

Psychosocial Support on an Established AIDS Unit:
An Interdisciplinary Model

DANIEL A. BARNES

c/o The ACCESS Group, Ltd.
SFGH Box 201
1001 Potrero Avenue
San Francisco, CA 94110

The interdisciplinary model of psychosocial care which has evolved on the Acquired Immunodeficiency Syndrome (AIDS) care unit at San Francisco General Hospital (SFGH) is presented. While providing medical and nursing care services to over four hundred AIDS inpatients during the past two years, the clinical staff on the twelve bed AIDS unit has developed and refined a model of psychosocial care and support which relies on the cooperative action of hospital and community based service providers.

The role and significant aspects of the hospital based Shanti counseling service, social services, nursing, and psychiatry are discussed from the clients' and providers' perspective. Among the specific topics to be examined are:

- supporting the newly diagnosed
- evaluating and addressing the emotional impact of AIDS and its sequellae
- assisting patients with decisions about advanced life support
- supporting dying patients and their loved ones

The impact and scope of community based services which have been incorporated into the care plan are also discussed with particular attention paid to their role in discharge planning, and implementation. AIDS hospice, home health care, the Shanti emotional and practical support programs, and the AIDS residence programs insure quality and continuity of psychosocial support services upon discharge.

Medical and nursing staff also benefit from the psychosocial model and continue to provide quality care in the face of a sixty-four percent mortality rate (256 deaths in two years).

PSYCHOSOCIAL SUPPORT ON AN ESTABLISHED AIDS UNIT: AN INTERDISCIPLINARY MODEL

Daniel A. Barnes

The ACCESS Group, Ltd.; University of California, San Francisco, USA

I. SHANTI STAFF COUNSELORS

Shanti staff counselors, the nursing staff and social workers are the three primary sources of psychosocial support on the AIDS unit at San Francisco General Hospital. With the support of the Shanti Counseling Coordinator, staff counselors provide direct counseling services to persons with AIDS, AIDS-related conditions and their loved ones. They assess, evaluate and document the ongoing psychosocial, socioeconomic and educational concerns of patients and visitors. Interventions with clients are prioritized in order to insure adequate support is provided to those who need it most. They provide crisis intervention, mediation, advocacy and support services to patients, loved ones and staff. Counselors frequently give and receive consultation, referrals and feedback from medical staff, nursing personnel, social workers and other hospital and community based care providers. The staff counselors also facilitate discussion of sensitive and difficult issues and decisions such as those involving advanced life support, durable power of attorney, chaotic dynamics within the patient's support network, and problematic patient or visitor interaction with hospital and support staff. The counseling coordinator and staff also participate in weekly discharge planning, patient care, and counseling support group meetings.

II. SOCIAL WORKERS

Social workers assigned to the AIDS unit are the primary source of information, referral, and counseling for patients' financial and discharge planning concerns. This includes assessment of patients' living arrangements, degree of social support, and coordination of an appropriate discharge situation and support services. They help patients apply for state disability, SSI, Veteran's benefits and work closely with community AIDS organizations that provide other services which may assist the person with AIDS. They also advocate and insure that eligibility workers from various government assistance programs (Medical, Social Security and General Assistance) are aware of AIDS patients and their concerns. These programs fund many of the medical, home care, and transportation services social workers are involved in coordinating for patients upon discharge. Social workers also work closely with AIDS unit nurses and staff counselors to provide comprehensive and coordinated psychosocial support of our patients and their loved ones.

III. NURSING STAFF

Nursing staff choose to work with persons with AIDS for a variety of reasons. As a group, they are invested and involved in the holistic model of care which has evolved on the AIDS unit at San Francisco General Hospital. Nurses provide the most consistent and coordinated presence on the AIDS unit, enabling them to synthesize patients' medical, emotional, and social issues. Those who are involved expressly in the psychosocial support of patients on the AIDS unit (e.g. Shanti staff counselors, social workers, volunteers, and chaplains), rely heavily on structured reports and informal feedback, information and referral provided by the nursing staff. Though a nurse's primary concern is with the physical condition of the patient, they also work to educate and involve the patient, and his or her support network in the caregiving process. The nursing staff also contributes to the direct psychosocial support of patients and visitors on the AIDS unit.

IV. CHAPLAINS

The interdenominational protestant AIDS chaplaincy works closely with the primary caregivers on the AIDS unit (nursing, social work, and Shanti staff counselors) who are more familiar with patients and their loved ones. This group of approximately 7-10 gay and straight men and women provide a warm and reassuring presence for patients, visitors and staff. They are screened, trained and supervised by an experienced hospital chaplain coordinator to avoid situations in which patients and families feel uncomfortable rather than supported. Chaplains on the AIDS unit offer general psychosocial support in addition to their clerical duties. Their presence can be an important and symbolic source of support for patients' families that are being exposed to their son's homosexuality for the first time. The unit also maintains a roster of gay-sensitive Jewish and Catholic clergy.

V. PSYCHIATRY

AIDS patients with psychiatric problems are typically admitted or transferred to one of the psychiatric units which has established an AIDS focused team. The contribution of psychiatry to the psychosocial support of AIDS patients on the designated AIDS unit has come primarily in the form of assessment and consultation following referral from medical and nursing staff. Patients are most often referred for psychiatric consultation for the following reasons:

- suspicion of organicity
- serious depression
- suicidal ideation and/or gestures
- psychotic behavior
- history of psychiatric illness and/or medication
- patient requests.

VI. VOLUNTEERS

Following an interview with the AIDS volunteer coordinator and a month long orientation, volunteers are asked for a three month commitment of 2-3 hours once or twice a week, and to attend a monthly group meeting. There is one volunteer on the unit in the late morning and after dinner each day. On evenings when there is no ward clerk, an additional volunteer covers the phones and front desk. Volunteers assist patients and visitors by providing creature comforts (such as juices, reading materials, freshening up rooms, running errands, orienting visitors, etc.), transportation to appointments, massage, and sitting and talking with those who are anxious or frightened. Volunteers assist the staff by screening calls, answering call lights, running errands, feeding patients, picking up donations, and straightening visitor and staff areas.

VII. HOSPICE COORDINATOR

The hospital hospice coordinator spends approximately fifty percent of her time working directly and indirectly on AIDS issues. The hospice coordinator receives referrals and works closely with medical, nursing, social work and counseling staff. The AIDS Hospice Program of the Hospice of San Francisco is represented at the weekly discharge planning meetings to receive referrals and give feedback on inpatients that are already involved in their program. The hospice coordinator provides psychosocial support to those patients and support networks (families, friends and lovers) that are receiving or considering home hospice care.

VIII. MEDICAL STAFF

The contribution of medical staff to the emotional and social well being of AIDS patients has the most inconsistent nature of any form of psychosocial support on the unit. This is due in part to the training, orientation, time and role constraints, and frequently uncoordinated rotation of medical students, interns, and residents. This remains an issue of understandable concern to caregivers. Our experience has generally been that successful interdisciplinary referral and coordination with medical staff has been reflected in better patient and physician dynamics. Difficulties between medical and AIDS unit staff are usually dealt with directly in case discussions and conferences. These difficulties have usually involved discussions of DNR (Do Not Resuscitate) orders, advanced life-sustaining measures and unskillful communication directly or indirectly involving the patient and/or his loved ones. As mentioned above, our experience with medical staff has generally been one which enhanced treatment and support of patients and their loved ones on the AIDS Unit.

SCHEDULED MEETINGS AND CONFERENCES

MEETING	WHEN	WHO ATTENDS	PURPOSE
NURSING REPORT	Twice daily	Nursing Staff	Coordination of nursing care
PSYCHOSOCIAL REPORT	Daily	Charge Nurse, C.N.S., Social Workers, and Staff Counselors	Coordination of psychosocial care
DISCHARGE PLANNING	Weekly	Nursing, Social Work, Staff Counselors, and Community Organizations (Hospice, Shanti, AIDS Foundation, AIDS Health Project, AIDS Substance Abuse Program, Public Health and Visiting Nurses, etc.), and Representative AIDS Clinic Staff	Coordination of discharge planning
AIDS PATIENT CARE CONFERENCE	Weekly	Attendance includes Representatives from the AIDS Unit and Clinic Medical, Nursing, Social Work, and Counseling Staffs, Psychiatry and Other Support Services	AIDS research, policy, and clinical issues
UNIT STAFF MEETING	Monthly	Representative Staff from Nursing, Social Work and Shanti Staff Counselors	Improvement of interdisciplinary cooperation and care



SAN FRANCISCO GENERAL HOSPITAL AIDS INPATIENT UNIT BACKGROUND

San Francisco General Hospital opened the first 12 bed AIDS inpatient unit in the nation in July 1983. The original staff of 12 nurses who chose to work in the Medical Special Care Unit 5B (now 5A) received intensive training in the treatment of AIDS, with special emphasis on the patient's need for psychosocial support and specific clinical needs related to the disease.

In March 1986 San Francisco General expanded the AIDS unit to 20 beds, although the SFGH AIDS census usually ranges from 25 to 30 patients. The unit staffing now consists of 24 full and part time nurses and nine half-time Shanti counselors. A clinical nurse specialist and two social workers see patients both on and off the unit. Medical care of the hospitalized AIDS patient is under the direction of Dr. Merle Sande, UC-San Francisco professor and chief of medicine at SFGH.

Cliff Morrison, RN, CS, MS, was the original clinical coordinator and principle designer of the unit and served as director of Medical Nursing and clinical coordinator of AIDS at SFGH. At present he is project director for a California Nursing Association grant and clinical consultant to the San Francisco Department of Public Health AIDS Activity Office. Michael Clement, MD, is now the liaison between the inpatient unit 5A and clinical services at SFGH.

Morrison has described how the unit was needed for the large number of AIDS patients scattered throughout the hospital. SFGH treats more than half of the AIDS patients in the city. The AIDS unit has made it possible to coordinate adequately the quality of care, centralize resources and staff expertise and to deal with the many patient care issues confronting the staff.

The unit was designed using a nursing model that provides humane and quality care for the AIDS patient. From the onset, the main focus of the hospital was to develop and implement discharge planning, as it would be more cost effective to treat patients at home as outpatients, in hospices or at long-term care facilities.

Daily cost for home care averages \$100 and the daily cost at a long-term care facility is \$300 compared with \$800 a day in the hospital. Hospital costs at San Francisco General average \$878 per day or \$29,000 per patient lifetime compared to the national average of \$140,000. (The Robert Wood Johnson Foundation, a national philanthropy, is making a commitment to provide \$17.2 million to ten cities in the

country with the highest AIDS case loads if they offer humane and less costly health services for AIDS patients modeled after the San Francisco program.)

Ward 5A is also notable for its high level of community participation. An active group of volunteers enhances the services provided on the unit. Others provide entertainment and special dinners on weekends and holidays for the patients.

AIDS INFORMATION SOURCES
SAN FRANCISCO GENERAL HOSPITAL
and
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Jack Percelay
San Francisco Department of Public Health
Student Intern
October-December, 1985

I. Introduction

As a student intern in the San Francisco Department of Public Health, I investigated what AIDS related information is available from the San Francisco Department of Public Health (DPH) and San Francisco General Hospital (SFGH) in particular. The impetus for this project came from a meeting between state and city officials where state officials had information "from San Francisco" which conflicted with figures of city officials. The basis of this conflicting information was neither incompetence nor conspiracy. Rather, two separate sources at SFGH had been consulted and each had attempted to supply the most accurate information available to it. Despite the large amount of AIDS related information available in San Francisco, there was no clearly identified single source from which a person could receive accurate, complete AIDS information.

A reliable AIDS data base is important for a number of reasons. First and foremost, as a new, contagious and fatal disease complex, rapid communication of medical advances is necessary to prevent HTLV-III infection within the population and in arresting progress of the disease in the individual patient. The AIDS epidemic has hit San Francisco particularly hard. San Francisco has the highest per capita incidence of AIDS among urban centers in the country. In FY 1984/85, there were 667 new cases diagnosed, 390 deaths, and AIDS related expenses in San Francisco are in the tens of millions of dollars. Accurate financial and utilization information is necessary to effectively manage the San Francisco program and receive needed funding from state and federal sources. Finally, as the national leader in AIDS care, San Francisco has a responsibility to provide as much information as possible about its program to other communities and to the state and federal governments so that others may profit from San Francisco's experiences.

The first step in formulating such a data base is to determine what data are available. As a DPH student intern in the Planning Department, I interviewed people involved in AIDS care at SFGH, SFDPH and the community and sent surveys to virtually all SFGH departments to determine the current state of AIDS information collection and what information is desired, which departments are involved with the care of AIDS patients and which have research activity, where AIDS has caused increased expenses, and the current status of AIDS billing. The results of this project are presented below, including identified problem areas and recommendations.

II. Problems in Developing an AIDS Data Base.

A variety of factors contribute to difficulty in obtaining a complete AIDS data base. AIDS is a new illness and the information gathering capabilities are evolving as the structure of AIDS care evolves. To wit, there is no formal ICD-9 code number for AIDS. Information collection is further complicated by the fact that AIDS is a syndrome, a group of diseases, not a single disease, and the manifestations of HTLV-III infection are multiple. The issues of sexuality and death and dying associated with AIDS demand a greater respect for patient privacy than would infection with the influenza

virus. The comprehensive constellation of care provided people with AIDS and the widespread involvement of community groups means that a complete data base must include information from these sources as well. As each agency generally has its own client record, centralization of information becomes very problematic.

Problems Specific to San Francisco

The current SFGH MIS system is unable to readily generate average cost and utilization figures per person over the course of a disease. Special investigations are required to provide average cost and utilization information critical to effective management and planning. Cross referencing of billing, which does not include diagnosis, to medical records, which does include diagnosis, must be done manually. Furthermore, each hospitalization is a separate account and is not cross referenced to outpatient billing. Thus, a San Francisco AIDS data base has three distinct components: inpatient, outpatient (ambulatory care), and community based services, and within the hospital based services, there are few provisions for gathering AIDS specific information.

III. Current Information Sources

A. DPH Epidemiology

The Bureau for Communicable Disease Control (BCDC) is the city agency responsible for following the epidemiology of AIDS. The BCDC receives reports from community providers, actively searches out new cases which have not been reported, updates reports every six months, and records mortality. The Bureau has developed a sophisticated code system to assure case anonymity while gathering needed data. This information is published in monthly reports and passed on to the CDC in Atlanta. While a recent state report suggests the incidence of AIDS underreporting may be as high as 17%, San Francisco has a >95% rate of reporting cases because of its active surveillance mechanisms. The BCDC is also actively involved in educational programs to prevent the spread of HTLV-III infection.

B. SFGH Sources of Data

Inpatient

Information on costs and utilization rates are the least complete of all AIDS information. The Department of Medicine does maintain a daily census of AIDS patients, including patients off of 5B. This hand log consists of a list of names, from which one could compute average length of stay. However, Medical Record statistics are generated to supply this data as well as other information. In its case abstracts, the Medical Records Department does have an internally consistent and standard ICD-9 code number for AIDS and is developing a system for coding ARC. The case abstract includes information on age, sex, payment source, diagnoses, length of stay, procedure(s), and billed costs (not actual or reimbursed costs) at the time of coding. These forms are usually completed 10 days after discharge, so costs recorded after this time are not included. Final total costs probably average about 10%

higher than the 10 day figure. The above information is summarized on a monthly printout for AIDS patients, and is available from Mary Ann Reese in medical records. The printout does not compute averages, and does not include any data about previous hospitalizations, unless they occurred in the same month. This information is further summarized in quarterly reports from the West Bay Hospital Group.

Additionally, some departments (Chest, FCM, Gastroenterology, Surgery and Neurosurgery) keep specific handlogs of the AIDS patients they see. Other departments serving people with AIDS have no specific records for AIDS patients, but do include the diagnosis of AIDS in their paperwork and by going back to their charts/records could provide information about specific (AIDS) patients. However, this data is not available in any collated form.

Outpatient

Outpatient information is even less formalized. Ward 86 does maintain a daily log of the number of visits by AIDS patients and the type of visit. It does not, however, formally tabulate average frequency of visits. This information would have to be drawn from the (clinic) medical record. No other clinics which may see people with AIDS keep a thorough record. Dermatology, Gastroenterology, Hematology and Substance Abuse Services have limited handlogs recording total number of visits and some diagnostic information. Other departments note the diagnosis of AIDS in their records, but have no tabulated information available. Again, generation of such information would require a manual search of the clinic records.

Billing and Accounting

The billing department maintains financial records for individual admissions. It has the most complete information on payer category and cost of care. However, it does not collate data. As such, it is a source of data for special investigations but does not serve to disseminate information. The accounting department maintains cost figures for the various cost centers. Thus, accurate monthly figures are available for 5B, but because only half of AIDS patients stay on 5B, these figures do not reflect total AIDS inpatient costs. Outpatient cost figures are also available per ward. Since ward 86 is the primary care center for most AIDS patients followed at SFGH, these figures seem to reflect outpatient costs. However, these costs are not broken down for AIDS vs. oncology. Furthermore, there is no means to include care administered to AIDS patients by other clinics.

Problems with MediCal Eligibility and Insurance Coverage

Once diagnosed with AIDS, most individuals become eligible for MediCal if they do not have private insurance. MediCal eligibility is especially important because many people lose their private insurance when declining health causes them to cease their employment. Previous difficulties processing eligibility occurred primarily when clinic patients were hospitalized as inpatients without updating eligibility. More vigorous eligibility review with each admission has effectively eliminated this problem at the inpatient level. For patients seen only on an outpatient basis, eligibility is reviewed every 3-6 months. Changes in eligibility during this interval (e.g. loss of private

insurance, progression from ARC to AIDS) are not necessarily immediately acted upon.

The major current conflict involves experimental drug administration. This is not covered by MediCal, although the provisions of Medicaid allow for such coverage if a given state so decides. Current California policy is not to reimburse expenditures for experimental drugs. San Francisco has established a policy to fund administration of these experimental drugs as part of continued treatment for AIDS and search for a "cure." Charges for hospitalizations solely for experimental drugs are not, reportedly, billed to MediCal because of the policy of denied claims. Hence, an examination of SFGH MediCal claims will inherently underestimate hospital costs of AIDS care. However, the exact status of billing for experimental drugs is unclear; while the Utilization Review Committee reports it is submitting some appeals to MediCal, the Billing Department reports no denied claims. Further investigation is necessary to determine if in fact some bills not being submitted.

C. Other SFGH AIDS Activity

Clinical Research Activity

Research activity is concentrated in the Department of Medicine under the AIDS-Oncology Unit, which functions as the coordinating center for the hospital's response to AIDS. This unit's activity has been described previously by Roberta Wilson and Gayling Gee, and listings of its extensive research are available. Other clinical departments studying particular aspects of AIDS include Chest, ENT, Gastroenterology, Neurosurgery, Ophthalmology, Pathology, Radiology and Surgery. Most of these projects are case series of patients encountered by the given department as it participates in the care of people with AIDS. This is part of the ongoing activity of a research and teaching hospital and has been provided for by a reallocation of already existing resources. This knowledge is disseminated through the medical literature, conferences, and personal contacts. A special effort is made to disperse information to community physicians through regular sessions arranged with the San Francisco Medical Society.

Educational Activity

Virtually all departments have received training in infectious control aspects of AIDS by Grace Lusby, the Infection Control Coordinator. Staff dealing more directly with patients have regular sessions covering medical and psychosocial aspects. These sessions are managed primarily by the Nursing Staff and Development Department. (Estimated costs for educational programs for the two month period 10/85-11/85 were \$14,000.) Physicians, counselors, and other primary caregivers also participate.

Increased Costs

Increased costs for departments have been manifested primarily by the creation of 5B and the expansion of Ward 86. The increased census has presumably led to an overall proportionate increase in hospital staff, but no

respondents aside from 5B or 86 noted new personnel explicitly for AIDS. Service oriented departments have an increased workload which has been handled by reallocating already funded positions rather than creating new positions. For example, 3 FTE's from Social Services have been switched specifically to AIDS cases, leaving 3 less FTE's for the rest of the hospital's clientele. Departments performing invasive and thus potentially infectious procedures have increased their use of disposable equipment.

D. Social and Community Programs

Information about social and community programs is most readily obtained from the AIDS Activity Office. This umbrella office helps coordinate the extensive social and community programs involved in the constellation of care for people with AIDS. Through the cost monitoring process, accurate information is kept on cost per program, and for some programs, data can be identified on a cost per client basis. However, there is no means available of determining utilization of different services by one person. One would be hard pressed to compute an average figure of extra-hospital care, except by dividing total figures for the AIDS Activities Office by the number of people with AIDS. Summary information about utilization of support services (both in and out of hospital) and disposition on discharge are very limited from hospital sources because of the brevity of the discharge summary. Social Services maintains individual patient records, but this is not tabulated. Furthermore, many services provided in the hospital setting by community agencies (e.g., Shanti) are not documented in hospital records.

E. Cost Studies to Date

Studies of average cost and utilization have been performed twice each time by people outside of SFGH. Anne Scitowski has examined SFGH AIDS costs for the 1984 calendar year, including inpatient, outpatient, professional fee and pharmacy looking at billed costs. This information was used by Peter Arno to document decreased costs of AIDS care in San Francisco compared to New York. Actuaries at the state Department of Health and Human Services have examined inpatient and outpatient MediCal reimbursements for AIDS patients statewide. Both studies have produced figures for average total cost per hospitalization (though the former reflects amount billed and the latter amount MediCal reimbursed.) The state study computes figures over the course of the disease while The SFGH study attempts to determine average annual cost per living patient. These two studies are probably the most accurate studies available for the cost of AIDS. Each, however, has its shortcomings. Many argue that the figure to examine is neither amount billed nor amount reimbursed, but actual cost. The state study, by examining MediCal patients only, may suffer a selection bias. Any errors or nuances of MediCal billing and reimbursement will be magnified in this study. In particular, any costs related to experimental drugs will not be included in this study since MediCal currently does not cover experimental drug therapy. Nonetheless, these studies are the most thorough currently available, and if San Francisco is to argue effectively, its data must be as complete and rigorous as that of the state. There are no studies to date examining ARC costs and utilization.

IV. Conclusions

A. Summary of Problems Detected

Additional description of these problems can be found in the text.

- o Lack of standardized ARC/AIDS coding.
- o Inability to monitor use of social and community services by one individual due to the multiple agencies involved.
- o Lack of an integrated MIS System and the subsequent inability to generate average cost and utilization figures over the course of the disease.
- o Incomplete cost data on medical records discharge summaries due to delays in processing bills.
- o Delays in processing MediCal eligibility for outpatients because changes in eligibility status may not be recorded in between regularly scheduled reviews.
- o Lack of MediCal coverage for experimental drug therapy.
- o Conflicting reports from the Billing Department and Utilization Review Committee regarding bills submitted to MediCal for experimental drug therapy.
- o No complete AIDS cost studies to date.
- o No ARC cost studies to date.

B. Recommendations

- o Continue development of standardized ARC/AIDS coding.
- o Continue development of the MIS system.
- o Recognize the incomplete nature of cost information on medical records discharge summaries.
- o Instruct patients to inform eligibility workers when eligibility status changes (e.g. loss of private insurance, progression from ARC to AIDS).
- o Continue to lobby for MediCal coverage for experimental drug therapy.
- o Investigate the following areas further:
 - o total outpatient and inpatient costs.
 - o use of social and community services.
 - o status of MediCal claims for experimental drug therapy.

- o Establish a centralized AIDS data base.

Despite the deficiencies of documented numerical AIDS information, it is imminently clear that San Francisco and SFGH have a wealth of practical experience and information for the comprehensive prevention and treatment of AIDS and the people affected by it, and that many other communities can profit from San Francisco's experience. However, this information and experience is diffusely spread throughout the community, SFGH and the DPH. While the experience cannot be centralized, much of the information can be. 31 of 34 respondents favored creation of a centralized data base. The advantages are clear. There would be an identified initial contact source for inquiries who could provide referrals as needed. Exchange of information would be facilitated, program management improved through more complete data, and staff time spent deflecting and referring questions saved. Conflicting information could be rapidly identified, and one hopes, the conflicts resolved, or at least the basis of the conflicts made clear.

- o Establish centralized site visits.

Site visits are another major area in which central coordination could improve the efficiency of the information dispersal system. 14 of 24 respondents favored coordination of site visits, but 75% of those most frequently contracted favored central coordination, including both 5B and 86. Municipal, state, federal and foreign visitors come through at different times, all desiring first hand insight into the San Francisco AIDS program. Because of the large number of inquiries, staff working on 5B and 86 a having patient care resources strained by performing this function. Most of this information can be conveyed outside the intimacy of a 3-4 person group. While large tours through Wards 5B and 86 are clearly inappropriate, formal presentations to groups of 30 or more are very appropriate to outline the San Francisco program. Scheduling these presentations once every 1-2 weeks as needed (e.g. every Wednesday) would save a great deal of staff time by minimizing duplication and providing for a regularly scheduled site visit time around which other work could be arranged.

- o Conduct a prospective study of total ARC/AIDS care.

The success of the San Francisco program of total ARC/AIDS care argues for a prospective study to document the nature, utilization and costs of the program. Ms. Scitowski is currently conducting a prospective study for use of hospital and ambulatory care facilities. While this study will provide more complete information about medical costs of AIDS, the design of the study is such that information about utilization of community based services will be incomplete. And it is precisely these services which are unique about the care provided people with AIDS in San Francisco. Retrospective reviews of service usage is possible, but given the wide number of agencies involved, it would be impossible to accurately track retrospectively the services utilized by a given person.

THE

Pursuit

OF HEALTH

San Francisco Department of Public Health

May 1986

Stretching the heart for AIDS

By Gloria Rodriguez
Pursuit staff

"I think people who are dying should get whatever they want, within certain limits. And people with AIDS should get the best of everything. They don't have much time left and what time they do have left we want to make as comfortable and enjoyable as possible."---Steve Keith, R.N.

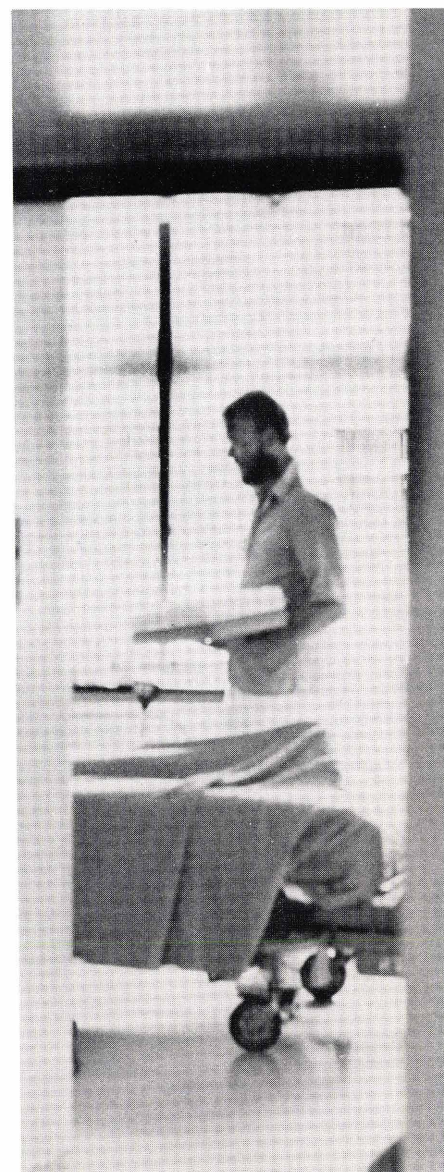
The AIDS ward at San Francisco General Hospital, the 5A Unit, expanded from 12 to 20 bed capacity in March. The unit has received world-wide attention because it was the first such ward in the country and because it has been successful in keeping hospital stays to a minimum time and has kept treatment costs at a remarkably low level.

Treating a patient at SFGH costs an average of \$29,000 compared to the \$140,000 national average. An AIDS patient will generally stay at SFGH for 12 days, compared to the national figures that range between 45 and 60 days.

The AIDS ward is well known for more than its statistics, however.

The staff of 5A has earned a reputation as being a dedicated, tough and warm group. All nurses on the ward are volunteers and today 11 of the original 14 are still there after three years.

Alison Moed, head nurse, is clearly a powerful anchor to the team of nurses she calls a "strong, independent, and outspoken group who possess real



Steve Keith attends a patient in the 5A Unit.

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Sowa: from the south to SFGH

Phillip E. Sowa, 37, has been named executive director of San Francisco General Hospital.

He fills a job that has been performed on an acting basis by Health Director Dr. David Werdegarr since June, 1985.

Sowa has been in hospital administration since 1972. He is a native of Rhode Island and has extensive hospital experience in the South and Midwest. His appointment was announced on Jan. 22.

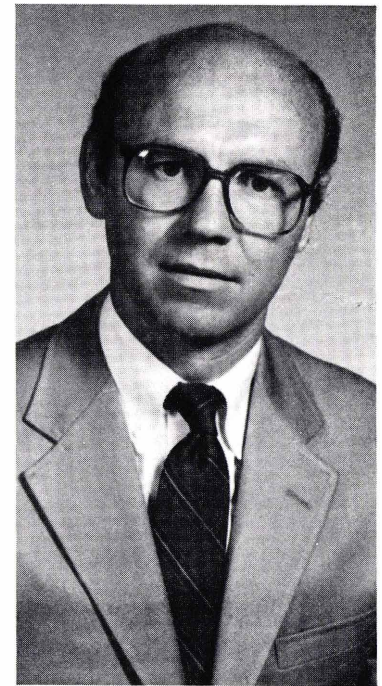
His last job was president of the Regional Medical Center in Memphis, a 450-bed public teaching hospital. He joined the staff there in 1982. He also became a member of the faculty of the Memphis State

University Graduate Program in Public

Administration and a lecturer for the University of Tennessee's School of Allied Health Sciences.

Before that, Sowa was assistant executive director of operations for University Hospital in Louisville, Ky. for four years.

He is a member of the executive board of the National Public Hospital Association, the major policy and lobbying organization for public teaching hospitals. Despite opportunities in the private sector, Sowa has dedicated his administrative career to the public teaching hospital, which he considers a unique community resource.



Phillip E. Sowa

Sowa has a bachelor's degree in biology and a master's degree in hospital and health care administration from St. Louis University.

Dr. True directs Mental Health

Dr. Reiko True



Director of Health, Dr. David Werdegarr has appointed Reiko True, Ph.D., as deputy director for mental health.

Dr. True, a native of Niigata, Japan, has been a resident of the Bay Area since 1958 and joined the Department of Public Health in 1980.

She is a 1956 graduate of the University of Tokyo and earned her Masters degree in Social Welfare at the University of California, Berkeley in 1964 and her Ph.D. in

Clinical Psychology at the California School of Professional Psychology in Berkeley.

Since April, 1985, Dr. True has worked as associate administrator for mental health and managed geriatrics, children and youth, and substance abuse programs.

As deputy director for mental health Dr. True manages a \$50 million budget devoted to a full spectrum of mental health services.

The WIC way to health

A supplemental food program for Women, Infants and Children (WIC) will open a new branch office on May 1 at St. Lukes hospital, 3555 Army St.

The program, operated by the San Francisco City and County Department of Public Health, now runs four such offices in district health centers 2,3,4 and 5 and one at San Francisco General Hospital.

A federally-funded program providing vouchers for food, WIC has been shown to increase the average birth weight of infants.

Better nutrition through the WIC program has also been successful at increasing the time of gestation. The result is a decrease in infant mortality and healthier mothers and children.

For infants and preschool children, WIC has been especially successful in increasing the intake of iron, vitamin C

and general nutrition in children of high-risk families.

Children in the WIC program are also more likely to have a regular source of medical care. A medical referral is necessary to get into the program.

WIC has been in existence in San Francisco for five years and serves about 7,000 people a year.

Women in the program receive vouchers that range in value up to \$60. They are used to purchase certain basic foods, such as milk, eggs, cereals, formulas, cheese and juices. Estimates by WIC workers are that for every \$1 spent in the program \$3 is saved in future health care costs.

For information or appointments call 558-5311.

AIDS ward expansion

continued from page 1

thoughtfulness and softness.

"You've got to remember," Moed said, "that they are here because they want to be and they are engaged in the kind of work that is very meaningful to them. For many of them the reason they stay is because AIDS has impacted their lives in some way; they have watched their friends die one by one, they are gay, they have compassion. Everyone here has been touched in some very individual way by the disease."

Moed stresses the toughness and tenderness of the 5A staff when she talks about the family that came from Idaho to discover their son is gay and dying from AIDS.

"You can't ignore a family that's standing there in such dire need. Their feelings may range from horror about the disease to overwhelming grief at the loss of a son," Moed said.

Steve Keith, a 5A registered nurse, says he sees stress in the ward that other units don't feel.

"Some parents tell their family at home that their son has cancer or leukemia.

They can't talk about it when they go home so while they are here for a week or two we are their only resource to talk to and unload some of those feelings. I feel a real responsibility to the families," he said.

The number of AIDS patients at SFGH ranges from 25-35 each day. That means some patients are housed in wards other than 5A.

What concerns Charles Cloniger, a 5A registered nurse, is that some may think only 5A nurses feel the stress of AIDS.

"The reality is that it's less stressful in 5A because we are better staffed with lots of volunteers and Shanti counselors," Cloniger said.

"So stress is much lower in 5A, for example, than in Unit 5C where you have other patients to take care of. I think the nurses in other units do a great job and should get recognition for giving good care to AIDS patients."

Keith said one benefit of working in 5A is the appreciation one gets.

"Sometimes patients will come back to visit and they will say, 'You know, you were the greatest nurse I ever had.'"

Preventing

By Ruth Rankin
Pursuit Staff

Many parents who are at risk of abusing or neglecting their children live their lives outside any system that can help them with support and advice.

But under a voluntary program that tries to identify such families while the mother and new-born baby are still under care at San Francisco General Hospital, help may be available before abuse occurs.

The Early Parenting Project at SFGH, funded by the Department of Social Services, looks for family situations where there is high risk of child neglect or abuse: immigrants and other new residents who may be living in isolation, families with a history of unstable housing, drug addicted mothers, teenage mothers, and those with a history of violence to spouses or other children.

Using trained family visitors, the program sends women to the newborn's home every week for the first month and then monthly for the first year of life. The visitors report back to physicians who will provide medical care to the infants and mothers.

A baby is born to an 18-year-old Chinese woman. In observance of Chinese tradition,

she stays inside her home with the baby for a full month following delivery. Isolated from friends and overwhelmed by the responsibilities, the mother feels frightened and resentful. Unable to cope with her feelings, she begins to take out her frustrations physically on her baby.

A 17-year-old woman becomes pregnant, the outcome of sexual abuse by her father. Fearful of discovery, she manages to conceal her pregnancy while living at home for nine months. Terrified and alone, she gives birth to her baby in a dark closet.

Both examples describe "at risk" situations in which children are at risk for physical and emotional abuse or neglect. Each is the kind of family the Early Parenting Project seeks to help.

Family visitors, all of whom are women, receive 40 hours of initial training and then six hours of continuing education monthly.

Visitors are bicultural and bilingual. Following a year of visits it is hoped that participating families will be helped. Families will have an increased awareness of supporting

neglect

community agencies and will feel comfortable using their services.

"Based on information from family visitors, my medical visits can be focused on problems that otherwise might not be known to me," Ellen Wolfe, R.N., co-director of the program, said.

Visitors hear about children taking care of younger ones, unsafe health and safety conditions in the home, and improper nutrition and sanitary practices involving the care of infants.

"These families also begin to show up for more medical visits when they are in the program," Wolfe said "Otherwise we may lose track of them, only to hear from them after a child is injured. We see more children with injuries resulting from neglect than abuse."

Dr. Colin Partridge, a Neonatologist

working in the Newborn Nursery at SFGH, said the Early Parenting Project does more than any court system can to prevent child neglect and abuse.

"We have to help the parents or the child doesn't have a chance," he said. "My relationship with families is broadened because I have more information about a given family and I can be more caring and more involved. I depend very heavily on the family visitors."

The project also seems to be cost effective.

According to figures from the Children's Home Society Emergency Family Care Program, it costs \$4,600 a month to provide shelter care for a child removed from its home.

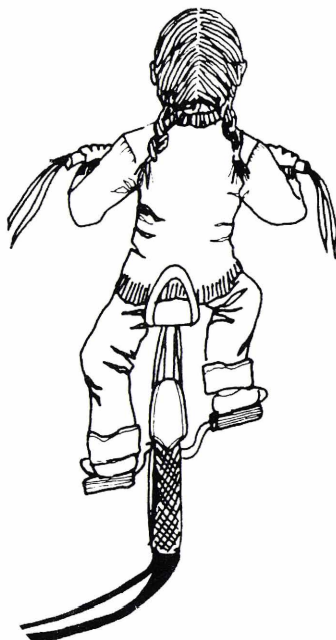
Monthly foster care can cost the Department of Social Services between \$1,200 and \$4,600.

Participation in the Early Parenting Project costs \$1,000 per family, per year.

The real savings, according to the staff, is the reduction in risk of injury and death to infants.

More than 300 families have participated in the program.

Of those participating in the program now, 19 percent are teenage mothers, 21 percent are substance abusers, 49 percent are single parents and 35 percent have some mental health problem.



Epstein-Barr Syndrome

Is it or isn't it there?

A ubiquitous but elusive syndrome of illnesses that may be debilitating some Bay Area residents deserves more attention and research, the San Francisco Health Commission decided on April 15.

No one knows how many people are suffering from Epstein-Barr Virus Syndrome. Some doctors say there is no such syndrome, but several people who testified before the Health Commission listed a variety of ailments they said were diagnosed as Epstein-Barr.

The symptoms, according to those patients, include extreme malaise, night sweats, exhaustion, joint pains, and loss of concentration.

Each person said several doctors were consulted before a diagnosis of Epstein-Barr was finally made.

Some witnesses testified they were told their ailment was in their mind, indicating the trouble physicians may have in recognizing the symptoms as a syndrome.

After hearing from patients and from several doctors who are treating EBV Syndrome sufferers, the commissioners unanimously approved recommendations made by the Health Department staff to make the department a San Francisco clearinghouse for information on the syndrome.

Staff of the department's Bureau of Disease Control will continue gathering current research information on EBV Syndrome and will send that data to health

care providers in San Francisco and to local support groups formed to help those who suffer from the syndrome.

The Health Department staff will also report back to the commission in six months about new research findings dealing with EBV Syndrome.

A department report prepared by Dr. Gisella Schechter noted that 90 percent of the adult American population carry antibodies to the virus, although most people never develop symptoms.

Dr. Schechter's report pointed out certain problems physicians and researchers have with the syndrome. They know, for example, that the virus can be transmitted between people. But they are not convinced the syndrome (the accumulation of symptoms) can be transmitted from one person to another.

Also, some physicians aren't convinced the presence of the virus is necessarily the cause of the illnesses people complain about.

Dr. Schechter said, however, that most of the reported cases of EBV syndrome involve more females than males, include white and highly educated people and include persons between the ages of 20-40.

As of now, Dr. Schechter said EBV syndrome lacks "a rigorous clinical definition."

For that reason it cannot be made a reportable disease and no accurate count of the number of people who suffer from it can be calculated.

Doing their homework on AIDS

Students in grades 9 through 12 in San Francisco schools should receive at least one session of instruction on AIDS, according to a report prepared by health, school officials and parents.

The Health and Family Life Education Advisory Committee made its

recommendations recently to the Board of Education in a proposed lesson plan that explains the purpose of the class is to "reduce hysteria about AIDS," and to "provide current information that will enable students to adopt behaviors that reduce the risk of acquiring AIDS."

In vitro fertilization

Dear Editor,

I am writing to alert women of the health department who have been clinically diagnosed with infertility problems, and who have been members of the Bay Pacific Health Plan prior to January, 1986, that they may be candidates for invitro fertilization and eligible for insurance coverage.

I was diagnosed in November, 1985 with bilateral tubal blockage. Both my primary care physician and my gynecologist recommended invitro fertilization as their last choice of treatment.

The referral for treatment was made to my health plan and promptly turned down. However, that decision was reversed with the help of a lawyer.

It is currently estimated that one in six couples of reproductive age in the U.S. are plagued with infertility. While many of these problems may be remedied using a

variety of interventions, for people like us the options are few.

Until recently the only option for a women with tubal blockage was major abdominal surgery. The recovery is lengthy and includes physical and emotional stress. Perhaps worse, the success rates for carrying a baby to term are low.

As of January, 1985, invitro fertilization is no longer considered experimental.

However, insurance companies continue to balk at coverage, even though IVF is considered a safer procedure.

If a woman feels she may be eligible I urge her to contact me at 728-5070.

Buffy Bunting, M.P.H.
Health Educator

Appetite for the heart

Dear Editor,

"A Guide to Heart-Healthy Dining," featuring 63 San Francisco restaurants has been recently revised.

It provides a list and brief description of the restaurants and provides tips on how to order meals that are considered safe for your heart.

Copies are available through the American Heart Association, 421, Powell St., San Francisco, Ca. 94102. Call 443-2273 for information.

The first copy is free and additional copies are 50 cents each, plus 15 percent of the total amount for shipping costs.

More information on proper nutrition is available through the Health Department's nutritionist, Lois Borgmann, at 558-2920.

Lois Bormann, R.D., M.P.H.
Nutritionist

On April 17 over 500 medical personnel, including staff of the Department of Public Health, participated in an exercise dealing with mass casualties following a major earthquake.

Here paramedics work with mock victims.



SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
NEWSLETTER

Director of Health:
David Werdegarr, M.D., M.P.H.
Editor:
Paul Barnes
Associate Editors:
Gloria Rodriguez
Ruth Rankin

101 Grove St. Room 312
San Francisco, Ca. 94102
Phone: (415) 558-5123

Who cares for you?

Your Health

A variety of senior services provided by the Office of Senior Information, Referral and Health Promotion are offered at Health Center 5 from 10 a.m. to 2 p.m. the third Friday of each month.

Health Center 5 is located at 1351 24th Ave., between Irving and Judah. Public transportation to the center includes the N Judah and bus lines 71, 72, 29 and 16X. For information call 626-1033.

Your Insides

A free take-home test that can reveal early symptoms of bowel cancer is available free of charge from the San Francisco

Department of Public Health's Office of Senior Information, Referral and Health Promotion.

Appointments for the kit may be made by calling 626-1033.

Your Directory

A free mini directory of elderly services is available in Chinese to seniors in San Francisco. It contains over 75 important phone numbers and is available by calling 626-1033. The directory is a service of the Health Department's Office of Senior Information Referral and Health Promotion.

The same directory is available in English.

FEAR IN SAN FRANCISCO

About the only place in the city you *won't* find it is on the AIDS ward at San Francisco General.

BY NORA GALLAGHER

BECAUSE NO BLACK flags fly from the church bell towers, no red slashes mark the doors of the households where the dying lie, no penitent processions wind through the streets, there are no visible signs in San Francisco that something is terribly wrong. Yet the city is in the midst of the most threatening epidemic in its history. It is estimated that half the gay men in the city—35,000 people—have been infected with the AIDS virus; 890 people are dead.

The epidemic is felt in pockets of the city. It stays indoors, behind the lacquered gold and crimson doors of the Victorians, inside the concrete hospital walls, within small gatherings of people trying to talk about what, exactly, they are afraid of.

After you have been in the city awhile, you find that an amazing number of people have known someone who died or who is sick or who might be sick. (People don't compete in this; the stories they tell are subdued and unhappy.) An equally large number, gay men, live in dread that the cold they have now is not a cold, that the blemish on the heel wasn't there a week ago. Others, especially the

mothers of small children, live in apprehension, not believing the carefully chosen words of the doctors quoted in the papers, but not knowing whom to believe. After you have been in the city, you almost want to see the flags, as were raised in the villages of Normandy when the plague hit them during the Middle Ages; black ones, flying from the church towers.

But there is nothing, just the beautiful city shining in the sun and people trying to go about their business. "I have three friends dying of AIDS," a young editor said, "and I go to work every day. Somehow, AIDS has become a fact of life."

It wasn't always like that. For two years, waves of hysteria set the whole city on edge. In 1983, bus drivers whose routes went through gay neighborhoods threatened to wear surgical masks. The police union demanded that its members be given tubes to use when giving mouth-to-mouth resuscitation. In 1984, fistfights broke out at meetings of gay political organizations. The director of public health was pressured to resign. Blood banks lost donors (and have not regained them). A city supervisor questioned whether there was a connection

"For two years, waves of hysteria set the whole city on edge. In 1983, bus drivers whose routes went through gay neighborhoods threatened to wear surgical masks. . . ."

Nora Gallagher is a frequent contributor to the Santa Barbara News & Review. Her writing has also appeared in The New York Times Magazine and the Village Voice.

between suppression of the immune system and fluoride in the water.

A curious rationale lies behind all of this. AIDS is often compared to the black plague because it is both communicable and fatal. It is compared to leprosy because its victims are ostracized, and to polio because that's the communicable disease we can remember. Those comparisons are made not because these diseases are medically similar but because of the human emotions they all evoke.

AIDS comes right out of history as if emerging from the depths of a swamp. The terror it arouses comes from an archetypal memory and is, therefore, almost immune to fact. Its victims are most often homosexuals, drug users and prostitutes—historically oppressed, outlaw communities; thus, it attracts the fears and prejudices a person has about “those people” from the start. Add to that its connection to sex—often sexual practices that are both fascinating and repellent—and you have a disease of awesome powers.

What is unusual in San Francisco is not the hysteria, but the way the city has coped. The city government has spent more on AIDS than any other in the country. San Francisco is the only city with what amounts to a volunteer army committed to defeating AIDS: From the Shanti Project to the Godfather Fund, thousands of people—most of them gay—nurse, counsel, raise money, find housing, cook, clean and shop for AIDS patients. It is the first city where medical researchers, politicians and gay political organizations have teamed up in an effort to close the bathhouses. It has launched the most sophisticated and extensive AIDS educational network to date. Most extraordinary is how the city has held together as a community.

As a result, San Francisco is a model of how to deal with AIDS and its attendant hysteria. Researchers from all over the world come here to observe the clinics, the educational efforts, the hospice work. The city's three-pronged challenge—political, medical and social—is cohesive and largely organized from the grass roots up. San Francisco's citizens have come up with better solutions than anywhere else, but that is not to say that fear has gone away. Fear never goes away.

It comes up at the oddest moments without warning. At a houseboat party in Sausalito, the conversation turned to AIDS and the guests gathered around that party's authority, a reporter working on a story for a local paper. As the words “incubation period of two to five years” floated out to a woman on the deck outside who was playing with her baby son, she looked up. “A person could have caught AIDS in 1982,” the

reporter went on to say, “and it wouldn't show up till now.” The mother's arms tightened around her boy's waist and her face lost its color. “He was born that year,” she whispered, “and he had blood transfusions.”

At churches in San Francisco, parishioners have discussed whether to continue to serve the wine from the chalice, wiped clean by a cloth, or whether to dip the wafer in the wine and then give it to each communicant, no mouth touching a common cup—a method called “intincture.” “I still drink from the cup,” said a woman who regularly attends mass, “but I think about it. I don't know what to do with these thoughts.”

Downtown, in an airline shipping office, the clerks know that one of the men working there is gay. People began to worry when he missed work, then came in looking drawn and thin. He doesn't talk about it so they don't talk about it to him. “We're very worried,” said an executive. “He's our friend.” Are they afraid? “No. The only thing that's happened is he used one of the secretary's phones last week and someone suggested maybe she should clean it off.” Even people so familiar with AIDS that they can practically recite the most recent findings in the *New England Journal of Medicine* are nervous around toilet seats.

You realize, finally, that fear itself must be dealt with squarely, face-to-face, or something dark and inhuman will result. It comes up on a daily basis: whether to hug or kiss a gay friend, whether to share food, whether to shake the hand of someone with Kaposi's sarcoma lesions on his face, whether to risk for the sake of connectedness.

But when you reach the very heart of AIDS, on the ward at San Francisco General Hospital, where nearly 300 men have died; where they keep a book of names, written at first in normal script and then smaller and smaller, until two columns are filled out; where a nurse said, “You can hear the sound of grief in the air”—this is where the disease has been finally vanquished. No staff on this ward is afraid.

This is a victory. It will remain a victory no matter how many more die. Most of the men and women who have worked on this ward have been frightened, but they have, by and large, talked themselves out of their fear. What you see here is that it is human to be afraid of AIDS, but it is also human to overcome fear when something more is at stake.

A nurse on this ward, Bill Nelson, a gay man, cared for one of the first AIDS patients at Kaiser Hospital in 1981. Then, AIDS patients were kept in strict isolation. Everyone who saw

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COMING UP FOR AYEROFF

The hottest name in pop music, and he's never cut a record. You know his work, though—videos that provide those few moments when MTV is more than just empty TV. Senior VP of creative marketing for Warner Bros. Records, Jeff Ayeroff oversees all the visual imagery Warner's uses to sell records. The 39-year-old former lawyer is the “supra-manager” for Madonna, shares ideas with David Byrne and signs the checks for David Lee Roth. As an “ideas man,” he brings together artists, directors and musicians for upscale videos like Don Henley's haunting “Boys of Summer.” Now involved in Warner's reprise of its old Reprise label, Ayeroff will work with newer, more creative bands, but it's only a matter of time before he is top dog at a major label. Ayeroff collects old cars and modern art, sees Max Perkins as a role model and proves what has long been suspected: The number one act in pop music can't sing.

Fear in S.F.

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them was gowned, gloved and masked.

Nelson left Kaiser, worked for a nursing registry and then was hired at San Francisco General. As he worked with one AIDS patient after another, he made a kind of journey, all by himself, first removing his gloves, then his gown and finally his mask.

There, in the intensive care unit, he had an AIDS patient, Julian, who was dying. Julian couldn't sleep. Valium, morphine—nothing worked. One night, his patient restless and sleep-deprived, Nelson, wearing powdered plastic gloves, began gently massaging Julian's feet. "And then I thought, now this is silly. How am I going to get AIDS from this man by rubbing his feet?" Nelson took off his gloves. With his bare hands he massaged Julian's feet and Julian slept.

The mask was the last to come off. In November 1982, four of the six beds on that ward were filled with men who had AIDS. One of them had *Pneumocystis carinii* pneumonia, a pneumonia caused by a protozoa parasite that lodges itself in the sac at the base of the lungs, where carbon dioxide is exchanged for oxygen. The *Pneumocystis* parasite turns the lungs into rigid bags by forming cysts, making efforts to treat the patient as mad as the disease itself. Once the lungs are hardened, ventilator machines, which help a patient breathe by forcing air into a balloon placed in the lungs, can literally blow a hole through the lung membrane.

The tubes that are placed down the throat and into the lungs bring sputum right back up, bypassing the various internal tissues we all have to catch fluid before it goes out into the air. Nelson worked with this man, and he, like everyone else on that ward, wore a mask. Then he remembered what he had read about the protozoa: how it is present everywhere—on the tabletops, on the hands and in the air—and only lethal to those with suppressed immune systems. "I thought, why wear a mask and not let him see my smile?"

"It made a world of difference. I saw it in his face. He smiled at me and said, 'You're not afraid of me anymore, are you?' And I said, 'No.'"

IN 1981, IN San Francisco, a nurse at the oncology outpatient clinic at San Francisco General had a patient with strange purple lesions on his thighs. She had never seen anything like it before. The lesions grew, until the skin from the man's hips to his knees was a solid, purple mass. The man lived on the streets, and later that year, he died on a doctor.

In that same year, a doctor working

in the San Francisco Department of Public Health drew a chart and put it on her wall. It listed six sets of roommates, all of whom had Kaposi's sarcoma or *Pneumocystis* pneumonia. Lines were drawn from two of the roommates to two friends, both of whom had KS. On the chart was another group of four men, all of whom had died, all of whom were roommates, lovers or both.

During the same period, an epidemiologist, Andrew Moss, working at the University of California, San Francisco, began to see references to a possibly "communicable cancer" in professional journals. Headlines in the gay press, which referred to some sort of "plague," caught his eye. He told himself that it didn't seem likely.

By early 1982, each of these people—the nurse, the doctor and the epidemiologist—had entered what amounted to a time warp. They worked on a medical mystery that grew increasingly alarming. When they remember those days, only four years ago, they refer to them as "back then." Nationwide, 527 cases of KS and other AIDS-related diseases had been diagnosed. Most of the victims were gay men; half of them were dead.

Articles began to appear in newspapers and magazines. In San Francisco, the diseases were loosely referred to as "gay cancer." A suspicious virus called cytomegalovirus, or CMV, was thought to be related to Kaposi's sarcoma. And CMV, the doctors knew, could be sexually transmitted through semen. The first tremors of AIDS began to be felt within the gay community. Stores catering to gay men sold megavitamins (\$25 bought a month's supply) for the "sexually active male." Ads appeared in gay publications for men free of disease who were looking for monogamous relationships. A debate began, wary and tense. It was not over AIDS alone. Within the gay community, there had been startling rises in gonorrhea, hepatitis, amoebiasis (from an amoeba) and giardiasis (from a gastrointestinal parasite). A gay internist, Dan William, was quoted in an article in *The Advocate*, a gay newspaper. "There's a problem in gay men, including myself," Dr. William said, "who have used sex the way other people smoke cigarettes or drink alcohol or chew their fingernails. It becomes compulsive. Sex [at bathhouses] is available for \$5 or \$10 and it fulfills a need. And there's nothing wrong with that, except that it's turning out that now, in 1982, it's very, very unhealthy. In fact, I think the guys who go to the baths once a week and do everything put themselves at the same risk as if they were smoking six packs of cigarettes a day. They are

destined to be sick; there's no doubt about it."

But at the same time, other men cautioned against embracing such advice. "People are very vulnerable to doctors," said Edmund White, coauthor of *The Joy of Gay Sex* and author of *States of Desire*, "and gays are particularly vulnerable to moralistic garbage. The sexual revolution is momentarily breaking down or pausing because of technological problems. People who are getting moralistic toward it, or preachy, aren't going to stop anyone."

That year, 1982, the federal government, with an obvious health crisis on its hands, gave only \$5.5 million to AIDS research. The situation was so bad that in 1983, Andrew Moss and 30 other scientists went to the speaker of the California State Assembly, Willie Brown, and begged him for money. Several months later, the legislature, in what was a highly unusual move for a state, voted to give \$2.9 million to researchers working on AIDS in California. Elsewhere, researchers had almost no money at all.

By 1985, the chances that a gay man in San Francisco would be exposed to the AIDS virus during sex were one in two. "An individual who today has two unsafe sexual contacts when the prevalence of infection is 50 percent, for example," said the director of Communicable Disease Control at the city's Department of Public Health, "is at just as high a risk as he was in the early eighties if he went out 50 times when the prevalence was 2 percent."

During last summer, Andrew Moss, now working at San Francisco General Hospital, declared in testimony to a congressional subcommittee that his experience of seeing the epidemic grow from five cases in San Francisco in 1981 to over 1,300 cases four years later was like "the classic nightmare in which you shout as loudly as you can about the coming danger but nobody can hear you."

He believes there were two reasons for what amounted to a deaf ear turned to AIDS. "We, in this generation, had forgotten about infectious diseases. We had assumed that, in Western countries at least, infectious diseases had passed out of the ranks of great enemies of the people. AIDS showed us we were wrong."

Second, said Moss, "We failed to deal with AIDS in homosexual men. They didn't believe it could be happening and we—researchers, doctors, public health people, politicians—hoped it would go away. We couldn't deal collectively with a disease in a stigmatized population. Somehow the homosexuality of 70 percent of the cases froze the bureaucracy, frightened off the

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Fear in S.F.

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funding agencies. It made us reluctant to take the preventive measures that might have held the disease down to 10 percent or 15 percent of the gay population instead of the 45 or 50 percent that have now met the AIDS virus and are waiting to find out what's going to happen to them."

The frustration and urgency in Moss's tone is caused not only by rage and bafflement, but by the fact that every day last year he had to walk through the AIDS clinic at the hospital to get to his office. On the day I went there, he sat inside his cubbyhole, a tall, dark-haired man with pale skin and an English accent, who ran his hands through his hair and shifted in his wobbly office chair as he described how every day it's been "eight hours of writing grants for funding, eight hours of teaching, eight hours of talking to the press, eight hours of writing more grant proposals—four years of trying to get AIDS on the damned agenda." Outside his door, ten men waited for appointments at the clinic. Each of them was young and pale, with the almost-translucent skin of the very ill. Standing closest to the harassed receptionist's desk was a woman in her late middle age dressed in ratty tweeds, her hair once fashionably cut, now grown shaggy. She was holding the arm of a thin boy dressed in a black leather bomber jacket, who had the vacant eyes of someone not altogether there. "David?" she asked him, "David? Would you like to go to the bathroom?"

"It's very much like trying to turn the Titanic around," said Moss. "San Francisco is ahead of everyone else and still it's late. Thousands are going to die."

THE BATHHOUSE CONTROVERSY, which San Francisco went through in 1984 and other cities debated in 1985, was the most visible aspect of how difficult AIDS is to deal with and prevent. By 1984, it was an accepted fact that AIDS was sexually transmitted. The virus associated with AIDS had been isolated in France and in the United States. Once the virus was isolated, a test for antibodies to it was developed. The "ELISA" test, as it is called, found that the presence of antibodies to the AIDS virus is virtually 100 percent in most people infected by the AIDS virus while, by contrast, it is present in only .06 percent of blood donors in New York. There is disagreement as to whether the virus itself is the cause of AIDS or whether it works in conjunction with other factors—say, an immune system, already impaired by other infections. In any case, it has

been repeatedly isolated from blood and from semen, and, very occasionally, from saliva, although not one single case of transmission by this route has been documented. Medical researchers believe the virus must be virtually injected into the bloodstream in order to infect.

A sexual practice common to gay men, rectal sex is a particularly easy route for the AIDS virus to be transmitted. The sigmoid colon does not have thick, elastic walls, but instead is made up of tissue the consistency, as *The Joy of Gay Sex* describes it, of "wet paper towels."

Semen entering the rectum can pass through the walls of the colon and into the bloodstream.

A further aspect of gay life, in its sexual context, is a tolerance of multiple sexual partners, sometimes anonymous sexual partners. The most concentrated places for such sex to be practiced have been in the bathhouses.

Over the last fifteen years, gay men had won the freedom, against great odds, to have semi-public places where they could drink together, dance together and have sex together without fear of reprisal from the police. The freedom was hard won. In the sixties, gay men were forced to dance ten inches away from their partners, ever mindful that the police could arrive on the scene at any moment and empty the whole dance floor into a waiting paddy wagon. But because of a series of events, most famous among them the Stonewall riot in New York, when gay men in a bar fought with the police, this arbitrary action grew more and more rare. By this time, the sheer concentration of openly gay men in the major cities had also gained the gay population some political clout.

By the eighties, bathhouses were a multimillion-dollar industry in San Francisco, having evolved into health-spa gymnasiums with movie rooms, delis and private cubicles. Dropping in at the baths was a perfectly acceptable way to spend a Friday night. Many gay men frequented the baths every weekend, while others went only occasionally. Others went not at all. But because of the long fight to establish the right of gay men to be together, nearly everyone upheld the baths as symbolic of the struggle. If the baths were to be shut down, for any reason, what would be next?

Within the medical community, however, the baths were never popular. If it had been up to the doctors alone, one can imagine, the baths would have been closed years ago—not because they were "sinful" but because they were breeding places for disease. But it wasn't up to the doctors, so they went on giving their penicillin shots and registering yet one

more case of rectal gonorrhea to their totals—which, in San Francisco in 1981, were 400 cases per month on average.

But when AIDS hit, it caused AIDS was not just another disease. San Francisco in 1984, after men AIDS had been seen in the bathhouse, medical researchers decided the should be closed. Andrew Moss was among them. It was not an easy decision, even then. "We wondered," Moss, "whether closing the baths would result in opening the doors to concentration camps. It was very painful. But if you didn't do anything, AIDS was going to spread."

Moss and other researchers met with the then public health director in the city, Mervyn Silverman. They put pressure on Silverman. But Silverman was hesitant to act without the backing of the gay community, which was divided on the issue (and remained divided to this day). Everything came to a standstill.

Into the deadlock stepped a long-time gay activist, Larry Littlejohn, who threatened to put an initiative on the November ballot that year that would prohibit sexual activity in the bathhouses. His threat had exactly the effect he hoped it would. The mayor, who did not want the issue kicking around during the Democratic Convention, learned harder on Silverman. Finally, in October, Silverman ordered the city's nine bathhouses to close. He also shut down five bookstores and a theater where sexual activity was known to take place. Shortly thereafter, he resigned.

The owners of the baths took the case to court. In November, a superior court judge in the city ruled in their favor, but he issued an injunction restricting activities within the baths. He ordered the clubs to remove the doors of private rooms and to assign monitors to patrol the corridors every ten minutes. The lights were to be kept up. Already present in the baths were free condoms and pamphlets on safe sex.

Within weeks of the restrictions, many of the baths closed because of drops in clientele. Today, only three bathhouses and one sex club remain open. The prevalence of rectal gonorrhea dropped in 1985 to 40 cases per month.

There is still disagreement in the community over the attempt by the city to close the baths. The drop in gonorrhea rates could be attributed to the education campaigns so prevalent in the city. The incidence of AIDS has leveled off in San Francisco: For the last nine months, new cases have remained at an average of 62 per month. In other cities, the rate of new cases is still doubling every twelve months.

In other cities, education has still not caught up with AIDS, nor have the bathhouses closed. "It's really disheartening to go to Denver or Tulsa or Dallas," said Tim Wolfred, who heads the San Francisco AIDS Foundation. "A staff person just returned from a visit to those cities, and he went to the baths to see what was going on. It was fairly shocking. He saw very unsafe sexual practices."

What is significant about the attempt to close the baths in San Francisco is that it came not from hysteria or from overzealous religious fundamentalists, but from the medical community. The people who worked with AIDS patients every day simply couldn't tolerate their own helplessness. This is not to say that there are not homophobes among the medical ranks, but judging by the evidence, the doctors who acted did so out of a desire to prevent more deaths.

Further, if the bathhouses are to be regarded as symbolic of gay liberation, the attempt to close them is symbolic as well. What the attempt symbolizes is the need of a community to act on behalf of its citizens—in this case, the gay men within its confines. The issue remained local to San Francisco. "It's better to do it on a local level," said Andrew Moss, as he stepped to the door of his office to go out into the clinic. "You can trust the local level: the intertwining of the gay democratic clubs, the researchers, the doctors, the politicians. If you don't do it locally, someone will do it for you."

"I T STARTED OUT like a blot on the horizon," said Chet Roaman, a gay man in his forties. "At first, it was very far off, very far away, as if you saw a cloud and wondered, is it going to rain today? Then one of my friends, who had pre-AIDS symptoms for two years, came down with *Pneumocystis* pneumonia. His name is Charles. His name was Charles."

"Then another friend came down with it. Leonard had edema of the feet. They took him to the hospital and he began to blow up. They couldn't counter it. His body weight nearly doubled. Three days before Leonard died, Charles went into the hospital. They were in adjoining rooms. I would go to visit and say, okay, who do I go to see first? Leonard died in January. Charles died in July. At that point I thought, I've paid."

In the last two years, Roaman has gone to five funerals. He can recite the opening lines of the Episcopal service for the burial of the dead. A handsome, generous man, Roaman is a writer and a teacher at San Francisco Community College. When he came to my wedding three years ago, he wore rose-colored

pants and a tight white T-shirt. He was erotic then, he gloried in eros. He attracted wedding guests to his side as if he were Pan come to the wedding, a proper place for Pan to be.

I had lunch with him last fall during the course of this article. We went to one of our favorite places in the city. Ordering different things to eat with the agreement we would share, it was as it has always been. But when the food arrived, Chet asked the waiter to bring an extra plate and, before touching his pasta, he measured out my portion onto the white china the waiter had brought. Later, when we ordered a piece of chocolate cake to split, he took one bite and then stopped eating.

"Why are you doing this?" I asked him.

"Because I won't take a risk with you," he replied. "Who knows what I may or may not have."

"But you can't get AIDS from sharing food," I said weakly. I realized it had been on my mind from the moment we sat down at the table. I was grateful that he had been the one to make those awkward moves so that I didn't have to. In him, awkwardness had become a graceful gesture.

This is how it is now, a never-ending supply of small changes that add up. When Scott Smith, a graphic artist, gets up in the morning, he has a new routine. He makes coffee, reads the front page and then turns to the obituaries. When he walks out onto the street, he scans the faces going by. "It's so good to see a person you haven't seen for a while," he said, "but it's devastating if they look ill. At the bank just a couple of days ago, I ran into a man I used to see a lot, but haven't seen for years. He was obviously very sick and very angry at his illness. We had a cursory, 30-second conversation in which we talked about nothing."

Smith lives in the Castro district, the place where gay liberation began in San Francisco. It was in the Castro that Harvey Milk, the first gay man to be elected to the city's board of supervisors, opened his camera shop and launched his first political campaign. It was here that gay men first organized and made a life together, until the Castro finally came to represent gay pride. Milk and George Moscone, the mayor of San Francisco, were assassinated in 1978. Scott Smith was Milk's lover. "When Harvey was killed, he was one of the first persons in the gay community to be publicly mourned," Smith said. "This year, when we had the candlelight memorial march for George and Harvey, we also carried the names of 400 people who had died. Finally, we've had some public mourning for our dead."

In the old days, the Castro bars were packed by five o'clock every evening. You could barely walk down the sidewalk on a Saturday night. On Sunday afternoons, crowds of men almost stopped traffic on Castro Street. The neighborhood felt as if it belonged to gay men: Mannequins in store windows often took sexual poses; men sat in the sun outside the Hibernia Bank every day until it was dubbed "Hibernia Beach"; there was a strong sense of male energy in the air. Now the neighborhood feels less defined as gay. There are more women and children on the streets and more people just shopping or walking along. No one cavorts on the streets, men don't dress as flamboyantly. Things feel toned down. There are tensions here and there: ABUSE YOUR DRUGS ELSEWHERE reads a sign over the bathroom door in a bar. There are signs everywhere for AIDS-related activities. The AIDS Food Bank advertises on one door, the ARC/AIDS Vigil on another. No longer, say men who live in the neighborhood, do masses of gay men gather here regularly.

To Smith, the Castro wasn't just a place to party. It was and is his village. It had, as neighborhoods in cities have, a familiar cast of people who were fixtures of his days. The oil painter whose easel Smith skirted once, sometimes twice, a day. The owner of the plant store that opened the same year Harvey Milk bought his camera shop. The man who ran the restaurant in the middle of the block Smith passed coming home. Ramon Vidali. Tommy Zalewski. Bill Neer. These men are dead.

Jon Sims, the founder of the Gay Men's Chorus. Paul Dague, the director of Operation Concern, one of the first clinics to counsel gay men, lesbians and their families. Allan Estes Jr., founder of Theatre Rhinoceros, the largest community theater in the city. Steven Block, a founder of Bay Area Lawyers for Individual Freedom. Douglas MacDonald, sheriff's deputy.

In studies of the way epidemics affect history, one author, William H. McNeill, pointed out that the most devastating are those that cut down people in the prime of their lives—those who would have carried the culture forward on their backs. There is no knowing how the deaths of so many men in their thirties and forties will affect the future of gay liberation. Said Tim Wolfred of the AIDS Foundation, "On the one hand, the epidemic has stopped gay liberation as we once knew it in its tracks. Every resource is going to AIDS. On the other hand, in our struggle with AIDS, we've broadened our civil rights battle and, because of television programs and documentaries

(continued on page 126)

Fear in S.F.

(continued from page 113)

on AIDS, gay people have been humanized. We are no longer a distant, deviant group."

AIDS is a costly disease. Young men who have enjoyed high salaries lose them, either because they are asked to leave their jobs or because they simply cannot work. A case in point: An accountant came down with AIDS two and a half years ago. At first, still working and dipping into his savings, he was able to hold on to his apartment. Then he sold his possessions. Finally, he moved into a flat with two other men

who also had AIDS. He watched both of them die. He moved again, to a building leased by the Shanti Project, which rents apartments in the city to AIDS patients, keeping the locations of the housing secret. The accountant now lives on Social Security, which pays him \$675 a month. A medicine for oral thrush, an oft-related AIDS condition, costs \$44 for a bottle that will last two weeks.

"They simply have to give up on meeting a lot of financial obligations," said a social worker with the AIDS Foundation. "Many of them have been responsible all their lives. I advise them to collect their bills once a month, take

them out and look at them, and then put them away."

"I don't know what the emotional price is," said Eileen Lemus, the coordinator of Hospice at San Francisco General. "I'll make an educated guess, knowing what grief and fear can do to people. Men who do not have AIDS are living in fear. Many are withdrawn, very withdrawn. There must be more clinical depression."

Gay men are occasionally afraid of each other. There are men who have no social lives, who are afraid to go to dinner parties or to restaurants where there are gay waiters. One man, I was told, is even afraid to enter a bookstore.

Men without AIDS live under not only fear, but the tyranny of rumor. A man whose lover died of AIDS was fired three weeks after he told someone at work. Another, tested and found free of the virus, asked the head nurse at the AIDS clinic to write a letter to his superiors. They were suspicious. They had asked questions. If a man is diagnosed with AIDS or AIDS Related Condition, the advice of the AIDS Foundation is: "Think before you tell anyone."

While all of this goes on about them, gay men in private and in small groups try to work out a profound change in their sexual lives. Most gay men in the city know by now what is "safe" and what is "unsafe" sex. But dealing with it is another matter. Recent forums have been held on "Eroticizing Safe Sex." Workshops have been held on intimacy.

"We have become a much more social community," said Scott Smith. "Families of men have sprung up. This Christmas we had fourteen people over. We spent two days cooking. Everyone came early and we played games all afternoon, without a thought to sex."

"We have always wanted to be part of the mainstream, and now we seem more like the mainstream. I mean, people have dates. Plopping down on the couch in front of the TV is now a nice way to spend an evening."

"I won't go home with someone on the first encounter," said another man, "or even on the second or the third. We talk about our history first. If I sense there isn't honesty, that ends it right there. The hard part was trying to figure out how the hell you bring it up in a tasteful way."

For many gay men, what has replaced unsafe sex is no sex at all. Sex itself is so intertwined with death that even safe sex doesn't feel safe at all. This is of concern to Bill Nelson, who has had experience with celibacy because he was once a Dominican Brother. "Celibacy is supposed to be a gift from God," he said. "If you don't have that gift, it becomes very, very difficult. It leads to

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social withdrawal, to lack of human warmth, to a lonely, lonesome person."

Nelson isn't only worried about the emotional pain of celibacy. As a nurse, he has noticed occasional spurts in the number of cases of rectal gonorrhea in the city. "I think they represent men who have had enough of celibacy. They head off to the baths or the parks and have a fling. Then they go back to being celibate."

"And when I went to Hawaii last year, the bars were jammed. Around the corner from one bar was a bathhouse. One night, there was a line to get in. I saw a number of faces in the line that I recognized from the Castro district. I thought, come on, guys, just because you're in Hawaii doesn't mean you're getting away from it."

Although these "slippages" are cause for concern, the great majority of gay men in San Francisco have done something remarkable. And they have done so not only because they are afraid for themselves, but also out of concern for their brothers. Leon McKusick, a psychotherapist in the city, has noticed this in interviews with men who have taken the AIDS test and turned up positive. "Before a man ascertains that he has the antibody, his concern is for himself," said McKusick. "But when one realizes that he is a transmitter, his concern shifts toward others. It's like a Zen rap on the head."

Many men point out that, although they wouldn't have asked that this be the price, the community has "matured"; men are learning how to be intimate together; couples are remaining together. Said Tim Wolfred, "Sex is in better perspective."

Over lunch that day in the fall, Chet Roaman sat at the table in the sun, flirted in a friendly manner with the waiter and talked about his former life.

"Always before, I could satisfy any kind of lust," he said. "If I caught VD, I could take pills or get a shot and in three days be ready for whatever else I wanted. But this whole thing has completely blown my mind about the morality of my life. Maybe, just maybe, there is something wrong with being promiscuous. After all, there is this disease."

"We never had to look at it before in a moral way. If gay people were not creating families, then promiscuity was another sexual expression. Why should it be wrong? Biologically, on the other hand, it does seem to be wrong. It raises a real medical issue. How do you separate that from the moral issue?"

He leaned forward across the table. "Someone characterized gay life as based on sensuality, on sensation rather than feeling. What this has done is bring up the feeling in me, certainly, and in a lot of other people. Feelings

that were retarded or frozen before.

"Gay life was really getting repulsive. Flaunting in everyone's face, retreating into a ghetto, beginning to believe personal mythologies like 'Gay Is the Way.' After coming out, taking off those shackles, people were going mad. There was no reason not to be mad, but it interfered with personal growth, with humanity, with creativity. What took their place was endless, endless...self."

"The past is over. In the seventies, there was a kind of freedom that had no bounds. A prosperity without an end. A glowing future of endless, endless libertinism, pleasure forever. Of course it had to end. But," he finished quietly, "I don't know of anything else that could have ended it."

Later, as I followed Chet down the aisle of a store where he and his lover of a year and a half were shopping for hardware for the house they're fixing up ("Tap on wood," his lover said when Chet mentioned how long they'd been together), I noticed that his hips were thickening, the swivel was gone. Part of it, of course, is that he, like all the rest of us, is getting older. He, like many of us, is settling down. But his wonderful eroticism, which might have gradually softened with age, has been literally cut off. This is worthy of mourning. Not the addiction to sex or the way sexual

expression for some gays had hardened into an ideology, but a vision of sex as fun-loving and free and generous. Sex in that light could feed the body and give it erotic dimension. It was a way of loving the world.

SAN FRANCISCO GENERAL Hospital lies out near the freeway in the flatlands of the city, near industrial buildings and faded Victorians. The old wings, built of red brick, blackened by exhaust, look like the sinister past when doctors wore black gowns caked with blood. The newer buildings, built of prestressed concrete and glass, are antiseptically cold, but at least their corridors don't feel as if they are seeping years of disease. General is the city and county hospital, and it is the teaching hospital for the University of California, so young interns make up much of the staff. The patients they see are generally without insurance—indigent, homeless, the elderly poor or people who have simply run out of money.

In San Francisco, there are so many volunteer agencies to help AIDS patients with home care that they don't have to use the hospital as a place to live. This is not the case in other cities. In New York, the average stay in hospital for an AIDS patient is 25 days. In San Francisco, it is 12.

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In 1983, a ward was established at San Francisco General specifically for AIDS patients. Five A, as it is known, is an all-volunteer ward. The staff has created it. "This is the first time," said Bill Nelson, "that I've been able to practice nursing the way I was taught in school."

No gates or quarantine signs bar the entrance to 5A. You walk down a wide corridor, through an archway to the nurses' station. Small private rooms open off the center hall. On each door, Day-Glo red signs warn the staff to gown and glove should they have to deal with urine, blood or feces. Other than that, nothing is out of the ordinary.

Like polio before the Salk vaccine, AIDS is a nurses' disease. The sophisticated tools of Western medicine are helpless before it. What is left is for the nurses to do, to help the young men—"cut down in their short, sweet, sad lives," as a Hospice worker put it—get through the suffering to their deaths. Nearly 300 men have died on this ward, their names and pictures recorded in the book. They have died of diseases horrible and insulting. Lungs turned to glass, lesions in the gut, infection in the covering of the brain, when light becomes a stab and reason is lost. Diarrhea so relentless that body weight is shed like water off a stone.

Swollen tissues and suffocation, relentless fevers and seizures. So much horror is suffered here that to walk onto this ward must be like crossing a border into hell. But it is not like that.

What you feel when you arrive is relief. I have felt this in a few other places at other times. I remember in particular a Benedictine monastery in the mountains of Colorado, where the brothers kept a vow of silence all week long, only breaking it on Sundays. In the chapel, a nondescript, modern sort of building, silence had become material, as if it were a house, a dwelling place. To make a structure of silence requires enormous concentration and discipline; on this ward, a similar effort has been made. The nurses talk about how their patients, as they are dying, become more and more "real"; they reach a point of clarity. Everything beside the point is gone here and what is left is put completely to use.

"I feel as if our race memory is being affected," said Alison Moed, the head nurse. "We are going back so far, so deep, something is going to be changed structurally. We can't begin to comprehend it. It's such an old thing. This has gone on forever."

Moed, a small woman with a firm and direct manner, has been a nurse for fourteen years. She volunteered on 5A because she was appalled by the in-

attention paid to AIDS patients in the hospital. She saw patients left alone in dirty sheets. She heard homophobic remarks that left her "with the smile frozen on my face." Her colleague Diane Jones, a tall woman with a mass of curly hair, volunteered because she thought she might be of use, as a lesbian, to other gay persons. She once heard a surgeon suggest "sticking a tube down this fag" while standing in the doorway of an AIDS patient's room.

When a seriously ill patient arrives on 5A, within 24 to 72 hours the staff will have a conversation with him about his "code status." Code status refers to lifesaving measures. Whenever a person enters a hospital, it is assumed that everything will be done to save his or her life. If something goes deeply wrong, the patient will be rushed to the intensive care unit, where invasive procedures are the norm: tubes stuck down the throat, catheters put into the bladder. For patients with AIDS, all this usually means is that death will be postponed.

AIDS patients are presented with an alternative. "We tell them we will keep them as comfortable as possible," said Bill Nelson. "We will give them large amounts of morphine. We will do everything we can so that they will die with dignity." The percentage of patients who decide to go to intensive care is now very low.

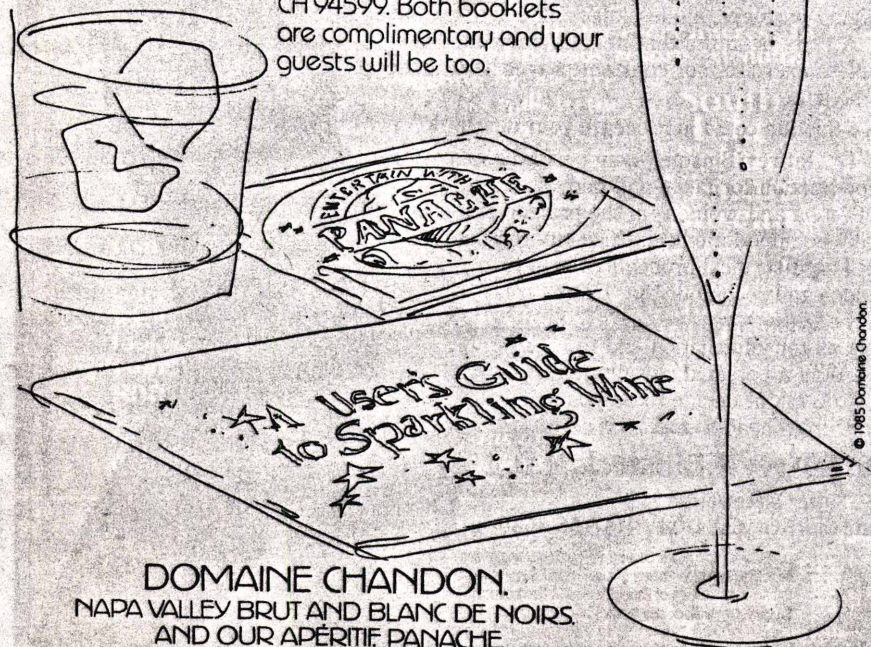
This does not mean everyone who comes onto 5A dies right away. Sixty percent survive their first bout of *Pneumocystis pneumonia*, for example, and leave the ward. The problem is that there is always a second bout. "I feel like I'm in the middle of a war," said Nelson. "We're patching up these boys and sending them back to the battlefields with gaping, open wounds and no bandages." Only 24 percent of the patients survive their second bout. Kaposi's sarcoma takes longer; men with KS have lived for years. But no one, so far, has recovered from AIDS.

The essential work of 5A, then, is learning how to die. A very specific population must learn to do this. They are young men, many of whom have never been seriously sick. "They are demanding and articulate," said Hospice director Lemus. "They have a lot of style, great flair. A lot of flowers and gourmet food arrive on 5A. But they are people accustomed to grief and rejection. They have had to leave their communities, their schools, their wives and their children. They are kings of letting go."

Many of the men who come onto 5A have never told their families they are gay. So when the mother in Arkansas and the sister in Illinois learn the son or the brother is dying, they also learn

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at he is a homosexual—all in one tone call. These families have a special place in the hearts of the people he work on 5A.

Lemus tells the story of the mother from Arkansas who came out to San Francisco to be with her son when he died. He was her favorite boy. She did not understand much about homosexuality—but she tried. At one point she rew Lemus aside and asked, "Honey, how do they do it?" She stayed with her son; she was with him when he died weeping blood. She arranged to bring the body home to Little Rock. Her last ideal was the death certificate: What had to go on it was not cancer but AIDS as cause of death. Not everyone in her town would understand.

A young woman was urged by her family and friends not to go to her brother's side because, they said, she asked carrying the disease back to her children. She came alone and sat for days beside him, and finally broke apart as she told a social worker she could not bring herself to touch her brother.

Visitors are allowed on this ward 24 hours a day. A wake was held here with seventeen people crammed into one little room. Bodies may remain in the beds for several hours after death so lovers and relatives can bid them farewell—a slight stretching of administrative regulations because so many people have died here.

"When death is so much a part of your life," said Diane Jones, in a tiny office off the main hallway, "there's a different light, mostly on living. What you have to do is give up a sense of control."

For the men, it goes by stages. A lot of fight at the start. "But as they get near the end," said Jones, "they feel extremely lousy; their patience is tried."

"They want to know," said Alison Moed, "so when is it going to come already?"

The moment of realizing that the fight is over comes in odd moments, in odd ways. "I had one guy call me in a panic at 2 A.M.," remembered Jones. "He'd been watching TV because he couldn't sleep and there was a commercial for I.R.A. accounts. He realized that he would never have any use for an I.R.A."

"A lot of them get a sort of gentleness about them," said Moed. "You see them at the clinic, getting thinner, walking slower. You ask them how they are doing and they say, 'Okay. Not too bad.' They have an immense patience."

"The worst thing of all is the ones who are neurologically impaired. They come in, their hands picking at the covers. They can't make the transition. You can see how afraid they are. You try to reach them. You try to communi-

cate to them that at least you are there."

"We're getting experience in the ways people die," said Jones. "Let me tell you a story. I had this patient. He had asked not to be put on a ventilator. He knew he was dying, probably within the hour. His lover, two nurses and a friend were there. Nobody knew what to do."

"He kept saying, 'I'm sorry.' He was really straining, all over the bed, and he kept apologizing. Finally, I asked him, 'Why do you keep saying you're sorry?' And he replied, 'I don't know how to do this. I've never done it before.' And then he laughed. This big belly laugh. And ten minutes later, he died."

"It was so down to earth. No organs or violins. We all want to know—what am I supposed to do? How am I supposed to die?"

OUT IN A neighborhood less-than-fashionable, Shanti Project is holding a meeting in a building that was once a convent. In the chapel, huge and vaulted, flooded with light, decorated with "Gloria in Excelsis Deo" and a swan feeding her young, where Dominican nuns once prayed for the souls of the departed, nearly 100 men and women have gathered for the weekend. This afternoon, a Saturday, when the city is bright with the clear beauty of fall, they will watch what is called "the role play."

The role play is part of the training done by Shanti, which has emerged as the leading service organization in the nation since the AIDS epidemic began. Organized in 1974, Shanti's purpose was to counsel men and women who had life-threatening diseases. In the last two years, it has grown exponentially. Now it is responsible for having trained over 2,000 people to be with AIDS patients as they live and as they die.

The director of Shanti is Jim Geary, a slight man who wears a large opal earring. On that Saturday, he had just returned from a week-long trip to Yosemite, where he and other members of the project had scattered the ashes of one of their dead.

Toward the end of the day, Geary sat down in the middle of the chapel, with the volunteers grouped in chairs around him. Across from him sat a man named Dave, dressed in shorts and a tank top with "Hot Flash" scrawled across the front. All over Dave's face and chest were purple lesions. He was diagnosed in January, after he noticed that the small bumps on his skin, the ones that looked like pimples, were growing. On the day after his thirty-second birthday, he was told he had Kaposi's sarcoma.

"Some things have started to go wrong," he told Geary. "I have a lesion in my throat that bumps up against my

tonsils. It's creating a strange sensation. I have nasal problems that won't go away. I have these lesions on my face."

"I'm real up-front about my AIDS. When I go out, I wear a tank top down Castro Street. People stare. People look at you and you can hear them"—he covered his mouth with his hand and mimicked people whispering. "Dealing with that is sort of hard."

Dave had recently taken a trip with some friends up to the Yuba River, north of the city. "I went with these guys and it was really great," he said. "We didn't talk AIDS. I'm very burned out on AIDS."

But that was not what he wanted to talk about today. He had just received a letter from the man who had been his lover.

"He can't deal with my illness," Dave said in his deep Texas drawl. "He said he loves me very much, but he's afraid I'm going to die on him. And so, therefore, instead of loving me in the now, enjoying me while I'm still healthy enough to get around and do things, he just closed me off. That's been real hard."

"I got to thinking about who is going to be with me when I die. Am I going to have to die alone? You know, I'd like to have this real fairy-tale death. I'm laying in bed, this man—probably the closest to me of anyone—holding my hand. I look up in his eyes. He looks into my eyes. And I say, 'Goodbye,' and that's that."

Dave laughed. "Well," he said, "that's not realistic. I realized all I've got is myself and my guardian angel. My self, when I die, that's all I need."

"Some things can't be changed. I can't change my friend Mike, or his fears. I can't change anyone in this room. It's just the situation I'm in; try to make the best of it. But I get lonely. The chances are that I'll never, I don't think I'll ever, fall in love again."

"In this part of my life, I have so much to give. And everybody wants to give to me. It's got me sort of freaked-out. You see, for me, it's important to give. I'd like to think that for other people with AIDS, it's important to give. Just like it makes you guys feel good and useful, it makes us feel good and useful, too."

CREDITS

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LIFE ON WARD 5B

BY RANDY SHILTS

Chanteuse Sharon McKnight tugged her black and white feathered boa over the web of clear plastic tubes threaded into one patient's arm as she stooped to examine the light blue hospital gown of another.

"Love it," cooed McKnight, affecting her Bette Davis accent. "It looks designer."

"See the Dior label?" parried Nick DiLoreta, tugging the gown around his neck like a precious mink.

"San Francisco General Hospital," gushed the entertainer, fingering the gown. "Yes, yes. This is the only place where I like *not* playing to a full house."

Nobody was insulted; McKnight was giving her little performance in Ward 5B of San Francisco General Hospital — the AIDS ward.

McKnight, a performer with enormous popularity in the gay community, was singing here that cold, drizzly night because she knew that most of the patients would never get to a night club again. More people die in 5B than in any other ward in the hospital.

The outbreak of Acquired Immune Deficiency Syndrome has been so virulent that a malady unimagined just four years ago and unnamed until two years ago commands its own 12-bed ward now. The ward exists in large part because AIDS had so much terror and stigma associated with it that patients weren't getting decent treatment elsewhere. Everyone was too scared of them.

As stage for the most frightening epidemic since polio, the AIDS ward has provided the setting for many anomalies. A fiercely committed nursing staff works 12-hour shifts daily, knowing its work will not save lives but will simply make death comfortable. All members of the ward staff insist they would work nowhere else, even though the job gets so jarring that nurses meet twice weekly in encounter groups to work out their anxieties.

The texture of life and death in Ward 5B is described most succinctly in the nightmares of the patients.

For Bruce Schneider, the recurring nightmare has him fading, dissolving like some phantasm into the air. His friends hover in the vague distance, asking him: "Bruce, why are you fading away?" He tries to answer, but they don't hear; he just continues to fade away.

The dream has come many times in the two months that Bruce has been in the hospital. Before August, when his illness started, Bruce was just another hard-working guy in the Castro, holding down a weekday job with the phone company and pulling in weekend shifts as a brunch cook. Within weeks of the diagnosis of *Pneumocystis carinii* pneumonia, however, Bruce wound up in the hospital, his nights filled with bad dreams. At times the days, too, are plagued with the hopeless, terrified moods of nightmares.

Randy Shilts is a Chronicle reporter.

From Castro Street to San Francisco General, the story of the AIDS epidemic

"You'll talk to somebody here one day and they'll say that they're feeling better," Bruce says. "The next day you'll see the nurses taking the sheets off the bed. You don't have to ask what happened because you know."

Often fatigued and sometimes depressed, Bruce spends most of his time watching television. Much of what he sees doesn't make sense now. The commercials about retirement accounts and pension funds are particularly painful. A normal 30-year-old single male like Bruce should expect to live 43.2 years more, according to insurance actuarial tables. But the average victim of PCP can expect to live 10 months after diagnosis; few have survived for longer than two years.

"This is like being on Death Row," Bruce sighs. "But it's worse. You don't know when it's going to happen or how it's going to happen. Will it be the pneumonia or some other disease you've never heard of? You know it probably will be painful. At least on Death Row you know the date and that it's going to be pretty quick and painless."

When Cliff Morrison, a 32-year-old clinical nurse specialist with a background in hospital administration, suggested a special ward for the soaring number of AIDS patients early last year, hospital administrators told him he was crazy. He was told that nobody would want to work in a ward full of dying gay men. Even at San Francisco General Hospital, where AIDS patients were treated better than just about anywhere else in the country, some nurses were bristling at handling the ever-growing AIDS caseload. This was the very reason the city needed a unit to treat AIDS patients exclusive-

ly, argued Morrison. Ward 5B exists because Morrison won his argument.

Three times as many people applied to work in the ward than Morrison needed. Drawn largely from registered nurses experienced in emergency room and intensive care work, the 5B staff is one of the most highly trained teams in any San Francisco hospital, operating in one of the most unconventional wards in California medicine. A determined administrator, Morrison has a distaste for the traditional pecking orders and hierarchies of hospitals.

"The traditional ways wouldn't work here," he says. "Normally, the doctors rule over the nurses and the patients have little involvement in their own care. They don't want visitors or other outsiders in the ward. But we're writing the book on AIDS care here."

"Nurses sometimes know more than the doctors about this; it's not something the doctors have studied in school. The patients sometimes know more than the nurses. And we encourage visitors. They're a tremendous asset in keeping up the will to live."

Painted in cheerful yellows and oranges, and overgrown with house plants, 5B is an informal place. Patients and staff chat about treatments over coffee and doughnuts in the morning. Gay nurses sometimes drop in from other units. The conversations sometimes evolve into high camp, eerily punctuated by painfully long coughs that echo from the rooms of the many pneumonia patients.

Why should I keep from identifying with the patients?" wonders Bill Barrick, a gay registered nurse who transferred to 5B from the clinic at the county jail. "Of course I identify with them. They're my age; I knew some of them before they got here. We're told that it's not professional if our emotions show through. But we couldn't work that way in this ward. It's too intense. To me, working here has gotten me in touch with what nursing was in the beginning — personal care given by an extended family."

Many patients of Ward 5B say night supervisor Cathy Juristo is the most reassuring presence for them. A gray-haired grandmother, Juristo counts her six months in the ward as the most rewarding work in her 37 years as a nurse, even though she has confronted an unprecedented level of grief.

"It makes me feel like a better person to work here; you can do so much to make their stay more comfortable," she says. "They might not get that if you don't give it to them. They're such wonderful guys, they deserve it."

The ward also receives community support unknown to other units in the hospital. Every day, Martin Cox, who has a half-dozen AIDS-related diseases himself, troops from room to room with newspapers, donated pastries and compassion for the dozen patients who normally lie in the ward. Entertainers — McKnight, for example — donate time and money for the AIDS Patient Fund, which finances small comforts

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Deotis McMath

WARD 5B

Continued From Page 9

for the sometimes-destitute patients. Volunteer grief counselors spend hours with patients.

"This is a part of the gay community that doesn't get publicity," says nurse Barrick. "The level of support is astounding."

The ward is dealing with avant garde issues of medical care, most notably the question of when a patient has a right to stop fighting and die. "No Code" is the medical term that sums it up. "No Code" means that no "extreme measures" be taken to preserve a life. Patients go "No Code" in 5B more often than in any other place in the hospital.

Deotis McMath holds the distinction of dying faster than any of the unlucky men in 5B.

A native of the hills of southern Virginia, Deotis had lived a somewhat seamy life, hustling tricks and shooting drugs in the Tenderloin. Last April he noticed purplish bruises all over his body. Not knowing anything about medicine, Deotis had no way of knowing that his immune system had gone haywire and had stopped producing the cells called platelets that make blood clot. Instead of clotting, his blood began to leak from his capillaries with each bump he suffered; the little bruises were external evidence of the deficiency.

By late October, a friend told him his back was covered with them. Deotis himself knew he was very sick; he checked into the hospital for tests. The news that he was getting tested for AIDS prompted his roommate to have Deotis' belongings packed and sent

off to a friend's house.

"Never come back here again," the roommate said.

"I guess it shows you who your friends are," said Deotis stoically.

A week into his hospital stay, the doctors determined that Deotis had idiopathic thrombocytopenic purpura, another one of the bizarre diseases that are associated with AIDS. Because this had inflamed a good portion of his abdominal organs, doctors cut out McMath's spleen and parts of his liver and stomach.

About two weeks later, Deotis' already sad disposition turned grim. "I don't want to be around and be a drain on other people," he said. His condition deteriorated and he was put on a respirator. Then, within hours of the deaths of two other 5B patients, Deotis asked nurses to take out the breathing tubes. At the age of 27, Deotis McMath quietly died.

THE MEDICAL MYSTERY

BY DAVID PERLMAN

SCIENCE EDITOR

The strange epidemic called AIDS — and indeed it is an epidemic by all the criteria physicians use to place fast-spreading diseases in their proper perspective — is more mysterious today than ever.

No cause is known; no cure is known; its true definition is still unclear, and the count of AIDS victims continues to rise: Cases diagnosed in America still increase by the hundreds every six months, and AIDS has now been reported in 42 states and nearly 30 foreign countries.

Yet — as is true in the history of so many other diseases — the tragic human toll of AIDS and the mysteries surrounding it offer at least one ironically hopeful prospect: As research intensifies, there is a real possibility that major new insights will emerge to clarify the molecular nature of the defensive mechanisms the human body has developed to fight disease over millennia of evolution.

Those mechanisms involve arsenals of the specialized cells the human body elaborates when it falls under attack by alien germs or proteins, and immunologists are only now beginning to perceive the details of the molecular battle.

Understanding the immune system fully would enable science at last to work a host of wonders: possibly to cure or even avert cancer, for example; or to conquer the truly catastrophic infectious and parasitic diseases that decimate the Third World; or to expand the still-limited numbers of patients who can successfully retain organs transplanted from the dead to the living. The spread of the AIDS diseases, and the public's fearful reactions, will themselves add to the understanding of medical epidemiologists and behavioral scientists.

"AIDS is an extremely interesting experiment of nature," says Dr. Mathilde Krim of Memorial-Sloan-Kettering Cancer Center in New York, "and the results will be relevant to many different areas of medicine. AIDS is a terrific example of the interlocking connection between infections, immune deficiency and malignant disease."

This is why the problem generates such fascination among biomedical scientists, even while it frustrates and saddens the epidemiologists and clinical physicians who must deal with the daily human tragedies the AIDS diseases cause.

For however great the hope may be that AIDS-related science will help lead to the future conquest of other diseases, the present state of knowledge offers little comfort to the victims of the acquired immune deficiency syndrome, nor to members of population groups known to be at highest risk for becoming victims.

Nearly half the more than 3000 AIDS patients who have been diagnosed in America since the first cases were identified and described some three years ago are dead now (see chart at right), and despite some recent indications that new AIDS cases might be leveling off, most epidemiologists believe the epidemic's spread is by no means slowing. AIDS is now legally reportable in many states; although this chart shows a recent decline, statisticians believe that final tabulations for 1983 will show a continuing increase.

The death rate among patients diagnosed before 1982 is already more than 75 percent. And using the most rigid possible definition of AIDS, doctors fear that unless effective treatments are found soon, the death toll from the major AIDS infections will eventually prove to be 100 percent.

Above all, among those most at risk are young male homosexuals, who were the first to be identified as a unique AIDS group. Most noticeable in that group are gay men living in the "fast lane," marked by indiscriminating, intense sexual activity — often with anonymous partners encountered in bars or bathhouses. Today gay and bisexual men account for 72 percent of all the AIDS cases in America, and it is because of their affliction that the term "Gay Plague" first made sensational — if inaccurate — headlines less than three years ago.

By now these other groups are known to be at risk:

□ Present or past drug users who inject their favorite uppers or downers into their veins and often share contaminated needles. These men and women make up 17 per cent of the reported cases.

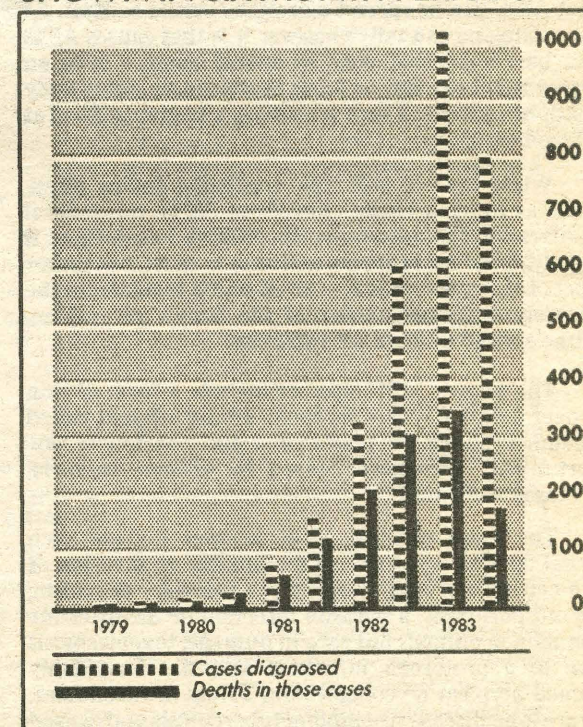
□ Immigrants from Haiti, most of them in New York or Miami, who pose a special mystery because there is so little firm evidence that the 120 known Haitian AIDS patients are either homosexual or involved in intravenous drug use. About 5 percent of AIDS patients are Haitian-born.

□ Hemophilia patients, whose blood will not clot and who must therefore use a special clotting preparation made from blood plasma that is pooled from thousands of unknown paid donors. Twenty-two hemophiliacs have been diagnosed so far as victims of AIDS.

AIDS diseases are known in many others, too. In

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CASES AND DEATHS BY YEARS SHOWN IN SIX-MONTH PERIODS



Source: U.S. Centers for Disease Control

"We can make death comfortable," says Morrison. "They'll fight and fight and fight. And then it comes to the point that they'll say, I just can't take it anymore, and then, they'll die."

The brisk weeks of winter brought bad times for 5B. With the damp, cold weather, painful *Pneumocystis* pneumonia flared in the lungs of many AIDS patients. The beds of 5B were full. In one 24-hour period, three men died on the ward.

Bruce Schneider's voice barely carries over the hum of traffic on the freeway a few hundred feet from the window of his corner room.

"Every day, you watch television, for some word, some sign that maybe they've found something, some miracle cure, some quick fix," he says. "You're on Death Row here, but maybe you'll get a reprieve from the governor. Maybe you'll get another chance." ■



Clinical nurse specialist Cliff Morrison (right) talks with AIDS patient Nick DiLoreta

MEDICAL MYSTERY

Continued From Page 11

San Francisco, Dr. Arthur J. Amman of the University of California and his colleagues have studied nearly 50 infants and children who have developed the opportunistic infections associated with the syndrome, and whose diseases Amman calls "pediatric AIDS." There may be 100 or more around the country.

Their mothers are often intravenous drug users, prostitutes or immigrants from Haiti, or live in households with AIDS patients. Most of the infant victims become ill between 3 and 6 months of age, and some have survived as long as four years — thus dating the onset of their AIDS diseases even before the syndrome was recognized. But their death rates are high, Amman says.

Then there are the less well-defined categories: Female prostitutes; sexual partners of AIDS patients or of individuals in the known high-risk groups; a very small number of patients — certainly no more than 20 or so — who may have received contaminated blood or commercial plasma by transfusion.

One thing is definitely clear by now, however: No one, certainly no one in the general public, need fear that AIDS can be spread merely by casual contact. As far as anyone can tell, whatever it is that causes AIDS can be transmitted only by sexual contact with an active AIDS carrier, or from the blood or other body fluids of a carrier. There is no danger in giving blood at a blood bank.

While there is still wide confusion among physicians as to what really constitutes AIDS, the federal Centers for Disease Control in Atlanta has defined it rigidly. It is, first of all, not a disease in itself, but rather a set of many symptoms — all of which result from the severely depressed ability of the body's natural immune system to ward off infection.

The known AIDS diseases include a form of skin cancer called Kaposi's sarcoma, a lung ailment called Pneumocystis carinii pneumonia, and a variety of "opportunistic" infections caused by viruses, bacteria, protozoa and fungi.

The more obscure AIDS diseases include such lethal ones as cryptococcal meningitis, an invasion of the central nervous system by a yeastlike organism; cryptosporidiosis, a parasite infection of the intestine common in animals but rare in humans; toxoplasmosis due to a protozoan infection, and the formidably named atypical mycobacterium avium-intracellulare, a rare lung disease resembling tuberculosis and caused by bacteria that most commonly infect chickens and swine.

Most people with normal immune systems can fight off these infections quickly without falling ill or developing any symptoms at all; in AIDS victims any of the infections can be swiftly fatal.

There are even less clear illnesses that may be related to AIDS, too. One is marked by chronically swollen lymph glands in young gay males who show few other symptoms although many have been under observation for more than two years. Physicians studying them, like Dr. Donald Abrams of UCSF, who cares for AIDS patients at San Francisco General Hospital, are still puzzled as to whether this isolated lymph node problem is a forerunner of more serious disease or merely an unusually mild form of AIDS.

Other obscure illnesses that stem from defective immunity may also prove to be non-lethal AIDS. When medical science finally fixes on a definition of AIDS, the total of true cases may turn out to be 10 times the presently accepted total.

According to Dr. James Curran, who heads the federal CDC's task force on AIDS, Kaposi's sarcoma (known to doctors more simply as KS) and Pneumocystis pneumonia (PCP) are the major killers in AIDS.

AIDS CASES

THROUGH DECEMBER 22, 1983

Alabama	5	Mississippi	1
Arkansas	1	N. Carolina	9
Arizona	9	Nebraska	2
California	686	N. Hampshire	2
Colorado	26	N. Jersey	191
Connecticut	28	N. Mexico	1
D.C.	22	Nevada	3
Delaware	1	New York	1373
Florida	213	Ohio	15
Georgia	37	Oklahoma	4
Hawaii	8	Oregon	8
Iowa	1	Pennsylvania	53
Illinois	56	Puerto Rico	18
Indiana	3	Rhode Island	3
Kansas	2	S. Carolina	11
Kentucky	4	Tennessee	3
Louisiana	18	Texas	105
Massachusetts	46	Utah	2
Maryland	27	Virginia	27
Michigan	12	Vermont	1
Minnesota	8	Washington	10
Missouri	7	Wisconsin	2

Source: U.S. Centers for Disease Control

Those who develop KS alone show a death rate of 21 percent; the death rate for those with PCP alone is 46 percent; the death rate for patients who suffer from both diseases is now 57 percent. Among patients who acquire any of the more obscure opportunistic infections, the death rate is 49 percent.

Not surprisingly, the largest proportion of AIDS cases strike in the American cities with the largest gay populations. New York City alone accounts for more than 40 percent of the nation's victims; San Francisco has 12 percent; Los Angeles has nearly 7 percent, Miami about 5 percent. The remaining cases are scattered through the nation.

One fascinating mystery about the risks and origins of AIDS came to light late last year at an international conference on the problem sponsored by the New York Academy of Sciences. A Belgian physician, Dr. Jan Desmyter, reported what may have been some of the world's first AIDS cases — a group of patients that included one person diagnosed as far back as 1977.

Most intriguing about his report was that all 38 patients known to the Belgian doctors have come from Zaire in Africa, the former Belgian Congo. Unlike the situation in America, where white male homosexuals are the victims, 90 percent of the Zaire patients were black, and all the white patients were born in that African territory. All the patients — both black and white — were educated and upper middle-class. Only two were apparently homosexual; none had ever undergone a blood transfusion; none were drug-users; none had ever experienced malnutrition or any of the parasitic diseases that might have threatened their immune systems. French physicians reported similar AIDS patients who also came from nearby African nations, yet who were not in any of the known high-risk groups.

Commented Dr. Paul Volberding, the cancer specialist who treats AIDS patients at San Francisco General Hospital: "The Belgian report is really intriguing. It strengthens the case for the theory that AIDS has existed for a long, long time at a very low level, but remained undiagnosed until it reached the gay community in the United States as a new disease, and then flared into a true epidemic."

Also intriguing in the European cases is their locale. "Classical" forms of Kaposi's sarcoma have been known for many decades in those African areas. The specific skin cancer, in fact, was first described back in 1872 by a Hungarian-born Viennese doctor named Moriz Kaposi. It was seen then as an "indolent" cancer that spread in the tissues of its patients only very slowly, a far cry from the swift deadliness of today's KS.

The same African regions are also known for the prevalence of a type of lymphatic cancer called Burkitt's lymphoma, which many scientists believe is caused by a specific organism known as the Epstein-Barr virus. That germ is one of the family of herpes viruses, and is commonly known as a cause of infectious mononucleosis.

So the most recent reports suggest a strong circumstantial connection between Africa as a possible point of origin for AIDS — perhaps having moved from there through Haiti to the United States. The reports provide still another in the many suspected links between AIDS and a wide variety of viruses.

The theory most prevalent now among AIDS experts is that the immunity defect is caused by a single agent — probably a virus — that is most often transmitted in blood or semen and that acts most viciously on population groups whose immunity has already been compromised by previous infections or by a host of other damaging life experiences.

Kidney transplant patients, for example, must take drugs that suppress the immune system, so that they will not reject the alien kidneys whose tissues normally would provoke a strong immune response in the recipients. Therefore, although their diseases are not classified as AIDS, they are prone to many infections and even to Kaposi's sarcoma.

According to Dr. Gene M. Shearer, an immunologist. See Page 19

AN EPIDEMIC OF FEAR

BY ERICA GOODE

It was a small thing, and not many people noticed when a young, well-dressed man and his girlfriend stood up in the Bridge movie theater in San Francisco a few weeks ago and changed seats.

Two men were sitting about halfway down the aisle. They were holding hands. The couple walked in. The half-light in the theater made them squint. They spotted two empty seats next to the gay men and started to sit down, but the woman stopped abruptly.

"No, let's sit somewhere else," she said to her companion. "One of them might have AIDS."

Few things dig as deeply into the fears and imaginings buried in the human mind as does the spread of a deadly disease that has no known cause or cure. While imposing a lingering and painful death on its victims, AIDS has extended its impact far beyond those suffering the physical ravages of the illness.

Epidemics, in other years and other centuries, have brought close on their heels a second, altogether different kind of contagion that infects the still healthy: dread, panic; the chilly fear of dying. AIDS is no exception.

When the news media first began reporting on homosexual men dying from a puzzling type of cancer, alarm and uneasiness were already stirring in the gay community. But with the exception of public health workers who had forebodings of what was to come, the heterosexual world remained undisturbed and largely uninterested. After all, many thought, this thing had nothing to do with them.

Then, quite abruptly it seemed, it was there in the headlines: AIDS — a collapse of the immune system, a horrible vulnerability to nearly any voracious infection that came along. A killer.

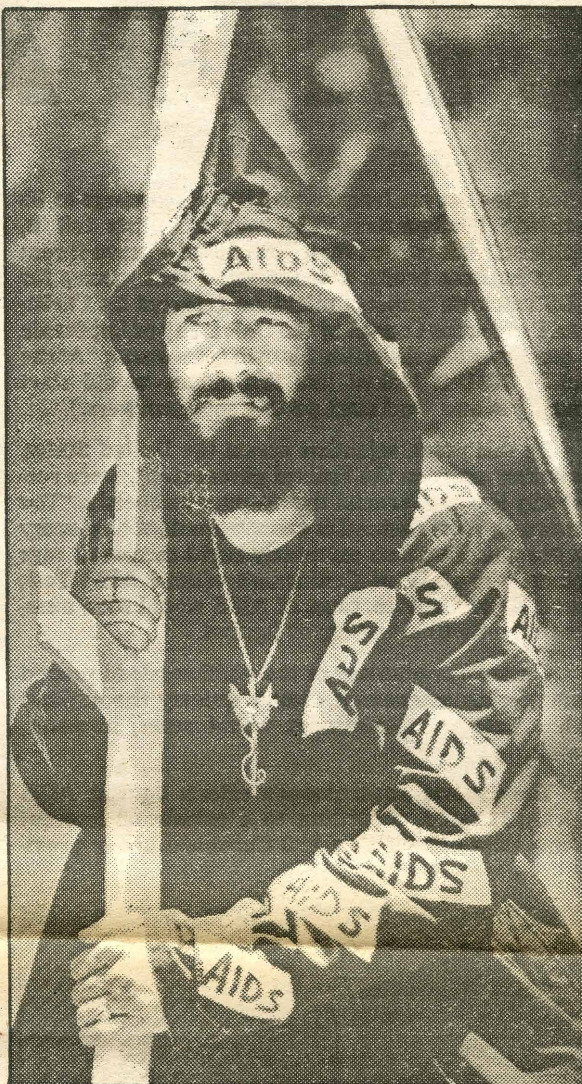
AIDS was suddenly something to think about, to talk about, to worry about. Rumors started. Questions multiplied: "Can I get it from sitting next to a gay man on the Muni?" "Can I get it from eating in a restaurant?" "Should I take blood from the blood bank?"

The spread of AIDS posed a challenge to heterosexual liberals who thought they were above caring about the gender of bed partners.

The crowd of straight diners at Castro Street restaurants thinned considerably. Dinner invitations from gay friends were turned down with mumbled excuses. Highly educated, sophisticated men and women commented at cocktail parties that, despite repeated explanations from the health department, they still thought you might contract AIDS from breathing the same air as someone who had it. Most disturbing, things began to happen that, whatever the actuality, looked a lot like the emergence of a vicious prejudice and homophobia.

Fundamentalists, such as the Reverend Jerry Falwell, preached that AIDS was punishment for the sins of Sodom and Gomorrah, and gays were simply now paying the price for their immoral ways. In offices and at social gatherings, those who had remained silent in their dislike of homosexuality suddenly found it permissible to get off sharp barbs about gays now and then — always in the context of AIDS, of course.

The fear penetrated the medical world. Some nurses — who routinely deal with everything from



Panic in perspective

cancer to bubonic plague — refused to treat AIDS patients dying on their wards. Some attribute this reluctance to anxiety; no one was absolutely certain how the malady was spread. Others say that if children had been dying, instead of gay men, their response may have been different.

Employees of at least one San Francisco hospital quickly turned their trepidation into gallows humor. A wisecrack circulated the floors: There might soon be a fifth "H" to add to the four "H" groups at risk from AIDS — homosexuals, Haitians, heroin users and hemophiliacs. The fifth "H" was "House Staff."

In scattered incidents, jury members and television technicians refused to occupy the same room with men with AIDS. Then, late last spring, the panic seemed to reach its peak when four city gardeners donned disposable suits and surgical masks to clean up trash from the annual Gay Freedom Day Parade.

Dr. Mervin Silverman, San Francisco's director of public health, looks at AIDS as one of the strangest, most challenging and fascinating problems he has faced in his career of fending off the spread of communicable diseases.

"I've probably spent more time thinking about and worrying about AIDS than I have with any other subject since I've been here," Silverman says.

Because AIDS embodied the almost unprecedented convergence of an outbreak within a minority group — the gay community — and a group already politically organized, Silverman says, "it was the most socio-psychological disease" he had encountered.

"When you had polio you could say, 'Don't go to the swimming pool this summer,'" he says. "Here, you had a situation where you didn't have all of the information but you still had to be responsible in what you said. There were people in the gay community who felt that it was not government's role to tell people what to do with their sex lives."

He thinks there was an unnecessary amount of fear in the straight population. The public's fright grew into a second epidemic, he says, compounding and complicating the first.

"It wasn't irrational to have anxiety," Silverman says. "What the hell, we're talking fatality.... At the same time, even though we don't have all the answers, the disease didn't come from outer space. We know about disease process.... When we're talking about AIDS, it turns out AIDS is not a highly infectious disease."

Citizens made panicked calls to the health department, asking whether they might have been exposed to the malady. Silverman even received a letter asking if the court clerk could accept documents that an AIDS patient delivered by hand.

"I changed what I was saying to the public," he says. "I said, 'There's every reason to be concerned, but let me tell you why you don't have to worry about it.'"

Silverman and the department's highly respected epidemiologist, Dr. Selma Dritz, explained over and over again — on television, in the newspapers, at public gatherings — exactly what was known about AIDS and how it was believed to pass from one person to the next.

"You had an attention-getting disease in an attention-worthy group," said Dritz recently. "But people who are hysterically anti-gay forget that there are human beings dying young, with lots of potential left."

Finally last summer, it seemed, the wave of fear began to recede, at least in its most overt and dramatic forms. Perhaps, as Dritz commented, people tend to have short memories for these things. Or perhaps the news had just quietly settled in.

Experts in mass behavior say they were not surprised by the public's response to the spread of the illness. The situation, they explain, contained all of the elements that produce anxiety and hysteria, and after all, epidemics have occurred before with similar results. AIDS is only the newest variation on plague and pestilence — a periodic reminder that no matter how advanced our technology, nature continues to pull surprises from her bag of horrors.

In the first half of this century poliomyelitis ran rampant, crippling and killing children and adults alike.

"I remember it when I was a child," says University of California-Berkeley epidemiologist Warren Winkelstein, who is now launching a study of AIDS. "There's a lot of hysteria when there is an epidemic and people don't understand it or can't control it. Polio was epidemic every year. When it was serious, the level of hysteria was very high and people determined their actions by it. They didn't go to the movies and wouldn't let their children go to swimming pools."

"And everyone was frightened," he says. "I

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Erica Goode is a Chronicle reporter.

THE ESTABLISHMENT LURCHES INTO ACTION

The national picture

BY RANDY SHILTS

With no apparent malice, Bill Kurtis, anchorman of the CBS Morning News, started a recent speech at the San Francisco Press Club with a joke.

"You know the hard part of having AIDS?" he asked, before handing out the annual press club newspaper awards. "Trying to convince your wife you're Haitian."

That the joke was greeted only with mild titters and nervous glances was a sign of the uneasiness the topic generated. That the joke was made at all, by an influential television reporter, is emblematic of a fundamental stumbling block to a public fight against AIDS.

Because AIDS has largely been an affliction of homosexuals, spread mainly through sexual contact, public institutions — more attuned to more traditional diseases in more conventional groups — spent two years waffling before any taking substantive action. In some cases, the official response to the outbreak of a deadly new syndrome was nil; when the malady became too widespread to ignore, it became something of an uncomfortable dirty joke.

A four-month Chronicle survey of health officials, researchers and political figures active in various aspects of the AIDS crisis has found a near-unanimous opinion that handling of the epidemic was bungled. Government, medical and media institutions failed to provide adequate resources, expertise and awareness to solve the mysteries — or at least curb the devastation — of the syndrome.

Many decades ago, the puzzles of sundry scourges were solved by scientists laboring in small laboratories with small budgets. After World War II, when research costs began soaring, private foundations — like the National Foundation for Infantile Paralysis, which sponsored much of the exploration into polio — started picking up the tab. Since the '60s, however, as research has become increasingly expensive, the government has assumed the central role in the nation's medical studies, financing research and employing thousands of scientists in the National Institutes of Health. In 1983 alone, the federal government spent a total of \$5.4 billion on health research in America.

When doctors first connected a handful of mysterious diseases to the phenomenon now known as AIDS in April 1981, the federal Centers for Disease Control in Atlanta jumped on the emerging epidemic with the kind of timeliness that had earned its reputation as the federal government's most effective health agency. By June, an AIDS Task Force emerged from the agency's venereal disease team, the staffers who had already been working with the gay community for several years. Money was pirated from other health projects. The task force quickly documented startling increases of AIDS — some 111 cases were detected within the first seven weeks of the task force's work. Ominously, half of the stricken were already dead.

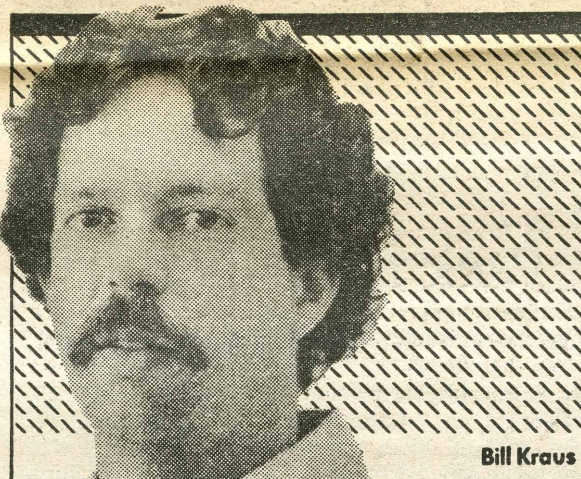
In September 1981 the National Cancer Institute

called the first conference of AIDS researchers at its Bethesda headquarters. The way scientists tell it, health officials agreed that AIDS posed a grave threat to the nation's health and indicated that money for AIDS research projects might be released by Christmas. Dr. Marcus Conant of the University of California at San Francisco describes his own assessment: "At the end of 1981, it looked like the money would start pouring in and we'd start getting some answers."

By this point, scientists across the United States, including many in the federal government, were seeing why it was so crucial that inquiry be speedy. "The pattern showed that AIDS cases were doubling every six months. That's an extremely rapid increase," says Conant, the chair of California's official AIDS Task Force. At such a rate, cases of AIDS would soon number in the thousands, Conant figured.

Conant's predictions of the AIDS caseload proved accurate; his assessment of how quickly the nation's public health establishment would react, however, wasn't.

The federal government's efforts against AIDS quickly faltered, according to a review of internal memoranda obtained by The Chronicle under provi-



Bill Kraus

"You could tell something was funny from the start Funding levels were incredibly minuscule considering the scope of the problem"

sions of the Freedom of Information Act. The memos, and a subsequent report issued by the House Committee on Governmental Operations, show a stark conflict between government scientists eager to tackle the AIDS problem and administration budget slashers.

By December 1981, while the national AIDS caseload soared, the Task Force was already suffering from a lack of funds. Dr. James Curran, coordinator of the federal AIDS effort, submitted a modest \$833,000 budget to the CDC director; the request was never approved, according to the congressional report. Eight months later, Congress allocated an extra \$500,000 for

AIDS work; President Reagan vetoed the appropriations bill. The veto ultimately was overridden by Congress.

In the 10 months between the time Curran asked for extra funding and the time he received it, however, the number of AIDS cases had skyrocketed to more than 500. Meanwhile, hundreds more cases were incubating.

Budget requests for the 1983 fiscal year, submitted to the Office of Management and Budget in mid-1982, also met with opposition from administration budget officials. The AIDS Task Force had to submit its budget three times before it was cut back sufficiently to satisfy the strict budget constraints.

"As you know, the attached budget is insufficient to adequately fund AIDS surveillance and epidemiologic studies," wrote Dr. William Rushing, the administrative officer of the AIDS Task Force, when he handed in the final scaled-down budget.

Bureaucratic red tape slowed research outside the government. The National Cancer Institute, which had hinted at money by December 1981, didn't issue a call for funding applications until August 1982. Money from this appropriation was not released until May 1983.

It also appears that much of the money spent within federal agencies with the understanding it would support AIDS research may have been diverted to already-established projects that were only tangentially related to AIDS. Only about 10 percent of the money to be given to non-government researchers for AIDS went to scientists delving specifically into the syndrome, according to the congressional report. "The remaining 90 percent comprised previously awarded grants to investigators who diverted 20 percent or less of their funds to AIDS research," the congressional investigators asserted.

Confusion erupted over the assignment of AIDS to a particular bureaucratic turf. Since AIDS first manifested itself as a skin cancer, the cancer institute initially handled the syndrome. Later, when it became obvious that the cancer was only part of an overall breakdown in the immune system, much of AIDS research fell under the aegis of another agency.

"We ended up spending much of our time writing and rewriting grant proposals for the bureaucracy," complains Dr. Andrew Moss of UCSF, one of the nation's most respected epidemiologists. "The whole grant process also put us in competition with each other. Rather than collaborating, we were scrapping. That's not the way things should work in an emergency. It slowed our work immeasurably."

Attempts to trace the spread of the disease were all but nonexistent. The National Institutes of Health said this work was the responsibility of the Centers for Disease Control; the Centers for Disease Control thought it was being handled by the National Institutes of Health. As a result of the confusion, very little of the important epidemiology was ever analyzed.

The one comprehensive case-control study by the Centers for Disease Control was so out of date by the time it was published in the *Annals of Internal Medi-*

cine last August that it was met with almost universal derision by AIDS researchers.

Federal health officials weren't alone in ignoring the rapid spread of the deadly new syndrome. Most of the nation's major media institutions pretended that AIDS did not exist. Except for a few tidbits on "gay cancer" or "gay pneumonia," AIDS generated little national press attention.

The scientific and medical establishments were also slow to react to the crisis. San Francisco AIDS researchers, for example, say privately that the city's AIDS clinic was established in San Francisco General Hospital because the University of California was not enamored with the idea of hosting a clinic catering to gays.

"The homophobia is probably less than most people imagine among medical people, but it certainly was there," says one prominent AIDS researcher, who asked not to be named. "AIDS certainly wasn't considered something respectable scientists did. There wasn't the money or the media attention at the time to make it attractive."

Another researcher, Dr. Donald I. Abrams, says that colleagues warned he might be committing "professional suicide" by working at the hospital's AIDS clinic instead of sticking to laboratory research. These problems of prejudice were far greater in other cities than they were here.

During the first two years of the crisis, few in the gay community sounded alarms. Political leaders often played down the growing health threat, in part because the notion of a sexually transmitted deadly disease represented a public-relations disaster for the gay rights movement. Gay newspapers largely shunned talk of AIDS and all its messy implications.

Though growing numbers of intravenous drug users and Haitian refugees were found to suffer from the disorder in 1982, AIDS was widely perceived as the "gay plague," as one unfortunate wire service story called it. A handful of committed scientists worked heroically in various cities with little public recognition and scanty budgets. Through the two years of inaction, one suspicion lurked among the handful of people who bothered to form an opinion.

"There are no doubts in my mind that if the same disease had appeared among Americans of Norwegian descent, or among tennis players, rather than among gay males, the response of both the government and the medical community would have been different," said Congressman Henry Waxman of Los Angeles in early 1982.

The sight of a once-muscular and handsome friend withering away from a mysterious new disease disturbed and frightened Bill Kraus. Like many gay men, Kraus had kept the threat of the new epidemic comfortably out of mind. Then, in the summer of 1982, it hit a gym buddy. Kraus, then an aide to the late Representative Phil Burton, made a routine request from the U.S. Department of Health and Human Services for the AIDS funding levels; he wanted to see what was being done.

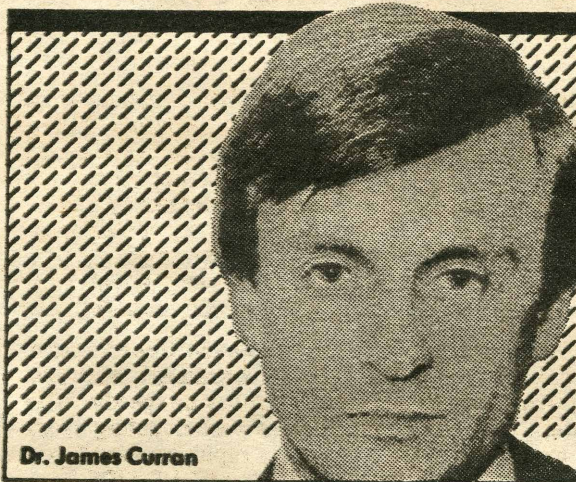
"You could tell something was funny from the start," says Kraus, former president of the Harvey Milk Gay Democratic Club and now an aide to Representative Sala Burton, D-SF. "It was very hard to get information. What I did get showed that funding levels were incredibly miniscule considering the scope of the problem."

At the beginning of 1983, Kraus discovered that the National Institutes of Health were spending only two-tenths of one percent of their budget on the deadliest fastest-spreading epidemic to hit the United States since polio. "I was appalled," says Kraus. "But these federal people treated me as though I were hysterical — they kept saying, over and over, that the scientists had plenty of money to fight AIDS."

The sheer volume of AIDS cases across the coun-

try snapped the gay community to attention in March 1983, when the AIDS casualty rate topped the 1000 mark. Gay papers started running stories about AIDS and gay activists angrily denounced the lack of government funding. A series of dramatic candlelight marches in major cities, led by AIDS patients, successfully garnered what AIDS had long lacked: substantial media attention.

With the sudden discovery of AIDS by the media, attention to — and concern about — the baffling



Dr. James Curran

'You can't single out the government; everybody was late in picking up on how serious this was'

syndrome exploded into an onslaught of news magazine cover stories, network television reports and daily headlines. The attention engendered political pressure on congressmen from districts with gay constituencies. Suddenly, Congress was clamoring to give AIDS researchers all the money they wanted.

The assistant secretary of health and human services, who is in charge of all federal health efforts, Dr. Edward Brandt, quickly labeled AIDS the administration's "number-one health priority." Despite the rhetoric, however, budget officials still resisted giving AIDS researchers more money. In appearances before congressional committees, Brandt simply assured legislators that government AIDS researchers had all the money they could spend.

Despite Brandt's public stance, a private battle was taking shape within the administration. Days after telling Congress that the government did not want any more AIDS money, Brandt wrote an administration

budget official that "It has reached the point where important AIDS work cannot be undertaken because of the lack of available resources."

Dr. William Foege, director of the Centers for Disease Control, who said publicly that his agency needed no money, was privately pleading for funds. "Clearly we can effectively use more funds and positions this year and definitely should be expanding our efforts in 1983," he wrote in May. Two years of pirating money from other health programs to fund AIDS probes had cut significantly into other important health work. The government's lack of funding, Foege wrote, left his agency "in the frustrating position" of "playing catchup in regards to AIDS money."

The administration, however, held a tough budget line and told Congressional aides that they opposed increased funding for AIDS research.

"It got to the point where we had to force money on them," says Representative Barbara Boxer, D-SF/Marin. "It was the strangest thing. Normally in an epidemic, health officials come begging Congress for more money. It seemed that we had to beg them to say they needed it."

In May, over the objections of the administration, Congress allocated an extra \$12 million for last year's AIDS research. Again over administration objections, Congress passed \$41 million more for AIDS research in the current fiscal year. With this appropriation, the tide had turned on AIDS research. With money in place, the nation's scientists turned their attention to the disorder; with media attention, prestige awaited the researchers who ferreted out the cause of the ailment. "Everybody sees a Nobel Prize in this, of course," says Dr. Warren Winklesstein of UC-Berkeley, the recent recipient of a \$3 million federal grant for AIDS research. "But that's not bad — that means you'll get the best minds in the country working on this."

For their part, government officials are defensive about the criticism they've endured from frustrated researchers and angry politicians.

"This is cursing the darkness after the candles have been lit," says Curran of the federal AIDS Task Force. "You can't single out the government; everybody was late in picking up on how serious this was. The media wasn't around two years ago and neither were the congressmen who are talking so much now."

Still, the administration's handling of AIDS remains such a touchy issue that last month the House Committee on Government Operations asked that all funding decisions be taken out of the hands of Reagan budget officials and entrusted to an independent commission of scientists.

"Unfortunately, the lives of countless Americans may be jeopardized when the scope of AIDS research and surveillance is dictated by budget considerations rather than the professional judgments of public health and medical experts," the committee wrote in its final report.

Politics and Bathhouses: Local Complexities

Recent rumors that AIDS patients were cavorting in San Francisco's bathhouses presented Dr. Selma Dritz, of the city's Bureau of Communicable Diseases, with one of the most complicated dilemmas she had faced in nearly two decades of work in public health.

"There were questions of civil rights and privacy, up against the problem of protecting the public health," Dritz recalled recently. "We didn't know which way to turn."

A deputy city attorney eventually ruled that the medical uncertainties surrounding AIDS precluded any action by the city: Authorities can't keep AIDS patients out of bathhouses — in effect, quarantine them — because scientists don't know exactly what causes the disorder.

Still, the entire issue demonstrates what enormous complexities a syndrome sexually transmitted among an unconventional minority poses for local

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POLITICS AND BATHHOUSES

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health authorities.

The course of policy-making over this uncertain terrain has been rocky. While federal efforts to fight AIDS floundered because gays wield so little clout on the national level, local efforts to deal with the syndrome in San Francisco floundered because gays have so much power that health officials were worried about angering the political Goliath.

The city's confusion about how to deal with gay bathhouses was a prime example. From the start, studies have shown that AIDS victims tend to be the men who engage in frequent anonymous sex at bathhouses. AIDS researchers make little secret of the fact that they consider baths to be breeding grounds of the syndrome. Pragmatic homosexual activists wouldn't mind seeing the baths closed. Gay radicals, however, have loudly maintained that gays have a right to be promiscuous, even if it means contracting AIDS.

Caught between warring gay factions, the Department of Public Health stalled on making any moves that might be controversial. Dr. Mervyn Silverman, the public health director, first said he did not have the authority to require baths to post warnings about AIDS, but changed his mind after Mayor Dianne Feinstein and a majority of the board of supervisors clamored for such warnings.

"The information people listen to is what comes from their own peers," said Silverman when he announced he would require AIDS pamphlets in baths last summer. "We'd have a very hard time getting into the business of telling people how to have sex."

AIDS researchers, who have to confront the dead and dying on a daily basis, insist that officials do need to tackle the sexual issue head-on; sex is clearly the major mode of transmission in a city where more than 95 percent of AIDS victims are gay or bisexual men.

"The baths should be locked up — or at least there should be giant signs in big red letters saying 'This Place Can Kill You,'" says one prominent AIDS researcher, who asked not to be named. "But they won't do it. They're pussyfooting around this because of politics."

It would be hard to avoid politics with AIDS in San Francisco, the site of the largest and most politically

The baths should be locked up,' says one researcher. 'But they won't do it. They're pussyfooting around this because of politics'

powerful gay community in the country. During the first two years of the epidemic, for example, the health department's AIDS efforts were coordinated by Pat Norman, a lesbian who was then preparing her current campaign for a seat on the board of supervisors. Norman gave AIDS a low profile, she says, because she didn't want to engender hysteria; her detractors say she didn't want to muddy the waters of her own political future. No matter why, the health department did not even put together an AIDS brochure until May

1983, more than two years after AIDS was detected here.

For all the barbs San Francisco officials have faced, a Chronicle survey of other major American cities has found that San Francisco's handling of AIDS is considered the national prototype. Chicago has not allocated any funds at all for public education. Los Angeles got its AIDS program off the ground only last fall. New York City, with about half the nation's AIDS cases, has spent \$1 million for its non-hospital health activities relating to AIDS.

San Francisco has also aggressively conducted the best epidemiology on AIDS in the country, work that some scientists say is more comprehensive than that done by the federal Centers for Disease Control. Because relations between public health officials and gay physicians have long been cordial, cooperation has marked efforts by health authorities to monitor information about the spread of AIDS. In New York City, where gay physicians are far more suspicious of health officials, some gay doctors have simply refused to report AIDS cases, throwing attempts to chart national AIDS trends into disarray.

The headaches for local jurisdictions may only be starting. The costliest aspects of AIDS involve hospital treatment for patients who lack health insurance. Patient services consume most of the \$4 million San Francisco is spending on AIDS this year. New York City is spending \$30,000 a day to treat patients, and officials expect this sum to soar higher as patients diagnosed within the past year begin needing hospital care. "It's going to be a staggering cost," said Marvin Bogner, assistant health commissioner for New York City. "We're terribly concerned."

Mayor Dianne Feinstein, who heads the U.S. Conference of Mayors AIDS Task Force, has asked the federal government to help cities pay for the immense costs of hospital care. Secretary Margaret Heckler of the U.S. Department of Health and Human Services, however, has maintained that such costs are a local responsibility.

— R.S.

'OF COURSE, NOBODY HAD PLANNED ON THIS'

BY RANDY SHILTS

Having non-lethal sex isn't as tricky as it may seem, suggested the speaker at the "Sex in the Age of AIDS" seminar.

As the earnest crowd of 300 listened raptly in the overflowing gay church off Castro Street several weeks ago, David Lourea, the head of the city's Bisexual Center, explained what to do if, for example, a guy feels the urge to wander over to a bathhouse.

Call a friend, Lourea suggested, and explain: "I'm feeling really turned on, but if I went to a bathhouse, I don't know if I would refrain from exchanging semen. I'd feel a lot safer if we shared an erotic fantasy. What are you thinking right now?"

One spectator shook his head incredulously: "I think I'd put him on hold."

For gay men who couldn't be tempted by sex-telephone, other speakers at the three-hour program presented a slide show on how to have "low-risk sex"; one pair even role-played the negotiation of a "safe sex" tryst in a gay bar.

A few nostalgic years ago, the notion of having seminars to teach gay men how to cruise would have seemed as ludicrous as a class to teach Parisians the art of buttering croissants. Those years, however, preceded the outbreak of acquired immune deficiency syndrome and the stark reality that some forms of gay sex may be hazardous to your health.

AIDS has frightened gay men so much that after 15 years of boisterous gay liberation, a program with a how-to-have-sex slide show is packing houses in the world's trendiest gay neighborhood.

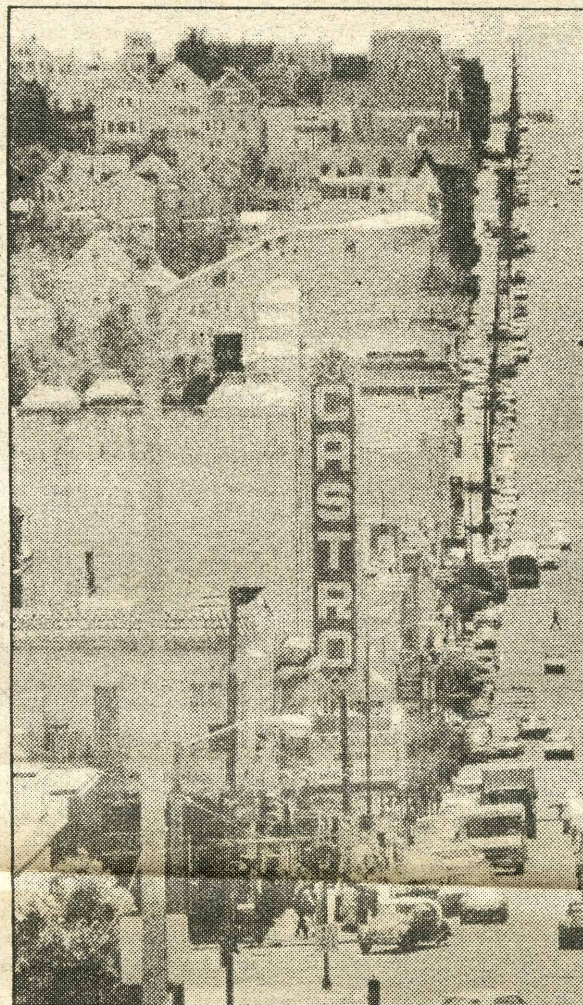
The same night as the show at the church, there was another sign of the times, at the Club Baths. Though gays jokingly refer to the 8th & Howard site of the libidinous facility as "AIDS & Howard," fears of the disease didn't stop a brisk business that night. In fact, after a summer of trepidations, many gay men were returning to the bathhouses and resuming the type of promiscuous sexual activity that, scientists say, may be a prescription for death.

While some sleaze centers were folding up shop last year — such temples to perpetual indulgence as The Hothouse and The Balcony — business is booming again in bathhouses and gay cruise bars. Men, hundreds and hundreds of them, can be found there every night, many under the influence of substances that make it doubtful they're pondering the Public Health Department's AIDS risk-reduction guidelines.

"Fear does not last as a motivating factor," says Leon McKusick, a psychotherapist who has spent much of last year researching how gay men have reacted to the AIDS epidemic.

"There was a rush of fear when AIDS first hit the headlines last summer, but it has become something like people who are afraid of dying of lung cancer because they smoke," says McKusick. "The fear may work for a while, but it doesn't keep people from smoking. The scare tactics aren't working anymore."

At Operation Concern, one of the gay community's major social service groups, Dr. Sam Pichotto has spent much of 1983 leading therapy groups for gay men. Many of them are so fearful of AIDS that they develop psychosomatic symptoms of the malady. After months of such anxiety, however, he's also seeing recent backsliding among young men unable to leave



The gay community reacts

the fast lane, the only lifestyle some have known.

"You find two different types of response among men," says Pichotto. "One man deals with his anxiety by finding a lover, building a support network and changing his lifestyle. Another isn't able to find this kind of substitute for his old lifestyle.... A person can only stay anxious so long; when the anxiety goes down, they tend to let their guard off. They slip back."

To be sure, evidence abounds that many gay men are working arduously to create a new gay urban lifestyle that takes into account the perils posed by a usually-deadly, sexually transmitted disease. Non-sexual social alternatives like the Castro Country Club, where gay men play checkers and watch "Dynasty" in an ambience devoid of drugs and alcohol, are prospering. Gay Alcoholics Anonymous groups are being flooded with newly health-conscious members.

Some gay men are sublimating their sexuality into less dangerous pursuits. Private clubs — The Cauldron is one — have found popularity by sponsoring nights with sexual activity where partners do not exchange the bodily fluids that may transmit AIDS. This "Boy Scout sex," as some gay men call it, is making a come-

back. Video salons in the gay community report a dramatic surge in rentals that feature nude actors. Also popular are new "telephone sex" services, which provide lusty men with the chance to talk to professionals well versed in erotic fantasies, all timed and charged to Visa or MasterCard.

The change in lifestyle represents the most dramatic shift the gay community has undergone since the development of contemporary gay neighborhoods in cities across the country during the early 1970s. With sweaty palms and sleepless nights, gay men have spent much of last year being petrified, terrified and preoccupied with all things relating to their immune systems. They've crowded into therapy groups on "AIDS anxiety" for the "worried well." They race fearfully to their doctor's offices at the hint of pimples that might, just perhaps, be Kaposi's sarcoma lesions.

Given the long incubation period for AIDS, it's too early for such changes in behavior to show up in the rates of AIDS cases, which are still soaring. Public health officials in San Francisco, however, said changing sexual habits could well be behind the plummeting rates of gonorrhea among men at the end of last year.

The social impact of this scourge on the gay community can't be so easily quantified; it has attained a profound psychological dimension. AIDS has brought something of a premature mid-life crisis to the collective gay community, even for the men whose behavior seems oblivious to the plague. Death, disease and mortality have come to a subculture that, even more than mainstream society, has worshiped youth and beauty. The past is tinged with regret; the future seems uncertain. For one man, this means getting serious and buckling down; for another, it means frenetically grasping at lost youth.

"In their 40s, most men see friends start dying of heart attacks — they realize they too are vulnerable and they're going to die," says McKusick. "This is happening now in the gay community, except to men in their 20s and 30s. You get some people going wild, but then others carry on their lives in a more compassionate and meaningful way. If there's any silver lining, it's that many, many people are experiencing new depths to their own emotions, depths they never knew they had before. They're growing immensely."

'You tell me what to do this Saturday night," says Danny, a 34-year-old gay man who has lived in San Francisco for eight years. He's embarrassed that he still goes to bathhouses, but he hasn't figured out how else he can spend his weekends.

"I know what can happen," he concedes. "It's just that when it gets to be 10 o'clock on Saturday night, I get that impulse, and after a couple of beers I think that one more time won't hurt, and..."

His voice trails off.

Danny does not feel he has grown immensely because of AIDS; instead, he just feels hassled. Changing his lifestyle today means changing the only way of socializing he has ever known. Efforts to adjust his lifestyle end up like so many broken New Year's resolutions.

This gets to an unpleasant truth that most gay leaders would prefer not to discuss. Though many wholesome alternatives exist within the gay community, many gay men are attuned only to a fast-lane lifestyle. This goes a long way in explaining not only

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GAY REACTION

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why so many are having such a tough time changing their sexual mores, but also why AIDS was able to so quickly proliferate in San Francisco.

There is an irony to it all. After all, throughout the early 1970s, gay political leaders spent years arguing that homosexuals certainly did not fit the old stereotypes of depraved, drugged-out, alcoholic, promiscuous, sex-obsessed men with penchants for kinky sexual acts.

The success of this argument brought a liberal atmosphere to San Francisco that enticed gay men from all over the country, tens of thousands of them, to move here. Because many gay men came drawn from backgrounds in which they'd never had a chance to experience the basic adolescent courtship and dating rituals, there was an adolescent emphasis on sex. They had a lot of catching up to do. The immigrants practiced a lusty lifestyle, like sailors on shore leave after years before the mast. They told themselves that they weren't cavorting any more than heterosexual men would if they had willing partners. They were just men being men.

By the mid-1970s, promiscuity was less a lifestyle than an article of faith. Some gay theorists even saw sexual promiscuity as a step toward broader political freedom. Before long, an entire subculture and business network grew up, catering to drugged-out, alcoholic, promiscuous, sex-obsessed gay men with penchants for kinky sexual acts.

San Francisco's many spacious bathhouses were unprecedented businesses in that they were created solely for the purpose of quick multiple sexual contacts, often accomplished without speaking so much as one word. In sex palaces like The Hothouse off Folsom Street, a man might reserve a room for an entire weekend. With a supply of methedrine, he could spend up to 48 sleepless hours in sexual euphoria. Every weekend, discos pulsated with dulling, synthesized

music well after sunrise.

At the zenith of the new, unabashed gay subculture of the late 1970s, all-night parties became the rage. Every major homosexual high holiday — from New Year's Eve to Valentine's Day, Gay Freedom Day and Halloween — featured an all-night party in a fashionable locale, such as The Galleria. The late-late hours were made possible by ample supplies of drugs: LSD and MDA, speed and cocaine.

The patrons of the bathhouses and all-night discos certainly were only a fraction of San Francisco's gay men. But even 10 percent of, say, 100,000 gay men in San Francisco would add up to a massive fast-lane subculture: 10,000 men. Though stricken by wave after wave of progressively more serious sexually-related diseases — from syphilis to hepatitis to pandemic levels of amebiasis — the party jived on.

Then came the deaths that nobody could explain. There was the baffling illness of Michael Maletta, the man who pioneered all-night gay parties; within months, he was dead. "Gay cancer" struck Patrick Cowley, the brilliant 32-year-old record producer who wrote the disco music for the all-night parties. He died in 1982. By the time the man who sold \$6 bottles of amyl nitrate at the seedy Ambush bar on Harrison Street got sick last year, people knew the syndrome as AIDS.

The entire scenario was ripe for many small tragic tales. Richard Brian Herbaugh, a 29-year-old from Seattle, was among the thousands who moved to Gay Mecca. About a year ago he noticed tell-tale purple spots on his body. A doctor quickly diagnosed the spots as the lesions associated with Kaposi's sarcoma, the skin cancer common among AIDS patients.

The way his acquaintances later told the story, Herbaugh was a loner with few intimates. His life, like the lives of so many others, didn't have much time for socializing. Once finished with his working hours at the Emporium, Richard spent much of his free time at the Club Baths on Howard Street, where, a roommate later recalled, he would stay all night and "take on all comers." Once diagnosed with AIDS, he sat down in his Clayton Street apartment and wrote a note.

"I can no longer stand the pain. My head constantly hurts... I am weak and no one to touch, to hold, to cry on. Oh my loneliness. The void. I sigh."

Richard Herbaugh folded up his note, walked six blocks to a secluded glen of Golden Gate Park and hanged himself.

"Maybe this wouldn't have happened if I had liked myself more," he wrote in the note found near his body.

Lying in his designer sheets, in his comfortable apartment above Castro Street, Gary Walsh smiles as he ponders the fantasy he's so frequently had in the long months he's spent lying in bed. He'd like to go to a park down the street, he says, and toss dimes, quarters and half-dollars — unexpected treasures — to the children who play there.

Gary's face is pale now, after fighting the onslaughts of a half-dozen AIDS-related diseases. When he's reminded that he is a psychologist who should be able to interpret his own fantasy, his eyes still shine. For the children, coins would be treasure. For Gary, the treasure is more elusive: health.

"Sometimes I think of what it would be like if they found some silver bullet to end this," sighs Walsh. "There'd be dancing on Castro Street. It would be behind us, like a bad dream."

The bad dream is not fading away; Gary is. He had come to Castro Street a decade ago, when being gay here meant being a part of a certain idealistic vision. Now, after finding professional success and personal fulfillment, he lies in bed, wondering which infection will put him in the hospital next time, and whether that will be the last time.

"I feel I have learned a lot about gay love from this, not gay sex, but the true vision of what we were talking about in the beginning — standing together, helping each other out and being proud of who we are, against all odds," he says.

As the fading sunlight falls across his face, he adds, "Of course, nobody had planned on this."

EPIDEMIC OF FEAR

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thought I had polio every year, every time I got a headache."

In a climate of uncertainty, the experts say, rumors and superstitions flourish. The cry of "Epidemic!" goes up. Social mores may change suddenly to accommodate fear and minimize the risk of contracting the illness. If medical science is unable to provide the public with a clear villain, the panicky healthy will often come up with their own answers.

In the 14th century, for example, when the Black Death swept through Europe, medieval "plague doctors" touched their patients only with long sticks. Unaware of how the sickness was transmitted, they threw open the windows in the houses of the dying and wore strange and elaborate suits of armor — equipped with long beaks filled with aromatic herbs — to try to purify the air and avoid contamination.

When a ready-made "outgroup," such as the gay community, is linked with the illness, ignorance and anxiety often feed prejudice and suspicion, scientists say.

"There is a history in the West of the notion of disease as retribution," says UCSF research fellow Barbara Koenig. "If you were a member of an African tribe sitting under your granary just as the termites ate through it, your first thought would not be that it was coincidence; you would first think about who did it and what caused it to happen."

"That's why there's been such a fundamentalist

Christian reaction to AIDS," says Koenig, a specialist in medical ethics. "They are opposed on Biblical grounds and believe that sin brings on disease. As a nurse, I know that is frequently a problem today, and it's still a problem with disease. Although people can say they just happened to get sick, they still wonder what they did wrong to cause it." Scapegoating and its companion

Scapegoating and its companion, 'blaming the victim,' are ways of pushing away the fear

ion, "blame the victim," are also ways of pushing away the fear, the experts say. We need to be assured that the world works in some rational way, not in a random, hodge-podge manner out of our control.

The fact that AIDS primarily occurred in the homosexual population, says Thomas Pettigrew, a UC sociologist and expert on prejudice, has not served to

reassure people that they are less likely to get sick, as might be expected. Rather, "It seems to enforce what they thought anyway about gays. People can say they got what they deserve, or if they'd just straighten up and fly right they would be all right," he says.

Stigma and prejudice tend to foster wrong-headed beliefs about the target group, says Pettigrew. There was a great hue and cry in the South, for instance, when people wanted to build swimming pools to accommodate both blacks and whites.

"If you pressed people on this," he says, "the theory turned out to be that blacks were diseased. If you pressed people on what the disease was, they would say 'Syphilis.' Now, indeed, the syphilis rates for blacks at the time were slightly higher than for whites; but they certainly weren't going to get syphilis in the swimming pool."

Many people, including public health officials, believe the AIDS panic is now over. Yet people still move away from gays at movie theaters.

AIDS has changed things, and there may still be changes to come. If nothing else, we are reminded that infectious disease is not a thing of the past.

"The point all this makes," says AIDS specialist Dr. Marcus Conant of UCSF, "is that we just aren't set up for a real public health disaster. We're prepared for war, or natural disasters like earthquakes or floods, but not for a brand-new infectious disease."

"We should use this as a model," Conant says, "and not make the same mistakes again. Because plagues most certainly will happen again. Man is a biological system, and we are always going to be attacked by infectious diseases."

MEDICAL MYSTERY

Continued From Page 12

gist at the National Cancer Institute, "The evidence that AIDS involves an infectious agent is compelling although circumstantial." He believes that infectious "co-factors," such as the interaction between two or more different viruses, may play a role, and that non-infectious factors are also involved in suppressing the immune system.

These other factors could include repeated exposure through the blood stream to semen and sperm cells that depress the ability of disease-fighting white cells to reproduce; repeated infections from sexually transmitted diseases like syphilis and gonorrhea; "recreational" drugs like marijuana; a history of severe malnutrition; and even a genetic predisposition to lowered immunity.

In the gay community the AIDS toll is greatest among young men who have had scores — if not hundreds — of anonymous sexual encounters, and particularly men whose experiences include oral-anal sex or who have acted as passive partners in an anal sex activity known as fisting. Physicians know that delicate anal tissues are extremely susceptible to tearing — and therefore can be a source of contact with blood, as well as a portal of entry for immunity-suppressing semen and sperm cells.

U.S. Public Health Service experts and physicians who have treated many AIDS patients have listed the most logical recommendations for preventing the lethal problem:

- ☐ People should avoid sexual contact with persons known or suspected of having AIDS. Having multiple sex partners increases the AIDS risk, and so do oral-anal contact, genital-anal penetration and similar practices. Condoms are a must, to prevent direct contact with blood, semen or other body fluids from potential AIDS carriers.
- ☐ Members of population groups at increased risk for AIDS should refrain from donating plasma or blood.
- ☐ Intravenous drug users should never share needles.
- ☐ Physicians should administer blood transfusions only when medically necessary, and should encourage surgical patients to allow their own blood to be drawn before an operation for possible transfusion after surgery.

In research laboratories all over the country today, scientists from many disciplines are trying to ferret out the elusive cause of AIDS.

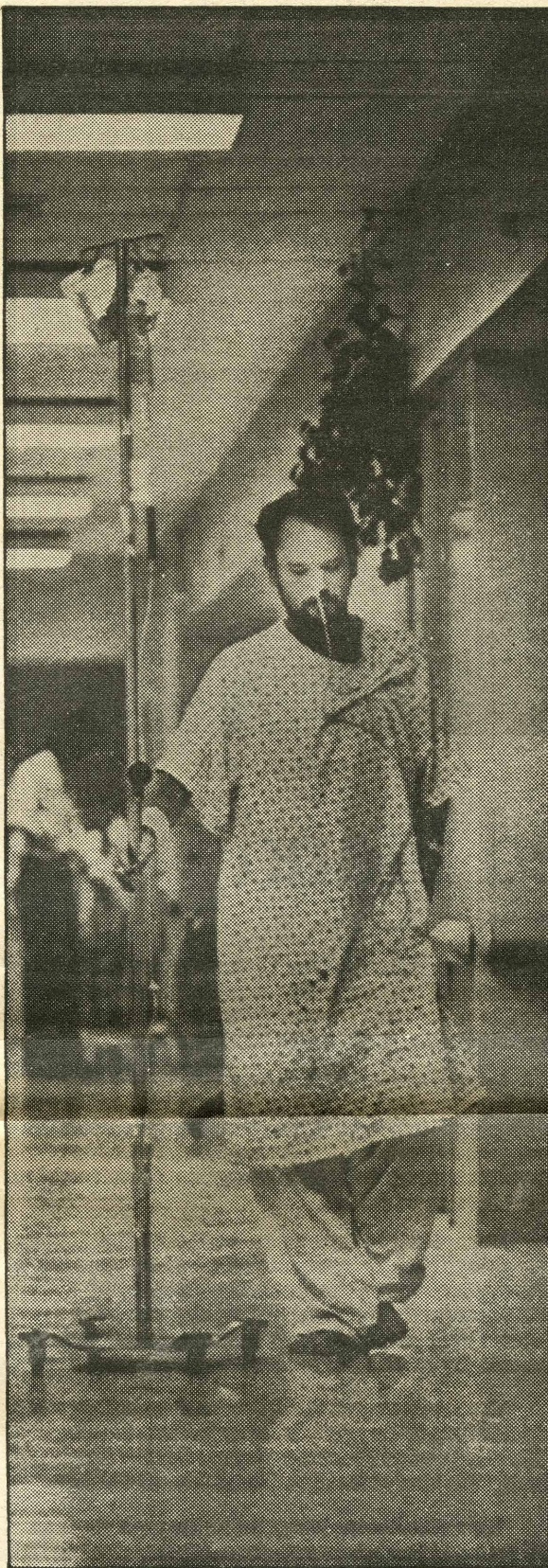
Some, like Dr. Jay A. Levy and John L. Ziegler in San Francisco, believe that whatever the AIDS agent may turn out to be, it can strike only victims whose immune systems have already been damaged by earlier assaults such as repeated viral infections, repeated bouts of sexually transmitted diseases or repeated treatments with antibiotics.

A small minority, like Dr. Joseph A. Sonnabend, a New York pathologist, argue that there is no single AIDS agent, and that repeated infections plus sexual promiscuity and "fast track" lifestyles are responsible for destroying immunity.

Most researchers, however, continue to theorize that a single virus or perhaps one that has undergone a recent unsuspected genetic change will eventually be indicted in the crucial role as the infectious agent triggering AIDS.

The evidence that the primary cause of AIDS is a single transmissible agent, says Dr. Anthony Fauci of the National Institutes of Health, is so overwhelming "it hits you like a Mack truck." Among the leading viral candidates is cytomegalovirus (CMV), a major cause of congenital disease in infants, infectious mononucleosis in young people and severe pneumonia in adults.

Dr. Lawrence Drew of Mount Zion Hospital has found evidence of CMV infection in nearly 100 percent of all AIDS patients he has studied, compared with 70 percent in disease-free gay subjects. Evidence of past



Deotis McMath

CMV infection, apparently harmless, has been found in about half of a group of currently healthy subjects tested. CMV is also common among heterosexual men with a history of venereal disease, and the virus is known to be carried in semen and infected blood.

According to Dr. Martin S. Hirsch and Dr. Donna Felsenstein of Harvard Medical School, CMV suppresses the immune-fighting ability of white blood cells that are known as T lymphocytes, the so-called "helper" cells. The virus also increases the numbers of other white blood cells, called "suppressor" cells, which impede the functioning of the "helper" cells in the body's immune system. A decreased ratio of "helper" to "suppressor" cells is a key sign of AIDS.

Among other immunity-suppressing organisms that have been suggested as causes of AIDS is a virus known as HTLV, which is believed to cause some leukemias in humans by immobilizing the immune

activity of T-cells. Researchers detect HTLV in about 30 percent of AIDS patients.

Another suspect is the Epstein-Barr virus mentioned above, the organism involved in Burkitt's lymphoma and also in infectious mononucleosis. Some scientists even suspect an animal organism called a parvovirus, which causes lymph node defects, diarrhea and damaged white blood cells in dogs.

The discouragingly elusive nature of the infectious AIDS organism — if there is one, and whatever it is — strikes home in the most recent report from researchers who believe they have discovered a rare fungus as the cause of the syndrome.

A team from the National Institutes of Health in Bethesda, Md., reported in November that the fungus they detected in white blood cells from six AIDS patients released a substance similar to cyclosporin, a recently purified compound now widely used as an immunity-suppressing agent in kidney and heart transplant patients to keep them from rejecting their newly transplanted organs.

But Dr. Jay Levy at UCSF argues that the fungus is most unlikely as a culprit, because it fails to explain the AIDS cases in hemophilia patients. AIDS is most probably transmitted to those patients in the clotting substance they must use to prevent uncontrolled bleeding, and that substance — called Factor VIII — is prepared from blood plasma that has been finely filtered and freeze-dried. But fungus spores, Levy points out, can't possibly pass through the filters used in preparing Factor VIII. And therefore, he maintains, any presumed AIDS organism must be far, far smaller than a fungus.

So the frustrating search for the cause of AIDS — so essential to hopes for an ultimate cure and perhaps even a vaccine — continues.

Prospects for the permanent cure of the AIDS diseases are dim at best, although concerned physicians can use standard treatments to help victims temporarily, and support groups can assist them to cope with the devastating psychological impact of the problem.

In Kaposi's sarcoma, because radiation and many of the standard chemicals used in cancer chemotherapy also depress the immune system, they must be used only sparingly. Researchers have been experimenting with interferon, a natural human protein that is known to attack viruses and that has been used experimentally against other forms of cancer.

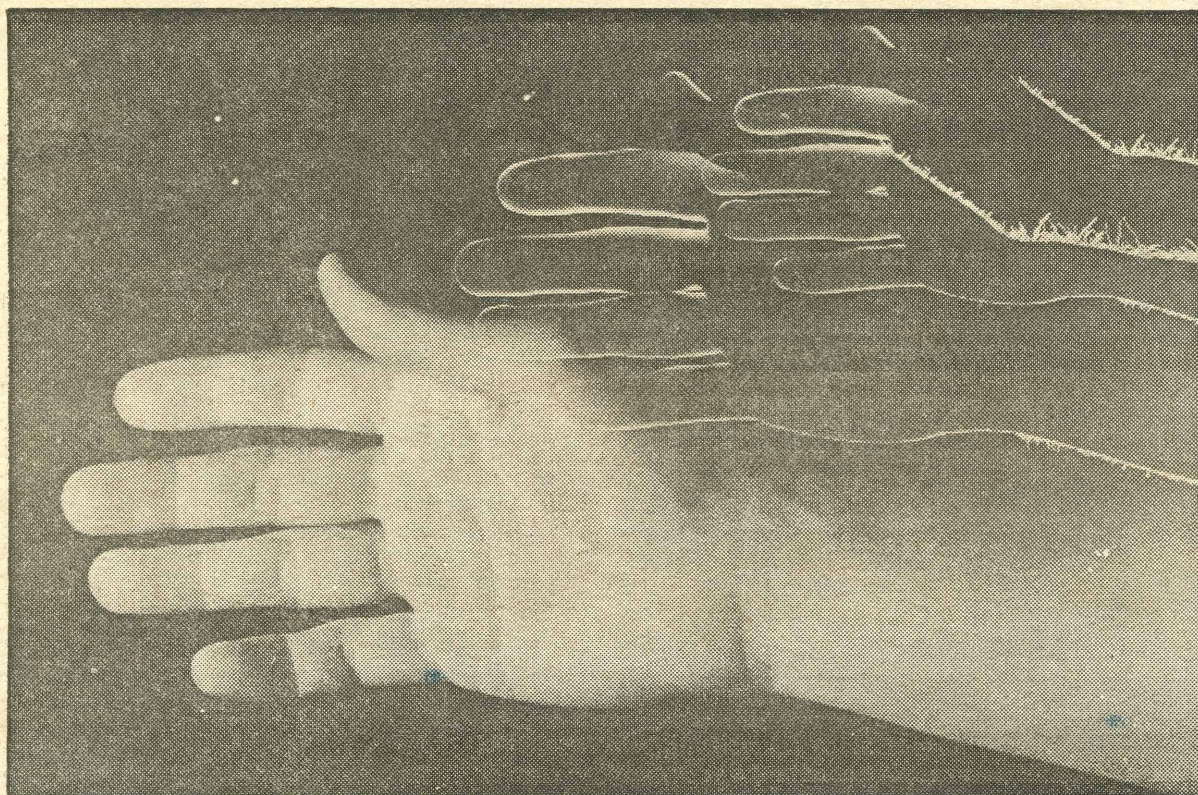
At San Francisco General Hospital, Volberding and his colleagues have been testing a form of interferon made by genetic engineering techniques. They report cautiously that the drug seems to induce a remission of the tumors in about 40 percent of the patients treated. Other medical centers are testing other types of interferon with similar results.

As for pneumocystis pneumonia, the standard drugs for treating other types of pneumonia are in use. But because the immune systems of these patients are so badly depressed, the drugs provide only temporary slowing of the disease.

At some research centers, physicians are trying to rebuild the immunity of AIDS patients with hormones derived from the thymus gland, a major center of the immune system, while others are testing a substance called interleukin-2 in the laboratory. Produced by normal white blood cells, interleukin-2 seems to restore the disease-fighting ability of white cells taken from AIDS patients. This research, however, is only in its earliest stages as yet.

Despite all the focus of public and medical attention and the slowly increasing level of government funding — an estimated \$41 million in research funds this coming year from the National Institutes of Health — AIDS is still the world's most puzzling medical mystery.

It is also, as one physician has called it, "an epidemiological, diagnostic, therapeutic and political nightmare."



STEVE RINGMAN

An Outstretched Hand

END PAPER

BY NORMAN C. NEWHOUSE

A few weeks ago, Terry and I were standing in line on Van Ness to get movie tickets. She saw a friend of hers, and they exchanged enthusiastic hellos. She introduced me and then asked about someone else: "Is he back yet?"

"Just got back last night. We're in line around the corner."

"How is he?" Terry asked.

"Good, great. We're going for pizza after the movie. Want to join us?"

Terry and I had met at a party the week before and were just getting acquainted. I could tell, though, that these were good friends of hers and that she was interested in seeing the man who'd been away. I said that pizza after the movie sounded fine.

We got through the turnstile and bought our popcorn, took off our jackets and settled into our seats. Terry said to me, "The guy I introduced you to outside... he's gay."

"Uh huh," I said.

Terry said, "His roommate — actually, they're more than roommates — they've been together for years. The guy in line around the corner... has AIDS."

I said, "Oh."

"If you don't want to meet them for pizza after the movie, that's all right." She didn't seem to expect an immediate answer, and I didn't know what to say. The house lights dimmed, signaling the start of the movie, so I didn't say anything.

I've paid attention to AIDS, but it hasn't affected my life much. I've modified my habits a little, tending to stay out of gay stores and restaurants, and otherwise decided not to worry. I've listened to the reasonable-sounding doctors on TV saying that

ordinary social contact can't communicate AIDS. I've also listened to a reasonable-sounding nurse tell me that, in private, the doctors say not to take any chances because no one has any idea what's going on.

I watched the movie, but my mind groaned at having to decide what to do. I was afraid; then I argued with myself that my fear was unreasonable. I felt trapped, not wanting to take any risk but feeling I couldn't turn my back on a dying man. I didn't want to hurt the man's feelings.

I remembered myself as a small child standing on our garage roof. Terry reminded me of my younger sister, who stood on the ground below and said matter-of-factly that she didn't think I was going to jump. I jumped immediately thereafter and cracked a bone in my ankle. I'm a sucker for an "I dare ya."

The movie ended, the lights came on and we stood up. As I helped Terry slip into her jacket, she asked, "How do you feel about meeting my friends for pizza?" I said, "I'm kind of hungry. Sounds like a good idea."

We walked to the lobby, lingering until the man I'd seen and two others appeared. All three looked fit and healthy. I stood a half-step back and smiled woodenly as Terry said everyone's name. I instantly forgot, or never even heard, theirs. We had two cars and decided to meet at a place in the Marina.

In the car, Terry asked me if I was sure this was all right, and I said yes and then asked, "Now, which of them is the one with AIDS? They all look pretty healthy to me."

The man who had the disease was, I thought, the handsomest of the three — thick black, brushed hair, tanned skin, nice mustache — a bit of a Tom Selleck look-alike. "Gosh," I said, "he doesn't even look sick." "Yes," Terry agreed, "he doesn't look any different. I'm glad he's doing so well."

"How long's he had it?" I asked.

"About a year."

"Are they... are they doing anything for him?"

"He gets chemotherapy," Terry said.

The two of us fell silent. I wondered what it would be like sitting down, talking, eating.

We got to Chestnut Street and drove around looking for a parking place. Walking to the restaurant, I felt a knot grow in my stomach. I stayed quiet, hoping to not let my apprehension show.

The others had already arrived, and we were seated immediately. We were all crowded around a table that was too small for five, and I sat across from the man with AIDS. My skin began to itch as if bugs were crawling all over me. I hid my panic, the urge to leave that was almost uncontrollable.

The drink order came and I drank my beer in three quick swallows, needing the liquid courage. The alcohol spread from my belly toward my brain, numbing panic. I calmed down enough to look around and see that my companions seemed relaxed and unconcerned, chattering happily, catching up with one another.

I told myself that I could get up and leave if I wanted, but that I had decided to stay. All the same, I was relieved when, after some discussion of sharing a pizza, the man with AIDS said he wanted a different flavor and ordered a pizza-for-one.

I was able to calm down enough to be sociable, and our meal was congenial. The man with AIDS had just returned from a long trip to New York City with his family. He talked of the theater there. The third man in the group had been a waiter in an expensive Manhattan restaurant, and filled in the New York stories with local color and background.

The roommate got the best laughs of the evening, agonizing drolly about a house he and the man with AIDS owned and were remodeling — the cost and time overruns. He said they'd been living in a construction zone for two years and wore hard hats in the bathroom.

I joked about my difficulty starting a law practice in San Francisco and got a laugh when I estimated that probably as many as a third of the people in the theater that evening had been San Francisco attorneys.

Over the coffee, Terry and the others discussed friends and social events. We divided the bill and drifted out onto the street, a contented late-evening crowd splitting up and heading home. The night was unusually warm, starlit and windless. Our two groups were drawing apart, saying the assorted "bye nows," "Drive carefullys" and "See you soon." The man with AIDS stayed closer to Terry and me, his friends having moved a few steps along the sidewalk. Suddenly he fixed my eyes with his gaze, said "Good-by" and held out his hand.

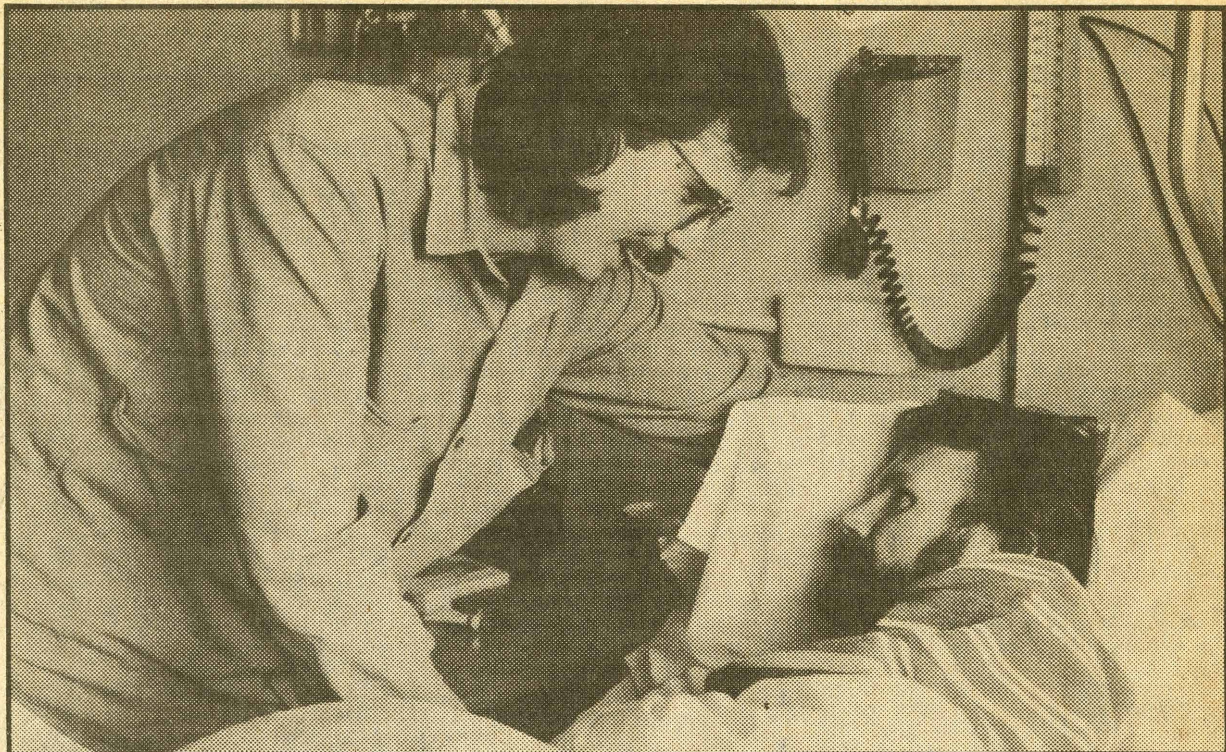
Time switched from motion picture speed to a series of still frames for me. I saw the two men in midstride, Terry half-turned, the hand stretching toward me. I realized I could ignore the hand, simply say good-by and walk away. Then, I didn't want my hesitation to be obvious. I guess I was the little kid on the garage roof again. I took the hand, making my grip firm, and said, "See you again."

The still frame of that moment is vivid in my mind. I no longer believe the man was trying to infect me. I believe he was saying, "Thank you. Thank you for understanding that I touch my friends, my family, and that nothing's happened to them. I share a house with my roommate; he's not sick. I know I have an insane disease surrounded by insane fears, but I still want to live. Thank you for just trying to act naturally."

That's what I now believe the handshake meant. But, that night, I couldn't wait to get home and wash my hands.

A week after I met the man with AIDS, I went to dinner at a friend's and told the story of the handshake. At the end of my story, I noticed my friend's older brother, whom I'd first met that evening, looking at his right hand, the one I'd shaken two hours earlier, and holding it away from his body. He looked up at me, still holding the hand away, and said, "You know, you're crazy." He stood up and went to the bathroom, where he washed his hands.

Norman C. Newhouse is a lawyer in San Francisco.



The New York Times/Terrence McCarthy

John Lere, an AIDS patient, being attended to by Charles Cloniger at San Francisco General Hospital.

Ward 5B: A Model of Care for AIDS

By KATHERINE BISHOP

Special to The New York Times

SAN FRANCISCO, Dec. 13 — Even sitting exhausted in a chair in his room at San Francisco General Hospital, John Lere can still talk about how he likes to raid the communal refrigerator at night. Talking between breaths from an oxygen mask, he likes to joke that his primary care nurse, Charles Cloniger, is "like having Mom at home."

This is Mr. Lere's third stay at the hospital since he was diagnosed as having AIDS a year ago. And he has come to a conclusion about his hospital care. "I'd stay home and die if I couldn't come here," he said, referring to the Special Care Unit at San Francisco General Hospital.

Model Unit for AIDS Patients

The unit is believed to be the only one in the country designed especially for the care of AIDS patients. Known within the hospital and the larger community as 5B, for its location on the fifth floor, the unit and its companion outpatient clinic, Ward 86, represent the unusual response by this city's health care workers to acquired im-

mune deficiency syndrome.

The usually fatal disease, which so far is incurable, has ravaged homosexuals here, giving San Francisco the highest number of AIDS cases per capita in the nation. The city is second only to New York City in the number of diagnosed cases.

Health experts say that AIDS, which ravages the body's immune system, is transmitted by contaminated blood or semen. Groups at highest risk are homosexual men and hemophiliacs; 97 percent of the AIDS patients at San Francisco General are homosexual.

For health care workers, 5B represents a victory over their own fears of the disease. It also forces them to focus on their feelings about homosexuality and their role in caring for a group of patients who will most surely die.

"You feel a lot of anger seeing young people cut down," said the head nurse, Alison Moed. "But there is such a sense of love and basic human sharing here. It's a place where a disease has brought out the best in people."

Dr. Julie Gerberding, now the chief medical resident at San Francisco General, was an intern when the first patient with what has come to be known as AIDS was admitted in 1981. The patient was admitted with Kaposi's sarcoma, a cancer of the lining of the capillaries that is now commonly associated with AIDS. Back then, the case was treated simply as an unusual cancer, Dr. Gerberding said.

A year later, when she returned for her residency, Dr. Gerberding learned how to recognize AIDS and that it was an infectious disease. But health experts knew little about how the disease was transmitted, and that lack of information touched off a variety of feelings, ranging from concern to paranoia.

Cliff Morrison, a nurse who was assigned as the hospital's AIDS coordinator, said that San Francisco General initially isolated AIDS patients in rooms throughout the hospital with little direct care from a fearful staff.

Fears of 'Leper Colony'

Mr. Morrison, now the assistant director of nursing, said he originally opposed the idea of a separate ward for the AIDS patients, fearing it would be treated like a "leper colony" or "quarantine area" within the hospital.

But as the numbers of AIDS cases climbed into the hundreds in 1983, it became clear that San Francisco General, as the city's public hospital, would have to find a way to consolidate its resources for caring for patients.

Mr. Morrison undertook to set up 5B as a model ward.

The staff members were recruited from a group who volunteered to work in the ward.

Coordination was arranged with community support groups, including hospices for the dying and the Shanti Project, which provides volunteers for counseling, running errands and doing chores and also provides housing in eight centers around the city to assist patients when they leave the hospital. More volunteers came from among the city's homosexuals.

As in the rest of the hospital, a family member or "significant other," such as a lover or close friend, is allowed to spend the night in a patient's room.

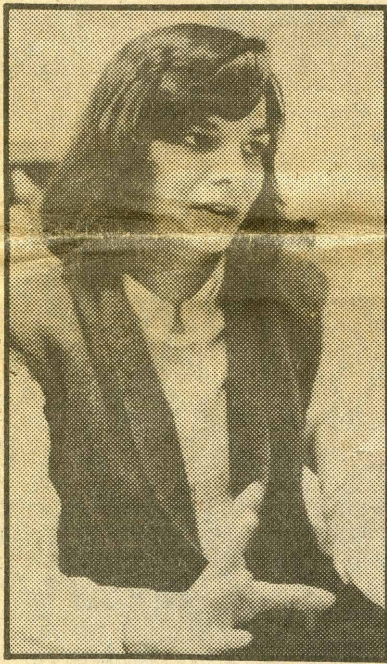
The staff members have become the subject of a study to learn more about the transmission of the disease. Dr. Gerberding is the chief investigator for the study, which is looking at more than 300 people who work in the AIDS ward or who have experienced a possible exposure to the virus, either from breaking the skin with a needle that had been used on a patient or from an accidental splash of a patient's body fluids into an open wound.

"Health care workers have more exposure to AIDS than anyone in the world," Dr. Gerberding said. In 18 months of evaluation, no health care worker who was not already in a high risk group for the disease, such as homosexual men, has been found to have antibodies that signal exposure to the virus. Her findings echo those from the Federal Centers for Disease Control in Atlanta.

"We don't treat the AIDS patients any different than other patients," Dr. Gerberding said. "Those who feel strong enough can move about the hospital and even eat at the cafeteria. Only those with weeping skin lesions or other contagious diseases are confined to their rooms. The staff does not normally wear protective gear unless the patients has a bad cough or they are handling patient's body fluids. Those are extreme precautions."

Knowing that they cannot heal their patients has focused the staff's efforts on the day-to-day needs or their patients, Miss Moed said. "There are a lot of ways in which we are impotent," she said. "We can't save them, we can't reverse the process and we can't mollify some of the terrible manifestations of the disease."

In such a situation, she said, "being sure that the patients have good care becomes a way of empowering ourselves."



The New York Times

Dr. Julie Gerberding, chief medical resident at San Francisco General Hospital, in her office.

A Bay Guardian investigative report

The sweetheart leases at SF General Hospital

Why is the private Gladstone Foundation still paying only \$1 a month rent for an ever-increasing chunk of space at an ever-more crowded public hospital?

B Y M A R Y B A K E R
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Since 1977, one of the nation's most prestigious private research laboratories has occupied a city-owned building at San Francisco General Hospital for just \$1-a-month rent, the Bay Guardian has learned.

The Gladstone Cardiovascular Laboratories has expanded three times in its nine years at General, more than doubling its floor space at the crowded public hospital, yet the city has never demanded an extra penny in rent. Based on the rent paid by other private research labs at General, the "sweetheart lease," as former city Health Director Mervyn Silverman called it, has cost the city more than \$1 million.

Hospital administrators and Gladstone officials say the city derives substantial benefits from Gladstone's presence at General. However, clinical staff members at General say Gladstone researchers contribute little to patient care at the hospital. And, with Gladstone planning yet another expansion, critics are beginning to worry that the private lab will compete with important public health programs for increasingly scarce space on the General campus.

Current city health officials said they were not familiar with the details of the arrangement. But when contacted by the Bay Guardian and informed of the situation, Public Health Director David Werdegard and Health Commission President Phillip Lee said they would investigate the matter. And two members of the Board of Supervisors said the lease arrangement might be legally invalid.

A touch of class

The Gladstone Laboratory is run by the Gladstone Foundation, a research foundation established through a 1971 trust by the late J. David Gladstone, a Los Angeles real estate developer. The laboratory does research into the cause and prevention of atherosclerosis, or the accumulation of cholesterol in the arteries. The foundation has an endowment of more than \$100 million.

Gladstone moved into Building 40, a 1915 brick building on the southwest side of the campus, nine years ago, after the city moved its patient-care facilities into newer, earthquake-proof buildings. At the time, former Chief Hospital Administrator Geoffrey Lang told the Bay Guardian, the city had no immediate use for the older buildings. Instead of leaving them vacant, he said, hospital officials decided to look for private research labs interested in moving to the General campus.

"The idea was to get some real class research programs in buildings that sat there vacant, and get more talent on the site at essentially no salary cost to the city," said Lang, who left the Public Health Department in April.

Gladstone was the first lab to accept the city's offer. Under the 1977 lease agreement, Gladstone agreed to assume the cost of renovating 15,000 square feet of space in the building — two floors — at a cost not to exceed \$1.5 million. "Actually, they did a lot more. They must have put millions into that building," Lang said.

In a separate operating agreement, the foundation agreed to "become associated with the hospital in the con-

tinuous active conduct of medical research," with the implied understanding, Lang said, that Gladstone researchers would be available to hospital staff for consultation and occasional clinical assistance.

More for their dollar

Gladstone was granted a seven-year lease at \$1 a month. Upon expiration, the lease was automatically renewable every five years. The lease agreement was approved by former Mayor George R. Moscone, the Board of Supervisors, hospital administrators and Deputy Chief Administrative Officer Paul Scannell.

Over the next nine years, the lease

was amended three times to allow Gladstone to expand. Today, the lab occupies some 33,000 square feet, more than double the amount in the original lease. The lease was amended in 1977, 1979 and 1980. In each instance, the amendments were approved by the mayor, the Board of Supervisors, the hospital and the deputy CAO. Yet the \$1-a-month rent has not increased.

Gladstone is not the only private lab with a \$1-a-month lease at General. In 1980, both the Rosalind Russell Arthritis Research Laboratory and the Rice Liver Laboratory moved into vacant hospital buildings under similar lease agreements. However, the Russell and Rice labs occupy considerably less space — 7,645 and 4,865 square feet, respectively — and neither has expanded beyond its original allotment.

The presence of the private labs is due in part to the complex relationship between San Francisco General and the University of California. Since the hospital's founding in 1870, General has been a primary teaching hospital for the UCSF medical school. According to the city's 1959 contract with the university, UC provides "house

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The double standard in rents at SF General

Starting Date	Lab	Space Occupied (per sq. ft.)	Monthly Rent	Rent Per Year	Total Amt. Paid*
1977	Gladstone Foundation	33,948 sq. ft.	\$1	\$12	\$108
1980	Arthritis Lab	7,645 sq. ft.	\$1	\$12	\$72
1980	Liver Lab	4,065 sq. ft.	\$1	\$12	\$72
1982	Infectious Diseases Lab	4,558 sq. ft.	\$1,248	\$14,976	\$59,904
1982	Gallo Research	11,326 sq. ft.	\$4,216	\$50,590	\$202,366
1983	Koret Nutrition Lab	3,580 sq. ft.	\$1,297	\$15,564	\$46,692

*Based on current rent levels.

This chart shows a two-tier rent standard for private labs occupying city-owned buildings on the SF General campus. Gladstone and two other private labs that signed leases prior to 1981 pay just \$1 a month rent. The three labs that signed leases in 1982 or 1983

pay rent based on the market value of the research space. Based on what the Gallo and Koret labs are paying, the \$1-a-month Gladstone lease amounts to a \$160,000-a-year loss to the city.

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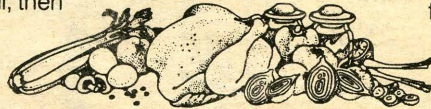
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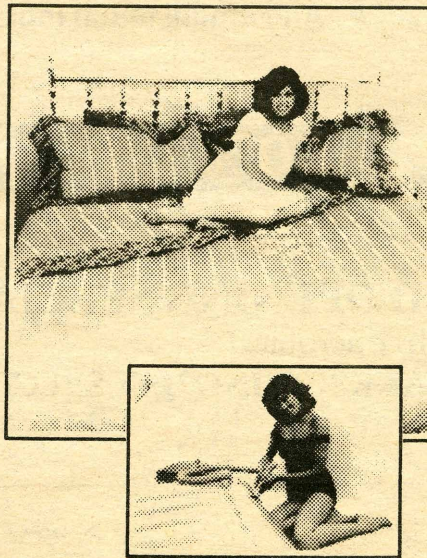
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— **Outpatient Clinic Director**
Dr. Dick Fine

continued from page 7

The Gladstone difference

The 'quid pro quo'

Health officials say Gladstone, with some 33,000 square feet of space, pays less than some other laboratories because of the benefits General derives from the facility. The main "quid pro quo," as Public Health Director Werdegarr describes it, is the physical improvements Gladstone has made to the property. According to Mahley, since the late 1970s the foundation has sunk about \$7 million into the renovation of vacant hospital space for its offices. The foundation now occupies four floors in Building 40.

Clinical role 'virtually nil'

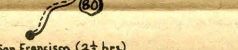
Rapaport, who is also chief of cardiology at General, said the majority of Gladstone researchers study cellular biology and do not work closely with

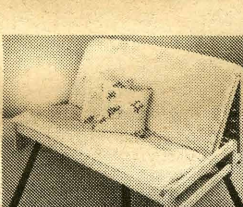
Another expansion plan

Mahley said the foundation is promising to build a new 1,500-square-foot laboratory to lure the coronary disease

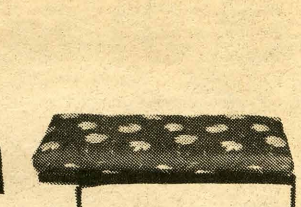
Fine agreed that there is "a desperate crunch for out-patient space" at General. The space that the ATU has occupied, he said, is already earmarked

continued page 11

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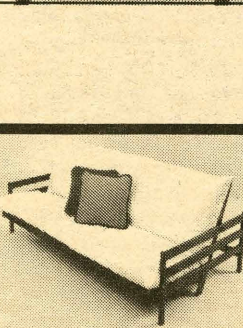
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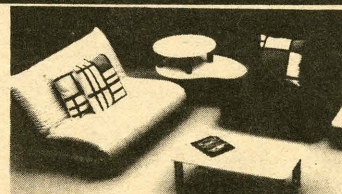


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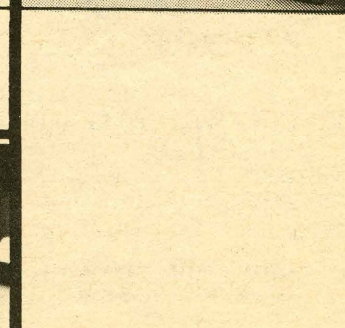


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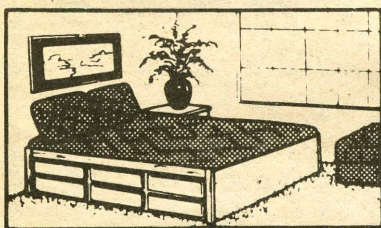
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Dir: Hwy 101-ARMY ST. east-Rt on EVANS-Rt on TOLAND ST-Rt on TOLAND PL (just after BofA)

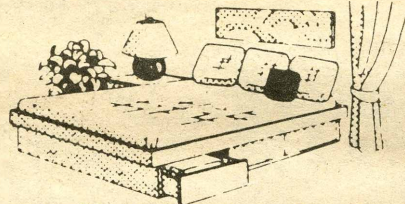
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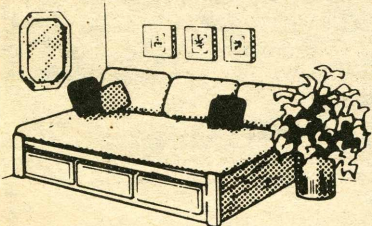
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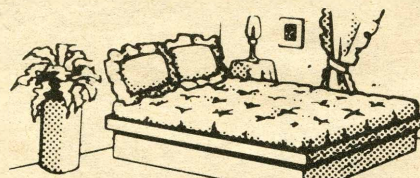
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POLITICAL ALERTS

(Of saying no to war toys and
drug tests)

Santa Claus is an arms dealer: Camouflage fatigues for designer dolls, Rambo dolls equipped with M-16s and artillery lasers, missile systems, machetes, rockets, cannons, miniature soldiers and helicopters, all with their connotations of killing and destruction, are making their usual appearance on toy store shelves this holiday season. The SF-based **War Resisters League/West** is urging gift-givers to avoid filling stockings with the model arsenals. And it has planned a two-day demonstration to educate shoppers about war toys. A meeting is planned for **Saturday/22** to organize leaflet distribution at toy stores during the **International Days of Protest Against War Toys, Friday/28 and Saturday/29**. "The militarization of children's toys is a kind of propaganda that affects all of us. It is what will make it possible and easier to send another generation of our young and innocent children off to die in another immoral war," explains WRL member Peggy Akers. 10:30 am, WRL office, Room 705, 942 Market, SF. Free. Info.: 433-6676.

The threat of urinalysis: Prohibitionist politicians and employers are planning to make drug testing a feature of their future platforms and hiring policies. The ACLU Right to Dissent Committee holds a forum titled "Drug Testing in the Workplace: What Are Your Rights?" on **Saturday/22**. Speakers include **Walter Johnson**, president of the SF Labor Council, **Daphne Macklin**, ACLU legislative advocate and **Nick Nichols**, of the National Treasury Employees Union. 10:30 am-1 pm, 1663 Mission, SF. Free. Info.: 621-2488.

Moore on Mother Jones: Michael Moore, who was recently fired after working as editor for four months at the SF-based magazine *Mother Jones*, and **Richard Shaufler**, who was released from the magazine's advertising department after one day allegedly because of his former connections with the **Democratic Workers Party**, speak **Friday/21** about the firings and their implications for the U.S. political left. Moore has charged that the firing was politically motivated and is suing the magazine for \$2 million. MoJo publisher **Adam Hochschild** says the dismissal was due to poor job performance and "bad chemistry" between Moore and the rest of the magazine's staff, and that politics had nothing to do with it. Shaufler has filed a grievance against *Mother Jones* through UAW District 65, the union that represents *Mother Jones* workers. The event is sponsored by **Open Forum**, a group described by organizer **Stan Woods** as a committee of left journalists, trade unionists and political activists. *Mother Jones* Managing Editor **Bruce Dancis**

Political announcements, inside information, legislative alerts and other items concerning the electoral and cultural machinations of power may be sent to: Political Alerts, San Francisco Bay Guardian, 2700 19th St., SF 94110. Be sure to include a daytime phone number where you can be reached. For dated material, please give us a 14-day lead time prior to the event.

he'd been invited by the organizers to debate Moore at the event. "I said if Moore's willing to drop his lawsuit against the magazine, I'll debate him anywhere at anytime." Questions and discussions will follow the talks. 7 pm, Longshoreman's Union Hall, 400 Northpoint, SF. \$3 donation, \$1 unemployed. Info.: 362-6649 or 655-1364.

Congratulations to Lowell Bergman and Raul Ramirez, who won a crucial California Supreme Court decision last week voiding a \$4.56 million libel judgment against the two journalists. Bergman, now a producer for 60 Minutes, and Ramirez, an editor at the Oakland Tribune, were sued by two SF police inspectors and an assistant district attorney over a 1976 series published in the SF Examiner about prosecutorial misconduct in a Chinatown murder case. Chief Justice Rose Bird wrote the decision, which saves Bergman and Ramirez about \$780,000 each and saves the Examiner \$3 million. The Examiner, let us not forget, urged voters to reject Bird's reconfirmation. If the case had come up just a few months later, the new Deukmejian-dominated court might well have sided with the plaintiffs.

Short takes: Friday/21 — Bikes, Not Bombs, a group dedicated to sending bicycles and spare parts to Nicaragua, holds the first of two slide shows featuring Carl Kurz, who founded the group. Reception, 6:30 pm, show 8 pm, Unitas House, College and Bancroft, Berk. \$3-\$5. Info.: 849-0237. . . . Rev. Peter J. Sammon, pastor of St. Teresa's Church; Carla Flores, a Catholic Social Services workers; and Hayden Perry, staff writer for the newspaper Socialist Action, discuss the new wave of oppression following the October earthquake in El Salvador. 8 pm, Room 308, 3435 Army, SF. \$3, \$1.50 unemployed and students. Info.: 821-0458. . . . SF photojournalist Adam Kufeld presents a slide show on the current situation in El Salvador in an event sponsored by Solidarity Publications. Kufeld spent six weeks in El Salvador last spring and returned for two weeks after the earthquake. 7:30 pm, Dolores St. Baptist Church, 203 Dolores, SF. Donation \$4. Info: 626-6626. . . . **Saturday/22** — Jack Mingo of the Couch Potatoes, an organization dedicated to watching television, debates Steve Wagner of the Society for the Eradication of Television. 5:45 pm, KALX radio, 90.7 FM. Free. Info.: 530-2056. . . . Bikes, Not Bombs holds its second slide show (see Friday/21). 8 pm, Media Center, Building D, Fort Mason, SF. \$3-\$5. Info.: 849-0237. . . . **Wednesday/26** — Entries are due for the poster contest conducted by the sister city program between Berkeley and Leon, Nicaragua. The Berkeley City Council declared Leon a sister city in July to create bonds of friendship between Americans and Nicaraguans. The winner of the poster contest receives \$50 in art supplies. The winning poster will be reproduced and sold to raise funds for humanitarian aid projects for Leon. Send 11-by-14-inch entries to: Nicaragua Information Center, 2103 Woolsey, Berkeley, 94705. Free. Info.: 549-1387.

— Charles Heimler

ON GUARD

continued from page 5

2.2-million-square-foot project, including two 28-story towers and one of 17 stories, on Eighth and Market streets opposite United Nations Plaza. "This thing is twice the size of God," said Supervisor Bill Maher, who with Supervisor Nancy Walker has sponsored legislation to downzone the area and cut the project size in half.

According to the Draft Environmental Impact Report on the project, released Nov. 7th, the project would violate at least nine different provisions of the City Planning Code, including height and bulk limitations and restrictions on shadowing public parks.

In fact, community activists say the project is so far beyond the bounds of reasonable planning policy they are amazed it is even under consideration. "Under normal circumstances," said Brad Paul, director of the North of Market Planning Coalition, "this thing would have been laughed out of town."

Circumstances, however, are not normal. Sangiacomo has hired Duane Garret — one of the most powerful attorneys in town and perhaps the single most important Democratic fundraiser in Northern California — to represent him.

Garrett, who rarely handles development cases, is a partner in the firm of Hanson, Bridgett, Marcus Vlahos and Rudy. He was one of the key fundraisers for Walter Mondale's 1984 presidential bid, and has helped raise money for virtually every Democratic official in San Francisco.

"We were glad at least to get the decision

postponed until after the election," Paul told the Bay Guardian. "Garrett raises money for just about every Democratic politician in town. At least now they won't be in the middle of running for office when he calls to push for this thing."

The Maher-Walker legislation would reduce the height limits for the project area from the current 240 feet to 90 feet on the perimeter of the block and 120 feet in the interior. The special PH&D hearing, open to the public, begins at noon in Room 282, City Hall, McAllister at Polk.

LETTERS

continued from page 4

Lemon's final defense of Nazism didn't strike me with the force of a personal moral confrontation — frankly, it seemed too ludicrous. I didn't, couldn't, take it seriously — except as an indication of the extent to which poor Lemon had been deluded — and by inference, some members of society whom I do not count myself among. I suppose that's what really disturbed me: The framing of the play seemed too antagonistic to the morally complacent to ever convince them. (We know how heinous were Kissinger's crimes, and Shawn knows we know, which partly determines our response to Aunt Dan's uncritical hero-worship.) Having said all that, I did find parts of the work, and much of the acting, compelling. But if this is great theater, I for one am disheartened.

— Kim Addonizio
San Francisco

San Francisco General's Building 40, home of Gladstone Cardiovascular Laboratories: Today, the lab occupies some 33,000 square feet — more than double the amount in the original lease — for \$1 a month.



GUARDIAN PHOTO BY GERALD GROPP

HOSPITAL

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for an out-patient clinic that would offer alternative drug-addiction treatments like acupuncture.

The squeaky wheel

Rapaport suggested that Gladstone has acquired more space in part because it has been more vocal.

"All the policies point towards the pressure for clinical services," Rapaport said. "But when you have qualified people, they are going to push for more space. They all may not be pushing as hard as Gladstone."

Moreover, he said, growth limits at UC's Parnassus campus have put pressure on researchers to find more space at General.

"There's a total freeze on the amount of space available at the Parnassus campus," Rapaport said. "Nobody's gone out and deliberately given Gladstone a special deal. It's been more fortuitous than anything else."

Gladstone's generous lease arrangements may also reflect the conflict between differing priorities among the two major institutions that share responsibility for SF General. Research has always played a key role at universities like UC, and it comes as little surprise that UC medical school officials would see a private lab that attracted top intellectual talent as an asset.

However, San Francisco General Hospital is more than a university facility — it's the city's public hospital, the only source of medical care for thousands of medically indigent adults in the city. And when clinical space becomes scarce, the city has to balance the needs of those patients with the less tangible benefits of a private research facility.

"We mustn't forget that the primary mission of the hospital is to take care of patients that have no other place to go," Krieger, the primary-care resident, told the Bay Guardian. "The hospital's role as a training institution ranks second in priority, and UC's research function ranks third."

Lee, president of San Francisco's Health Commission, said that since the late 1970s, the demand for clinical space at General has become more acute.

"When they first got that space, space was not an issue," Lee said. "But now it's at a premium. Now if you expand, you take away from somebody else."

Silverman agreed. "It isn't black and white. There's something to be said for having a medical center that draws money and intellect. A lot of the

benefits are intangible. But maybe it should be re-looked at."

Fine was more blunt. "In any other major city," he told the Bay Guardian, "Gladstone would be up at the ivory towers of the university."

Who's really in charge?

It appears that many of the decisions involving Gladstone's expansion were made not by top city health officials but by hospital administrators. In fact, some city health officials told the Bay Guardian they knew little or nothing about Gladstone's lease at the hospital.

According to Health Commission President Lee, the lease arrangements for the private labs always have been considered "administrative" matters, handled by hospital administrators with little oversight from the head of the health department or from the commission.

Under the terms of the 1977 agreement, Gladstone's lease expires every five years — but it is renewed "automatically" unless either party gives written notice one year or more prior to expiration. It was renewed most recently in April 1986.

Werdegart, the city's health director since January 1985, said he was not present at Gladstone's latest lease-renewal signing because it was never brought to his attention.

"This \$1-a-month arrangement happened well before my time, but it was a function of the quid pro quo relationship between the university and the city," Werdegart said. "Looking back, it's probably not an unreasonable arrangement."

Although Boas was the city official ultimately responsible for the Gladstone lease, he admitted he was not aware it had been amended three times since 1977 to include more space. However, Boas said, he was involved in the 1981 decision to stop offering the \$1-a-month leases. At the time, Boas said, the issue of whether rents should increase was a point of disagreement between him and the former Dean of UC Medicine Julius Krevans, now the university chancellor.

"I told him we should get the maximum dollar, and Krevans said that would hurt the labs," Boas said. "The argument went back and forth. But in the end, fair market was charged."

A telling symptom?

Supervisor Quentin Kopp, who sat on the board when the original lease was approved in 1977, said he vaguely recalls the lease agreement. However, he said, if the Board of Supervisors approved the original lease, it should have approved the renewals as well.

"If they've taken up more space

there are some serious questions," Kopp said. "If the terms have been broken, we can break the lease. There should be a careful scrutiny of what's occurred."

Supervisor Nancy Walker, former chair of the Health Committee and board president-elect, agreed. "It's questionable whether the lease is even valid," Walker said. "The obvious first place to raise questions would be at the city Health Department itself."

After consulting with the city attorney's office, Werdegart told the Bay Guardian he'd like to be advised the next time Gladstone expands. And Lee said the Health Commission also should take a look at the lease arrangement.

"Certainly, if they're asking for more space, the lease should be taken a look at," said Lee. Lee noted that recently, when the hospital faced increasing demands for AIDS research and in-patient care at General, the commission asked for and received money from the State Legislature to build new in-patient AIDS facilities at General, "to prevent any more intrusion into patient care."

"The demand for clinical space has increased significantly over the past two years with federal and state cut-backs," Lee said.

Lee said one possibility would be to calculate what Gladstone would have paid in rent over the past nine years and "see if the city has gotten its money's worth. There's got to be some point when they've got to take a look at it."

However, Mahley said the lab owes the city nothing. "If they gave us a deal, then we have given back generously," said Mahley. "As the first one out here, we had to make something of nothing and show the rest of the institutes it could be done. When we set up, these buildings were abandoned and filthy."

Meanwhile, some health activists suggest that the Gladstone lease deal is typical of a larger problem — the cozy and largely undefined relationship between the city and UC.

It was exactly this sort of problem, Walker said, that led her to sponsor the successful ballot initiative shifting control of the Health Department away from the CAO's office and placing it under the Health Commission. The Gladstone lease, she said, raises questions about whether the new oversight procedures are functioning properly.

"Theoretically, if the lease was renewed, the city Health Department should have reviewed it," Walker said. "It appears some of the checks and balances we set up to prevent abuses and sweetheart deals from going on haven't been working."

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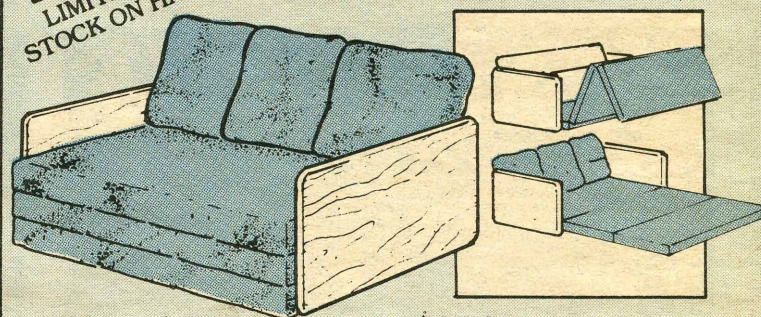
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