboma) may mimic a venereal wart.</td>
<td>Ova and parasites observed in stool exam.</td>
<td>Asymptomatic intestinal infection: Metronidazole (Flagyl), 750 mg tid for 10 days; dilodohydroxyquin (Yodoxin), 650 mg tid for 21 days; or, diloxanide furoate.* 500 mg tid for 10 days. Mild symptomatic intestinal infection: A combined regimen of diloxanide furoate,* 500 mg tid for 21 days; oxytetracycline (Terramycin), 250 mg qid for 10 days; and chloroquine phosphate (Aralen), 500 mg bid for 2 days, and then 250 mg bid for 12 days. Or, treat with metronidazole. 750 mg tid for 10 days, followed by diloxanide furoate.* 500 mg tid for 10 days, or diodohydroxyquin, 650 mg tid for 21 days. Severe intestinal symptoms: Begin with dehydroemetine** or emetine HCl, 1 mg/kg/day IM or subcutaneously until symptoms are controlled (up to a maximum of 5 days).</td>
<td>Proscribe alcohol during treatment with metronidazole (Flagyl). These drugs may cause cardiac arrhythmia, chest pain, muscle weakness, and cellulitis; cardiac monitoring is essential.</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Patient complaints</td>
<td>Signs and clues</td>
<td>Laboratory findings</td>
<td>Treatment</td>
<td>Remarks</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>Parasitic infestation continued Giardiasis</td>
<td>Diarrhea, flatulence, cramps, and bloating</td>
<td>Ova and parasites observed upon examination. OR Positive jejunal biopsy.</td>
<td>Metronidazole (Flagyl), 250 mg tid for 10 days. OR Quinacrine HCl (Atabrine), 100 mg tid after meals for 7 days.</td>
<td>Prosonibe alcohol. Counsel patients that risk for enteric infection is high with oral-anal contact.</td>
<td></td>
</tr>
<tr>
<td>Enterobiasis (pinworms, threadworms)</td>
<td>Itchy anus</td>
<td>Positive cellophane tape test for perianal area.</td>
<td>Choose among the following recommendations: Pyrantel pamoate (Antiminth), 11 mg/kg in a single dose, not to exceed a total dose of 1 gm, pyrvinium pamoate (Povan), 5 mg/kg in a single dose; piperazine citrate (Antepar, Multiflue, Vermizine, etc.), 65 mg/kg/day for 7 consecutive days; or mebendazole (Vermox), 1 tablet regardless of age or weight.</td>
<td>Povan may cause red staining of stools; all drugs may cause GI side effects, such as nausea and vomiting, as well as rash. Be sure to treat all sexual contacts and family members who also may have been infected. Re-treat the patient in about 2 weeks to prevent reinfection.</td>
<td></td>
</tr>
<tr>
<td>Prostatitis</td>
<td>Urinary symptoms: burning, increased frequency, urgency, dribbling Systemic symptoms: perineal discomfort, rectal pain, pain on defecation, chills, fever Urinary symptoms: hematuria, obstruction in acute or chronic prostatitis. Systemic symptoms: referred pain in chronic or acute prostatitis, swollen, tender prostate in acute cases; over half of patients with chronic prostatitis have a normal prostate; others have boggy or indurated prostate.</td>
<td>Urinary symptoms: hematuria, obstruction in acute or chronic prostatitis. Urinary symptoms: hematuria, obstruction in acute or chronic prostatitis.</td>
<td>Increased WBCs in voided urine after rectal exam. Urine C&amp;S from this specimen may identify specific organism.</td>
<td>Trimethoprim and sulfamethoxazole (Bactrim, Septra), 160 mg/800 mg po every 12 hours for 10-21 days in acute prostatitis and for 21 days in chronic prostatitis. Bed rest, hydration, analgesics, stool softeners in acute prostatitis, hot sitz baths in chronic prostatitis. Prostatic massage not advisable in acute prostatitis since massage may precipitate septicemia; massage at weekly intervals is useful in chronic prostatitis.</td>
<td></td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>Fever, sore throat, cough, rash Pharyngitis, fever circumoral pallor, milk-white patches on buccal mucosa, strawberry tongue, sandpaper rash, desquamation of skin, Pasta's sign (creases in elbow flexure).</td>
<td>Elevated WBC; beta-hemolytic streptococci group A on throat culture.</td>
<td>Benzathine penicillin G (Bicillin L-A, Permaphan), 1.2 million units IM, or erythromycin, 250 mg po qid for 10-14 days.</td>
<td>Outbreak reported in San Francisco homosexual community in 1976; transmission by oral or oral-anal contact.</td>
<td></td>
</tr>
</tbody>
</table>

Because of space limitations, not all medical problems in this chart are included in the accompanying article.
### Treating infections common in the homosexual community*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Patient complaints</th>
<th>Signs and clues</th>
<th>Laboratory findings</th>
<th>Treatment</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Syphilis</strong></td>
<td>Genital, oral, or anal lesions; sore throat; rectal pain; may be asymptomatic</td>
<td>May need anoscopy to see anal chancre; oral chancre may be anywhere in oral cavity or pharynx</td>
<td>Positive VDRL. Do rapid plasma reagin test surveillance and dark-field microscopic examination of all suspicious genital, oral, and anal lesions. Perform cerebral spinal fluid VDRL to exclude asymptomatic neurosyphilis in patients with latent syphilis of more than a year’s duration.</td>
<td>Benzathine penicillin G (Bicillin L-A, Permapen), 2.4 million units IM, for primary syphilis of less than a year’s duration. Multiple injections—usually 3 weekly injections of 2.4 million units IM of benzathine penicillin G—are required for latent syphilis of more than a year’s duration. Use oral tetracycline for penicillin-allergic patients, 500 mg qid for 15 days for early syphilis and for 30 days for latent syphilis of more than a year’s duration.</td>
<td>Do serologic tests every 3 months in sexually active homosexual males with multiple partners.</td>
</tr>
<tr>
<td><strong>Urethritis</strong></td>
<td>Burning on urination, penile discharge, urethral drip</td>
<td>Penile discharge.</td>
<td>Increased leukocytes in urethral smear or first-morning urine.</td>
<td>Oral tetracycline HCl, 250 mg qid for 14-21 days.</td>
<td>Culture all orifices of sexual contacts and treat if positive to prevent new symptomatic infection in patient.</td>
</tr>
<tr>
<td><strong>Nongonococcal urethritis</strong> (NGU) (Chlamydia trachomatis)</td>
<td>Burning on urination, penile discharge, urethral drip</td>
<td>Penile discharge.</td>
<td>Positive culture for meningococcus.</td>
<td>Treat with same regimen as for gonorrhea only if patient is symptomatic.</td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal urethritis</strong></td>
<td>Burning on urination, penile discharge, urethral drip</td>
<td>Penile discharge.</td>
<td>Positive culture for meningococcus.</td>
<td>Treat with same regimen as for gonorrhea only if patient is symptomatic.</td>
<td></td>
</tr>
<tr>
<td><strong>Vaginitis</strong></td>
<td>Vaginal itching and irritation, vaginal discharge</td>
<td>White, curdy vaginal discharge with yeasty odor.</td>
<td>Positive culture or positive wet prep for <em>Candida</em>. KOH wet mount positive for budding yeasts and/or mycelia.</td>
<td>Fungicide cream or suppository for 7-14 days.</td>
<td>Frequently seen in women taking antibiotics.</td>
</tr>
<tr>
<td><strong>Candidal</strong></td>
<td>Vaginal itching and irritation, vaginal discharge</td>
<td>White, curdy vaginal discharge with yeasty odor.</td>
<td>Positive culture or positive wet prep for <em>Candida</em>. KOH wet mount positive for budding yeasts and/or mycelia.</td>
<td>Fungicide cream or suppository for 7-14 days.</td>
<td>Frequently seen in women taking antibiotics.</td>
</tr>
<tr>
<td><strong>Hemophilus vaginalis</strong></td>
<td>Vaginal itching and irritation, burning on urination, vaginal discharge</td>
<td>Gray, malodorous vaginal discharge.</td>
<td>Gram-negative or gram-variable “clue” cells upon Gram’s stain.</td>
<td>Metronidazole (Flagyl), 250 mg tid for 7 days; ampicillin, 500 mg qid for 5-7 days; or vaginal preparations containing sulfonamides.</td>
<td>Instruct patients to avoid alcohol while on metronidazole. Treat the patient’s partner if infection recurs.</td>
</tr>
<tr>
<td><strong>Trichomoniasis</strong></td>
<td>Vaginal itching and irritation, burning on urination, vaginal discharge</td>
<td>Yellowish-green, foamy vaginal discharge, slight bleeding of vaginal walls.</td>
<td>Positive vaginal saline prep for <em>Trichomonas</em>.</td>
<td>Metronidazole (Flagyl), 250 mg tid for 10 days or 2 grams in one dose.</td>
<td>Instruct patient to avoid alcohol while on metronidazole. Treat both the patient and her partner.</td>
</tr>
<tr>
<td><strong>Warts, venereal</strong></td>
<td>Venereal warts</td>
<td>Penile, vaginal, or anal warts; anorectal lesions only evident upon proctoscopic exam; usually have cauliflower appearance.</td>
<td></td>
<td>Treat external warts with podophyllin or cryosurgery. For internal warts, use electrocautery.</td>
<td>Recommend colposcopy for venereal warts on the cervix. Do not use podophyllin in pregnant females. Some malignant lesions and ameboma (cutaneous amebiasis) may mimic warts.</td>
</tr>
</tbody>
</table>

*Because of space limitations, not all medical problems in this chart are included in the accompanying article.*
## Treating noninfectious problems of homosexual patients

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Patient complaints</th>
<th>Signs and clues</th>
<th>Laboratory findings</th>
<th>Treatment</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Edema, penile</strong></td>
<td>Swelling of penis</td>
<td>Penis edematous above the area of use of penile ring, or diffusely edematous with erythema or specific allergic lesions in case of contact dermatitis; history of chronic use of penile rings or allergenic lubricants.</td>
<td>None.</td>
<td>Discontinue use of penile rings or offending lubricants. Application of triamcinolone acetonide (Aristocort, Kenalog), 0.025 percent bid, in cases of offending contact dermatitis.</td>
<td></td>
</tr>
<tr>
<td><strong>Hemorrhoids</strong></td>
<td>Itching, rectal bleeding</td>
<td>Prolapsed hemorrhoids; anoscopy may reveal swollen or bleeding internal hemorrhoids.</td>
<td>Obtain anal culture and VDRL.</td>
<td>Rest, abstention from anal sex for 2 weeks; hot sitz baths twice daily. Stool softeners; occasionally, localized treatment such as suppositories or anti-inflammatory agents may be necessary.</td>
<td>Exclude other possible causes of rectal pain and bleeding such as syphilis, gonorrhea, herpes, LGV, and allergic proctitis.</td>
</tr>
<tr>
<td><strong>Proctitis, allergic</strong></td>
<td>Anal irritation and pain</td>
<td>Anal inflammation; use of irritating lubricants during anal intercourse.</td>
<td>None.</td>
<td>Counsel patients to avoid lubricants or douches containing allergenic coloring agents or scents.</td>
<td></td>
</tr>
<tr>
<td><strong>Sinusitis, chemical</strong></td>
<td>Sinus trouble; painful nasal skin or mucosa</td>
<td>Inflammation of sinus; inhalation of amyl nitrite or its analogues.</td>
<td>Counsel patients to avoid use of these agents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trauma</strong></td>
<td>Painful anorectal area</td>
<td>Anorectal lesions, fissures; local damage to anal sphincter is unusual, ask about insertion of objects such as dildos or vibrators during intercourse.</td>
<td>Surgical repair for major tears; conservative management—sitz baths, stool softeners, and analgesics—for minor fissures.</td>
<td>Anal intercourse performed with adequate, nonirritating lubricant and with the receptive partner relaxed rarely results in local trauma.</td>
<td></td>
</tr>
<tr>
<td><strong>Anorectal trauma with colonic perforation</strong></td>
<td>Painful anorectal area, acute GI distress and abdominal pain, rectal bleeding</td>
<td>Acute abdominal symptoms after peritoneal signs develop; history of &quot;fisting.&quot;</td>
<td>Surgical repair.</td>
<td>Anoscopy and/or sigmoidoscopy may be necessary for diagnosis prior to development of peritoneal signs.</td>
<td></td>
</tr>
<tr>
<td><strong>Anorectal foreign bodies</strong></td>
<td>Foreign body in rectum</td>
<td></td>
<td>Removal of foreign body in emergency department of hospital.</td>
<td>Foreign bodies not accessible to anorectum may need to be removed using forceps in operating room under general anesthesia. Obtain surgical consultation for foreign bodies containing glass.</td>
<td></td>
</tr>
</tbody>
</table>

*PATIENT CARE / OCTOBER 30, 1980*
Sexually Transmitted Diseases and Traumatic Problems in Homosexual Men

WILLIAM F. OWEN, Jr., M.D.; San Francisco, California

In addition to gonorrhea and syphilis, both of which may develop primarily at anorectal or pharyngeal sites, a number of conditions, including Neisseria meningitidis urethritis, nonspecific urethritis, anorectal herpes, condyloma acuminatum, amebiasis, giardiasis, shigellosis, typhoid fever, enterobiasis, and hepatitis A and B, have been identified as being transmitted by male homosexual contact. Proctologic complications of anal intercourse include allergic reactions to anal lubricants, prolapsed hemorrhoids, anal fistulas, and fissures. Rectosigmoid tears may result from fist, forearm, and foreign body penetration of the bowel. Physicians can best help their homosexual patients by accepting their relationships nonjudgmentally and by understanding their special health needs.

Homosexual men with multiple sex partners are at increased risk of acquiring sexually transmitted diseases (1). "Maleness," "homosexuality," and "multiple sex partners" may be evaluated as risk factors (2). The male urethra is a significant factor because it may be exposed to infection when inserted into a mouth, rectum, or vagina. The penis then efficiently transmits the infectious agent to the mouths, rectums, and vaginas of partners by penetrating deeply into these cavities in conjunction with the forceful ejaculation of semen. Homosexualitiy is not a major risk factor by itself if, for instance, the person is in the "close-coupled" (monogamous) or "asexual" categories of Bell and Weinberg (3). Having multiple sex partners may increase the risk of sexually transmitted disease, but this increased risk is related to the anonymity rather than the number of partners. Anononymous partners make it nearly impossible to interrupt disease transmission through contact tracing and treatment (4). Lesbians appear to have a lower prevalence of sexually transmitted disease than either homosexual men or heterosexuals (ROBERTSON PA, ANDERSON LJ, SCHACHTER J. Gynecological health care needs of homosexual women. Unpublished material). This also is related to the absence of the male urethra and the virtual absence of anonymity in lesbian sexual intercourse.

Old Diseases in New Locations: Gonorrhea and Syphilis

Although data do not exist for the entire homosexual population, homosexual men attending venereal disease clinics have a greater prevalence of syphilis and gonorrhea than heterosexuals (5). A recent report from the Center for Disease Control indicates that nearly half the male patients with syphilis claimed homosexual or bisexual contacts (2).

Anorectal and pharyngeal gonorrhea are particularly prevalent in homosexual men (6-18). Gonorrhea in the pharynx may present with sore throat and in the anus with burning, itching, bleeding, mucopurulent discharge, or painful defecation, but most cases are asymptomatic (10, 13, 14, 17, 18).

In a study of 500 homosexual men done in the venereal disease clinic of the Los Angeles Gay Community Services Center, it was found that 66% of anal gonococcal infections and 89% of pharyngeal gonococcal infections were asymptomatic compared to only 7% of urethral infections (19). In a screening clinic for homosexual men at one of the Denver steam baths, 48 of 419 men (11.5%) were found to have asymptomatic gonorrhea (20).

Primary syphilis may also occur in the anorectal area (20, 21). Anorectal chancres may be either asymptomatic, like classic penile chancres, or extremely painful. Some patients who present with manifestations of secondary syphilis may not have observed a primary lesion because their chancre could be both asymptomatic and situated in an occult location, particularly the anorectal area.

If the chain of infection originating in asymptomatic oral and pharyngeal reservoirs is to be broken, physicians must take the initiative in ascertaining whether their male homosexual patients have had multiple, anonymous sexual contacts; in ensuring diligent contact tracing; and in educating sexually active homosexual patients about the need for periodic screening cultures and serologic tests for syphilis. Although the ideal screening interval is difficult to determine (4), one recommendation is that screening tests be done every 3 months (22).

Enteric Pathogens in Homosexual Men

Several colonic and rectal conditions occur frequently in homosexual men. These conditions, sometimes collectively termed the "gay bowel syndrome" (22, 23), include several proctologic complications of anal intercourse, infectious diarrhea caused by amebiasis and shigellosis, and viral illnesses like hepatitis and herpes. Heterosexual patients may be subject to the same range of enteric diseases and proctologic problems, but the recorded prevalence may not be as high because physicians in general have not been sensitized to look for these conditions as have physicians with many homosexual patients (24).

Bacterial and protozoal diarrheas in Americans have until recently been associated with contamination of water supplies by sewage and travel to certain areas. Giardiasis, for instance, has frequently been reported in travelers to Leningrad and to a few Colorado ski areas such as Aspen and Vail. There is now a growing trend, howev-
er, of finding these illnesses in homosexual men without the requisite travel experience. In San Francisco (25, 26), Seattle (27), and New York (28) shigellosis has been identified with increasing frequency in the homosexual community. Amoebiasis (22, 23, 26, 29, 30) and giardiasis (31, 32) are also being seen increasingly in homosexual men. Mixed bacterial and protozoal enteric infections have also been identified (33-35). Transmission of enteric infections probably occurs either as a result of oral-anal and oral-perineal intercourse or when fellatio follows anal sex, thus resulting in ingestion of infectious material from a contaminated penis. These enteric infections can also exist in the asymptomatic carrier state (35), making interruption of transmission very difficult. Correct diagnosis and treatment of the sexually transmitted enteric infections is important to prevent the development of serious complications, for example, amebic hepatic or brain abscesses.

Other enteric diseases that have been reported as homosexually transmitted include typhoid fever (36), enterobiasis (37), and campylobacter infections (38).

**Other Infectious Diseases in Homosexual Men**

A high prevalence of hepatitis B surface antigen (HBsAg) (39-42) and antibody (anti-HBs) (41, 42) has been noted in homosexual men. This large reservoir of infection is consistent with the high prevalence of hepatitis B noted in certain homosexual communities. (1, 22, 23, 26) Because saliva, urine, and semen transmit the hepatitis B virus (43, 44), infection may occur through anal sex, analingus, fellatio, or by mouth-to-mouth transmission of saliva. Chronic active hepatitis may occur as a complication of hepatitis B and should be considered in the setting of failure to resolve clinical symptoms or serum enzymes. (See Addendum.)

Herpes simplex infections of the genitalia are commonly recognized in homosexual and heterosexual patients, but herpes (usually HSV-2) can also be a frequent cause of disease in the anorectal area. It is seen less often than condyloma acuminatum or gonorrhea but more often than anorectal primary syphilis (45). Presenting symptoms usually are pruritis ani or intense anal pain (46). Relapses occur but are generally less severe than the initial episode. Herpetic proctitis may be associated with a lumbosacral radiculomyelopathy or a localized sacral meningomyelitis. These are manifested by localized neurologic signs (paresthesias and neuralgias in the buttocks and upper thighs), by urinary dysfunction (difficulty in starting urination, a poor stream, and a sensation of incomplete emptying of the bladder), or by erectile difficulties (47). Other venereal diseases and noninfectious problems, such as mechanical trauma, must be differentiated from herpes. A serious but rare complication of genital herpes is herpetic meningoencephalitis.

Anorectal cultures from homosexual men that yield *Neisseria* are considered to be *N. gonorrhoeae* by some laboratories without doing further speciation. Recent reports indicate that *N. meningitidis* can be isolated from many of these cultures (48). Meningococcal infections of the male urethra have also been described but are less common than the infections of the anal canal (49). Urethral meningococcal infections may be accompanied by painful discharge, whereas the anorectal infections are usually asymptomatic. The clinical significance of anogenital meningococcal infections in homosexual men is not clear in terms of development of more serious sequelae, such as meningitis or meningococcemia. The issue of whether to treat anorectal *N. meningitidis* is controversial; a case can be made for treatment of the asymptomatic anorectal infection because it serves as a reservoir for the less common but very painful urethral infection (49).

Chlamydiae have been recovered from the throats and rectums of homosexual men (50). Their role in producing pharyngitis or proctitis is not clear, and the role of tetracycline in the treatment of chlamydial proctitis needs to be evaluated. Another factor besides chlamydiae to be considered in the differential diagnosis of culture-negative proctitis is allergy to the coloring agents and scents found in some of the lubricants used in anal intercourse.

Nongonococcal urethritis is thought to be rare in male homosexuals (51). There also appears to be a lower risk of postgonococcal urethritis among homosexual than among heterosexual men (52). Oriel and associates (53), however, reported on 22 homosexual men with nongonococcal urethritis; chlamydiae were isolated from the urethral material of seven of those patients.

**Proctologic and Genital Complications of Sexual Intercourse**

Sohn and Robilotti (22) have identified a number of proctologic complications of anal intercourse in homosexual men, including condylomata acuminata, prolapsed hemorrhoids, nonspecific proctitis, anal fistulas and fissures, perirectal abscesses, and rectal ulcers, tears, and foreign bodies. Fecal incontinence did not appear to be a significant problem in this series. The reported prevalence in this series reflects the experience of a proctologic practice; the true incidence of anorectal complications in patients who practice anal receptive intercourse remains to be ascertained.

Several cases of peritonitis resulting from rectosigmoid tears after insertion of a fist or even a forearm for sexual gratification are seen in the emergency rooms of hospitals in San Francisco and other cities each year (54, 55). Although the prevalence of complications of anal fist penetration is also unknown, this practice should be discouraged because of the potential severity of complications.

Trauma to the external genitalia may occur during homosexual intercourse. Staphylococcal pyoderma has been reported as a complication of fellatio (56). Penile edema may develop in heterosexual or homosexual men who have frequent intercourse (57); penile edema may also be seen in patients who habitually utilize penile rings (58).

Although the legal definition of rape in most jurisdictions refers to the involuntary penetration of a female by the male sexual organ, men can also be sexually abused. The patient who comes to the physician with the complaint of rape must be treated with concern and compassion and with due regard for the victim's right to seek prosecution of the alleged assailant(s), regardless of the victim's sex or sexual orientation. Most hospital emer-
gency rooms and other primary care facilities have not addressed this issue adequately and should develop protocols for dealing with all patients who claim to be victims of sexual assault (59).

Conclusion

Diseases in homosexual men may be caused by "exotic" organisms (such as Giardia lamblia) or by common organisms present in nontraditional locations (such as gonorrhea of the pharynx or anorectum). Also, several problems may occur simultaneously. For example, the homosexual patient offering a complaint of "painful hemorrhoids" may also have gonorrhea, chlamydial, or allergic proctitis. Traumatic problems may occur in conjunction with infectious diseases (55). In order to make the proper diagnosis, the physician must take an adequate sexual history and do a sufficient physical examination. The physician can best help his homosexual patients by accepting them and their relationships nonjudgmentally and by understanding their special health needs. Where this is not possible, referral to another physician is necessary.

Requests for reprints should be addressed to William F. Owen, Jr., M.D.; 1580 Valencia Street, Suite 202; San Francisco, CA 94110.

Received 9 April 1979; revision accepted 11 February 1980.

Addendum

In a recent study, transmission of hepatitis B virus appeared to be significantly correlated with the frequency of anal receptive intercourse (60). Possibly hepatitis B virus carried in the semen of the active partner is transmitted through microscopic breaks in the anal mucosa of the passive partner.

Hepatitis A has also been shown to be prevalent in homosexual men (60). Oral-anal contact has been associated with acquisition of hepatitis A (60).

References

The Clinical Approach to the Homosexual Patient

WILLIAM F. OWEN, Jr., M.D.; San Francisco, California

Since publication of the Kinsey report more than 30 years ago, which estimated that 10% of the white American male population was predominantly or exclusively homosexual, several studies have indicated that heterosexuals and homosexuals cannot be distinguished on the basis of psychological adjustment or sexual response. Recent studies have also indicated the absence of homosexual stereotypes; homosexual men and women are quite diverse in the way they organize their lives sexually as well as socially. The implication of this finding for physicians is that a complete history, including sexual history, is necessary in any patient regardless of sexual orientation to determine factors that may be placing the patient at an increased risk for disease. Additionally, the primary care physician may be called upon by the homosexual patient to provide psychosexual counselling or treatment of sexual dysfunctions. Certain verbal and nonverbal signals may facilitate or inhibit the relationship between the physician and the homosexual patient. Homosexual patients may need special reassurance about confidentiality in the doctor-patient relationship and about the physician's respect for their life-styles and significant relationships.

All physicians treating adult patients see many homosexual patients throughout their careers. Most physicians, however, are totally unaware of these encounters. The effeminate homosexual man and the masculine lesbian are stereotypes that apply to only a small minority of homosexual patients. The typical picture many heterosexuals have of homosexuals is that they are outlandish in their conduct, are emotionally crippled and filled with emotional torment, and contribute to the decay of our society. Often transvestism is confused with homosexuality. The stereotypical view also holds that homosexuals have different occupational interests and work histories from their heterosexual counterparts. In fact, less than 10% of homosexual men are in so-called "feminine" occupations, such as hairdressing or interior decoration, and less than 10% of lesbians are engaged in occupations most people think of as "masculine."

Psychological Adjustment and Sexual Response

The stereotype was never really seriously challenged until 30 years ago when Kinsey published his now classic report in which he estimated that 10% of white American men were predominantly homosexual (1). Many studies published since the Kinsey report have indicated that heterosexuals and homosexuals cannot be distinguished on the basis of psychological adjustment (2-4). These findings have led many investigators to conclude that homosexuality is a variation of sexual expression that is within the normal range psychologically. These studies also led to a reconsideration of the nature of homosexuality by psychiatrists. In 1973, the board of trustees of the American Psychiatric Association removed homosexuality from its official Diagnostic and Statistical Manual of Mental Disorders.

Sexual response patterns in homosexual patients have recently been evaluated from a physiologic standpoint. It was determined that, at least for selected heterosexual and homosexual study subjects in a laboratory environment, there are no significant statistical differences in facility of orgasmic attainment in response to masturbation, partner manipulation, or fellatio/cunnilingus regardless of the sexual preference or the gender of the interacting study subjects (5). Additionally, a higher level of subjective involvement in sexual interaction (including a greater degree of communication between partners) was observed in committed homosexual couples compared to their heterosexual counterparts.

A monolithic homosexual life-style does not exist. A recent study in San Francisco by the Kinsey Institute for Sex Research reveals that at least five clusters of homosexual people may be identified from the way homosexual men and women organize their sexual lives as well as from social and psychological factors (6). The "close-coupled" are involved in a relatively monogamous and lasting relationship, have fewer sexual problems than married heterosexual couples, and, for the men in the study, tend to be happier and more exuberant than their heterosexual counterparts. Ten percent of the male and 28% of the female homosexuals in the study were classified as close-coupled. "Open-couples," comprising 18% of homosexual men and 17% of homosexual women (a percentage similar to the married heterosexual control group) are couples living together but also pursuing sexual contacts outside the home.

Fifteen percent of the men and 10% of the women were classified as "functionals." These single individuals are interested in sex more than those in other groups, have multiple sexual partners, have a high level of exuberance, and are more socially involved with friends and with the homosexual subculture. The "functionals" have their counterpart in the "swinging singles" of heterosexual society. "Asexuals," making up 16% of the homosexual men and 11% of the homosexual women interviewed, are generally single and have a low level of sexual activity but are content with their social circumstances. Twelve percent of homosexual men and 5% of homosexual women are considered to be "dysfunctionals," and these individuals are more in conformity with the homosexual stereotype, regretting their homosexuality and displaying poor social and psychological adjustment. Twenty-nine percent of the men and 28% of the women could not be classified in the Kinsey Institute study of homosexuality.

The functional usefulness of this classification is that it serves to remind the physician that simply asking about a patient's homosexuality is inadequate. A complete family, social, and sexual history is necessary in any patient,
regardless of sexual orientation, to determine factors that may be placing the patient at an increased risk for disease. Giardiasis, for instance, might be an important cause of diarrhea in a functional or open-coupled homosexual but would be less likely in a close-coupled or asexual patient. Similarly, it would be indicated to refer a dysfunctional patient for sexual or psychological counselling but might be inappropriate to do the same for a homosexual in the close-coupled or functional categories. Because of societal, familial, and peer pressure, many homosexuals experience heterosexual relationships and even enter into heterosexual marriages, often while continuing to pursue homosexual contacts. The Kinsey Institute survey found, for example, that 20% of homosexual men and 35% of homosexual women had been married at least once. In considering risk factors for sexually transmitted diseases, therefore, it is important to be aware that a patient who is dating or married to a person of the opposite sex is not necessarily heterosexual.

**Communicating with the Homosexual Patient**

Homosexual men and women daily encounter many problems and barriers in dealing with our health care system that are often not recognized by providers of that care. Lack of knowledge of certain problems seen frequently in homosexual males with multiple sexual partners (for example, anal gonorrhea, giardiasis) may account for omission of the laboratory tests needed for diagnosis of these conditions. Lack of sensitivity results in the erection of barriers not faced by heterosexual patients, as when critically ill homosexual patients are denied the emotional support of visits from lovers and friends.

Verbal language can alienate homosexual men and women, interfering with development of a therapeutic doctor-patient relationship. A question such as “When did you last have intercourse?” indicates to the lesbian patient that the gynecologist who is asking the question is assuming that she is heterosexually active. The burden for explanation then devolves upon her. If she is reticent about disclosing her lesbianism, she may find herself the recipient of an unneeded prescription for oral contraceptives. Absence of the necessary verbal communication between doctor and patient may also lead to inadequate medical care. Failure to ask whether the “straight-appearing” male patient presenting with a sore throat has had oral sex, for example, may deprive him of the additional throat culture needed to diagnose gonococcal pharyngitis.

Specific words may also either facilitate or inhibit communication between physicians and their homosexual patients. Obviously words such as “queer” and “faggot” are directly alienating to homosexual men and women, but many also feel uncomfortable with the formal term “homosexual” (7). Use of “gay” implies some degree of understanding and empathy and is preferred if the physician feels comfortable with it. The physician who feels awkward asking the patient whether he is “gay” or homosexual and who suspects a problem such as anal gonorrhea may ask the patient whether he wishes his pharynx or anal canal cultured. Another way the physician may approach this question is to ask the patient, “Is there anything about your life-style, such as recent travel, sexual practices, or use of drugs that might help me to diagnose your medical problem?”

Nonverbal communication can either interfere with or facilitate the relationship between the patient and physician. Body tension indicates physical anxiety, crossed arms or distance implies resistance, and raised eyebrows when the patient discusses homosexuality may mean rejection of the patient’s sexual orientation (8).

Just as with any patient, it is important for the physician to determine the social environment of the homosexual patient. Is there a significant individual (lover, mate, boyfriend, or girlfriend) in the patient’s life? Is this person a roommate? Does the patient have other roommates? What is the nature of their relationships? Does the relationship allow for seeing other people sexually?

An adequate sexual history should be recorded from any patient, regardless of sexual orientation. Which sexual practices are employed? Colloquial terms should be used if the physician feels comfortable with them. In general, homosexual patients will be more at ease using sexual terms that they are most familiar with. Heterosexual physicians may be surprised to discover that most members of today’s “liberated” homosexual subculture use a wide repertoire of sexual techniques and are not restricted exclusively or even predominantly to either “active” or “passive” roles.

Is the patient having any functional problems with sexual intercourse? The Masters and Johnson Institute study of homosexuality indicates that homosexual dysfunctions should be treated with the same psychotherapeutic techniques, with the same professional personnel, and with the same psychosexual objectivity with which heterosexual dysfunctions are treated (9).

Are drugs used? Amyl nitrite or butyl nitrite is used by some homosexual men to cause a euphoric “rush” and anal sphincter relaxation. Are sexual toys (dildos, vibrators, penile rings, and the like) used? Where does the patient usually have sex? Are homosexual bars and baths (10) visited?

The physician can help the homosexual patient practice preventive medicine by assessing the totality of his or her life-style. What is the patient’s nutritional status? Does the patient smoke or drink alcohol, and how much? Does the patient get enough sleep? What is the patient’s employment status and level of job satisfaction? Does the patient obtain regular periodic screening examinations for sexually transmitted diseases? Patients with multiple anonymous sexual partners must be advised about the necessity for periodic laboratory tests for syphilis, anal and pharyngeal gonorrhea, and hepatitis B surface antigen.

Assessing the homosexual patient’s social milieu can help the physician decide whether specific practices have contributed to the patient’s problem. More important, however, the process of assessment indicates to the homosexual patient a sense of acceptance and nonjudgmental concern.

Owen • Clinical Approach to the Homosexual Patient
Psychosexual Counselling

Physicians and clergymen are the professionals most likely to be consulted by homosexual men and women searching for answers about their identity. Questions about masturbatory fantasies and about whom the patient notices when encountering a male-female couple may provide the physician with insights into the patient's sexual object choice (8). Physicians can assist families who are dealing with this issue by reassuring them that homosexuality is a normal variant rather than a medical illness (11). Books written for the lay public on this subject can be useful in facilitating understanding by homosexual patients and their families (11). Medical professionals can also help by using the many local service organizations and referral agencies that have developed in recent years and are directed at a homosexual clientele (11).

Attempting to convert homosexuals to heterosexuality against their wishes is no more medically sound than forcibly changing left-handed persons to right-handedness. In misguided efforts to "cure" homosexuality, physicians have sometimes neglected serious medical, psychological, and social problems. By thinking of homosexuality as a disorder, maladaptation, or failure of development, terms that have been used in the past by some psychiatrists to characterize homosexuality, many physicians mistakenly assume there is some sickness associated with being homosexual that can be cured by the intervention of a mental health professional.

The Physician and the Homosexual Patient

One of the greatest problems homosexual men and women face is choosing a physician. Many homosexual patients harbor substantial suspicion of heterosexual physicians and believe them to be ill prepared, professionally and personally, to deal with the problems of sexual minorities (McGhee RD. Unpublished observations.). This suspicion is consistent with the acknowledgment of many physicians that they feel some degree of discomfort when treating the medical problems of male homosexuals (12). Fear of insufficient treatment and anxiety about the heterosexual physician's potentially adverse reaction to his or her homosexuality may deter the homosexual patient from seeking treatment or preventive care.

One issue of particular concern to many homosexual patients is that of confidentiality. In many jurisdictions, homosexual intercourse between consenting adults is still illegal. Even in those areas where homosexual intercourse has been legalized, persons may feel threatened because of the very real possibility of loss of employment or housing or because of the stigmas still attached to homosexuality by many segments of our society. The physician should take the necessary steps to ensure that knowledge of his patient's homosexuality remains inviolable. This may include a personalized coding system in the medical chart for helping the physician recall the sexual orienta-

MEDICAL ASPECTS IN SEXUAL ORIENTATION

SYMPOSIUM EVALUATION

Please take a few moments to complete this form to:

1. Help us evaluate the presentations
2. Plan future symposia
3. Verify your attendance for CME certifications.

1. Did this Symposium meet your learning objectives?

2. Was there sufficient time for questions, answers, and discussion?

3. Comment on the Symposium with general comments, suggestions, and constructive criticisms.

Please rate each speaker for clinical usefulness, delivery, and success in meeting your expectations.

<table>
<thead>
<tr>
<th>Speaker</th>
<th>5=excellent</th>
<th>4=Very Good</th>
<th>3=Good</th>
<th>2=Fair</th>
<th>1=Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drew</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friedman-Kien</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kapla</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capaldini</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kessler</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohen</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rankin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McGhee</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hall</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bush</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Krajewski</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your help.