LETTERS FROM PV JUL-SEP 1987

AMERICAN
FOUNDATION
FOR AIDS
RESEARCH

9601 WILSHIRE BOULEVARD
MEZZANINE
LOS ANGELES, CA 90210-5294
(213) 273-5547

MEMORANDUM

YOU HAVE BEEN ASSIGNED THE FOLLOWING REVIEWS AS SECONDARY REVIEWER

000320 TITLE: Inhibitory Human and Murine Monoclonal Antibodies to HIV
IMMUNOTHERAPY
PI: David B. Duggan , M.D. NO APPENDIX
INST: State University of New York Health Science Center , Syracuse , NY
REVIEWERS: VOLBERDING PURTILO

000389 TITLE: Phagocytosis of Opportunistic Mycobacteria in AIDS
COHIV OTHER OIS
PI: Marcus A. Horwitz , M.D.
INST: University of California, Los Angeles , Los Angeles , CA
REVIEWERS: VOLBERDING LOURIA

Reviews sent in 7/17/87 - E.
On Eileen's Disk #2

AMERICAN
FOUNDATION
FOR AIDS
RESEARCH

9601 WILSHIRE BOULEVARD
MEZZANINE
LOS ANGELES, CA 90210-5294
(213) 273-5547

MEMORANDUM

YOU HAVE BEEN ASSIGNED THE FOLLOWING REVIEWS AS THE PRIMARY REVIEWER

000280 TITLE: Enhancement of Blood-Brain Penetration by AZT and Analogs
R & D ANTIVIRAL THERAPY
PI: Jerome Horwitz , Ph.D.
INST: Michigan Cancer Foundation , Detroit , MI
REVIEWERS: VOLBERDING YOUNG

000302F TITLE: Fellowship Application
FELLOWSHIP
PI: Jonathan C. Goldsmith , M.D. NO APPENDIX
INST: University of Nebraska Medical Center , Omaha , NE
REVIEWERS: VOLBERDING LEVY

July 23, 1987

PERSONAL AND CONFIDENTIAL

Robert L. Anderson
Anderson, Galloway & Lucchese
1676 North California Blvd.
Suite 500
Walnut Creek, CA 94596-4642

Dear Mr. Anderson:

Thank you for your note of June 10th regarding the upcoming trial in SIMS vs. SILVERS.

I am more than happy to testify, but I am a little concerned about the trial date. Our third baby is due on October 4th; one day before the trial, the date that you have set for Hayward. It is easily possible that events closer to my heart might prevent me from making it to Hayward. How flexible is the trial date and my time of appearance therein?

Please let me know. I assume this won't interfere with my working with you.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

ROBERT L. ANDERSON
G. PATRICK GALLOWAY
DAVID R. LUCCHESE
MARTIN J. EVERSON
THOMAS J. DONNELLY
RALPH J. SMITH
JAMES M. NELSON
CATHLEEN A. WADHAMS
SCOTT E. MURRAY
ELIZABETH TYLER WATKINS
DAVID A. DEPOLO
ANDREW ALEXANDER DOSA

ANDERSON, GALLOWAY & LUCCHESE
A PROFESSIONAL CORPORATION
ATTORNEYS AND COUNSELORS AT LAW
1676 NORTH CALIFORNIA BOULEVARD
SUITE 500
WALNUT CREEK, CALIFORNIA 94596-4642

TELEPHONE 943-6383
AREA CODE 415

April 21, 1987

PERSONAL AND CONFIDENTIAL

Paul A. Volberding, M.D.
San Francisco General Hospital
Ward 84
995 Potrero Avenue
San Francisco, CA 94110

Re: **Chellie Sims (R.N.) vs. Jeffrey Silvers, M.D.**
Action No. H-108798-1, County of Alameda (Hayward)

Dear Dr. Volberding:

The above-entitled matter is now scheduled to commence trial in Hayward on Monday, June 8, 1987. If we are able to obtain a courtroom on that date, your testimony may be necessary in the course of the 3rd - 4th day of trial. As the date approaches, we will of course be in touch with you to apprise you of developments and in hopes of minimizing the inconvenience to you and your professional pursuits.

If you require a subpoena (as distinguished from our correspondence/ telephone arrangements) as to your appearance at trial, your earliest advices would be appreciated. Should you have any questions, please don't hesitate to call.

Yours very truly,

ANDERSON, GALLOWAY & LUCCHESE

By
Robert L. Anderson

RLA:se

ROBERT L. ANDERSON
G. PATRICK GALLOWAY
DAVID R. LUCCHESE
MARTIN J. EVERSON
THOMAS J. DONNELLY
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TELEPHONE 943-6383
AREA CODE 415

June 10, 1987

PERSONAL AND CONFIDENTIAL

Paul A. Volberding, M.D.
San Francisco General Hospital
Ward 84
995 Potrero Avenue
San Francisco, CA 94110

Re: **Sims vs. Silvers**

Dear Dr. Volberding:

The above-entitled matter is now scheduled to commence trial in Hayward on:

Monday, October 5, 1987 - Hayward

If we are able to obtain a courtroom on that date, your testimony may be necessary in the course of the 3rd - 4th day of trial. As the date approaches, we will of course be in touch with you to apprise you of developments and in hopes of minimizing the inconvenience to you and your professional pursuits.

If you require a subpoena (as distinguished from our correspondence/telephone arrangements) as to your appearance at trial, your earliest advices would be appreciated. Should you have any questions, please don't hesitate to call.

I enjoyed "seeing" you on Ted Koppel's Nightline on 6/5!

Yours very truly,

ANDERSON, GALLOWAY & LUCCHESE

By Robert L Anderson
Robert L. Anderson

RLA:se

copy

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 23, 1987

Scott Bougher
Attorney at Law
215 North Yakima St. Apt. 3
Tacoma, Washington 98403

Dear Mr. Bougher:

Thanks for your note of support about the composition of the President's Commission. I noticed in the New York Times the other day that he might in fact appoint a gay man to the Commission.

I sincerely hope so as I think the Commission would otherwise be unlikely to accomplish anything.

Thanks for your support.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

Scott Bougher
Attorney at Law
215 North Yakima Street, Apt. 3
Tacoma, Washington 98403

Dr. Paul Volberding
San Francisco General Hospital
San Francisco, California

June 1, 1987

Dear Sir,

I am writing in support of your protest against the federal administration decision not to appoint an openly gay person to the Presiden's new AIDS commission. I agree with you that the decision is a disgrace. I hope that your position on this issue will help cause the administration to change its decision. I am a "straight" male and I hope that other straight people will support you.

Sincerely,

Scott Bougher

Scott Bougher J.D.

P.S. My wife Janice asks that I mention that she too supports you. She does.

Copy

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SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 23, 1987

Joan C. Cassin
Assistant Editor
NURSING 87
Springhouse Corporation
111 Bethlehem Park
Springhouse, PA 19477

Dear Ms. Cassin:

Thanks for your letter regarding your question of confidentiality with respect to the AIDS diagnosis and nursing care.

I am concerned that some of the things that we do as a profession in the name of confidentiality protection, have, in the setting of AIDS, furthered the stigma that this disease causes in affected people. While I think our own studies and many others would say that the health care worker can take care of patients with HIV infection safely even without knowing whether or not the patient is infected. I think it is also true that the care of someone with AIDS is facilitated by the knowledge of that diagnosis on the part of the medical and nursing staff. Obviously, if the nurse caring for a patient does not know the underlying major diagnosis, he or she can play no effective role in the further education and support for the patient, with respect to that major disease process.

I would urge physicians and nurses to work together to share important information regarding the patients they are caring for to increase communication and improved patient care.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

Nursing87®

June 12, 1987

Paul Volberding, MD
San Francisco General Hospital Medical Center
1001 Potrero
San Francisco, California 94110

Dear Dr. Volberding:

We can surely appreciate how busy you are. However, we hope you'll take a few minutes to read the photocopied letter--and not the only one we've received like this--from a nurse who needs answers. We're counting on you, Dr. Volberding, to give us your expert opinion, so that we can give some answers to this nurse and others in her same situation. We're also asking a nurse lawyer for input as well.

From the beginning of the growing AIDS crisis, Nursing87 (the world's largest nursing journal) and our sister journal NursingLife have published articles encouraging quality care for these patients and protection for the nurses caring for them (sample articles enclosed). But how can nurses protect themselves if they're kept in the dark because of "medical confidentiality" and aren't told which patients have AIDS?

We're enclosing a stamped, self-addressed envelope. We hope to hear from you soon. And thanks.

Sincerely,

Joan C. Cassin

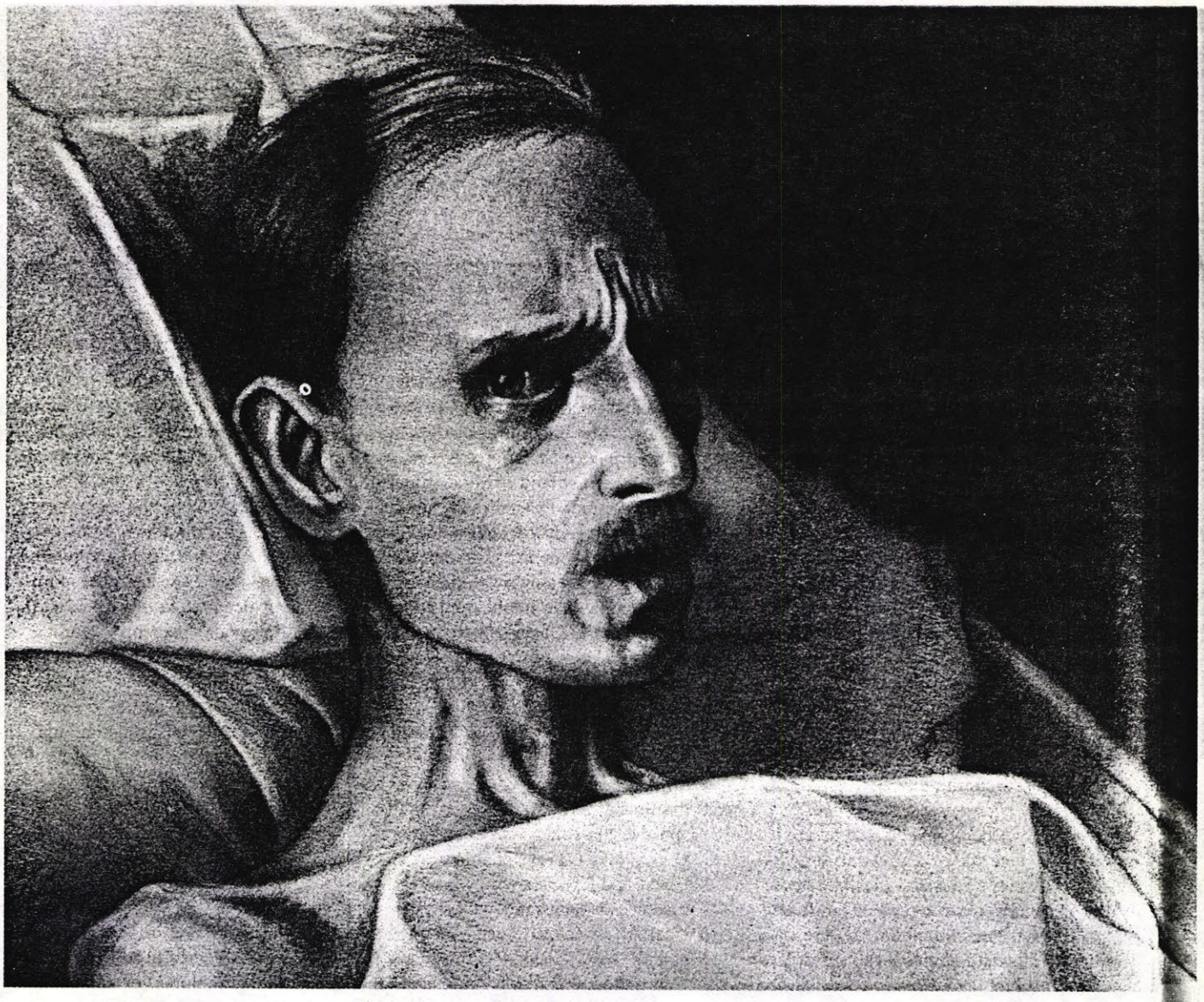
Joan C. Cassin
Assistant Editor

Enc.

I am an OB nurse in a small community hospital. Our clientelle includes many Hispanics, low income, drug abusers and those with multiple sexual partners. The nurses in our OB department are required to work L+D, Nursery and post partum.

One of the physicians has informed us that he is presently giving prenatal to three patients with A.I.D.S. He refuses to disclose the identity of the patients stating that they have a right to confidentality.

What are our rights as health care providers? Can we refuse to care for his patients? Do we have a right to know what we are dealing with in order to take appropriate precautions?



DAVID REINBOLD

ARE A.I.D.S. PATIENTS GETTING GOOD NURSING CARE?

AN AIDS PATIENT with severe *Pneumocystis carinii* pneumonia had lost 40 pounds and was near death when he was admitted to a Washington, D.C., hospital. Although he was too weak to feed himself, his nurses were so afraid of contracting acquired immune deficiency syndrome (AIDS) that they simply left trays of food in his room. He might have starved if another nurse hadn't noticed what was happening and called an AIDS social service agency.

But when two nurses caring for a hemophiliac with AIDS-related complex in a Chapel Hill, N.C., hospital found he'd suffered a cardiopulmonary arrest and collapsed in his hospital room, they automatically began mouth-to-mouth resuscitation. Each delivered 20 breaths before the patient was intubated.

As these true examples show, AIDS patients bring out the worst *and* the best in nurses. We've been told stories of paralyzed AIDS patients left lying on urine-soaked sheets, of infants with AIDS crying with hunger at children's hospitals, and of nurses calling patients "contaminated" or wearing full isolation garb to take temperatures.

Yet, we've also heard stories of nurses who held weeping AIDS patients in their arms and gave hourly back rubs to AIDS patients with intractable pain. On one unit, a semicomatose patient's family and friends had deserted him. So the nurses took turns sitting at his bedside and holding his hand, making sure he wouldn't die alone.

"We've had reports of excellent care and dedicated nurses in the same hospitals where we've had complaints about poor care," says Bob Tarbox, client representative for Gay Men's Health Crisis, Inc., in New York City.

So where does this leave us? Are most nurses who care for AIDS patients ignoring, neglecting, or even mistreating them? Or are they giving AIDS patients professional, compassionate care? We spent 6 months finding the answers to these questions. We asked nurses how they feel about caring for AIDS patients, what kinds of guidelines their hospitals have written, and how they've adapted them in actual work situations.

What did we discover? That many nurses are giving the best care they've ever given—and that if some aren't, it's mainly because of misunderstanding and fear.

For example, a hospice nurse told us how the staff at one suburban hospital was frightened of AIDS patients—and frighteningly uninformed. When she arrived to help discharge an AIDS patient, the nurses asked her, "What are those spots on his face?"

There's no excuse for being uninformed; staying up-to-date is a nurse's professional responsibility. On the other hand, there's no excuse for hospitals that don't help their staffs stay informed. The Reverend Harold Burris, director of housing services for the Whitman Walker Clinic—an AIDS social service agency in Washington, D.C.—reports that one city hospital admitted three dozen AIDS patients without ever writing guidelines for nurses. "Orientation was a one-shot session; they never followed up to see if their training was working," he says.

What if your hospital's in a small town that doesn't have "those kinds of problems," and you're wondering what all this has to do with you? Don't kid yourself! By 1991, the Public Health Service predicts 145,000 people will require medical care in the United States for AIDS. When one of them ends up on your unit, will you be prepared?

Linda Brooks, MS, MT, director of infection control and environmental health for the American Hospital Association (AHA), urges hospitals to write their own AIDS policies, following guidelines from the AHA and the Centers for Disease Control (CDC), and to "check their infection-

DAVID REINBOLD

Generally, *yes*. But every nurse we spoke to agrees: AIDS patients pose very special problems. When one arrives on your unit, will you be ready to give him the care he deserves? Here, nurses who care for AIDS patients every day answer your most urgent questions.

BY MARYLOU WEBSTER, SPECIAL CORRESPONDENT, *NURSINGLIFE*

control policies for appropriateness and consistency." She also recommends "aggressive education programs" for *all* staff members *before* the first AIDS patient is admitted.

If your hospital has yet to admit its first AIDS patient, or if you've seen only a few and still have no guidelines for their care, you probably have many unanswered questions. (Even if you've been caring for AIDS patients regularly, you're probably curious about what other nurses are doing.) The following comments from AIDS experts across the country will help answer your most urgent questions.

Should we put AIDS patients in private rooms, or can they room with other AIDS patients or with patients who don't have AIDS?

Nurses tell us that besides following CDC recommendations, their hospitals consider:

- the availability of private rooms and private bathrooms
- the number and types of AIDS patients they have at any given time
- the patients' preferences and personal feelings.

For example, M.D. Anderson Hospital and Tumor Institute in Houston admits AIDS patients to private rooms simply because the hospital doesn't have many semi-private ones. In contrast, Veterans Administration Medical Center in New York City puts AIDS patients in single rooms for privacy—and because only those rooms have private bathrooms and AIDS patients are often too ill to walk to hall bathrooms.

George Washington University Hospital in Washington, D.C., permits AIDS patients to room together, but only if the patient census is unusually high, if the patients can maintain good hygiene, and if they're at the same stage in their illness.

Guidelines at James M. Jackson Memorial Hospital in Miami state that AIDS patients may share a room "unless another indication exists." But Laurie Moser, RN, quality assurance education coordinator for medical nursing, admits this doesn't happen too often. "Most of our AIDS patients have an opportunistic infection that's out of control and that usually involves diarrhea. So we generally discourage AIDS patients from sharing rooms."

Memorial Sloan-Kettering Cancer Center in New York City has a "cohorting" policy that allows two AIDS patients to share a room if they can practice good hygiene and don't have active tuberculosis (TB) or parasites. But Alice Lucas, RN, BSN, infection-control nurse, says, "Because we're a cancer center, most of our patients are immunosuppressed. So unless we're out of beds, all patients go into private rooms."

At Los Angeles County-University of Southern California Medical Center, AIDS patients often share

14 WAYS TO PROTECT YOURSELF... AND YOUR A.I.D.S. PATIENTS

These patient care guidelines are recommended by the American Hospital Association (AHA), the Centers for Disease Control, and other experts. Follow them with all acquired immune deficiency syndrome (AIDS) and AIDS-related–complex patients, as well as with patients known to be positive for human immunodeficiency virus.

Remember: Don't go overboard on isolation procedures. Simply follow the same blood/body fluid precautions as you would for patients with hepatitis B, unless the patient has another infection that calls for additional safeguards.

1. *Rooms*—A private room isn't necessary unless a patient has special problems, such as severe diarrhea, bowel incontinence, or behavior changes from a central nervous system infection. AIDS patients shouldn't share rooms with patients who have other easily transmitted diseases, so use caution even when putting two AIDS patients together.
2. *Handwashing*—Wash your hands before and after caring for an AIDS patient, even if you've worn gloves. If your hands become contaminated with his blood, wash them immediately.
3. *Isolation clothing*—Wear nonsterile gloves if you expect to touch the patient's blood or other body fluids, a gown if body fluids might soil your clothes, and a mask or protective eye wear only if blood or body fluids might splash your face.
4. *Resuscitation equipment*—Keep artificial airways and Ambu bags handy; avoid mouth-to-mouth resuscitation.
5. *Pregnancy risks*—Pregnant workers aren't thought to be at greater risk for contracting AIDS. But because many AIDS patients excrete cytomegalovirus, which causes fetal abnormalities and stillbirths, pregnant workers should follow blood/body fluid precautions meticulously.
6. *Sharp items*—Consider all sharp items potentially infective and handle them with the utmost care. Use disposable needles and syringes, and discard them in rigid, puncture-proof containers. Never recap, bend, or break a needle or remove it from the syringe.
7. *Labeling*—Clearly label blood and other specimens with a sign such as "Blood/body fluid precautions," *not* "AIDS precautions." If the outside of the specimen container becomes contaminated with blood, clean it with a solution of 1 part household bleach in 10 parts water. Double-bag all blood specimens before transfer.
8. *Blood spills*—Clean up all spills immediately with the bleach solution.
9. *Linens*—Bag, label, and process soiled linens as you would any other isolation linens.
10. *Eating utensils*—Special precautions (such as disposable dishes) aren't necessary.
11. *Disposable and nondisposable articles*—Incinerate or discard disposable items, following hospital policies for disposing of infectious waste. Bag and label nondisposable articles contaminated with blood or body fluids before sending them for decontamination and reprocessing.
12. *Sterilization*—Sterilize equipment following hepatitis B precautions. Decontaminate surgical instruments by machine or by hand after use; don't just rinse them in water.
13. *Transporting AIDS patients*—Follow blood/body fluid precautions. Be sure that workers in areas where AIDS patients will be transported know what precautions to take.
14. *Outpatients with AIDS*—Outpatients can use the same waiting rooms and bathrooms as other patients unless they have other infections requiring special precautions.

If your hospital's an AHA member, your infection-control department will have a copy of the guidelines *Management of HTLV-III/LAV Infection in the Hospital.* If you'd like your own copy, send $3.90 (or $3.25 if your hospital's an AHA member) to the American Hospital Association, Dept. NL, 840 N. Lake Shore Dr., Chicago, IL 60611.

rooms with other AIDS patients and non-AIDS patients. "We work case-by-case," says Michael Hedderman, RN, BSN, nurse-manager for AIDS services. "Most of our AIDS patients are in three- to five-bed wards, and we haven't had a problem with cross-contamination."

Hospitals also take the patient's personal feelings into account when assigning rooms. Although nurses agree that privacy is important for severely ill AIDS patients and that patients can enjoy their visitors more in private rooms, they disagree on what's emotionally better for AIDS patients in the long run.

Christine Grady, RN, MSN, CS, clinical nurse specialist, allergy and infectious diseases, at the National Institutes of Health (NIH) in Bethesda, Md., feels that putting two AIDS patients together in one room is better for them psychologically. Michael Hedderman agrees: "It's therapeutic; it gives good peer support."

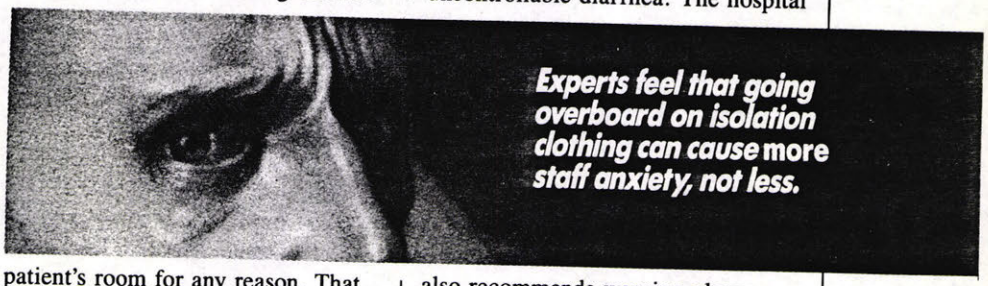
Richard Brock, RN, BSN, MA, nursing director of internal medicine nursing service at Los Angeles County-University of Southern California Medical Center, reports seeing few problems even when AIDS and non-AIDS patients are placed together. "It's rare for the patient without AIDS to ask for a transfer, but if he does, we oblige him as quickly as possible."

One nurse who's been involved in AIDS research at hospitals and with AIDS social service agencies in New York City feels differently. Mary Belmont, RN, BSN, EdD, research project director for the American Health Foundation, says, "It's not always in the patient's best interest to share a room with another AIDS patient. At the last hospital where I worked, we had one AIDS patient who was an intravenous drug abuser wanted for murder, another who was a nurse who got AIDS from a transfusion, clergymen, and even foreign diplomats with AIDS. You can't assume that just because two patients have AIDS they'll want to room together."

At George Washington University Hospital, Dixcy Bosley, RN, staff nurse, also sees problems with putting AIDS patients together. "To make this work, you need a strong assessment of both patients' acceptance levels and emotional states—and we don't usually have time to do this on admission. Once, we put a patient who was still denying his illness in with one who was weak and malnourished from end-stage *P. carinii* pneumonia. The first patient got so depressed we had to transfer him after 1 day."

How much isolation clothing is really necessary?

Only a few years ago, nurses were donning everything from masks to shoe covers before entering an AIDS patient's room for any reason. That was emotionally devastating for patients—and clinically unnecessary. And in fact, experts feel that going overboard on isolation clothing can cause *more* staff anxiety, not less.



Experts feel that going overboard on isolation clothing can cause more staff anxiety, not less.

But Joan Otten, RN, BSN, assistant administrator of quality assurance and infection control at James M. Jackson Memorial Hospital, suspects that "nurses in some community hospitals are still putting everything on and taking too many precautions." Mary Belmont agrees—to a point. "Some nurses might be using a few more precautions than necessary, but they're 'erring' on the side of the immunosuppressed patient. On the whole, though, I think nurses really have come to terms with the fear of contamination."

Of course, all the hospitals we contacted were following the CDC recommendations, although most have revised them to meet their special needs or have expanded them to cover more patient care situations. For example, hospitals usually advise nurses to gown, glove, and mask when AIDS patients have airborne infections, such as herpes zoster. But most nurses we talked to don't mask very often. At the NIH, for instance, nurses don't wear masks with *P. carinii* pneumonia patients, only around coughing patients with undiagnosed pulmonary diseases.

Monica Danna, RN, BSN, coordinator of the infectious-disease unit at St. Michael's Medical Center in Newark, N.J., says, "We used strict isolation before the AIDS virus was identified. But now we generally use blood and enteric precautions—the same as for any isolation patient—unless the patient has TB or an infection we haven't yet identified. Then we use stricter isolation."

Isolation gear at James M. Jackson Memorial Hospital includes plastic aprons instead of paper or cloth gowns when a blood splash or spill is possible or when a patient has uncontrollable diarrhea. The hospital also recommends wearing gloves when feeding AIDS patients to protect against contact with saliva. Nurses with cuts or hangnails should *always* wear gloves when caring for AIDS patients.

"We're finding a lot of atypical microbacterial infections," Laurie Moser says. "So when a patient has disseminated or active pulmonary TB, we mask. And we mask during invasive procedures. But we generally discourage getting decked out in all sorts of isolation paraphernalia."

Alison Moëd, RN, BSN, head nurse in the medical special care unit for AIDS patients at San Francisco General Hospital Medical Center, says, "We rarely wear masks—only when we suspect TB. If a patient's neutropenic, we mask for *his* protection. I think some caregivers are still overcautious."

The consensus? That isolation precautions for AIDS patients are mostly common sense and that each case must be assessed individually. As Joan Otten says, "Before you enter an AIDS patient's room, evaluate what contact you're going to have."

How can I avoid doing mouth-to-mouth resuscitation on an AIDS patient?

By being prepared. Always have resuscitation equipment handy—preferably at the bedside—for *any* patient who has a communicable disease or is at risk for respiratory or cardiac arrest. A recent follow-up study of the two nurses mentioned at

the beginning of this article, who gave mouth-to-mouth resuscitation to an AIDS patient, showed no seroconversion after 9 months. But the AIDS virus is known to be present in saliva, so you should always try to avoid mouth-to-mouth contact.

Here's how the nurses we interviewed accomplish that:

Nurses at several hospitals, including James M. Jackson Memorial and Los Angeles County-University of Southern California Medical Center, keep resuscitation equipment right at the AIDS patient's bedside when his condition warrants it. At George Washington University Hospital, nurses do this for all isolation patients. According to Michael Hedderman, at Los Angeles County-University of Southern California Medical Center, "You know your patients pretty well, so you'll have emergency equipment handy if they're really ill. Good nursing practice means thinking ahead."

Guidelines at Veterans Administration Medical Center specify that "mouth-to-mouth resuscitation should be avoided whenever possible. An Ambu bag should be used." In an emergency, the hospital protocol recommends placing a piece of gauze dressing over the patient's mouth to prevent direct mucous membrane contact with possibly contaminated secretions and blood.

If I'm pregnant, can I be excused from caring for AIDS patients?

Most hospitals we contacted have no written policy covering nurses who care for AIDS patients. But many do have policies covering pregnant workers' risk of exposure to cytomegalovirus (CMV), which causes fetal abnormalities and stillbirths—and they extend those policies to include human immunodeficiency virus (HIV).

James M. Jackson Memorial Hospital doesn't excuse pregnant nurses from caring for AIDS patients except those patients known to have CMV. The NIH tries to excuse pregnant nurses from caring for AIDS patients with CMV, Epstein-Barr virus, other herpesviruses, and toxoplasmosis. And at San Francisco General Hospital Medical Center, pregnant nurses are excused from caring for any AIDS patient to avoid possible exposure to CMV.

Two pregnant nurses at Los Angeles County-University of Southern California Medical Center were recently granted a transfer to a unit without AIDS patients, says Richard Brock. "But they went right back to their original unit after maternity leave," he adds.

At M.D. Anderson Hospital and Tumor Institute, too, pregnant nurses can request not to work with AIDS patients with CMV. But Roy Hopfer, PhD, chief of clinical microbiology and infection-control services, says, "Staff-education programs have virtually eliminated such requests."

The AHA's Linda Brooks encourages hospitals to address the issue of pregnant workers and AIDS patients. "If a hospital already has a policy prohibiting pregnant nurses from caring for CMV patients, they could logically extend it to AIDS patients. If not, they shouldn't write a new policy just for AIDS."

I'm scared about caring for my first AIDS patient. Do other nurses feel this way?

The nurses we interviewed felt

THE ULTIMATE A.I.D.S. UNIT

The Institute for Immunological Disorders in Houston has the ultimate acquired immune deficiency syndrome (AIDS) unit. It's the nation's first—and so far only—hospital excusively for the treatment of AIDS.

Opened in September 1986, the institute, owned by American Medical International (AMI), occupies the former Citizens General Hospital. One week after opening, the 120-bed facility had 14 inpatients and more than 200 outpatients.

"We're opening one 30-bed unit at a time, to see how things go," says Pat Kurowski, RN, research nurse. She emphasizes that the hospital is a research facility, not an attempt to segregate AIDS patients.

"We felt we could give better care and provide a more intense work situation," she explains.

No-sweat staffing

Staffing was never a problem. Citizens General staff members were given the choice of staying on or transferring to another AMI hospital: 80 percent stayed. Staff from affiliated M.D. Anderson Hospital and Tumor Institute could also transfer to the institute.

Every staff member—professional and nonprofessional—gets an intensive, 3-week orientation. To provide the personal touch, the hospital uses "cluster" nursing. Nurses care for all patient needs, including giving respiratory and physical therapy and drawing blood. "The patient gets fewer interruptions and more rest," Pat Kurowski says.

She adds that, although written guidelines were "still in the rough draft stage" when we went to press, the institute is following CDC recommendations. Also, disposable gloves, needle containers, and Ambu bags are placed in all patient rooms.

The patient's #1

"The patient comes first here," says Dorson Purdy, RN, staff nurse. "If he wants his bath in the afternoon instead of the morning, fine. We work around his needs.

"We have a very positive staff attitude," Purdy continues. "I've been to other hospitals where nurses cover themselves from head to foot, where food trays are left in the halls, where nurses ask *visitors* to give pain shots. We had one patient who'd felt like a leper at his previous hospital and was severely depressed. But after 2 days with us, he was like a different person."

Purdy says their nursing care plans emphasize psychological and social needs. "We hold patients' hands, and we hug them when they're upset or crying.

"Every nurse is here because he or she wants to be. I really feel I've found my calling. A nursing instructor once told me: 'Treat every patient as you'd want to be treated yourself.' That's what we're doing here."

anxious at first, too—it's only natural. But all say they feel very comfortable with AIDS patients now.

"In the early 1980s, we went so far as to look for disposable pillows. But we're not anywhere near that panic stage now," says Ronnie Leibowitz, RN, CIC, MA, nurse epidemiologist, Veterans Administration Medical Center.

"I've seen a big change in the degree of fear and the level of understanding in the last 2 years—not just for professionals but for all staff members," Dixcy Bosley reports.

Mary Belmont, who lectures on AIDS patient care, feels this isn't necessarily true in smaller hospitals. "I've spoken in hospitals where they're just starting to see AIDS patients, where they're doing now what we did 5 years ago. You can see the terror rising."

Laurie Moser says anxiety has decreased at her hospital but that tension mounts again whenever they have a high census of AIDS patients or the news media overpublicizes or sensationalizes AIDS.

How can I prepare myself for my first AIDS patient? What can my hospital do?

Prepare yourself by studying the AHA and CDC guidelines, by reading journal articles, and by talking to nurses who care for AIDS patients.

Your hospital can gear up by launching an all-out staff-education program. Here are some ideas:

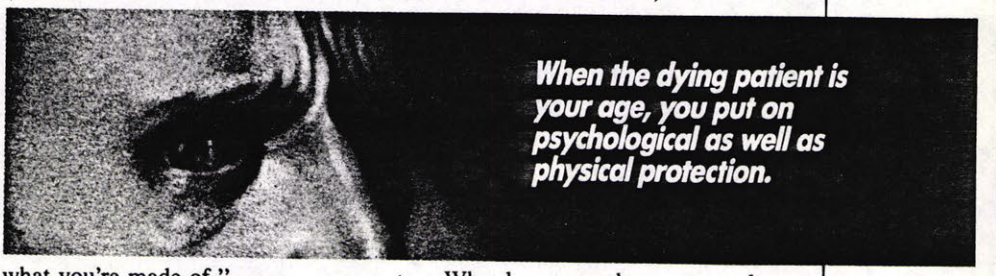
Los Angeles County-University of Southern California Medical Center has an AIDS task force that meets monthly to keep guidelines constantly up-to-date. James M. Jackson Memorial Hospital disseminates AIDS information via newsletter, lectures, and even statements in employee paychecks. Memorial Sloan-Kettering Cancer Center holds "AIDS update meetings" periodically, especially when something occurs that causes increased concern (for example, when the CDC reported that three U.S. health care workers had tested positive for HIV).

Newark Beth Israel Medical Center devoted an entire week to AIDS education in early 1986. Although nurses were the major audience during "AIDS Awareness Week," information was also available for the nonprofessional staff. The hospital plans to repeat the program at least once a year and offer it to other area hospitals.

Tell me the truth—how do nurses really feel about caring for AIDS patients?

We can't speak for all nurses, but those we talked to considered their work the ultimate challenge.

"I wish the disease had never existed," says Ronnie Leibowitz, "but I've grown tremendously as a nurse and as a person. When you care for AIDS patients, you find out what you're made of."



"It's a very challenging population to work with. Professionally, I'm right where I want to be," says Dixcy Bosley.

"It's been inspiring. I've learned so much from my patients about courage and love," says Alison Moëd.

On the dark side:

"Your goal has to be comfort and care, not cure," says Marianne Dabrowski, RN, BSN, infection-control practitioner at Newark Beth Israel Medical Center. "You might offer hope, but both you and the patient understand that he might not live long."

"It's the worst clinical picture you can imagine. The hardest part to cope with is the disease itself," Dixcy Bosley feels.

Kathy Martin, RN, BSN, nursing education coordinator at George Washington University Hospital, says, "AIDS is a triple-edged sword. It kills young people, it infects mostly gay men, and it's contagious. For some nurses, these things are hard to deal with."

Monica Danna says, "It takes a special type of nurse to work with AIDS patients. You have to be satisfied with just getting them as well as possible and home. What's hardest to cope with is that they're young and dying, not that they have AIDS."

And from Mary Belmont: "When the dying patient is your age, you don't just physically gown, you put on psychological protection, too."

Are some nurses actually choosing to work with AIDS patients?

Yes. At San Francisco General Hospital Medical Center, the first in the country to start a separate AIDS unit, staff turnover has been low since the unit opened in 1983. "Everyone who works here elects to work here," says Alison Moëd.

Staff at the Institute for Immunological Disorders in Houston, the country's first all-AIDS hospital, also work there by choice (see insert *The Ultimate AIDS Unit*).

Why do nurses choose to work with AIDS patients? "Some feel a commitment to the fact that many of these patients were badly treated," Mary Belmont believes. We've also heard of nurses who work with AIDS patients because a close friend or family member died of the syndrome or because they want to specialize or try something different. We've heard some inspiring reasons, too. One nurse told us, "For the first time in my life, I feel as if I'm really giving nursing care."

Finding something positive to say about a syndrome that's 100 percent fatal, that kills mostly young men, and that causes widespread fear isn't easy. But nurses who work with AIDS patients *are* being enriched professionally and personally. They're also setting standards of care for the whole profession: Now, nurses are more meticulous about preventing needle sticks, more scrupulous about handwashing and isolation procedures, and better prepared for emergencies. They're also more aware of patients'—and their own—emotional needs and biases.

Nurses have long been advised to keep a professional distance from patients, to avoid becoming too involved. But the AIDS crisis is forcing us to reexamine that advice. How can you care for an AIDS patient *without* becoming involved?

Perhaps Dixcy Bosley says it best: "I feel so fully utilized as a nurse. AIDS has given a whole new definition to the word 'caring.'"

CARING FOR THE AIDS PATIENT—FEARLESSLY

You've been hearing a lot about acquired immune deficiency syndrome and how deadly it can be. You must be wondering, "Am I at risk for contracting this disease?" The experience of these New York City nurses will help you separate the facts about AIDS from the hysteria.

The panelists for this Nursing Grand Rounds *article work at St. Vincent's Hospital and Medical Center of New York. They are: Barbara Popkin, RN, MA, staff education instructor; Peggy Madden, RN, BS, infection control nurse; and Pam Lavrich, RN, BS, and Mary Ellen Sherlock, RN, assistant nursing care coordinators, medical intensive care unit. The panel report was coordinated by Barbara Popkin and edited by the* Nursing83 *staff.*

The patient's name has been changed.

Nursing Grand Rounds

Mary Ellen Sherlock, RN, Assistant Nursing Care Coordinator, MICU: William Patterson, an emaciated, 37-year-old "street person," came to our emergency department (ED) on November 19, complaining of a general deterioration in his health over the previous year. He reported persistent fever, headache, night sweats, malaise, anorexia, dyspnea, and a productive cough. He described his sputum as thick, voluminous, and white to yellow, occasionally streaked with dark red blood.

William's life-style was typical of the thousands of street people found in New York City. Unemployed and undernourished, he lived at a men's shelter, smoked half a pack of cigarettes a day, and drank alcohol regularly. Most significantly, in light of his eventual diagnosis, he'd later deny ever having engaged in homosexual activity. He did admit to having used intravenous (I.V.) drugs while in the army, but said he'd quit after being discharged in 1980.

He was examined in the ED and found to have candidiasis of the nose, mouth, and throat. While his blood pressure was within normal limits, his respirations were increased at 28 per minute; his temperature was elevated at 101.6° F. (38.6° C.); and his weight was down to 134 pounds (60.3 kg), well below normal for his 6-foot (180-cm) frame.

Chest X-rays showed diffuse bilateral interstitial infiltrates, distributed in a butterfly pattern, with a single discrete nodular lesion over the left upper lung. Fine, dry, end-expiratory rales were heard bilaterally on auscultation. The results of a complete blood count were within normal limits. Arterial blood gas analysis, however, indicated respiratory alkalosis, which failed to improve with oxygen administration.

Hypotensive episode

William was then admitted to a medical/surgical floor for further examination to rule out pneumonia, pneumonitis, tuberculosis, lymphoma, legionnaires' disease, and acquired immune deficiency syndrome (AIDS). The next day he started receiving I.V. erythromycin, co-trimoxazole (Septra, Bactrim), and cefoxitin—three broad-spectrum antibiotics. He continued to receive 40% oxygen by face mask for respiratory alkalosis.

That afternoon his blood pressure suddenly fell from 140/70 to 80/40. Intravenous fluids were administered, then dopamine, with no improvement in his condition. He was transferred to the medical intensive care unit (MICU), where he was intubated and put on a ventilator. Blood cultures showed he was in septic shock secondary to streptococcal pneumonia. The number of antibiotics he was receiving was increased to seven.

Then, on November 21, a lung biopsy uncovered the causative organism—*Pneumocystis carinii*, a deadly parasite that often infects AIDS patients.

The guessing game was over. William had AIDS.

Frightening disease

Barbara Popkin, RN, MA, Staff Education Instructor: William wasn't the first AIDS patient to be treated here at St. Vincent's, nor would he be the last. Almost 50% of all AIDS patients have come from New York City, so we've seen quite a few.

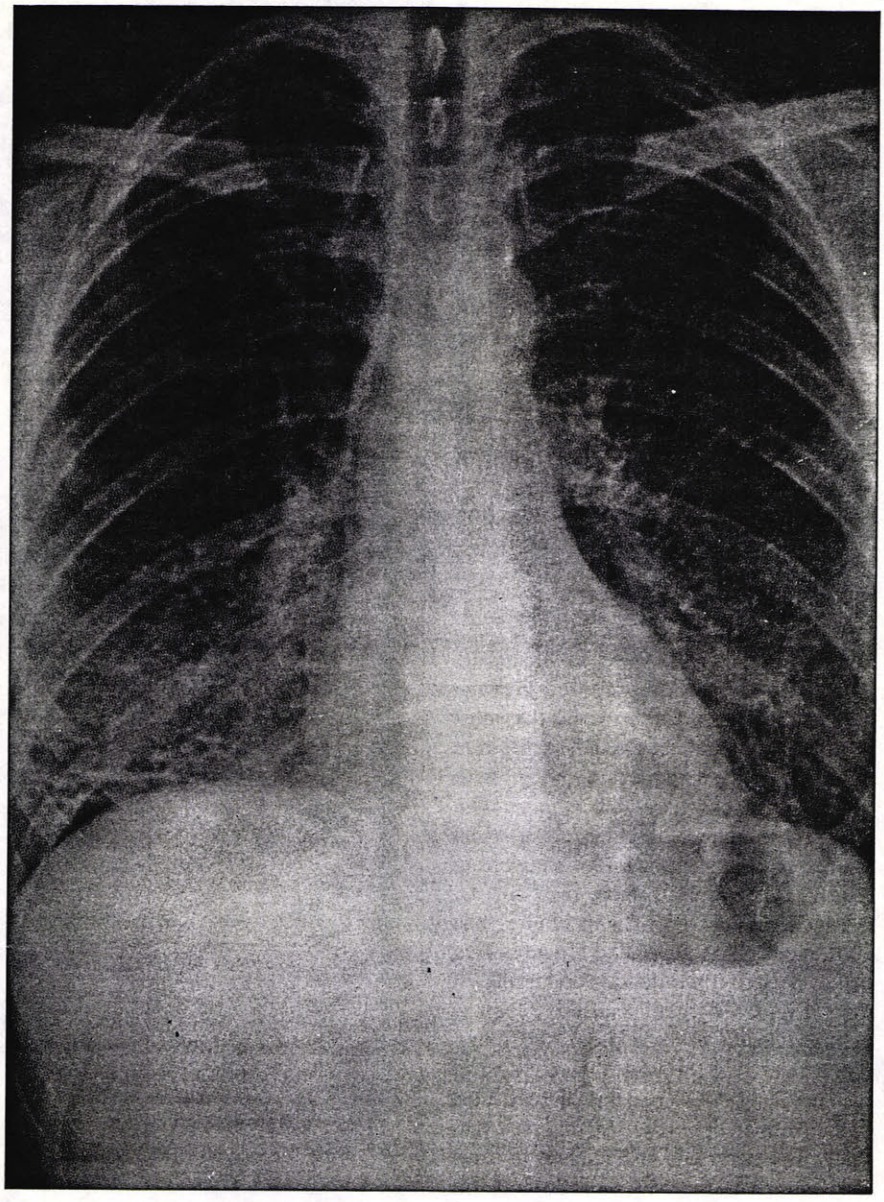
Photos courtesy of the Centers for Disease Control, Atlanta

And so far, none of our nurses has contracted AIDS after caring for a patient with the disease. We believe the precautions we take, as recommended by the Centers for Disease Control (CDC) in Atlanta, have a lot to do with that fact. During this case presentation, we'll share those precautions with you so you'll be better able to care for AIDS patients without fear. But first, let's take a closer look at the disease.

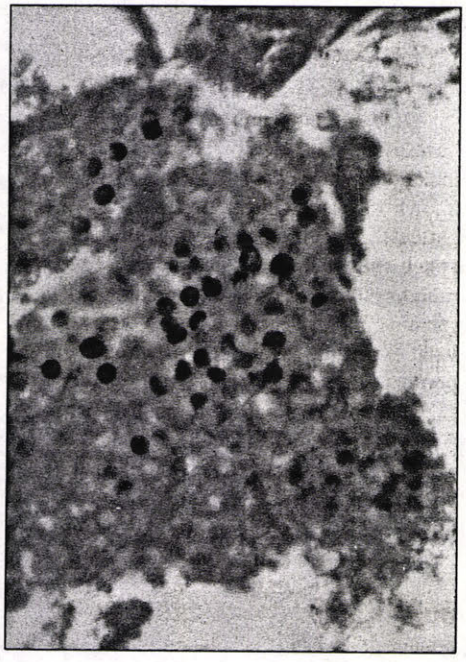
Acquired immune deficiency syndrome was first diagnosed in 1979. Its initial victims were male homosexuals, and for a time the disease was thought to be confined to that population group. In fact, the disease was then known as GRID—for gay-related immune deficiency.

Over the next 3 years, however, AIDS began to appear among heterosexual I.V. drug abusers, Haitian immigrants, and hemophiliacs. More recent cases have suggested that the disease might even be transmitted during pregnancy, routine blood transfusions, and heterosexual contact with AIDS victims.

The hallmark of AIDS is a suppressed immune system unattributable to any known cause, such as immunosuppressive therapy. For some unexplained reason, the body loses its ability to fight off disease. As a result, the patient becomes vulnerable



Chest X-ray (right) shows interstitial infiltrates caused by P. carinii *pneumonia, the most common opportunistic disease seen in AIDS patients.* Pneumocystis carinii *organisms appear in the microscopic slide below right. Also below, the distinctive purplish skin lesions of Kaposi's sarcoma, which occurs in 30% of AIDS patients, seen here on the heel and lateral foot.*



Photos courtesy of the Centers for Disease Control, Atlanta

to opportunistic diseases, especially:

- *Pneumocystis carinii pneumonia*—a parasitic pneumonia seen in 51% of AIDS patients. (This is the opportunistic disease that was causing William's signs and symptoms.)
- *Kaposi's sarcoma*—a malignant angiosarcoma that causes distinctive penny-sized purplish lesions to appear on the skin, mucous membranes, and lymph nodes. (Previously confined to older men of Italian or Jewish descent, this once-rare cancer is now seen in 30% of AIDS patients.)
- *cryptosporidiosis*—a parasitic infection that causes chronic, diffuse, watery diarrhea (often exceeding 15 liters a day).
- *toxoplasmosis*—a parasitic infection that causes encephalitis (seen primarily among the Haitian victims of AIDS).

High mortality rate

The opportunistic disease is what kills AIDS patients, not the acquired immune deficiency itself. And perhaps the most frightening thing about AIDS is the rate at which these patients are dying. In 4 years, the disease has struck more than 1,900 people. (The incidence has risen dramatically over the past 18 months, from 7 new cases a week to more than 40.) Of the total number of patients, more than 700 (about 40%) have died already. That makes AIDS more lethal—in terms of mortality rate—than smallpox, legionnaires' disease, or toxic shock syndrome.

But that's not the whole story. Most of the surviving AIDS patients are expected to die from an opportunistic disease eventually. It seems to be just a matter of time, as suggested by the 75% mortality rate for AIDS patients diagnosed before June 1981.

Despite exhaustive investigation by the CDC and other medical centers, the cause of AIDS remains unknown. Researchers have found evidence of the human T-cell leukemia-lymphoma virus, the only virus known to cause cancer, in 25% of AIDS patients tested. But whether the virus, conclusively linked to cancer of the immune system in 1980, also causes AIDS remains unclear because it's not known to what extent the virus occurs in the general population.

Most researchers continue to suspect that AIDS results from an infectious agent, probably a new virus, transmitted sexually and parenterally. Electron microscopy, however, has repeatedly failed to detect such an agent. Laboratory animals have been injected with body fluids and tissues from AIDS patients; so far, no animal has contracted the disease.

Homosexuals still hardest hit

Male homosexuals still make up the great majority of AIDS victims, accounting for 71% of all cases (see insert, *Who's at Risk for AIDS*). Intravenous drug abusers rank second (17% of all cases). Those percentages explain the high incidence of AIDS (61%) in the big cities of the United States—primarily New York, San Francisco, Los Angeles, Miami, and Houston—that have large populations of male homosexuals and I.V. drug abusers.

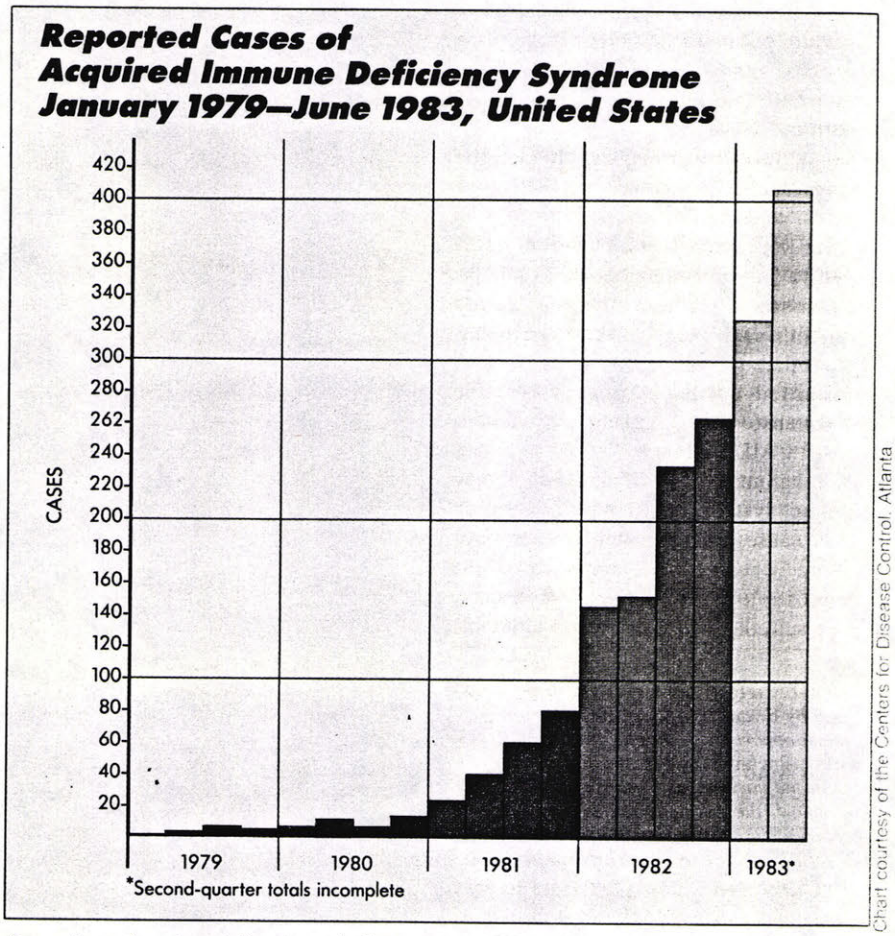


Chart courtesy of the Centers for Disease Control, Atlanta

The disease appears to have a long incubation period—a few months to a year, sometimes longer. The first signs and symptoms tend to be nonspecific, making an early diagnosis difficult. William had most of the usual complaints—fever, malaise, weight loss. Candidiasis occurs frequently; chronic lymphadenopathy is another common sign. Like William, the typical AIDS patient may tolerate his signs and symptoms for the better part of a year before seeking treatment.

No laboratory test can detect AIDS. Many patients have hepatitis B and cytomegalovirus antibodies in their blood, indicating they've been exposed to those infections. Others have an inverse ratio of helper T-cells, which activate the immune system, to suppressor T-cells, which suppress the immune system to keep it from overreacting to disease. A healthy person has about twice as many helper T-cells as suppressor T-cells. In AIDS patients, the ratio is often reversed. These findings, while helpful in suspecting AIDS, are not considered diagnostic.

Since no cure exists for AIDS itself, treatment is directed at curing the opportunistic disease (or opportunistic *diseases*, since an AIDS patient may have more than one). Interferon, for example, has been used successfully to treat some cases of Kaposi's sarcoma. Therapy is also available for *P. carinii* pneumonia.

Septra and pentamidine therapy

Pam Lavrich, RN, BS, Assistant Nursing Care Coordinator, MICU: As Barbara pointed out, *P. carinii* is the opportunistic disease that most often strikes AIDS patients. This particularly lethal pneumonia causes progressive occlusion of the alveoli in the lungs. Untreated, the patient deteriorates rapidly and may die of suffocation.

Pneumocystis carinii pneumonia is treated with Septra and the investigational drug pentamidine, which must be ordered from the CDC. William was already receiving Septra, administered intravenously at the rate of 4 ampuls in 250 ml of 5% dextrose in water every 6 hours. We administered a daily dose of 250 mg of pentamidine intramuscularly. Ampicillin

was administered for his septicemia; all other antibiotics were stopped.

Besides Septra and pentamidine, the AIDS patient with *P. carinii* pneumonia usually requires prolonged mechanical ventilation. As soon as he was transferred to the MICU, we put William on an MA-1 volume-cycled ventilator. We tried to wean him from it slowly, without success. On November 25, a tracheostomy had to be performed to ensure maximal arterial oxygenation.

That same day we started administering half-strength Magnacal through a Levin tube to provide him with adequate nutritional support. Unfortunately, this caused persistent diarrhea and had to be stopped. Total parenteral nutrition was started in its place.

William also developed leukopenia while in the MICU. In 4 days, his white blood cell count dropped from 14,000 to 1,000/cu mm (normal is 5,000 to 10,000). Since Septra can cause leukopenia, the doctors ordered the drug stopped, but it had to be resumed when William started running a fever again. Eventually, the leukopenia resolved without specific therapy.

By December 10, William was well enough to be transferred back to a medical/surgical floor. He was afebrile; chest X-rays showed no new infiltrates. Although he still needed the tracheostomy tube, he had progressed from the MA-1 to a Bird pressure-cycled ventilator. The Septra and pentamidine therapy appeared to have been successful—for now.

Suspected modes of transmission

Peggy Madden, RN, BS, Infection Control Nurse: William had a private room in the MICU and, for a time, on the medical/surgical floor to which he was transferred. But he was never placed on strict isolation. As you'll see in a minute, that's not necessary with all AIDS patients.

We did, however, take precautions to minimize the risk of transmission to hospital personnel. These precautions follow the CDC's recommendations, which are based on the suspicion that AIDS may be transmitted in the following ways:

- direct contact (including sexual contact) with an AIDS victim's contaminated body fluids (primarily infected blood, blood components, or serum), secretions (such as lung secretions, saliva, sputum, or mucus), or excretions (such as urine, feces, semen, wound drainage, or vomitus)
- self-inoculation with an AIDS victim's contaminated body fluids through a needle-stick injury.

As precautions against these possible modes of transmission, we wore gloves

Who's at risk for AIDS

MALE HOMOSEXUALS (71% of victims)

The first outbreak of AIDS occurred in late 1979 and 1980 among male homosexuals in New York City, Los Angeles, and San Francisco. These men had many sex partners—often anonymous encounters in bathhouses. They engaged in various forms of oral and anal sex, habitually using "poppers" (inhalant amyl or butyl nitrite) to enhance orgasm. Nearly all had long histories of sexually transmitted diseases.

Based on these initial findings, researchers entertained several theories on the cause of AIDS. They wondered if an infectious agent present in semen (the cytomegalovirus and the Epstein-Barr virus were early suspects) was somehow being transmitted during homosexual activity, possibly through breaks in the anal mucosa during anal sex. They considered the immunosuppressive effects of semen and poppers as contributing factors. They postulated that perhaps the immune systems of these AIDS victims had simply worn out over the years from the constant challenge of fighting off one disease after another.

These theories had to be viewed in a new light when AIDS started appearing among heterosexuals. Throughout the 4-year history of AIDS, however, male homosexuals have consistently been victimized far more often than any other population group. The original typical patient profile, therefore, is still valid, if no longer exclusive. (Keep in mind, too, that some members of this population group are bisexual.)

I.V. DRUG ABUSERS (17% of victims)

The second population group to be victimized by AIDS was I.V. drug abusers—both men and women, predominantly heterosexuals. The only thing they seemed to have in common with the homosexual victims of AIDS was the fact that they too were clustered in America's big cities. These new victims were hard-core addicts who frequently used contaminated needles and syringes. The appearance of AIDS in this group reinforced the suspicion that the disease was caused by an infectious agent—transmitted parenterally, it appeared, as well as sexually.

HAITIAN IMMIGRANTS (5% of victims)

This third population group represents one of the most puzzling aspects of the AIDS mystery. An infectious agent transmitted sexually and parenterally might account for the appearance of AIDS in homosexuals and drug abusers. But it doesn't explain the outbreak of AIDS among heterosexual Haitian immigrants who don't use I.V. drugs. The disease spread to members of this group during the summer of 1981. Why?

Several intriguing possibilities have been raised: Could the causative organism itself have originated in Haiti, where poverty, malnutrition, and poor sanitation are rampant? Could New York City homosexuals, some of whom vacation annually in Haiti, have picked up the disease in that Caribbean island and brought it back to the United States? Or could they have taken the disease to the island? Ancestors of today's Haitians hailed from what is now Zaire, Africa, where a mild form of Kaposi's sarcoma—the second most prevalent opportunistic disease seen in AIDS patients—is common. Could that fact be significant in unraveling the mystery of AIDS?

HEMOPHILIACS (1% of victims)

The appearance of AIDS in this fourth population group, first reported during the spring and summer of 1982, pushed the controversy surrounding the disease to a crisis point. Investigators suddenly found themselves confronted with the alarming specter of AIDS being transmitted to the general population through ordinary blood transfusions. This possibility was suggested by the presumed source of the latest outbreak—lyophilized (freeze-dried) blood-clotting medications containing factor VIII, widely used by hemophiliacs. These medications, which hemophiliacs can easily reconstitute with sterile water at home, are made from the blood of thousands of donors across the United States. The logical conclusion—especially in light of the fact that impoverished homosexuals and drug addicts often resort to giving blood to make money—was that some of those donors must have been AIDS victims.

As a precaution, hemophiliacs were urged to stop using the lyophilized medi-

cations and to go back to using the less convenient but safer cryoprecipitated antihemophilic factor, made from the blood of only a few donors. Acting on a recommendation by the federal Department of Health and Human Services, blood banks began discreetly questioning prospective donors about their sexual activities and drug use. The purpose of this controversial new policy, which angered the homosexual community, was to discourage possible AIDS victims from donating blood.

Not all investigators are convinced that the outbreak among hemophiliacs is a result of AIDS. Some suspect that the lyophilized medications themselves may have an immunosuppressive effect unrelated to the presence of an infectious agent contributed by AIDS donors. The "hemophiliac connection" could turn out to be the red herring in the AIDS mystery.

MISCELLANEOUS (6% of victims)
This final group consists of all suspected AIDS patients who don't fall into any of the above categories, or for whom information about risk factors is lacking (such as those AIDS victims who died before their risk factor could be identified). They include:

- *female sex partners* of AIDS victims who are bisexual or I.V. drug abusers (suggesting that AIDS can be transmitted during heterosexual activity as well as homosexual activity)
- *children* born to mothers who are I.V. drug abusers or Haitian immigrants (suggesting that AIDS can be transmitted transplacentally, or during or shortly after the birth process)
- *blood transfusion recipients* (suggesting that AIDS can be transmitted through single-donor lots of blood as well as multiple-donor lots, such as those used to make lyophilized blood-clotting medications).

The last subgroup includes an infant who died after being given a blood transfusion from a donor later diagnosed as having AIDS, and several patients who received blood transfusions before surgery. While these cases illustrate the potentially grave threat that AIDS may pose to the general population, the fact remains that millions of blood transfusions have been performed in the United States during the last 4 years without causing AIDS.

whenever direct contact with William became necessary—for example, when performing direct patient-care procedures, such as drawing blood or suctioning secretions. We also wore gloves whenever we had to touch any surfaces or equipment in the unit that may have become contaminated with William's body fluids, secretions, or excretions. We always washed our hands after removing the gloves and before leaving his room.

We advise our nurses to be especially careful not to let any matter from an AIDS patient come in contact with their mucous membranes (such as those in the mouth, conjunctiva, or nostrils) or with a break in their skin. The CDC suspects that AIDS may be transmitted more readily through such direct contact.

We double-bagged all contaminated equipment and articles before removing them from William's room. Lensed instruments, such as an endoscope, were gas-sterilized after being used. To disinfect spills of contaminated body fluids, we used a 1:10 solution of sodium hypochlorite (Dakin's solution). And to prevent needle-stick injuries, we placed all needles and syringes in puncture-proof containers, which we used only for William and left in his room.

When handling laboratory specimens, we attached a red-bordered isolation label, stamped with William's Addressograph plate, to the specimen container. We then placed the container in an impervious bag and attached another red-bordered label to the bag, with "R/O (for 'rule out') AIDS" written on it. Finally, we clipped the laboratory requisition slip to the outside of the bag and wrote "R/O AIDS" in the appropriate space on the slip. If the outside of the specimen container inadvertently became contaminated, we would disinfect it before sending it to the laboratory.

No more than reasonable precautions

These precautions, while rigorous and extensive, are far from extreme. You might recognize them as being similar to the precautions you'd take for a patient with hepatitis B. The modes of transmission appear to be the same for both diseases, so the CDC recommends taking similar precautions.

The point is: You needn't wrap yourself up in full infection control regalia every time you enter an AIDS patient's room. If you're just going to talk to the patient or give him an oral medication, then gloving, gowning, and masking are *not* necessary, since no evidence exists that AIDS can be transmitted through the air, like the common cold, or through casual contact.

Isolation techniques are required *only* when you're going to be in direct contact with the patient's body fluids, secretions, or excretions. Even then, gowning isn't really necessary unless the patient has copious secretions or excretions. The gown will protect your uniform from getting soiled and prevent the spread of potentially harmful microorganisms to other patients.

Neither is a mask always indicated, unless you're performing a procedure in which secretions or excretions may splatter inadvertently. For example, if you're suctioning a patient with excessive secretions, then a mask will prevent the secretions from coming in contact with your mucous membranes should the patient suddenly cough.

If the patient is too ill to practice good hygiene, he should be placed in a private room; otherwise, a private room may not be necessary. Two AIDS patients with the same opportunistic disease may be placed in the same room. But you wouldn't want to put an AIDS patient with *P. carinii* pneumonia in the same room as one with Kaposi's sarcoma, since their immunosuppressed states could cause them to contract each other's disease. In fact, an AIDS patient shouldn't be put in a room with *any* immunosuppressed patient, such as a patient receiving chemotherapy or some other form of immunosuppressive therapy.

Remember that these precautions are based on the CDC's *suspicions* about how AIDS is transmitted. As a nurse, you can certainly take comfort in the fact that, to date, no health care worker who has rendered direct care to an AIDS patient has contracted the disease. Still, under the circumstances, the CDC's suspicions appear well-founded, so reasonable precautions are in order.

Reasonable—that's the key word. Bear in mind that just because a disease has become epidemic among certain population groups, that doesn't necessarily mean it's highly contagious and a threat to the general population. Human nature being what it is, however, reason often gets trampled by fear when you're dealing with a disease like AIDS. We observed this reaction in ourselves when more and more AIDS patients started coming to St. Vincent's—and we had to care for them. Fear prompted some of us to gown, glove, and mask each time we entered an AIDS patient's room.

Now we realize we were overdoing it. We've learned that if you use the proper isolation techniques, when appropriate, you really don't have anything to fear.

Unfortunately, that's not true for the patient.

Depressed and angry

Pam Lavrich, RN, BS, Assistant Nursing Care Coordinator, MICU: After being transferred back to a medical/surgical floor, William started to participate in his care—shaving himself, for example. He also became increasingly depressed and angry. On several occasions, he refused medications and complained—in writing, since he couldn't speak with his tracheostomy—about always having to wait when he asked for something.

A psychiatrist talked with him and confirmed that William's depression and anger were reactions to his fear of dying from AIDS. One of his recommendations was that William receive more emotional support in the form of frequent visits from the staff and members of William's family. Our medical/surgical floor nurses made it a point to start dropping in to chat with William as often as possible—without using isolation techniques, which would've made him feel even more like a pariah. His loneliness must have been especially acute since he was used to living at the crowded men's shelter, where he had very little time or space to himself.

William's immediate family lived in Alabama, but he did have an aunt who lived in the Bronx. She came to see him several times and agreed to take William in for a while after he was discharged, until he could get back on his feet.

Patient teaching centered on William's practicing good personal hygiene and ensuring adequate nutritional intake after discharge. He was told to avoid exposure to infections; he was also warned not to take any drugs that suppress the immune system. Literature on AIDS, such as the newsletter put out by the Gay Men's Health Crisis Center in New York, was provided. The center has the latest information on AIDS, which can be helpful to all victims of the disease, even those, like William, who deny being gay.

William needed to learn to take his temperature every day at the same time and to recognize the signs and symptoms of infection. He was advised to restrict his sexual activity to one partner and to refrain from oral or anal sex entirely. A social worker helped him with living arrangements at his aunt's house and with financial concerns.

Discharge—and an uncertain fate

Mary Ellen Sherlock, RN, Assistant Nursing Care Coordinator, MICU: By January 7, William had been weaned from the ventilator and his tracheostomy tube was removed. His appetite returned, allowing his doctors to stop the total parenteral nutrition. He remained on antibiotics, however, because of intermittent fever.

He was discharged on February 5 in his aunt's care, with a prescription for nystatin (Mycostatin) to treat his candidiasis, which hadn't cleared completely. Chest X-rays still showed interstitial infiltrates, even though he had no other signs or symptoms of infection. An appointment was made for a follow-up visit in 6 weeks.

William never kept that appointment. When we contacted his aunt, she said he'd stayed with her for a couple of weeks, then left. No one at the men's shelter had seen him since his hospitalization. To this day, we don't know what happened to him. But one thing's for sure: If he failed to take care of himself properly, the odds are he contracted another opportunistic disease, which very well may have been fatal.

Caring for William *was* a little scary at times. I think we'd be less than honest if we didn't admit that. Anytime you have to care for a patient suffering from a disease with no known cause or cure, you're going to have some second thoughts. You're going to wonder whether you're jeopardizing your own health.

But the facts about this highly publicized disease called AIDS clearly indicate that if you take reasonable precautions, you can provide quality nursing care without putting unnecessary physical barriers between you and the patient, and without endangering yourself in any way. You can isolate the disease—without isolating the patient. You *can* care for the AIDS victim compassionately—and fearlessly.

Note: This article cites the latest research findings on AIDS as the magazine goes to press.

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KEY POINTS TO REMEMBER

Use the following isolation techniques when caring for an AIDS patient:

- *Glove* whenever you must come in direct contact with the patient's body fluids, secretions, or excretions. Wash your hands after removing the gloves and before leaving the patient's room.
- *Gown* only when the patient has copious secretions or excretions.
- *Mask* only when performing a procedure in which secretions or excretions may splatter inadvertently.

Don't use isolation techniques when:

- You're just going to talk to the patient. (Applies to visitors too.)
- You're going to administer an oral medication.
- You're otherwise not going to come in direct contact with the patient's body fluids, secretions, or excretions.

AIDS

COPING WITH THE FEAR

BY MARGARET KENNEDY, RN • Clinical Nurse • City of Hope National Medical Center • Duarte, California

Who's afraid of AIDS? Nearly everyone. But your nursing care can help the patient and those around him—even your colleagues—deal with their fears.

CARING FOR PATIENTS with acquired immune deficiency syndrome (AIDS) means grappling with its most contagious, debilitating effect: fear. But our experience has taught us that nursing interventions can help keep fear from overwhelming the patient, his family and friends, other patients, and even staff members.

Our patients, our teachers

Two years ago, when we learned that our medical/surgical unit would be accepting AIDS patients, many of us began to read everything we could find about the disease. That certainly made the clinical picture clearer.

Little information was available, however, about the AIDS patient's emotional status. That meant our patients would become our teachers. Meeting Richard, my first AIDS patient, gave me an insight I would draw on again and again.

I'd returned from a day off to find the nurses on my unit buzzing about the AIDS patient with Kaposi's sarcoma who'd been admitted the night before. Seems he'd made his presence felt—strongly—with incessant, irritable demands. I assigned myself to him for that evening.

When I went into his room, my "challenge" was lying in bed, covers pulled up to his chin. He interrupted my "Hello, I'm Margaret" with a testy recitation of what he would and would not do, and what he would permit *me* to do and not do.

"Stop!" he commanded, as I approached his bed. "Stay right where you are. Don't come near my I.V.—I was bruised enough last night when the nurse inserted this needle, and I don't need you to dislodge it.

"What you *can* do is call whoever's in charge. I want to register a formal complaint about the maid service here. Look at that sticky gunk on the floor and the dust on my nightstand. If I don't get prompt action, I'm calling my attorney."

"Well, that sounds fair enough," I said calmly.

I promised to look at—but not touch—his intravenous line. While I wiped up the orange juice on his floor and dusted off his nightstand, I chatted about using him as a reference to apply at the local Hilton. That small joke eased the tension, and he seemed to relax somewhat.

I started to leave the room, replaying the whole scene in my mind. "Unbelievable," I thought. "What's *really* happening here?" Suddenly it came to me: Richard was in crisis. Overwhelmed by his situation, he was sending out distress signals to everyone.

Turning back, I met Richard's eyes: I'll never forget the helpless, desperate look in them.

I touched his shoulder and said, "I have a feeling you and I are going to become very good friends." For the first time, I saw the little smile that would later become so familiar. All he said, though, was, "You know, you may be right."

In charting my assessment, I used a single word to describe Richard's number one problem—fear. Helping him cope with that fear would be my number one goal.

"I'm a dying man"

As I would discover during the next 2 years, AIDS patients may respond to their disease differently—with denial, anger, depression, or withdrawal. But the underlying emotion is fear. That's hardly surprising, given the disease's devastating effects and the fact that there is no cure.

One night while I was in Richard's room, a newscaster reported the latest mortality figures for AIDS. "Just a friendly reminder from the media that I'm a dying man," Richard said. Then he started to cry.

I tried to reassure Richard that his diagnosis didn't mean he'd die immediately: Infectious disease episodes are treatable; he could possibly live for a number of years. The point was to focus on living, not dying.

Other threats *are* more immediate, such as loss of income. Richard ran a very profitable real estate firm, which of course

Steve Early

While walking in the hall, a patient stopped at a door that had an isolation sign. She gasped as if it read "Live Explosives."

involved a great deal of public contact. A handsome man, he considered his attractiveness a business asset. But as his Kaposi's sarcoma worsened, he liked what he saw in the mirror less and less. Once he said to me, "Who would want someone with these ugly sores on his face showing people their home? How am I going to make a living?"

Another fear weighing on the patient is that AIDS may also strike those he cares about (and needs so much now). I remember Gary, a patient who had Kaposi's sarcoma, confiding to me, "I shudder whenever the phone rings—I've lost over 20 friends to AIDS in the past year. And I'm really worried about my roommate Tom. He has some sores on his legs, but he won't see a doctor." Gary's sense of guilt about having possibly passed the disease along to Tom was nearly as overwhelming as his concern for his friend's health.

When Tom came to visit, I asked if I could speak to him alone. We talked for over an hour; mostly, I listened as he tried to sort out his feelings. He finally agreed to see a doctor.

Fear among friends and family

As Tom's denial of his symptoms demonstrates, those close to the patient have fears of their own. Like Tom, many partners of AIDS patients remain loyal, spending a lot of time at the bedside. But they're dealing with a double-edged fear—anxiety about their partner's welfare and their own health ("Am I next?"). Information about safe sex practices and human immunodeficiency virus (HIV) screening can help allay some of that fear.

If an AIDS patient is married, the spouse may carry the added burden of worrying about their children's health. One patient's wife didn't know of his bisexuality until he became ill. After she and their infant daughter tested positive for the HIV virus, she rarely visited, despite pleading phone calls from him. Shortly before he died, she called only to tell him she'd given away his dog. Fear and anger here had turned into retaliation.

Because most AIDS patients are young, their parents are usually still living. The death of a child, regardless of his age, is a special grief, complicated by the stigma associated with AIDS. Besides worrying about losing their son, parents may dread public disclosure of his sexual preference. A mother of a young heterosexual male with AIDS told friends that her son had an immunodeficiency disease, but not AIDS.

Unfortunately, some parents learn about their son's homosexuality or bisexuality only when they learn his diagnosis. Richard once joked, "The hardest part of having AIDS is...how do I tell my mother I'm Haitian?" Not a very funny dilemma, though, for the patient, nor for parents dealing with two disturbing revelations.

Even friends of the patient may find their fears keep them from giving him the support he needs. Some of Richard's friends, for instance, asked if inviting him to their homes for dinner after his discharge would be "safe." I reassured them that transmission of AIDS occurs through direct contact of body secretions, primarily blood or semen. There is no evidence that the disease can be transmitted through casual contact.

Other patients' concerns

Although infection-control procedures can protect other patients physically, they may need *emotional* protection as well. They're afraid, too: AIDS may be the most talked about but least understood disease of our time.

While walking in the hall with her husband, a patient paused at a door that had an isolation sign. She gasped as if it read "Live Explosives." I heard her say, "I wonder if that patient has AIDS, because if he does, I'm getting out of here fast."

What should we say when patients ask, "Do you ever get AIDS patients on this unit?" As nurses, we can convey the *facts* about AIDS to patients and visitors. Usually, once they understand the means of transmission, their fear lessens.

Here's an example of how facts can reduce fear. A postsurgical patient refused to have a blood transfusion unless I would "guarantee" that she wouldn't get AIDS. After I reassured her about the blood bank's HIV virus screening and testing, she felt less threatened and agreed to the transfusion.

Confronting your own fears

Of course, before they can offer anyone else information and support, health care workers caring for AIDS patients must confront their own fears—fears that may be heightened by their families' concerns for their safety. My husband, for example, used to worry that I'd stick myself with a needle when starting an intravenous line for an AIDS patient. As time passed without any incidents, that fear faded.

The staff did have legitimate concerns. What if an AIDS patient needs cardiopulmonary resuscitation? Our unit's answer is to have a disposable Ambu bag and oral airway available.

Should nurses assigned to AIDS patients also care for other immunosuppressed patients? Could we spread the disease to these patients through some error in technique? Again, because time has shown us that careful technique is the best safeguard against infection, the nurses on our unit care for *all* patients.

Research suggests that some health care professionals display signs of homophobia—fear of homosexuals. (Some may even see AIDS as God's punishment for the "sin" of being homosexual.) To determine if such attitudes exist at our hospital, we're circulating a questionnaire to identify the feelings and concerns of those caring for AIDS patients. Based on the results, we'll plan interventions to ensure quality care.

Generally, though, our experience with AIDS has already taught us that the more staff members know about this disease—and the more AIDS patients they've cared for—the more comfortable they are.

Something else happens, too: Just as panic is contagious, patients and visitors seem to take on the staff's confidence.

Important thing is to try

We can do much to help the AIDS patient and those around him deal with their fears. But we also must recognize that we won't always succeed.

Despite constant and conscientious efforts, we were never able to help Richard cope with his fears. After many long hospitalizations, he had an emotional breakdown. When his friends withdrew, he depended on us more and more. We did our best for him, but when Richard died he was still a frightened man.

The important thing is we *tried* to help him. Had we done nothing, we would have failed in a far worse way. When working with AIDS patients, we have an obligation to use our skills and knowledge not just to prevent transmission of the disease itself but also to control the fear it creates, a fear to which no one is immune.

7-9

Paul -

I would appreciate knowing your reaction to any of this.

Have a great reunion!

MARILYN MORRIS CHASE
STAFF REPORTER

DOW JONES & COMPANY, INC.
THE WALL STREET JOURNAL

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COPY

July 21, 1987

Marilyn Chase
WALL STREET JOURNAL
220 Battery St.
San Francisco, CA 94111

Dear Marilyn,

Thanks for sending me the FDA rule change and other materials. Even after reading the rule change, I remain uncertain as to its ultimate impact. It obviously leaves a tremendous amount to the discretion of the commissioner of the FDA and it might have an effect on a much broader range of drugs than just those relating to AIDS.

The principal concern that I have, at least on first pass, is how the FDA will determine that the company is in fact pursuing a marketing of the drug "actively and diligently", to use their words. In some cases, I can imagine a company being satisfied with their ability to charge for the investigational drug under the treatment IND. At least in AIDS, advertising is not likely to be necessary to inform prospective recipients about the drugs availability. Therefore, the treatment IND phase of drug testing might be in fact prolonged under this rule change.It will be interesting to follow dideoxycytidine to see at what point the pressures on the system trigger the new rules.

I also enjoyed reading the information about Mayberry that you sent. It's hard to tell much about him from reading his CV, but in talking to people in Rochester when I was back there last week, he seems quite respected there as an administrator. Once the full commission is named, it might be a good idea for us to invite him to San Francisco to give him some first-hand contact with the realities of this epidemic.

Thanks again. See you soon.

Sincerely,

Paul Volberding, M.D.
Associate Professor of Medicine, UCSF

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Rockville MD 20857

May 21, 1987

FACT SHEET

FINAL RULE ON TREATMENT USE OF AND CHARGING FOR INVESTIGATIONAL DRUGS

INTRODUCTION: FDA is issuing final procedures to facilitate the availability of promising new drugs to desperately ill patients as early in the drug's development as possible and well before general marketing begins, and to obtain additional data on the drug's safety and effectiveness. The Agency is also defining conditions under which drug manufacturers may charge for investigational new drug products. These final procedures may be summarized as follows:

TREATMENT USE: Use of an investigational drug for treating patients outside of a controlled clinical trial will be permitted under the following conditions: 1) the drug is intended to treat a "serious" or "immediately life-threatening" disease; 2) there is no comparable or satisfactory alternative drug or other therapy available to treat that stage of the disease in the intended patient population; 3) the drug is under investigation in a controlled clinical trial under an IND in effect for the trial, or all clinical trials have been completed; and 4) the sponsor of the controlled clinical trial is actively pursuing marketing approval of the drug with due diligence.

Criteria: For "serious" diseases, the Commissioner may deny a request for treatment use if there is insufficient evidence of safety and effectiveness to support such use. For "immediately life-threatening" diseases, the Commissioner may deny a request for treatment use if the available scientific evidence, taken as a whole, fails to provide a reasonable basis for concluding that the drug: (1) may be effective for its intended use in its intended patient population; or (2) would not expose the patients to an unreasonable and significant additional risk of illness or injury.

Safeguards: The final rule also clarifies that treatment use of an investigational drug is conditioned on the sponsor and investigators complying with the safeguards of the IND process. Sponsors and investigators must comply with regulations governing informed consent and institutional review boards, and the applicable provisions of the IND regulations, including distribution of the drug through qualified experts, maintenance of adequate manufacturing facilities, and submission of IND safety reports.

(continued)

CHARGING FOR INVESTIGATIONAL DRUGS: To charge for an investigational drug during a clinical trial, prior FDA approval will be required, and approval would be granted only on a showing that charging is needed in order to undertake or continue the clinical trial. For treatment IND's, sponsors may charge for experimental drugs provided: (1) there is adequate enrollment in the ongoing clinical investigations under the authorized IND; (2) charging does not constitute commercial marketing of a new drug for which a marketing application has not been approved; (3) the drug is not being commercially promoted or advertised; and (4) the sponsor of the drug is actively pursuing marketing approval with due diligence. The sponsor must notify FDA at least 30 days prior to charging.

For both clinical trials and treatment IND's, the sponsor may not commercialize an investigational drug by charging a price larger than necessary to recover costs of manufacture, research, development, and handling. In addition, FDA can withdraw authorization for charging if the conditions underlying the initial authorization are no longer satisfied.

EFFECTIVE DATE: This regulation will become effective June 22, 1987.

CURRICULUM VITAE

WILLIAM EUGENE MAYBERRY - born August 22, 1929, Cookeville, Tennessee

Married: Jane G. Foster, December 29, 1953

Children: Ann Graves Mayberry
Paul Foster Mayberry

Education

Tennessee Technological University, 1947-49
University of Tennessee College of Medicine, M.D., 1953
Intern, U.S. Naval Hospital, Philadelphia, PA, 1953-54
Fellow, First Assistant and Assistant to Staff in Internal Medicine, Mayo Foundation, Rochester, MN, 1956-59
M.S., Internal Medicine, minor in Physiology, University of Minnesota, 1959
Certified, American Board of Internal Medicine, 1964

Trainee, National Institute of Arthritis and Metabolic Diseases
Research Fellow in Endocrinology, New England Center Hospital
Assistant in Medicine, Tufts University School of Medicine, Boston, MA, 1959-60
Postdoctoral Fellow of American Cancer Society in the National Institute of Arthritis and Metabolic Diseases, Bethesda, MD, 1962-64

Military Service - U.S. Navy, 1954-56

Mayo Clinic Career

Consultant in Medicine, Section of Endocrinology, 1960-62
Consultant in Internal Medicine (Endocrinology) and Head of Section of Biochemical Pharmacology, 1964-67
Consultant, Section of Endocrine Research, 1967-71
Consultant, Department of Laboratory Medicine, 1971-
Chairman, Department of Laboratory Medicine, 1971-75

Academic appointment as Instructor in Medicine, Mayo Graduate School of Medicine, 1960; Assistant Professor, 1964; Associate Professor, 1969
Professor of Laboratory Medicine, Mayo Medical School, 1974
Professor of Medicine, Mayo Medical School, 1983

Board of Governors, Mayo Clinic, 1971-; Vice Chairman, 1973-75; Chairman, 1976-; Administrative Committee 1973-86, Chairman, 1974-86

Board of Trustees, Mayo Foundation, 1971-; Vice Chairman, 1975-86; Chairman, Executive Committee, 1986; President, 1986-

Chief Executive Officer, Mayo Foundation, 1986-
Chairman, Hospital Management Board
Chairman, Board of Directors, RMH Health Services, Inc.
President, Board of Trustees, St. Marys Hospital
Chairman, Board of Directors, Rochester Methodist Hospital
Chairman, Board of Directors, RMH Foundation

Honors

Biology Medal, Tennessee Technological University, 1949
Postgraduate Travel Award for Excellence in Internal Medicine,
Mayo Graduate School of Medicine, 1959
Distinguished Alumnus Award, Tennessee Technological University, 1976
Outstanding Alumnus, University of Tennessee, 1982
Doctor of Humane Letters (hon.), Jacksonville (Florida) University, 1983
Mayor's Medal of Honor, Rochester, MN, 1985
1986 Medical Executive Award, American College of Medical Group Administrators

Professional Organizations

Endocrine Society
American Thyroid Association
American Federation for Clinical Research
Central Research Club
Society of Sigma Xi
Fellow, American College of Physicians
American Medical Association
Minnesota Medical Association
Zumbro Valley Medical Society
American Clinical and Climatological Association
Fellow, American College of Physician Executives
(Board of Regents, 1983; Vice President, 1985)
American Academy of Medical Directors
Society of Medical Administrators
Institute of Medicine, National Academy of Sciences

Civic and Corporate Activities

Member, Board of Trustees, Minnesota Mutual Life Insurance Company, 1983-
Trustee, Minneapolis Society of Fine Arts, 1983-
Minneapolis College of Art and Design, Board of Overseers, 1983-86
Museum Board of Overseers, 1986-
Financial Advisory Board, League of Women Voters of Minnesota Education Fund, 1984
Trustee, Cumberland University, Lebanon, TN, 1984-86
Board of Directors, Northwestern Bell Telephone, 1985-
Board of Overseers, University of Minnesota School of Management, 1985-
Governor's Task Force on Torture Victim Facility, 1985
Governor's Committee on Economic Future of Minnesota, 1986
Board of Directors, Kahler Corporation, 1986-
Rochester Civic Music, Endorsement Chairman, "Commitment to Excellence"
Fund Drive, 1986
Board of Directors, Geo. A. Hormel Co., 1986-
Member, Board of Directors, Minnesota Business Partnership, Inc., 1986-
Congressional District 1 Representative, State of Minnesota Compensation
Council, October-December, 1986
Board of Directors, Greater Rochester Area University Center, 1986
Board of Directors, Minnesota Academic Excellence Foundation, 1986-

Publications - 38; abstracts and editorials - 18

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 25, 1987

EXECUTIVE ORDER

- - - - - - -

PRESIDENTIAL COMMISSION ON THE
HUMAN IMMUNODEFICIENCY VIRUS EPIDEMIC

By the authority vested in me as President by the Constitution and laws of the United States of America, including the Federal Advisory Committee Act, as amended (5 U.S.C. App. I), and in order to create an advisory commission to investigate the spread of the human immunodeficiency virus (HIV) and the resultant acquired immune deficiency syndrome (AIDS) in the United States, it is hereby ordered as follows:

Section 1. Establishment. (a) There is established the Presidential Commission on the Human Immunodeficiency Virus Epidemic to investigate the spread of the HIV and the resultant AIDS. The Commission shall be composed of 11 members appointed or designated by the President. The members shall be distinguished individuals who have experience in such relevant disciplines as medicine, epidemiology, virology, law, insurance, education, and public health.

(b) The President shall designate a Chairman from among the members of the Commission.

Sec. 2. Functions. (a) The Commission shall advise the President, the Secretary of Health and Human Services, and other relevant Cabinet heads on the public health dangers including the medical, legal, ethical, social, and economic impact, from the spread of the HIV and resulting illnesses including AIDS, AIDS-related complex, and other related conditions.

(b) The primary focus of the Commission shall be to recommend measures that Federal, State, and local officials can take to (1) protect the public from contracting the HIV; (2) assist in finding a cure for AIDS; and (3) care for those who already have the disease.

(c) In particular, the Commission shall (1) evaluate efforts by educational institutions and other public and private entities to provide education and information concerning AIDS; (2) analyze the efforts currently underway by Federal, State, and local authorities to combat AIDS; (3) examine long-term impact of AIDS treatment needs on the health care delivery system, including the effect on non-AIDS patients in need of medical care; (4) review the United States history of dealing with communicable disease epidemics; (5) evaluate research activities relating to the prevention and treatment of AIDS; (6) identify future areas of research that might be needed to address the AIDS epidemic; (7) examine policies for development and release of drugs and vaccines to combat AIDS; (8) assess the progression of AIDS among the general population and among specific risk groups; (9) study legal and ethical issues relating to AIDS; and (10) review the role of the United States in the international AIDS pandemic.

more

(OVER)

(d) The Commission shall make a preliminary report to the President not later than 90 days after the date the members of the Commission are first appointed or designated. The Commission shall submit its final report no later than 1 year from the date of this Order.

Sec. 3. Administration. (a) The heads of Executive departments and agencies, to the extent permitted by law, shall provide the Commission, upon request, with such information as it may require for purposes of carrying out its functions.

(b) Members of the Commission may receive compensation for their work on the Commission at the daily rate specified for GS-18 of the General Schedule. While engaged in the work of the Commission, members appointed from among private citizens of the United States, to the extent funds are available, may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by law for persons serving intermittently in the government service (5 U.S.C. 5701-5707).

(c) The Office of the Secretary of Health and Human Services, subject to the availability of appropriations, shall provide the Commission with such administrative services, funds, facilities, staff, and other support services as may be necessary for the performance of its functions. The heads of other Executive departments and agencies, to the extent permitted by law, shall cooperate with the Commission and provide such personnel and administrative support as may be necessary for the performance of its functions.

Sec. 4. General Provisions. (a) The functions of the President under the Federal Advisory Committee Act, as amended (5 U.S.C. App. I), except that of reporting annually to the Congress, which are applicable to the Commission, shall be performed by the Secretary of Health and Human Services, in accordance with guidelines and procedures established by the Administrator of General Services.

(b) The Commission, unless sooner extended, shall terminate 30 days after submitting its final report to the President.

RONALD REAGAN

THE WHITE HOUSE,

June 24, 1987.

# # #

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Food and Drug Administration
Rockville MD 20857

May 21, 1987

FACT SHEET

FINAL RULE ON TREATMENT USE OF AND CHARGING FOR INVESTIGATIONAL DRUGS

INTRODUCTION: FDA is issuing final procedures to facilitate the availability of promising new drugs to desperately ill patients as early in the drug's development as possible and well before general marketing begins, and to obtain additional data on the drug's safety and effectiveness. The Agency is also defining conditions under which drug manufacturers may charge for investigational new drug products. These final procedures may be summarized as follows:

TREATMENT USE: Use of an investigational drug for treating patients outside of a controlled clinical trial will be permitted under the following conditions: 1) the drug is intended to treat a "serious" or "immediately life-threatening" disease; 2) there is no comparable or satisfactory alternative drug or other therapy available to treat that stage of the disease in the intended patient population; 3) the drug is under investigation in a controlled clinical trial under an IND in effect for the trial, or all clinical trials have been completed; and 4) the sponsor of the controlled clinical trial is actively pursuing marketing approval of the drug with due diligence.

Criteria: For "serious" diseases, the Commissioner may deny a request for treatment use if there is insufficient evidence of safety and effectiveness to support such use. For "immediately life-threatening" diseases, the Commissioner may deny a request for treatment use if the available scientific evidence, taken as a whole, fails to provide a reasonable basis for concluding that the drug: (1) may be effective for its intended use in its intended patient population; or (2) would not expose the patients to an unreasonable and significant additional risk of illness or injury.

Safeguards: The final rule also clarifies that treatment use of an investigational drug is conditioned on the sponsor and investigators complying with the safeguards of the IND process. Sponsors and investigators must comply with regulations governing informed consent and institutional review boards, and the applicable provisions of the IND regulations, including distribution of the drug through qualified experts, maintenance of adequate manufacturing facilities, and submission of IND safety reports.

(continued)

CHARGING FOR INVESTIGATIONAL DRUGS: To charge for an investigational drug during a clinical trial, prior FDA approval will be required, and approval would be granted only on a showing that charging is needed in order to undertake or continue the clinical trial. For treatment IND's, sponsors may charge for experimental drugs provided: (1) there is adequate enrollment in the ongoing clinical investigations under the authorized IND; (2) charging does not constitute commercial marketing of a new drug for which a marketing application has not been approved; (3) the drug is not being commercially promoted or advertised; and (4) the sponsor of the drug is actively pursuing marketing approval with due diligence. The sponsor must notify FDA at least 30 days prior to charging.

For both clinical trials and treatment IND's, the sponsor may not commercialize an investigational drug by charging a price larger than necessary to recover costs of manufacture, research, development, and handling. In addition, FDA can withdraw authorization for charging if the conditions underlying the initial authorization are no longer satisfied.

EFFECTIVE DATE: This regulation will become effective June 22, 1987.

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SCHOOL OF MEDICINE

July 23, 1987

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

I. Kelman Cohen, M.D.
Professor and Chairman
Medical College of Virginia
Virginia Commonwealth University
11th & Marshall Sts.
Box 154 Nelson Clinic
Richmond, Virginia 23298-0154

Dear Dr. Cohen:

I apologize for responding so late to your letter of June 11, 1987, regarding your patient with septal perforation who is HIV positive.

I, in fact, have seen at least two patients with chronic septic ulcerations who are HIV positive who denied any use of internasal drugs. My suspicion has been that this might represent cytomegalovirus infection, but this has not been confirmed. Another case that we saw recently might also be worth commenting on. This was a young, gay man with HIV infection presented with initially an enlarged tonsil, but quickly developed necrosis of the tonsil and tonsillar bed. Despite several biopsies, all we could find in the eroded area was evidence of chronic inflamation. A final biopsy, under anesthesia, then revealed an aggressive B cell lymphoma, from which the patient died rapidly despite attempts at therapy.

I raise this just to point out the complex effect of HIV on other disease processis. I would think the best thing for your patient would be to rebiopsy him at a latter point if the workup for CMV is negative and if the problem persists. I know this is a vague response, but we're learning as we're going along.

Again, my apologies for the delay.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

Medical College of Virginia
Virginia Commonwealth University
11th & Marshall Streets
Box 154 - Nelson Clinic
Richmond, VA 23298-0154
(804) 786-9318

June 11, 1987

Dr. Paul Volderbing
San Francisco General Hospital
995 Potrero Avenue
San Francisco, CA 94110

Dear Dr. Volderbing:

I am writing at the suggestion of the plastic surgeons at San Francisco General Hospital who thought you might have an answer.

A young homosexual came to me recently because of a massive septal perforation. He does not use drugs of any kind. The work-up was entirely negative but he is HTLV3 positive. The biopsy showed necrosis without evidence of inflammation.

Could the septal problem be AIDS-related in an otherwise asymptomatic patient?

Thanks for any ideas you might have.

Sincerely yours,

I. Kelman Cohen, M.D.
Professor and Chairman

IKC:slc

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 22, 1987

Joseph Cotropia, M.D.
Internal Medicine
The University of Texas at Austin
Box 7339 University Station
Austin, Texas 78713

Dear Joseph,

I am responding, as always incredibly delayed, to your letter of June 23rd regarding your patient who is asymptomatic and seropositive.

I think from your description that the patient is in the absolutely best prognostic group of HIV infected people. He has such a small chance of progressing to AIDS even in the intermediate future that I would probably would wait with respect to antiviral therapy or therapy to prophalax against opportunistic infections. Obviously, these can be considered as you get a better idea of the effect of the viral infection on his T4 population. If you repeat the T4 counts at approximately a 3 to 6 month interval and see a definite trend over two or more determinations, I might feel more inclined to get him on antiviral treatment. In the interim, of course, he would be eligible for some of the asymptomatic seropositive AZT trials that would be available through Peter Mansell's ATEU in Houston. In the meantime, I would reassure the patient.

Hope this is a little helpful.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

STUDENT HEALTH CENTER
THE UNIVERSITY OF TEXAS AT AUSTIN

Box 7339 · University Station · Austin, Texas 78713

June 23, 1987

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH
995 Potrero Avenue, Ward 84
San Francisco, CA 94110

Dear Dr. Volberding:

It was likewise a pleasure to me to meet you and also other important and experienced individuals at the AMFAR dinner and International AIDS Conference in Washington.

I remain optimistic that the battle against AIDS will be won. I certainly, as do all who are immediately involved, wish it would be very soon.

Paul, now that I have at least an initial acquaintance with you, who are at the forefront of AIDS protocol information, I would like to ask your advice concerning treatment for a friend who has been exposed to HIV.

This 43 year old gentlemen is asymptomatic (no weight loss, night sweats, diarrhea, thrush, or lymphadenopathy) with a positive HIV antibody test by ELISA and a Western Blot confirmation.

On two occasions, in viral culture assays by Dr. Hollinger's lab at Baylor, reverse transcriptase and p24 have not been detected. There has been no *in vitro* testing of lymphocyte function or DTH skin testing. Lab tests indicate past exposure to hepatitis B virus with no carrier state present and past exposure to EB virus. The CMV titer is 312 (normal less than 20).

CBC, platelet, and SMAC are normal, expect for 49% lymphocytes on the differential. The following values are presented concerning subpopulations of lymphocytes and immunoglobulins: Notably the T_4 absolute number is 1056/mm^3 (370-1482) with a T_8 of 833/mm^3 (162-682); and B cells of 500/mm^3 (112-439) and an IgG elevated at 1810 mg% (639-1349). The WBC is 5.5 with 44% PMN; the hematocrit is 47.6.

The person has had no history of syphilis, herpes simplex, or condyloma accuminata.

What would you recommend with regard to monitoring, or additional tests, and treatment (anti-viral(s) and/or immuno-modulators), if any.

Of course being close to Dr. Peter Mansell, with regard to friendship and geography, and having an available source of Ribavirin (Mexico), this would be one anti-viral to consider.

The individual, described health and lab- wise, resides in Philadelphia, and the question concerning the Ampligen protocol at Hahnemann has arisen.

What would you recommend doing; I, and my friend, would greatly appreciate your help.

Sincerely,

Joseph Cotropia

Joseph Cotropia, M.D.
Internal Medicine
The University of Texas at Austin
Student Health Center
(512) 471-4955, extension 258

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Paul Volberding, M.D.
Chief, Med. Oncology
San Francisco General Hosp.
995 Potrero Ave.
Ward 86
San Francisco, CA 94110

Dear Dr. Volberding:

We are in the process of updating our Speakers file.

I would appreciate a current Curriculum Vitae which includes your business phone, address; for confidential check processing only, please include your social security number.

In returning your Curriculum Vitae, please complete the attached survey form. This form will help us to select appropriate meetings where your skills and expertise are best utilized and appreciated.

Thank you for your participation in our Speakers Program. If you haven't participated, I look forward to the opportunity of your doing so.

Sincerely,

Brenda Ferrell

Brenda Ferrell
Speakers Program Manager

BW/11
Attachment

CV and form returned 7-8-87 L.

SPECIALIZED FIELD AIDS / ONCOLOGY

NAME PAUL VOLBERDING MD

TITLE ASSOC. PROF MED UNIV. OF SAN FRANCISCO

INSTITUTION AFFILIATE CHIEF DIVISIONS OF AIDS ACTIVITIES & MEDICAL ONCOLOGY SAN FRANCISCO GEN. HOSP

ADDRESS WARD 84 – SAN FRAN. GEN. HOSP.

995 POTRERO AV.

SAN FRANCISCO CA **ZIP** 94110

PHONE (415) 821-5531 **SS #** [redacted]

I prefer speaking to an audience size:

Greater than ____
Less than ____
Does Not Matter ✓

Small audience (< 150) OK depending on who they are.

I prefer an audience of:

☐ CRNA ☐ R.N. ☐ Other

☒ M.D./D.O. ☐ Pharmacists

TOPICS:

1. AIDS – OVERVIEW & UPDATE
2. PROSPECTS FOR CONTROL OF AIDS WITH ANTIVIRALS
3. THERAPY OF AIDS RELATED MALIGNANCIES
4.
5.
6.
7.

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TERRITORY ____

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Burroughs Wellcome Co.
Attn.: Speakers Program Department
3030 Cornwallis Road
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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 22, 1987

[redacted]

Dear Dr. Franco:

Your nephew is one of a very large group of people who are in the earlier stages of HIV infection. It is helpful to know the absolute number of T4 cells and we are using that more than the ratio currently to estimate prognosis.

Nevertheless, with a [redacted] he is likely to be in somewhat earlier stages of HIV infection. This would be consistent with his [redacted] and his lack of [redacted]. While there are experimental trials underway to test AZT in this type of patient, I do not think that it is imperative that he seek out one of those trials. I would expect that we would learn a good deal more within the next year or so and that he might be able to avail himself of the drug should things look promising.

Hope I've been of some help.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

[redacted]

TELEPHONE [redacted]

June 16, 1987

Paul Volverding, M.D.
Ward 84
San Francisco General Hospital
995 Potrero
San Francisco, CA 94110

Dear Dr. Volverding:

I called your office last week to invite you to give us an update on AIDS, at O°Connor Hospital, your secretary said that the date of July 21 may be fine, I hope that you accept our invitation.

However, I am writing now to ask you a personal favor. The situation is as follows:

I have a 40 year old nephew who lives in Italy, he sent me reports of tests performed at two large hospitals. [redacted].

[redacted]

His question, my question is" should he be taking some medication ,experimental or otherwise to prevent progression of the disease".

Any advice or help that you can give us will be much appreciated.

Sincerely,

[redacted] M.D.

[redacted]

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 21, 1987

Patrick Glasscock
[redacted]

Dear Mr. Glasscock:

I am sorry to respond so late to your letter of June 22nd concerning your research study, but I have been away a great deal from San Francisco.

I would be more than happy to post the notice you sent about your study. I might refer you to our acting head nurse, Tracy Moran, who has in fact, completed a very similar study. You might find that she has useful ideas for you.

Best wishes with your work.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

June 22, 1987

Patrick Glasscock
[redacted]

Dr. Paul Volberding
AIDS Activity Office
San Francisco General Hospital
995 Potrero Avenue, Building 80, Ward 84
San Francisco, CA 94110

Dear Dr. Volberding:

I am writing at the suggestion of Dr. Dean Echenberg to introduce myself and request your assistance with the completion of my doctoral dissertation. I am a doctoral candidate at The Institute for Advanced Study of Human Sexuality in San Francisco and Dr. Echenberg is a member of my dissertation committee.

The title of my dissertation is "What changes, if any, do gay and/or bisexual males with a diagnosis of AIDS make in their sexual behaviors?" It is a descriptive study of the incidence and frequency of the sexual behaviors of 50 men who have been diagnosed with AIDS for at least six months. The purpose of the study is to determine what effect(s), if any, AIDS has on an individual's sexual behaviors, his interest in sexual activity and the satisfaction derived from his sexual expression.

Data for the study is gathered by securing personal interviews with volunteers where I verbally take a complete and confidential sex history using Kinsey's concept of "Total Sexual Outlet". Participation in this study is completely voluntary and involves the completion of a one-time-only interview which I can schedule at the volunteer's convenience.

In reviewing the literature on the general topic of the sexual activities and needs of persons with terminal illnesses, I found there have been no empirical studies done in this area, due largely to the taboos associated in our society around sex and death. To date, I have completed 33 of the 50 interviews I have targeted for this study. Volunteers have been solicited through personal contacts, and advertisements in the PWA Update and Healing AIDS newsletters, and in various local gay newspapers.

Dr. Echenberg suggested contacting you to see if it would be possible to post a notice of my study in the out-patient clinic. I have enclosed several copies of a flyer advertising my study and an abstract describing the purpose and procedures followed. I would ask that you review these and if possible, post them on informational bulletin boards around the clinic.

I would be happy to answer any questions you or your staff might have regarding my request and this research project and can be reached during the day at (415) 627-6338. I will contact you later this week to get your decision and answer any questions you might have. Once my study is completed, I would be most happy to forward a copy of the results to you.

Thank you for taking the time to consider my request and I will look forward to talking with you later this week.

Sincerely,

Patrick Glasscock

Patrick Glasscock, Ph.D.(c)

Enclosures

cc: Dr. Dean Echenberg

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 21, 1987

Ms. E.H. Leoni
[redacted]

Dear Ms. Leoni:

Thank you for your letter of July 3rd expressing your interest in AIDS virus transmission.

In specific response to your questions concerning transmission by hepatitis immunoglobulin or vaccine, I feel we have a considerable amount of information to offer. While the gamma globulin preparations available have, in some cases, been positive for the antibody to the AIDS virus, no one has found the virus itself in those preparations, nor has anyone been infected after receiving gamma globulin shots. I researched this carefully before recommending that my father-in-law receive gamma globulin shots as prophylaxis before a trip recently, so I feel fairly confident in this area.

The hepatitis B vaccine is even more purified than the gamma globulin and contains neither the AIDS virus nor the antibody. I agree with your suspicion that anal intercourse is not the only way this virus can be transmitted sexually and at the recent AIDS meeting in Washington, heard quite a bit of research that showed that vaginal intercourse is able to spread the virus from men to women and from women to men.

Again, thank you for your interest.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

Dr. Paul Olberding
San Francisco General Hospital Medical Center
1001 Potrero Avenue
San Francisco, CAlifornia 94110

July 3, 1987

Dear Dr. Olberding:

Since being impressed by your contributions on an AIDS forum on TV, I have been intending, and just presently getting to, to try my best to get a response to a query epidemiology especially oriented to San Francisco, re which you are presumably currently a leading local authority, or even the.

Is it still the "official position" that there is no causal relationship involved in the huge percentage of the 6875 persons (all gay males?) in the "San Francisco Study Group" who, after receiving injections offering protection against hepatitis circa 1978-9, had been infected by the AIDS virus (under its various names) by 1984? I make the percentage 92% per the article by Dr. Curran et al. of CDC "The Epidemiology of AIDS:Current Status and Future Prospects" in the 27 September 1985 SCIENCE, especially pages 1353 and1356, wherein it is stated that the 24% who in 1980 "had antibody to HTLV-III/LAV" had by 1984 "increased 280 percent".

Elsewhere, the lack of causal connection is affirmed by the seeming irrelevance of "present" processes precluding the live virus, and some handful of subjects where "false positive" was found eventually, per only passively acquired antibodies. (Shades of Tobacco Lobby reasoning!)

However, Mathilde KRIM, Grande Dame of AIDS Research, has been in print since February,1987 (see relevant sections per enclosed xerox of INTERVIEW magazine of February,1987) that it was indeed via infected gamma globulin for protection against hepatitis that the gay community first acquired AIDS. (After implying perhaps up to 1000, she then implies the many additional thousands sexually transmitted, apparently always per anal intercourse, which, incidentally and rather amusingly, like her former AMFAR colleague Dr. Silverman, she feels is the only route also for sexual transmission per heterosexuals--which implies impossibility of sexual transmission acquisition for a male who has without exception been in "insertor" sexual role (with exceptions attributed to anecdotal falsification) and obviously at variance with prevailing "heterosexual sexual transmission by missionary position vaginal sex,to either partner" medical party line.

Dr./Mrs. Krim does indeed thoughtfully preclude the likelihood of any live virus being involved for the 6875, per the seemingly non-sequitur reasoning that if the first infection goes back to the early 1970s (somewhat arbitrarily assuming a "must" minimum of 5 years until "full-blown AIDS"after infection, with first clear in 1978) AND present processes preclude live virus in the globulin, then in late 1970s also there couldn't exist and be used any more globulin with AIDS-producing live virus (and same possibly into early 1980s).

While my query is specifically directed to the San Francisco scene,insofar as response would necessarily involve the world picture, I would suggest that there was probably parallel globulin infection in the 1970s in other countries (probably with UN WHO personnel playing a big role after spearheading Africa blood drives) and the spread from the originally infected in Africa (and possibly Haiti etc.) in such huge numbers being attributable to "shared needles" usage by doctors and paramedics (with usual excuse of "shortage") in the many varieties of injections for which there is an apparent great demand and yen there.

Trusting you will find time for most forthright response in your undoubted busy schedule,

Sincerely

C. H. Leavi [redacted]

Dr. Mathilde Krim of AMFAR (MK) interviewed by Larry Kramer (LK). Interview 2/87

guess it isn't: I mean, it took the New York gay community two years to get a meeting with Koch. Could you get Elizabeth Taylor to go on TV and say, "Mr. Reagan, please pay attention to this disease. I appeal to you as a fellow performer," or whatever? Maybe we need that kind of person to ask publicly, "Mr. President, help save my friends. They're dying." That's what it amounts to. You have yet to hear Ronald Reagan utter the word "AIDS." Maybe he has to be shamed into it.

MK: It's difficult to shame him, as you know—very difficult.

LK: How do you make the most of your time?

MK: I talk a lot to the media and the press on basically medical and scientific information. I do a lot of public speaking, because in many states they just now are setting up their educational program, and they're just learning. In the Midwest, this is a new problem for them. I try to fight the idea that the gay men are giving us AIDS. I explain that we probably gave it to the gay men to start with, by innoculating them with infected gamma globulin, which is probably what happened.

LK: The gamma globulin we received to protect us against exposure to hepatitis was infected?

MK: That's right. The gamma globulin was made in the early '70s out of pooled human blood that was not collected in this country. It was bought in the Caribbean and Africa.

LK: That's what you think?

MK: It's a hypothesis, but it makes a lot of sense to me, and it also makes a lot of sense from the epidemiological standpoint, because if one person had caught AIDS in Haiti or somewhere and had come back to this country and given it to another person, who gave it to another person, we would have seen a picture like this: one case one year, ten cases the next year, 20 cases a year later and so forth—a slow buildup. In 1981, after having identified the first five cases in L.A. and the first nine cases here, people started looking around, and suddenly we had several hundred *the same year*, and then several thousand a year later.

What occurred was what we call a multifocal infection. Many people must have become infected at the same time. How can such a thing happen? I first thought it was during the clinical trials of gamma globulin* preparations for prevention of hepatitis that the infection occurred, but I checked the dates. These trials started in '78, '79. That's too late; we already had cases then.* The infection occurred at least five years prior to that. It must have occurred in the early '70s, and in those years, industrial companies—not the not-for-profit blood centers, but the for-profit blood industry—were buying blood from prisoners and from overseas, including Africa and the Caribbean. If they purchased lots of blood where many individual blood donations were infected, and they pooled all this blood and concentrated all the gamma globulin, an infectious virus in large amounts would become trapped in the gamma globulin. The purification procedure is done under what they call very "mild" conditions. The purification steps, in combination, are able to inactivate a large proportion of the virus, but only a proportion, because one doesn't want to damage the antibody proteins in the process. If you start with a big enough concentration of virus in the original blood, you may end up with blood with an infectious virus at the end. The experiment was actually done in the lab and published: You need to start with a high concentration of virus, but if you do, you find infectious virus at the end. So it is technically possible in the time frame.

LK: We were all getting gamma globulin shots back in the early '70s. The minute you said you'd been to bed with someone who came down with hepatitis, your doctor would pop you a shot. It was like taking aspirin for a cold.

MK: That's right. As hepatitis is highly prevalent among gay men, doctors did that routinely. Recent gamma globulin is clean of virus. It's made up of American blood that is screened.*

LK: Well, then, why weren't there more straight cases in the early days?

MK: No other group was so constantly, almost habitually, given gamma globulin as gay men. Ron Grossman *[a physician with a large gay practice]* told me it was absolutely routine to give gamma globulin.

LK: How many shots in the course of a year is routine?

MK: Ten, twelve.

LK: Oh, I see—big, big receivers of gamma globulin, not just your odd shot here and there.

MK: Now, we don't have absolute proof, but there is this belief that a little dose of virus is perhaps something that we can overcome—even rabies virus, which is also lethal. When the dose is too big and the virus has time to multiply sufficiently to overcome antibody immune reactions and so forth, the infection really takes hold. So it's possible that rare, small doses would not achieve infection, but repeated or large doses would.

LK: Is this your idea?

MK: It's my idea; I don't know that anybody else thought of it. I've also never heard the question asked, "Why gay men?" Why? Certain behaviors may facilitate the spread of the infection, but they don't create it.

LK: Is there any way to investigate this?

MK: It's very difficult. These preparations of gamma globulin were made by private industry, and they're not going to volunteer the information to us. We could go through their freezers, dig out some of the preparations and check them, but it may be impossible. In order to preserve gamma globulin in a functioning condition, you have to keep it at a temperature that eventually destroys the virus.

LK: What do you think are our chances of getting a vaccine for AIDS?

MK: They're quite good. There's nothing that indicates the vaccine will not be possible. We don't have all the positive answers in yet, but we also don't have any major obstacles. We have five different methods for developing a vaccine, and several of them seem to work, so I'm pretty sure we'll have something.

LK: In a couple of years?

MK: It depends for whom. I think for people at risk, who are willing to volunteer for clinical trials of vaccines, safety trials, there may be something available within months—we're that close. Now, for the population at large, with little babies, that's ten years away.

LK: Do you think there will be a way to restore the immune system?

MK: Yes, I think so—to restore it enough to keep people out of bed and functioning.

LK: Something that will actually make the T cells go up?

MK: Yes. There are a number of things coming along, and this is why I think it's very important not to lose hope. If we really applied ourselves and used all we have, somebody diagnosed with AIDS today could be kept alive until the next drug comes along . . . and then the next drug and think AZT is capable of protecting their lives and well-being so they will never develop AIDS. I hope the price will not be so extravagant that people will have to die for lack of money, which is another little problem we're going to face soon.

We don't yet see a possibility of getting rid of the virus altogether, because it integrates itself into the human chromosome. It will sit there as a provirus, probably for life, but we will be able to suppress its multiplication and prevent it from doing any damage.

LK: Is AZT the drug that seems most promising?

MK: Now it is, but there are already others that, for reasons that have to do with their chemical structure and so forth, may be better than AZT in the future. They're coming along rather fast, now that we're becoming a little better at screening drugs in the proper systems. I know that we have at least two other drugs that seem to be better than AZT. Five years ago we didn't know what to do, where to start. It's clear now what needs to be done, so it should be a crusade of hope.

LK: How do you think our way of life might be changed in the future because of all the people who will have AIDS?

MK: We already have three or four million people infected, whether they know it or not. We're going to have many more before the thing slows down or is reversed, before a vaccine comes along. With the vaccine we'll have a very, very large population in this country and elsewhere that will be apparently healthy—

LK: But dependent on medication.

MK: Yes. Imagine how much that will cost—because it will be a lifelong condition. These people's life choices will be very limited. These are people who cannot think of getting into a boy-girl kind of marriage and having lots of children. They are not going to be able to have children, and they will be potentially infectious to others, although less so than untreated people because the virus' multiplication will be suppressed. I don't think we will ever be able to say, "You don't carry any virus at all." So I think for these people, a conventional kind of marriage will be out. They're going to need to live in a social group, because that's human nature, and so there will be all different sorts of families emerging from this. By necessity, I think we're going to have to become very tolerant of different lifestyles and living arrangements, including homosexual arrangements in the open.

LK: The Americal Civil Liberties Union has just come out in favor of gay marriages.

MK: Well, sure, to the extent that marriage is a business contract.

LK: It allows for insurance and beneficiaries.

MK: I hope that will be part of the change. Organized religions are going to have to do some rethinking. I think there will also be a decrease in birthrates, because large numbers of people will be effectively unable to procreate. There will also be a very large number of children who will be abandoned because they are infected, and since it

*Non-sequitur! Earliest globulin infection being in early 1970s and "recent" being "clean of virus" doesn't preclude virus being in globulin in late 1970s & early 80s.

Copy

July 21, 1987

Robert Makuch, Ph.D.
Associate Professor of Biostatistics
Yale University
Department of Epidemiology and Public Health
60 College St. P.O. Box 3333
New Haven, Connecticut 06510

Dear Bob,

Thanks for getting the Amfar Letter of Intent in. I tried to contact you, I think on the day of the deadline. As you can imagine, things are as hectic as ever here in Paradise.

I look forward to talking with you soon about the structure of the grant.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

Yale University

Department of Epidemiology
and Public Health
School of Medicine
60 College Street
P.O. Box 3333
New Haven, Connecticut 06510

June 17, 1987

Dr. Paul Volberding
San Francisco General Hospital
Ward 84
995 Potrero Avenue
San Francisco, California 94110

Dear Paul:

It was good seeing you again in Washington. Per our discussion please find enclosed a draft of an abstract to be presented to AMFAR. The RFP is attached. Also, AMFAR wants to have a brief cover letter [2 pages or less] attached to the abstract. Could you please draft the letter, and send it back to me along with your comments of the abstract, in time for me to receive it by June 29. I will call you early next week and check that all of this meets with your approval. With warmest regards,

Sincerely,

Bob

Robert W. Makuch, Ph.D.
Associate Professor of Biostatistics

RWM/kb
Enclosure

P.S. I tuned in to Koppel's AIDS nightline show and the first person I heard speak was the fellow to your right. I had to recheck my television dial to make sure I wasn't watching Saturday Night Live by mistake. He was wild!

Assessing Staging Information for HIV-Infected Individuals

Robert W. Makuch

Paul Volberding

Abstract

Proper staging of HIV-infected individuals is important in order to define homogeneous groups of individuals and characterize the efficacy of therapies with greater precision, and to provide a better understanding of the biology of the disease process. In this proposed research we will apply, compare, and hopefully improve upon existing staging schemes for the assessment of individuals at risk of developing AIDS or those currently suffering from AIDS. Current staging schemes include those developed at the University of California at San Francisco (UCSF), Centers for Disease Control, and Walter Reed. In excess of 1800 individuals with prolonged follow-up, the UCSF database will be the basis for our comparative evaluation. Through this effort we hope to identify areas where the current staging systems are deficient, and to propose alternatives to correct such deficiencies. Ultimately, this process should lead to more effective staging criteria to better discriminate among groups of HIV-infected individuals.

AmFAR

AMERICAN FOUNDATION FOR AIDS RESEARCH
LOS ANGELES OFFICE

May 1, 1987

TO: AIDS RESEARCHERS AND ADMINISTRATORS*

FROM: JAY THEODORE, GRANTS OFFICER

SUBJECT: REQUEST FOR PROPOSALS -- RFP: AmFAR587.4

===== REQUEST ==== FOR ==== PROPOSALS ==== ANNOUNCEMENT ==========

The American Foundation for AIDS Research (AmFAR) invites interested investigators to submit a letter of intent for grant awards in biomedical, humanistic and social sciences research relevant to AIDS. Awards are granted up to a maximum of U.S $50,000 in direct costs for one year. The Foundation also awards travel Fellowships to established investigators for training or short term study at U.S. institutions to a maximum of U.S. $5,000. Letters of Intent will not be accepted from for-profit entities. After review by the Foundation's Science Policy Committee, a limited number of research grant proposals will be solicited from among those submitting Letters of Intent. Eighty-five proposals will be solicited for this RFP.

To be considered for solicitation of a research grant application, please submit a Letter of Intent. A Letter of Intent consists of the following documents in the following order: 1) the Cover Page on the reverse of this RFP; 2) a brief Cover Letter [2 pages or less]; 3) a 200 word Abstract of the proposed project; 4) a not more than 2 page C.V. of the Principal Investigator including not more than 15 relevant and/or recent publications. The original and seven (7) copies of the Letter of Intent as requested above must be received at the folowing address by 5:00 P.M. PST, Tuesday, July 14, 1987:

AMERICAN FOUNDATION FOR AIDS RESEARCH
GRANTS DEPARTMENT
9601 WILSHIRE BOULEVARD, MEZZANINE LEVEL
BEVERLY HILLS, CALIFORNIA 90210-5294

Letters of Intent that arrive late or exceed the page limitations will not be accepted.

Awards will be made in November, 1987 after peer-review of solicited applications received in October, 1987.

For further information, please call the Grants Department at (213) 273-5547, or write to the address above.

* NOTE: Please see the reverse side of this RFP for important instructions.

July 8, 1987

David V. Milligan, Ph.D.
Vice President
Diagnostic Products
Research & Development
ABBOT LABORATORIES
Abbot Park, North Chicago
Illinois 60064

Dear Dr. Milligan:

I have received your letter of June 23rd in which you confirm my participation in your symposium to be held May 11th, 12th and 13th of 1988.

I am very sorry to have to cancel this engagement. I find that I am previously committed to an engagement in Hawaii that week. It happens in a busy office such as ours, that some engagements that are on my calendar do not appear on my secretary's calendar. I am very sorry for this confusion. Please understand.

Good luck on your symposium. I look forward to working with you in the future.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

ABBOTT

David V. Milligan, Ph. D.
Vice President
Diagnostic Products
Research & Development

Abbott Laboratories
Abbott Park
North Chicago, Illinois 60064

June 23, 1987

Paul Volberding, M.D.
Chief, Medical Oncology and
Director of AIDS Activities
Bldg. 80, Ward 86
San Francisco General Hospital
995 Potrero Avenue
San Francisco, CA 94110

Dear Dr. Volberding,

We were very pleased to learn from Dr. Allain that you have agreed to participate in our 1988 AIDS Symposium. To confirm specifics, a tentative agenda is attached. We will cover your travel costs for this meeting and have made hotel reservations for you for the evenings of May 11, 12 and 13th. Please let us know once you have firmed up your travel plans if your room needs differ from these reservations.

We very much look forward to working with you to make this a most successful symposium.

Sincerely,

Dave

David V. Milligan, Ph.D.

Attach.

cc: J. P. Allain

DVM:pj
0512N

CONFERENCE ON HUMAN RETROVIRUSES AND DISEASES THEY CAUSE

MAY 12 AND 13, 1988

PRELIMINARY PROGRAM

Day 1

8:30	Introduction	David Milligan, Abbott
	Session I Chairman	R. Gallo, USA
9:00	Molecular Biology of HIV 1	F. Wong-Staal, USA
9:45	Origin and Variations of Human Immune Deficiency Viruses	L. Montagnier, France
10:30	Coffee Break	
11:00	Other Human Retroviruses	Y. Kurimura
12:00	Lunch	
	Session II Chairman	I. Gust, Australia
13:30	Cell-Virus Interaction	F. Barre Sinoussi, France
14:15	Host-Virus Interaction	A. Fauci, USA
15:00	Coffee Break	
15:30	Diagnosis of HIV Infection	F. Deinhardt, W. Germany
16:45	Natural History of HIV Infection	J. Goudsmit, The Netherlands
17:00	Recess	
18:30	Cocktails and Dinner for Speakers	

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Day 2

	Session III Chairman	L. Montagnier, France
9:00	Epidemiology of HIV 1 and 2 in Africa	J. Mann, WHO
9:45	New Trends in HIV Epidemiology in the USA	J. Allen, USA
10:00	Coffee Break	
11:00	Clinical Aspects of AIDS and Related Disorders	P. Volberding, USA
12:00	Lunch	
	Session IV Chairman	F. Young, USA
13:30	Therapeutic Approaches to HIV Infection	S. Broder, USA
14:15	Current Status of Therapeutic Trials	W. Parks, USA
15:00	Coffee Break	
15:30	HIV Vaccine	R. Gallo, USA
16:30	End of Meeting	

Copy

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 15, 1987

Maria W. O'Rourke, DNS, RN, FAAN
Director, Staff Development and Research
Department of Nursing
UCSF Assistant Dean, Clinical Affairs, SFGH

Dear Dr. O'Rourke:

I noticed in finally getting to some correspondence your letter of June 16th inviting my support for your application to the Division of Nursing. I realize that I've missed the deadline for your grant, but I did want to take this opportunity to offer my encouragement and support for your ongoing educational activities.

Obviously, we see the AIDS problem growing and the need to educate more health professionals in front of us. I hope that you are able to secure NIH funding for your work.

I look forward to working with you and your trainees in any way we can. My apologies for the tardiness of this.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

City and County of San Francisco

Department of Public Health

San Francisco General Hospital Medical Center

June 16, 1987

Paul Volberding, MD
Director of AIDS Activities
San Francisco General Hospital
Bldg. 80, Ward 86
995 Potrero Street
San Francisco, CA 94110

Dear Dr. Volberding:

San Francisco General Hospital, Department of Nursing, will submit a grant proposal to the Division of Nursing, Health and Human Resources. The proposal request is for establishment of a continuing education program for nurses on care of HIV-infected patients. We are seeking a letter of support from you which speaks to the need and value of such a program and the resources necessary to support it. This program will establish a week-long core curriculum which will provide the students with the current and essential information required to care for patients with AIDS/HIV infections. In addition, the second week of the program will provide for application of this knowledge to their specific functional role, i.e., clinician, administrator, educator. A program such as this will provide a planned and systematic approach to increasing the knowledge and skill level of those responsible for providing care to patients with HIV infections.

The potential pool of applicants who might wish to avail themselves of this program is sizable. We plan to enroll 20 students for each two-week session, every eight weeks for the first year. In an attempt to provide a relevant clinical experience, we expect to provide placement at inpatient, outpatient, and community service settings, thus providing a multi-site approach. We have been assured by several hospitals and clinics that sufficient clinical placements are available for this program.

It is our belief that this proposal clearly demonstrates nursing's committment to patient care and most definitely establishes a cooperative and coordinated effort on the part of health care facilities.

(Cont'd...)

1001 Potrero Ave., San Francisco, CA 94110

The deadline for submission of the grant is July 1, 1987, and is fast approaching. Therefore, we would appreciate receiving your letter of support no later than June 26, 1987. Please direct your letter to my attention at the following address:

Maria W. O'Rourke, DNS, RN, FAAN
Director, Staff Development and Research
San Francisco General Hospital
Medical Center
1001 Potrero Avenue 2A35
San Francisco, CA 94110

If you have any questions, please do not hesitate to call me at 821-8761. Thanking you in advance for your consideration of this matter.

Sincerely,

Maria W. O'Rourke

Maria W. O'Rourke, DNS, RN, FAAN
Director, Staff Development and Research
Department of Nursing
UCSF Assistant Dean, Clinical Affairs, SFGH

MWOR/ct

Attachment: Draft of Grant

cc: Judy Spinella, MS, RN
Associate Hospital Administrator,
Clinical Services

MOGRNT.LET

San Francisco General Hospital
Department of Nursing

DRAFT

Selected portion of Division of Nursing Grant
to be submitted by July 1, 1987.

Objectives, Methodology, and Evaluation

The entire program will be presented over a period of two weeks every other month during the first year and may be increased by number and/or frequency in subsequent years. Twenty students will be admitted to each two week session. The core knowledge and skill sessions will be provided to all participants during the first week. During the second week the program will be tailored to the individual participant's needs.

Goal 1: To present a core of basic knowledge required by nurses to plan and/or care for patients with AIDS/HIV infections.

Teaching Objectives

At the end of the program the student will be able to:

1. Describe the epidemiology of HIV infection.
   a. primarily in the U.S.
   b. concise worldwide epidemiology including Africa and Haiti

2. Describe the spectrum of HIV infection and the 1986 CDC Classification System.

3. Differentiate between the normal immune response and the altered immune response of HIV infected individuals.

4. State awareness of appropriate infection control guidelines for HIV by describing blood and body fluid precautions and their operationalization.

5. Identify the common nursing care issues of HIV infected patients.

6. Recognize the clinical manifestations, and identify appropriate treatment and nursing implications of secondary infections and malignancies associated with HIV infection.

7. Identify the particular psycho-social issues of gay/bisexual men, IV drug users, ethnic minorities, women, and children with HIV infection.

8. Discuss legal and ethical issues, including confidentiality, as they relate to HIV infection.

9. Describe a collaborative model of discharge planning for HIV infected patients.

Course Outline

DAY 1

8:00 - 9:00A	Pre-test; introduction/round table; review objectives
9:00-10:30	Epidemiological overview of HIV infection; review CDC classification system for HIV infection
10:45-12:15	Review of Immune System; virology of HIV
1:30 - 2:30	Treatment of HIV infection; review of anti-virals, vaccine development
2:30 - 3:30	Infection control guidelines; blood and body fluid precautions; health care worker studies
3:45 - 4:15	Review of standardized nursing care plan

DAY 2

8:00 - 10:00	Secondary infections; treatments and nursing implications
10:00-11:00	Secondary malignancies; treatments and nursing implications
11:15-12:15	Other problems related to HIV infections: neuropsychiatric complications care of surgical patient

1:30 - 4:00 Psycho-social and special issues:
gay/bisexual men
IV drug users
hemophilliacs
ehtnic minorities
women
children
legal, ethical issues, confidentiality

DAY 3

Observations: 2 half day placements in inpatient, outpatient, home care or special services. (See Resource Section for description of agencies)

DAY 4

8:00 -10:30 Nursing Care Issues

10:30-12:00 PWA Panel

1:00 - 3:00 Death simulation; small group sessions; quesions and answers

DAY 5

8:00 -10:00 Discharge Planning; Collaboration with community resources

10:15-11:00 Wrap up of week one

11:00-12:00 Posttest, Getting ready for Week 2

12:00-2:00 Luncheon - Time for socializing

Evaluation, Objective 1

Objective 1 will utilize a pretest-posttest evaluation for content. In addition, participants will be asked to evaluate the content, presentation, use of equipment, and planned observations. The data will be compiled for each group and stored on a diskette and compiled in annual and the final report of the project. Changes based on participant evaluations will also be noted.

Objective 2: To provide a program of observations and supervised clinical practice for staff nurses in the comprehensive care of patients with HIV/AIDS infections.

WEEK 2

DAYS 1 - 4 Clinical experiences based on individual need after consultation with Advisor
2 hour seminar daily with all students and

clinical nurse specialist faculty
Each day two participants will present a patient case study for discussion

Clinical experiences on an inpatient unit will include being assigned to a unit nurse and being encouraged to participate in the patient's care as much as possible. A clinical nurse specialist (faculty) will be present to teach special procedures and conduct ward conferences. In Outpatient, Public Health, and Home Care and Hospice settings, the participant will be assigned to a nurse employed by the agency. (See Resources Section for description of agencies)

Agreement has been secured for clinical placement in the following agencies during each day of Week 2 during Year 1:

SFGH inpatient -	2 students on day shift
	2 students on evening shift
SFGH Outpatient	2 students AM
	2 students PM
UCSF Inpatient	1 student day shift
	1 student evening shift
UCSF Outpatient	1 student AM
	1 student PM
Home Care	2 students
Hospice	2 students
Public Health	3 students

The UCSF School of Nursing has contracts with all of the above agencies for placement of students. In addition, additional agreements have been solicited for this program, and may be found in the Letters of Agreement and Support Section of this Grant.

Participants from all settings will attend the seminar daily to discuss their problems, concerns, experiences, and to seminar around the case presentation which will be assigned by the clinical specialists.

DAY 5

9:00 - 12:00 Wrap-up; Post-test; Questions and Answers

12:00 - 2:00 Luncheon

Evaluation - Objective 2

During the latter part of Week 1, participants will be assigned to Advisors with whom they will meet on an individual basis to set goals for Week 2. In addition, each participant will be given a list of nursing activities which they will be expected to complete during the week. At the end of the week the participant will submit the completed activity list and a written summary of how he/she has met the goals previously set. Once again, following the completion of the two week presentation, the

data collected for the evaluation will be compiled for each individual group and stored on a diskette for use in annual and the final report of the project.

Objective 3: To provide a special program for nursing administrators and nursing managers on the development and administration and management of an AIDS/HIV infection program or unit.

Five participants of the total group of twenty will be admitted to the management/administrative section during Week 2. Criteria for inclusion in this special session requires having been appointed to a nursing administrative or management position of an AIDS/HIV infection unit or program.

Teaching Objectives

At the end of Week 2 the student will be able to

1. Determine the relative advantages of a designated unit as compared to the scattered bed approach for inpatient care.

2a. Develop a realistic budget based on patient care needs which speaks to human resources, equipment, and supplies.

b. Analyze financial resources available for the AIDS or HIV infected patient.

3. Write comprehensive policies and procedures based on the unique needs of the AIDS/HIV infected patient.

4. State educational and support needs of nursing staff caring for the AIDS/HIV infected patient.

5. State the process of proactive discharge planning.

6. Describe a community program for the prevention of HIV infections.

A seminar approach will be used . Individual sessions will be scheduled when appropriate. Faculty will include the Nursing Administrator of the AIDS unit, the Head Nurse of the AIDS unit, the Nurse Manager of the AIDS Clinic, and a clinical nurse specialist. Other persons may be scheduled for individual or group sessions as needs arise. Site visits to various inpatient, outpatient, and community agencies will be scheduled. (See Resource Section for agencies to be used)

DAY 1

8:30 - 9:30 Participants will describe their agency, experience with AIDS/HIV infections, what they hope to obtain from seminars. Pre-test

9:30 - 11:30	Relative advantages of designated unit as compared to scattered bed approach. Staffing implications.
1:00 - 2:30	Budget preparation
3:30 - 5:00	Analysis of financial resources available for AIDS or HIV infected patients
DAY 2	
8:30 - 10:00	Writing comprehensive policies and procedures based on unique needs of AIDS/HIV infected patients
10:15-12:15	Educational and support needs of staff
1:30 - 4:30	Visit inpatient units with opportunity to talk with staff
DAY 3	
8:00 -10:00	Process of proactive discharge planning
10:15-12:15	Need for community program for prevention of AIDS/HIV infections
1:30 - 4:30	Visit Health Center Testing Site Talk with Public Health Nurse
DAY 4	Visit other community agencies Individual conferences with faculty or others by appointment will be possible on this day
DAY 5	Join participants from Objective 2 for morning session and luncheon after completion of posttest.

Evaluation - Objective 3

Objective 3 will be evaluated by a pretest-postest design. In addition, data will be collected regarding perceptions of experiences in seminar, observational activities, interviews, and presentation of material. Data will be compiled as in other objectives for further use.

Objective 4: To provide seminars for nursing educators in the integration of AIDS/HIV infection content into an existing undergraduate or graduate curriculum.

The assumption is being made that most educators who participate in this program will do so primarily for the knowledge and experience in the care of the AIDS/HIV infected individual because they will be expected to teach this at the undergraduate or graduate level of nurse preparation. For this

reason most of their second week will follow the schedule outlined for the staff nurse with the exception of one half day during which the integration of content in the care of the AIDS/HIV infected patient into an existing curriculum will be discussed with faculty from the UCSF School of Nursing. Additional individual consultation will be available to educators, and opportunities to lead seminars will be provided.

Evaluation - Objective 4

Evaluation for Objective 4 will follow that of Objective 2 with the addition of collected data regarding the seminar and addition consultation each participant received on the integration of content into the curriculum. Each participant attending the curriculum seminar will be sent a questionnaire 3 months following his/her program attendance to determine whether AIDS/HIV infection content has been added, and if they are teaching this content. At this point they will also be asked what other information would have been helpful to them.

Evaluation - Overall Project

In addition to the data collected for evaluation of specific objectives, an overall evaluation of the project will be done. This portion of the evaluation will include demographic data on all participants (age, sex, type of institution from which they came, purpose in coming, nursing educational level, etc.)

All students will be mailed a questionnaire 3 months after completing the program asking them for an overall evaluation of each clinical site, faculty, housing, and program in general. They will also be asked if and how they are using the knowledge and skill acquired throughout the program.

Personnel in each clinical site will also be asked to provide their perception of how the program is going after each presentation, including numbers of participants, effectiveness of faculty, ability of participants to perform.

Project staff will be evaluated annually by the Project Director and the Project Director will be evaluated by the Program Director. All project staff will be asked to keep a weekly diary of their perceptions of how the program is going including problems faced and how they were resolved, the quality and quantity of participants, and any other information they feel relevant to the evaluation of the project.

All data will be compiled in both annual and the final report including any changes made as the project progresses.

Copy

July 21, 1987

William Paiss
Conference Coordinator
EXPLORING AIDS CHALLENGES & OPPORTUNITIES
2880 Folsom Suite 104
Boulder, Colorado 80302

Dear Mr. Paiss:

Thanks for your letter outlining your thoughts for an AIDS Conference. I agree that we need as much education concerning AIDS as possible.

There are a number of conferences that have been put on and others that are being planned. I would urge you to contact the San Francisco AIDS Foundation if you would like more ideas about perceptions of need for public education and structures for your conference.

I wish you success with your conference.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

Exploring AIDS
Challenges & Opportunities
2880 Folsom Suite 104 • Boulder, CO 80302 • (303)447-8777

July 1, 1987

Dr. Paul Volberding
San Francisco General
San Francisco, CA 94143

Dear Dr. Volberding,

Good morning and greetings from Colorado. I am sending you information concerning a national conference on AIDS to be held here during March of 1988. There is an important urgency to explore the AIDS epidemic within a broad based, optimistic framework. There are questions surrounding this issue which must be raised to promote further understanding.

What would an effective exploration of AIDS looks like? How would it be set up? What disciplines should be involved? What is currently being done? What are the criteria for improvement or remission of AIDS? What aspects of this issue are beyond the medical community?

Enclosed you will find the pre-conference invitation sheet. Please feel free to make copies and pass it on to anyone you think may be interested in the conference.

I'd like to take the liberty of calling you in the next week or so to discuss your feelings on this issue.

Sincerely,

William Paiss

William Paiss
Conference Coordinator

You are invited to participate in a conference on...

Exploring AIDS - Challenges and Opportunities

March 4, 5, 6, 1988
Boulder, Colorado

Even though leaders in the fields of medicine, research, business, insurance and government, as well as the people across the spectrum of H.I.V. illness, are putting more and more of their time and energy into ending the AIDS epidemic, clear answers have yet to emerge.

Background:

How do we approach a new type of disease for which science currently has few answers? AIDS affects young, healthy, productive people possibly killing them within a few days to several years after diagnosis. It creates fear, ostracism, hysteria and isolation within homes, families, religious groups, schools, the work place, the military and in the hearts of individuals. Its economic impact is rapidly overwhelming affected individuals, health care providers, insurance companies, businesses and the general economy. This epidemic is uniquely connected to sexual behavior and activities which are at variance with society's mainstream culture and relates to individual values and lifestyle alternatives often approached with fear, condemnation and ostracism themselves.

This conference will be a unique forum involving outstanding medical leaders, explorers in legitimate healing approaches, insurance companies, businesses, government leaders and those affected by the HIV personally. Participants will share "what is now known" in an atmosphere of safety and cooperation. Intensive dialogue must begin between the diverse communities involved in solving the AIDS challenge. This conference will be the beginning of an on-going forum. We will create a unique opportunity to move from crisis to greater understanding and relief of suffering. The time has come to consider all workable approaches regardless of their origin. AIDS is a disease which pushes us to reach beyond all boundaries.

The purposes of this conference are:

1. To provide accurate information concerning all workable treatment options and preventive measures to decision makers in the fields of medicine, business, education, government, religion and law.

2. To make available the current research in Psychoneuroimmunology, a new field of medicine, to professionals dealing with the AIDS epidemic.

3. To explore the role of variations in host immunity such as nutrition, attitudes and beliefs, and health practices as co-factors in the natural history of HIV infection.

4. To encourage the establishment of standards for the evaluation and documentation for claims of improvement and remission of AIDS and ARC.

5. To create a basis for cooperation and communication between the medical community and allied health care providers.

6. To identify points of agreement and potential breakthrough in a dialogue which emphasizes a respectful exploration and synthesis of divergent views about AIDS.

7. To establish an ongoing network between conference participants and the growing AIDS community through proceedings, informational mailings, workshops and future conferences.

Conference Design:

The conference design will include eminent Keynote speakers and small group sessions. This will allow for individual participation and interdisciplinary dialogue. Professional facilitators will be assigned to the small groups to assist with in-depth communication and will insure that critical concerns are addressed in a fair and sensitive manner. An emphasis will be placed on the resolution of issues. The small groups will be composed of representatives from each of the participating groups.

Sponsors:

Boulder College is a baccalaureate and graduate school authorized by the State of Colorado to grant BA/MA and MA degrees in Psychology and Counseling, and Holistic Health and Wellness. Boulder College is nationally known for its innovative orientation and ability to bridge the gap between traditional and non-traditional disciplines.

Wellspring , Partners in Health P.C. is a primary care family practice center which combines medical care with psychotherapy, wellness education, nutrition and other effective approaches in a positive and supportive atmosphere. Wellspring sponsors an ongoing AIDS support group while providing treatment for People with AIDS.

Spirit at Work is a Denver-based conference organizing firm which specializes in producing training events for leaders in Colorado and California. Events are regularly attended by CEO's, senior consultants, politicians, and other community leaders.

Who will be attending:

The conference will be limited to a maximum of 325 people to allow for adequate individual participation. It will be designed for doctors, nurses, medical researchers, mental health practitioners, social workers, other health care providers, nutritionists, hospital administrators, school superintendents, corporate CEO's, personnel directors, insurance administrators, local and national government representatives, lawyers, judges, clergy and other local and national community leaders. People with AIDS who have been able to demonstrate some control over the disease will attend from around the country to share their "expertise".

How you can participate:

We are seeking three groups to participate in the early development stages of this conference.

- Professionals in all health care fields who are working with AIDS or ARC patients.

- Persons with AIDS, ARC and other HIV infections who are discovering what works for them and are willing to participate in the conference as declared persons with AIDS. Those PWA's who are also trained group facilitators are especially encouraged to contact us.

- Groups and individuals who are interested in co-sponsoring this conference through financial contributions.

For more information on how to participate in this conference, please contact **William Paiss** at :

Exploring AIDS
Boulder College
2880 Folsom Suite 104
Boulder, CO 80302
(303) 447-8777

Copy

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

July 20, 1987

Richard B. Pearce, Ph.D.
P.O. Box 174
Guerneville, CA 95446

Dear Richard,

Thanks for your letter concerning your ongoing interest in post-parasite relationships in AIDS

It's a little bit hard to know how sincere the NIH's interest is in your proposal from the correspondance you've enclosed. Obviously, their standard reply to people with ideas is to suggest that they submit a grant proposal. Even in AIDS research, NIH grants find pretty stiff reviews facing them and I would think it would help you enormously to establish a close co-investigator relationship with someone within the university who is interested in working on this area.

The study you outline, namely comparing immulogic competence in HIV infected and uninfected individuals with and without intestinal parasite infections, would seem to be a straight forward way to begin to answer the question you've raised. You might also consider a grant request to the State of California which is accepting applications now. The review is somewhat less formidable and the amount of support I would think would be adequate to do your project.

Best wishes and good luck.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

July 13, 1987 Tel: 707/869-9690

Richard B. Pearce, PhD
P O Box 174
Guerneville, CA 95446

Paul Volberding, MD
Director AIDS Clinic
Ward 86
San Francisco General Hospital
San Francisco, CA 94110

Dear Dr Volberding:

I have just talked to Don Abrams about a letter I received from Dr La Montagne in which it is suggested that I may wish to pursue, by submitting a grant application, the "intriguing" concept that "chronic intestinal parasitism may predispose to AIDS" by activating T-cells or supressing T-cell mediated immune control over HIV infected cells -- much like malaria appears to do with respect to EBV-infected B cells ("T-cell control of Epstein-Barr virus-infected B cells is lost during *P. falciparum* malaria," Whittle, Greenwood et al *Nature* 1984, 312:449).

Quinn and Fauci have recently suggested (JAMA enclosed) that "the immune systems of African heterosexuals, similar to those of US homosexual men, are in a chronically activated state associated with chronic viral and parasitic antigenic exposure, which may cause them to be particularly susceptible to HIV infection of disease progression." So, obviously Fauci et al., are purusing this aspect themselves, though, so far, they have fallen short of doing the definitive study.

I am now wondering if I am facing a sincere invitation to submit a grant that has a fairly good chance of being accepted. Or is Dr La Montagne merely being conciliatory? Or even coy? I wrote back to La Montagne saying that I planned to make inquires to see whether any local researchers may wish to collaborate on a parasite study. Dr Heyneman, in fact, has said that he would handle all stool analyses.

July 13, 1987 Tel: 707/869-9690

A simple but convincing study would be to look at the immune status (Con A, T-cell enumeration, DR activation, autoantibodies, etc.,) of HIV-negative, parasite positive and negative men to see if there is any difference. If not, the matter can be put to rest (as similar studies have recently done for EBV and CMV). If so, it might be interesting to see if cytotoxic T-cells support HIV in culture or if helper cells are more readily infected in subjects with altered immune status due to chronic parasitic infection. The study would require an immunologist, parasitologist, statistician, virologist, physician investigators and support staff. My role may be that of a consultant and co-author. I would help design the study write the proposal and oversee all aspects of its execution.

Though about 50% of all gay men worldwide have now become positive for parasites, one problem might be finding HIV seronegatives who are positive for parasites -- that may entail going to Sydney, Australia, Finland, or somewhere equally remote to get the stool and blood samples. Alternatively we could look retrospectively at the local gay cohorts to identify seronegatives with altered immune systems, then do stool sampling. That would mean seeking cooperation from an epidemilogist like Moss or Wiley.

In any case, if you think such a study -- and the funding it promises (?) to bring -- would be worthwhile to pursue, let me know and perhaps we can talk further about the various options. With very little fuss we could at least prepare a grant of some kind.

Respectfully,

Richard B. Pearce, PhD

cc: Donald Abrams / Donald Heyneman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
Bethesda, Maryland 20892
Building : 31
Room : 7A/48
(301) 496- 8000

May 11, 1987

Dr. Richard B. Pearce
P.O. Box 174
Guernerville, California 95446

Dear Dr. Pearce:

Your letter of April 11 to Dr. Anthony S. Fauci, Director, NIAID, has been forwarded to me for response.

The role of infectious agents as cofactors in the progression of AIDS is an area that we have actively fostered. Within the last year, we issued two requests for applications, one on co-factors and the other on the role of opportunistic infections associated with AIDS. The applications received in response to these announcements are currently undergoing scientific review.

The concept that chronic intestinal parasitism may predispose to AIDS by activating or suppressing T-cell function is intriguing. I have enclosed a copy of a grant application form for your use should you wish to pursue this matter yourself by submitting a research grant application.

Sincerely,

John R. La Montagne

John R. La Montagne, Ph.D.
Director, AIDS Program
National Institute of Allergy and
Infectious Diseases

cc: Dr. Fauci
Dr. Ginzburg
Dr. Myers

enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
Atlanta GA 30333

April 30, 1987

(404) 320-2718
FTS: 236-2718

Richard B. Pearce, Ph.D.
P.O. Box 174
Guerneville, CA 95446

Dear Dr. Pearce:

Thank you for your letter of April 11 to Dr. Curran regarding possible co-factors in the development of AIDS. Since our section is most involved in this area, your letter was referred to me for comment. We, too, are interested in this issue which we are pursuing a couple of different ways.

We have been analyzing sera from men in our large cohort of homosexual men in San Francisco Cohort for titers of antibodies to cytomegalovirus, Epstein-Barr virus, and herpes simplex viruses types 1 and 2, before and at the time these men became HIV-infected or, if infected, before and at the time they developed AIDS or other HIV-associated diseases. So far, such analysis does not support the role of these herpesviruses as important co-factors in HIV infection or in AIDS.

We are also interested in the possible role of enteric parasites and bacteria, but, to our knowledge, no one has been prospectively collecting and analyzing stool from HIV-infected men. Thus, we intend to collect, analyze and store (aliquots of) stool from homosexual men who will be participants in a prospective study starting later this year to be conducted in San Francisco, Denver and Chicago.

Thank you for your thoughts and call for more research in the area of co-factors. If you have any specific ideas beyond our current plans, please feel free to communicate with us further.

Sincerely yours,

Scott D. Holmberg

Scott D. Holmberg, M.D.
Chief, Special Studies Section
Epidemiology Branch
AIDS Program

cc.
Dr. Curran

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health
National Cancer Institute
Bethesda, Maryland 20892
Bldg. 37, Rm. 6A09
(301) 496-6007

April 28, 1987

Richard B. Pearce, Ph.D.
P. O. Box 174
Guerneville, CA 95446

Dear Dr. Pearce:

Fundamentally, I agree with you. I was aware of the Melbye, et al. report because Jim Goedert (one of the authors) works closely with us.

Kind regards.

Sincerely yours,

Robert C. Gallo

Robert C. Gallo, M.D.

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July 9, 1987

Paul Volberding, MD
Chief, AIDS Activities and Medical Oncology
San Francisco General Hospital
Associate Professor of Medicine
University of California at San Francisco
995 Potrero Avenue
San Francisco, CA 94110

Dear Dr. Volberding:

Enclosed is an edited and word processed version of the interview Frances Pilot conducted with you prior to the Retrovir Update meeting in Washington, DC. It is to be included in the inaugural issue of Center to Center, which otherwise contains selected proceedings of the III International Conference on AIDS and an account of the Retrovir Update. Please review the material, make any changes you deem necessary, and return the approved copy in the Federal Express envelope furnished. Please be sure to provide us with your social security number so that we can process your honorarium.

Thanks for the interview and for looking the material over.

Yours,

Matthew Stenger

Matthew Stenger
Editorial Project Director
extension 409

Send B/W & color photo of me to Frances Pilot of World Health Communications in NYC
7/17

cc: Frances Pilot
enc.
MS:ek

July 21, 1987

George F.Solomon, M.D.
Professor of Psychiatry
Veterans Administration Medical Center
16111 Plummer Avenue
Sepulveda, CA 91343

Dear George,

Thanks for your note of June 14th about Candice Pert's research. I am sorry I didn't get back to you sooner, but ever since the AIDS meeting, things have been even busier than usual.

I share your concern that the scientific establishment seems all too willing to make snap decisions in the absence of facts in many cases about a new research idea. It is somewhat alarming, frankly, that we can so quickly see one approach identified as the "legitimate" theory and all others held up for ridicule before being tested. I completely support wider investigation of peptide-T applications as this might give us first of all additional information about the interaction of the virus with the host and also eventually, very useful therapy either alone or in combination with drugs acting in other sites in the virus life cycle.

Thanks for your interest and again, I apologize for the delay in correspondance.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division, SFGH

June 17, 1987

Paul Volberding, MD
SFGH - UCSF

Dear Paul,

I am in Paris following the AIDS meetings in Washington and an excellent small by-invitation NATO-sponsored conference on neuroimmunomodulation in cancer and aging on the island of Stromboli (Sicily). At both places, I spent a good deal of time with Candace Pert and had many discussions of her work on "Peptide T" with her and others.

Candace is a very bright, creative, enthusiastic (over?), dedicated "wild, crazy lady" (some psychiatric description!) I believe that the history of science is replete with examples of conceptual and applied "break-throughs" that were resisted by conservative "conventional" science. In my own experience, it took nearly 20 years for recognition of CNS-immune interaction, now an incredibly "hot" area of research. Obviously, AIDS requires some degree of "short-cutting" the usual process of openness to new approaches while still preserving scientific integrity and patient welfare. I think Candace's work on the T4 receptor and the toxicity of envelope protein fragments makes sense. T4-8 pentapeptide appears to be non-toxic. It may, as a hapten, be the basis for immunization even of infected individuals (as Salk - who was an early supporter of my work - suggests as an approach)

Candace heard of some of your negative comments. I assured her you are not only a superb physician but a magnificent, caring, dedicated, human being. You were supportive of our UCSF-BAP psychosocial and psychoimmunologic research, which is turning out to be so helpful, "early on". I said that my impression is that you are open-minded but protective of patients. She

is concerned lest a person of your stature oppose clinical trials of "peptide T".

Candace soon will be in S.F. (That is why I write from Paris) ~~She will be in touch with you~~. Please hear her out and form your own opinions of the possible value of her research. Of course, it may be garbage. On the other hand, it might be so much better than toxic AZT and controversial. Please go to her talk and speak with her. Thanks!

Cordially,
George Solomon
Professor of Psychiatry, UCSF
Adjunct " " " , UCSF

Premier pliage

Ce pli ne sera pas acheminé par avion
s'il contient un objet quelconque.

Deuxième pliage

PAR AVION

AÉROGRAMME

M

Urgent

Paul Volberding, MD.
AIDS Unit
San Francisco General Hospital
Ward 86
San Francisco, California
USA

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

3 September 1987

Gerard F. Hewitt
Executive Vice President
McLaren General Hospital, Inc.
401 S. Ballenger Highway
Flint, MI 48502

Dear Mr. Hewitt:

I am sorry to say that I am unable to send you handouts for the above-referenced conference because I did not use handouts.

Sincerely,

Paul A. Volberding, MD
Associate Professor of Medicine
Chief, AIDS Activities
San Francisco General Hospital

PV/mc

MGH
McLAREN GENERAL HOSPITAL, INC.

Gary R. Peterson
President

August 12, 1987

Paul Volberding, M.D.
San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94100

Dear Dr. Volberding:

As you are aware, the AIDS epidemic and the resulting social problems have become a national concern. According to information I received from the American Medical Association, you were a speaker at the AIDS Conference scheduled on April 20-24, 1987 in Chicago, Illinois. I was unable to attend the conference but am interested in obtaining any materials you used as handouts. As Executive Vice President of McLaren General Hospital, I believe I must be well informed on all pertinent issues regarding this matter.

Any assistance you can give me in obtaining the AIDS conference materials or other related information would be appreciated. Thank you.

Sincerely,

Gerard F. Hewitt

Gerard F. Hewitt
Executive Vice President

/db

401 South Ballenger Highway, Flint, Michigan 48502 (313) 762-2000

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

September 15, 1987

[DECKER]

Bruce Becker
Health Policy and Research Foundation of California
7985 Santa Monica Blvd., 109-251
Los Angeles, Ca 90045

Dear Bruce:

Thanks for your letter regarding your concern about the Presidential Commission. Obviously, I share your feelings that the Commission by virtue of it's membership will be unable to offer meaningful directions to the Country with the AIDS epidemic. It is, of course, being challenged from a number of sources.

As the recipient of substantial Federal Support, I am in a bit of a delicate situation and am not sure how direct my opposition should be at this point. I do, of course, support you and what you are doing and would be happy to be kept informed as the situation evolves.

Best Wishes,

Paul Volberding
Assoc. Professor of Medicine
Chief, AIDS Activities Divisions
San Francisco General Hospital

PAV/jw

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

September 15, 1987

Walter Almeida, M.D.
General Secretary
ABIA
Rua Vincente de Suza
24-CEP2251
Bota Fogo, Rio De Janeiro, Brazil

Dear Dr. Almeida:

Thank you for your letter of August 17, 1987 regarding your concerns about HIV infected individuals undergoing surgery. We, in general, do not feel that AIDS patients require any specific prophylactic antibiotic prior to surgical procedures and that the only real question that arises is whether or not an elected procedure is warranted given the clinical situation of the patient in question. For example, a patient with advanced AIDS with a very limited life expectancy may not in fact require surgical procedure if it is truly elective or cosmetic. On the other hand, somebody who is asymptomatic but infective with HIV should have the same access to surgical procedure as any other person in the population.

There has been some concern about the risk to the surgeon of HIV infection but we feel that this has been very adequately addressed in a number of publications including those from the Center of Disease Control. As they point out, the risk is extremely small and if a surgeon follows standard operating techniques to avoid exposure to infected blood, surgery can be performed safely.

I am sorry not to be able to offer you more direct information regarding your questions, but, as you point out, very little has in fact has been published.

Best wishes.

Sincerely,

Paul Volberding, M.D.
Assoc. Professor of Medicine
Chief, AIDS Activities Divisions
San Francisco General Hospital

PAV/jw

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

September 18, 1987

Mayor Dianne Feinstein
c/o Sally Osalke
200 City Hall
San Francisco, CA 94102

Honorable Mayor Feinstein:

I would like to express my appreciation for your substantial efforts and leadership in the area of AIDS. San Francisco is in many respects a leader and a model for the rest of the world in this epidemic.

As you know, we were successful in applying to the International AIDS Society to be the host city for the Sixth International AIDS Conference to be held in 1990. Dr. John Ziegler and I are the co-chairs of this conference and have begun to make plans for this large and important meeting. As we have discussed with you previously, we would like the City of San Francisco to be a co-sponsor of this conference along with the University of California, San Francisco and the American Foundation for AIDS Research. While many of the details of the meeting are obviously yet to be resolved, we are at the point in planning where contracts have to be developed for the convention space and for the companies involved in the logistics of a conference of this size. We estimate that approximately $400,000 to $500,000 is required for start-up costs. We are suggesting that this start-up funding be obtained equally from the co-sponsors with the understanding that this will be repaid at the time of the conference. I see no reason to think that the conference should not at least break even considering the growing scale of the public concern with the AIDS epidemic and with the obvious attraction that San Francisco has as a conference site.

We are in active discussion with the San Francisco Convention and Visitors Bureau and plan to use both the Moscone Center as well as the new Marriott Hotel which should be completed well before the planned June date of this AIDS

meeting. I look forward to working with your office at putting this meeting on. I certainly hope that it will be possible for San Francisco to be a co-sponsor. If your office could advise me further on the details involved in this type of arrangement, I would appreciate it. Again, thank you for your consideration.

Sincerely,

Paul Volberding, M.D.
Associate Professor of Medicine
Chief, AIDS Activities Division
San Francisco General Hospital

PAV/rs

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

18 September 1987

C.L. Hopper, M.D.
Vice President of Health Affairs
Office of Health Affairs
764 University Hall - 2199 Addison
University of California, Berkeley
Berkeley, CA 94720

Dear Con:

I'm sorry for the miscommunications last week regarding my concerns about AB1952. I, in fact, do have serious objections to our need for such legislation. I think it sends the wrong message to Washington at a time when there are some important requests that they need to hear from us. I at the same time had no intent to misrepresent the University's position or lack of a position on this issue. I respect the many competing responsibilities of the President of the University, and certainly wouldn't presume to state his position without having checked it with his office first. I've written to Bill Filante and apologized for the difficulties, while, at the same time, expressed my reservations about AB1952. I hope that this will prove to be a minor problem and that we can continue to all work effectively together to coordinate our work in this important epidemic.

Sincerely,

Paul

Paul Volberding, M.D.
Associate Professor of Medicine
Chief, AIDS Activities Division
San Francisco General Hospital

PAV/rs

SAN FRANCISCO: SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

September 23, 1987

To: Steve Hully, M.D.

From: Paul A. Volberding, M.D. PV

Re: Offsite space

I am sorry that I haven't gotten back to you sooner about your note. We are pretty obviously in need of more space ourselves, but my attention right now has been devoted to getting the move to Ward 95 at least underway before taking on any new space.

We have looked informally at CED space but it sounds like you are finding great space at substantially less than they are charging. Let me know if you can how your move is proceeding and I will see whether there is any way we can tag along. Again, thanks for letting me know.

Hi Paul

The attached flier seems like a super prospect – it is located right in the middle of the triangle formed by the buildings that house Rutherford, Weidgar + Clark and less than 2 blocks from each. It's also two blocks from BART, from the (usf) N Judah and the (double usf 9 and 47 Muni). So I think we'll go for it for our CAPS Center + numerous other mainly AIDS – involved groups.

We have enough people for a whole floor (8700 sq ft) but I'm wondering if we should tie down two floors. I'm sure we'd be kicking ourselves next year if we don't. The location is so ideal for UC – SF DPH collaboration, and the price is so good. It's a beautiful old building with windows that open + they will design interior (currently a shell) to suit us.

Please call me [redacted] Today (Thursday) + let me know if you would like to reserve some space. I think we will have a major ctr of AIDS activities.

Steve Hulley

PS. 10x nicer than CED, + half the price!!

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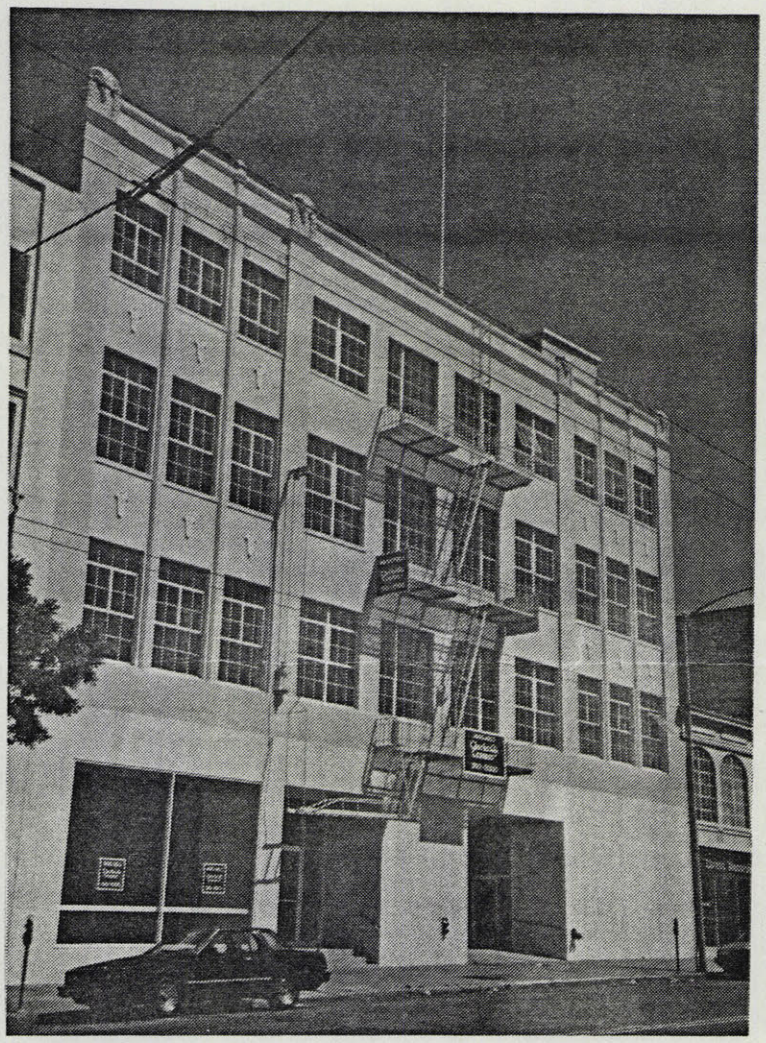

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SANTA BARBARA • SANTA CRUZ

SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

September 23, 1987

Theodore Hughes Waddell
Theodore Waddell Associates
1005 East Alameda
Santa Fe, NM. 87501

Dear Mr. Waddell:

I am in receipt of your letter of September 15th regarding possible contributions by your foundation for work in AIDS. I can think of numerous organizations that are committed to work that would come under the general guidelines that you include in your letter for support.

Locally, the San Francisco AIDS Foundation is doing exemplary work with public education. Of course, your letter opens up the opportunity for me to ask that you also consider the work my own organization is doing because I think we are increasingly devoted to the very issues that you raise.

With respect to education, we are, for example, in the midst of our first monthly program for practicing physicians to retrain them in the care of patients with AIDS, expecting that that will be one way that we can help ensure that patients with AIDS get more appropriate care at the community level.

We are, in the course of that educational experience, highlighting the problems faced by the racial and ethnic minority communities with the AIDS epidemic and the need for physician sensitivity when dealing with Black or Hispanic AIDS patients.

We also publish and distribute free of charge a quarterly newsletter to over 10,000 physicians and other health providers in the United States which is focused on treatment aspects of AIDS. This quarterly, called AIDS File, as well as our Physicians Education Program are in definite need of ongoing support.

I apologize for the somewhat self-serving tone of my response to your letter, but I am obviously very proud of the commitment that our program has demonstrated for the AIDS epidemic. As such, I am not afraid to ask for additional support. I think we can promise that any support we might receive would be efficiently directed to the problem and that the results of the support could be documented to your satisfaction. If you have any further need for clarification, I would of course be happy to be more complete in my response.

Best wishes in your deliberations.

Sincerely,

Paul A. Volberding, M.D.
Associate Professor of Medicine
Director
AIDS Activities
San Francisco General Hospital

PV:sb

theodore waddell associates
1005 EAST ALAMEDA, SANTA FE, NEW MEXICO 87501

September 15, 1987

Dr. Paul Volberding
San Francisco General Hospital
1001 Petrero Ave.
San Francisco, CA 94110

Dear Dr. Volberding:

I have your name from the excellent television program "On the Brink - an AIDS Chronicle", for which I congratulate both you and the producers.

I am writing on behalf of the Charles Evans Hughes Memorial Foundation. Our foundation is interested in helping in the AIDS crisis. We are restricted in our gifts by the charter of the foundation which allows gifts only in the following categories:

"... (1) for educational purposes;
(2) for legal aid, through legal aid organizations, to persons, groups, or associations of persons, whether incorporated or not, and irrespective of race, color or creed; and
(3) for the combating of prejudice based on race, color or religious belief;..."

Pure research may be beyond our permissable limits, but research, the products of which will imediately be shared, might be interpreted as education.

Can you help us by steering us to the organization or organizations which you feel are doing the best job? We would also be extremely grateful for whatever qualifying comments you can make.

We are having our annual meeting in New York on October 15, so I would appreciate your promptest response, so I can start a dialogue with whomever you recommend.

Thank you for this help.

Very truly yours,

Theodore Hughes Waddell

Theodore Hughes Waddell

THW:szm

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SCHOOL OF MEDICINE

Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

September 18, 1987

Lydia Seebach, M.D.
Kuzell-Gibbs Medical Group
Internal Medicine
450 Sutter Street, Suite 1003
San Francisco, Ca 94108-3994

Dear Dr. Seebach:

I thank you for your letter to Dr. Mayberry in which you suggest my being included in helping advise the Presidential AIDS Commission. I had the opportunity to meet Dr. Mayberry last week on his brief tour of San Francisco General Hospital. I am clearly impressed by his credentials and by his level of interest. The Commission finds itself in the midst of political turmoil with some serious questions raised as to the level of expertise of some of its members. I did offer my support to Dr. Mayberry and will help him as much as I can. Your letter was very kind, and I wanted to thank you directly.

Best wishes,

Paul Volberding, M.D.
Associate Professor of Medicine, UCSF
Chief, AIDS Activities Division
San Francisco General Hospital

PAV/jw

KUZELL - GIBBS MEDICAL GROUP
INTERNAL MEDICINE
450 SUTTER STREET • SUITE 1003
SAN FRANCISCO, CALIFORNIA 94108-3994
(415) 433-4940

August 17, 1987

W. Eugene Mayberry, M. D.
Mayo Clinic
Rochester, Minnesota 55905

Dear Doctor Mayberry:

I want to congratulate you on your appointment as Chairman of the President's AIDS Commission and on your interesting interview concerning this problem in the recent Mayovox.

I am a former Mayo Fellow presently serving as a member of the Board of Directors of the Mayo Alumni Association and a practicing internist in San Francisco. As I am sure you are aware of, San Francisco has a high percentage of AIDS patients. I know your commission has been appointed. You stated in your interview that there will be advisory groups, and although I have not discussed it with him, I would like to propose the name of Dr. Paul Volbering.

Dr. Volbering is an outstanding young man from Minnesota who has been at the forefront of basic and clinical research on AIDS in San Francisco. He is in charge of the largest AIDS ward in the United States in San Franciso General Hospital here. His clinical experience is second to none in this country and he is well-liked by everyone, his colleagues, his patients, and the community.

Again, I want to congratulate you on your appointment and I am sure that as Chairman of the AIDS Commission you will be as successful with that as you have been as our President and Chief Executive Officer of the Mayo Foundation.

Sincerely yours,

Lydia Seebach M.D.

LYDIA M. SEEBACH, M.D.

Lms/jc

cc: Paul Volbering, M. D.

File Copy

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Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

September 15, 1987

Lidia Seebach, M.D.
Kuselgives Medical Group
Internal Medicine
450 Sutter Street, Suite 103
San Francisco, Ca 94108-3994

Dear Dr. Seebach:

I thank you for your letter to Dr. Mayberry in which you suggest my being included in helping advise the Presidential AIDS Commission. I had the opportunity to meet Dr. Mayberry last week on his brief tour of San Francisco General Hospital. I am clearly impressed by his credentials and by his level of interest.

The Commission finds itself in the midst of political turmoil with some serious questions raised as to the level of expertise of some of its members. I did offer my support to Dr. Mayberry and will help him as much as I can. Your letter was very kind, and I wanted to thank you directly.

Best wishes,

Paul Volberding, M.D.
Associate Professor of Medicine
Chief, AIDS Activities Division
San Francisco General Hospital

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Please address reply to undersigned at
AIDS ACTIVITIES DIVISION
San Francisco General Hospital
Building 80, Ward 84
1001 Potrero Avenue
San Francisco, CA 94110

September 23, 1987

Myra J. Maddox
P.O. Box 255
Cameron, LA. 70631

Dear Ms. Maddox:

Thanks for your note of September 3rd regarding your questions concerning AIDS. I will try to answer each of them directly.

1. Can AIDS be transmitted by kissing?

There is evidence that the AIDS virus can be present in the saliva of people infected with it, but there is no case where this has led to the transmision of the virus by kissing. This is probably because the amount of virus is very low and that there are other substances in the saliva that inactivate the virus.

2. Can Mosquitos give it to us?

There has been substantial work looking at this question and what it shows is that mosquitos can take up blood into their systems containing the AIDS virus but that they don't seem to be able to spread the virus to someone else. There was a large study in a community in Southern Florida where there is a high rate of AIDS and also many mosquitos. In this community, the people getting infected with the virus were not the teenagers and elderly people the way you would guess if mosquitos were spreading the virus, but rather the people infected were young and sexually active and appeared to be spreading the virus by their sexual contact.

3. What are the signs of AIDS?

There are no easy answers to this question because the AIDS virus gradually causes a damage in the ability to resist infections and the symptoms are of those infections rather than of the AIDS virus itself. The immune deficiency of AIDS causes people to get many unusual infections and cancers and we look for those as evidence of immune deficiency.

4. What is the rate AIDS is spreading?

The spreading of the virus is probably somewhat slower now because homosexual men have changed their behavior which limits new people from getting infected. The problem we have though is that many people are already infected with the virus and are developing AIDS at an increasing rate. We see a doubling of the number of cases occurring about every year and a half.

5. Can it be spread by spit and tears?

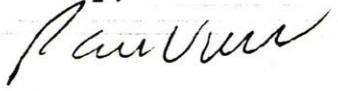
My answer to this is the same as for Number 1. Although the virus is found in many body fluids, it seems to only be spread by direct by direct sexual intercourse and by injecting blood from one person to another.

6. Is AIDS found in animals?

The answer to this is clearly no. The AIDS virus only infects humans and under artificial situations, chimpanzees.

I hope the above is of some value to you. Thanks for your interest and please feel free to help educate other people about this epidemic. While there is need for concern, there is certainly no need for panic.

Sincerely,



Paul A. Volberding, M.D.
Associate Professor of Medicine
Director
AIDS Activities
San Francisco General Hospital

PV:sb

Sept 3. 1987
P.O. Box 255
Cameron, La 70631

Dear Dr. Vollerding,

I know you won't remember me writing to you before, but I had wrote to you concerning Aids, as I am this time, my friends and I are more upset than ever and we have a few questions, I hope you don't mind.

① Can Aids be transmitted by Kissing.

② Can Mosquitos give it to us.

③. Is there signs we can look for to spot a person that has it.

④ What is the rate this ~~disease~~ "Aids" is spreading

⑤ Can it be spread by Spit + Tears.

⑥ Has Aids been found in Animals Dogs, Cats, ect.

②

When there's news on Television about Aids, its the same thing over + over and alot of Beating around the Bush, So far you have been the only person a I should say Doctor that we care to find out anything from.

I'll Close now, I know that you a very busy Man, And I wish you and your patients Alot of luck + prayers.

Please answer Soon

Thank you

Myra. J. Maddox
P. O. Box 255
Cameron, La 70631
[redacted]

SAN FRANCISCO: SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

September 22, 1987

To: Staff of Ward 86 and Ward 84

From: Paul A. Volberding, M.D. PV

I have a copy of a monograph that the Federal Office of Technology Assessment put together that goes through essentially all of what can be said about the possibility of insect transmission of HIV. It looks very complete and if anyone wants to brouse through it, drop by my office. If we want more copies, I think we can get them free of charge.

PV:sb