Summary of Meeting
On AIDS and the Bathhouses
With Medical Experts and Representatives of S.F. Medical Community
September 25, 1984

Attendees

Doctors

Centers Dis. Control: - Dr. James Curran
S.F. Medical Society: - Dr. Glenn Molyneaux, president
- Dr. Roberta Fenlon, past president
U.C.S.F./Med. Center: - Dr. J. Krevans, Dean
- Dr. John Conte, Professor, Infectious Diseases
- Dr. William Atchley, Chief of Staff
Pacific Med. Center: - Dr. James Cleaver, Chief of Staff
Children's Hospital: ~~- Dr. Waller~~
- Dr. George Hyde, Jr., Chief of Staff
- Dr. W. Lang
St. Mary's Hosptial: - Dr. Fred Mends
- Dr. Philip Morrissey, Chief of Staff
V.A. Med Center: - Dr. Ralph Goldsmith, Chief of Staff
Irwin Mem. Blood Bank: - Dr. Herbert Perkins
UC/SFGH: - Dr. Paul Volberding, Chief of Oncology
- Dr. Donald Abrams, AIDS Clinic
- Dr. Merle A. Sande, Chief of Medicine
Mt. Zion: - Dr. Herman Uhley, Chief of Staff
S.F. Health Dept.: - Dr. Mervyn Silverman, Director
- Dr. Dean Echenberg, Chief of Epidemiology and Communicable Diseases

Others

- Rev. Cecil Williams
- Roger Boas, Chief Administrative Officer
- George Agnost, City Attorney
- Dan Collins, Deputy City Attorney

Mayor's Staff

- Hadley Roff
- Tom Eastham
- Margaret Kisliuk
- Mike _____ (Coro Intern)

Discussion

Opening of Meeting: The Mayor began the meeting by stating that AIDS is a sobering and serious problem. She is especially concerned because there is no cure, the incubation period is up to 5 years, and S.F. has the highest contagion for the disease.

Summary of Research Evidence: Dr. Curran summarized the recent reseach evidence:

Latest Statistics

- AIDS was first reported 3 years and 4 months ago. As of September 24, 1984 there were 6,122 cases in the USA with nearly 2,800 deaths; a 45% death rate.
- Most AIDS patients will die within 2-3 years.

- There are 7 main risk groups in the U.S. and 8 elsewhere. In the U.S.:
  - Gay men (72%)
  - I.V. drug users
  - Blood transfusion recipients
  - Hemophiliacs
  - Haitains who entered the country after 1978
  - Infants born to infected mothers
  - Not in any risk group (less than 4%)

  People from Central Africa make up the eighth risk group.
- In California there have been 1,350 cases including 8 infants. 95% of them are gay men, and less than 2% are not in one of the identified risk groups.
- In S.F. 97% are gay men, 1% are not in risk groups and there have been 2-3 cases among infants.

Trends

Table 1
Increase in # of Cases of AIDS

	First 6 mo. of 1984 over 1983	First 6 mo. of 1985 over 1984 (predicted)
U.S.:	99% increase	over 40% increase
	These trends are uniform throughout risk groups and geographic areas.	
Calif.:	88% increase	55% increase

Table 2
Incidence rates over the last 12 months
June 1983-June 1984
3300 cases, U.S.A.
Cases per 100,000

Single men over 15 years old:
U.S.: 9 cases for every 100,000 single men
S.F.: 204/100,000 (25 times greater than nat'l average)
Manhattan: 175/100,000
Gay single men:
S.F.: 1,000/100,000 or 1% of all S.F. gay men.
I.V. drug users:
N.Y./N.J.: 200-250/100,000
Hemophiliacs:
U.S.: 200/100,000
Blood transfusion recipients receiving 10 or more units of blood at least 10 times:
U.S.: 0.4 adults; 2.4 infants per 100,000
General population:
U.S.: 0.1/100,000 (2000 less than for S.F. single men; 10,000 times less than for S.F. gay men)

By comparison, the incidence of heart disease (the most common disease) among single men is 200/100,000; the incidence of cancer is 133/100,000.

Research Findings

- Causal agent: AIDS is probably caused by the Human T-cell Leukemia Virus called HTLV3, a retrovirus.
  - A retrovirus is a more primitive form of a virus -- RNA without DNA. A virus requires another cell to divide; unlike bacteria which can grow on its own. It reproduces backward.
  - We don't fully know what the blood tests (that test to see whether the virus is present in the blood) mean.
- S.F. DPH/CDC Study: The two agencies worked together in a study of 6,875 gay men who came to the City Clinic for hepatitis B treatment from 1978-1980, before the onset of AIDS. For this group:
  - 1.7%, or 119 developed AIDS. An estimated 3.5% will eventually get AIDS.
  - These 119 cases comprised 16% of the AIDS cases in the Metropolotican Bay Area
  - A random sample of 10% of the group was asked back; 346, or 50% of came for subsequent testing. Of this sample:
    - -about 3% have AIDS;
    - -29% have symptoms associated with the AIDS virus;
    - -27% have generalized lymphadnopothy;
    - -average incubation period is 3.2 years;
    - -in 1978-80 5 1/2% of this group had antibodies -- in 1984 63% of the same group had antibodies (evidence of exposure), a 12 times increase over 5 years.
  - In a similar study in New York: 5% got AIDS; 20-30% have other symptoms; a larger percentage have the AIDS antibodies.
- General conclusions from DPH/CDC and similar studies:
  - Many more get lymphadnopothy than have AIDS;
  - Assume that at least 15-20% with the antibodies -- and perhaps all of them --have the virus.
  - The men in the study came to the City Clinic with potential hepatitis B; so they are probably the riskiest group in the City -- a "skewed sample."
  - In general, 30 times as many are exposed to the virus as have AIDS. It is estimated that 200-300,000 people in the U.S. have been exposed to the virus.
  - There are no known cases where someone had the virus and now doesn't.
- How is AIDS transmitted?
  - For gay men, the number of sexual partners is significant. Partners of those in the risk groups often get AIDS. However, researchers cannot rule out specific behaviors because the disease is present in white cells which are in most bodily fluids. No behavior is entirely safe, but being the recipient in unprotected rectal intercourse is the strongest risk.
  - For drug users, it is spread by needle sharing.
  - For hemophiliacs it is because of the pooling of plasma from thousands of donors (perhaps from 15-16 states). Hemophiliacs have been affected throughout the world; as many inside the U.S. as outside.

- How will technology help?
  For those not already exposed, technology will help:
  - A blood test will be on the market within the next 6 months to screen potential blood donors and thus blood and other blood products. AIDS from blood transfusions comprises 1 1/2% of the cases in the U.S. (fewer in San Francisco).
  - Hemophiliacs will be helped soon by heat treated products. The heat may destroy the virus, but may only work in labs. These two things will help perhaps 2% of the high-risk population. Other technologies are needed:
    - therapy for AIDS treatment
    - a vaccine for AIDS (certainly will not be available for the next few years.)
- What's can be done now to prevent spread of the disease?
  - Health promotion and education. This seems to be working; there have been massive changes in sexual practices:
    - a decrease in the number of sexual partners over the last 2 years;
    - a 30-70% decrease in the gonorrhea rate over the last 2 years.

    These behavior changes have been sustained. The effect on AIDS has not yet been seen, while the effect on gonorrhea has because of the short incubation period for gonorrhea. However, the chances of getting AIDS are now 12 times greater than they were in 1980 because there are 12 times as many cases; the risk is increasing.

Discussion about the bathhouses:

Curran:
- They should be closed if they can be kept closed. This will probably not impact on the problem but should convey the message of concern.
- Studies have shown a relationship between exposure to the AIDS virus and the number of sexual partners an individual has had. However, research evidence has not tied AIDS to attendance at the bathhouses.
- Originally, most cases may have started in the sex clubs and bathhouses, but now it is not as clear because such a high proportion of the population has been exposed. Now going to the bathhouses is close to suicidal because having sex with an anonymous sexual partner is close to suicidal.

Silverman: Summarized what has happened recently and where we are today:
- In April, on the unanimous advise of his medical experts, he decided to issue regulations that would restrict the type of activity that takes place in the bathhouses. However, these regulations were thwarted in the political process.
- Partially as a result of the announcement made in April- that the bathhouses would be regulated- four bathhouses have closed because of lack of business.
- In August, after the second meeting of his committee of experts he decided to close the bathhouses. Since that time he has been working with the City Attorney to develop a plan to close the bathhouses and sex clubs so that the action would be sustained in court- at least for a while.
- Closure is necessary despite the significant changes in behavior that have taken place. We have to try to maintain these changes in behavior.
- In order to close the bathhouses and sex clubs, they must first investigate to ascertain that "high-risk" behavior is taking place. They must then cite the owners of the offending establishments; then close them.

Agnost:

- The best strategy is regulations (everyone else felt these were unworkable.)
- The problem is not the structures it is the activity that goes on within them. That is why the example of the Bellevue Stratford and Legionnaire's Disease is not applicable.
- The sex clubs do not need a license to operate. They have to register for the payroll tax. This is not enough for the City to take action against them; we have to prove they are creating health problems.

Chief Murphy: Explained why the police could not be used to present testimony on what goes on in the bathhouses.

Volberding: Visitors to San Francisco and closeted gay men are the ones to worry about. They go to the bathhouses and sex clubs because they are the easiest places to have sex.

Dr. Felder: We close everything with infectious diseases and should close the bathhouses/sex clubs.

Dr. Lowry: San Francisco's doctors should make a loud and clear statement, not argue the legal issue on whether the action can be sustained.

Cecil Williams: The level of anxiety in the gay community is extremely high and must be dealt with.

General discussion:

- All the doctors seemed to agree that the bathhouses/sex clubs should be closed.
- Action against only the bathhouses and sex clubs is not enough. What about places like Buena Vista Park? The Mayor stated that activity in the parks is a police matter. Any type of sexual activity in the parks is already illegal.

Other Discussion

Dr. Curran responded to questions from the participants:

- Connection between AIDS and the number of sexual partners:
  - In a 1981 study, over 95% of the cases had had a large number of anonymous sexual partners.
  - In a different study, over 45% of those with AIDS antibodies had had an average of more than 4 sexual partners a month. About 18% of those without AIDS antibodies had had an average of more than 4 sexual partners a month.
- Does a membrane have to be pierced in order to get AIDS? They are not sure but they think there must be an abrasion; the virus must directly enter the blood stream.
- When will the article be published that states that the AIDS virus has been found in saliva? In about 3 weeks, in the New England Journal of Medicine.
- So far, AIDS has always been found in saliva if it has been found in the blood, but we don't know whether it can be present in saliva and not in the blood. However, the fact that no health care workers have gotten AIDS that were not in one of the high risk groups indicates that AIDS probably cannot be transmitted through saliva.
- AIDS is setting standards for the gay community. There are sex guidelines for the first time written on paper. It is at the least an attempt to set health standards for activities that generally only take place among gay men.
- San Francisco is the first, and so far the only City to contact the sexual partners of AIDS patients.

Need for expanded hospital services for AIDS patients:

Dr. Sande: In a year there will be probably be over 100 AIDS patients who need hospital care. San Francisco hospitals should consider establishing AIDS wards, just as SFGH did.

Dr. Krevans: UC sees AIDS patients but does not have a special ward and has not determined that one is necessary.

Dr. Silverman: The burden of treatment for AIDS patients should not fall on San Francisco alone. He spoke before the Congress to urge increased federal funding for AIDS research and treatment and funding of regional treatment centers. This would involve attention to eligibility rules under the jurisdiction of the US Health Care Financing Agency (part of HHS).

Dr. Curran: New York City does a census every week among all the hospitals in the City to determine how many beds have AIDS patients. There are about 200 AIDS patients a day in New York City.

Mayor: We need better coordination among our hospitals for the treatment of AIDS patients, and will be looking into this.

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We are People With AIDS.

Larry Littlejohn did not consult with us when he drafted his initiative to take sex out of gay bathhouses and private clubs, and so-called "gay leaders" did not consult with us when they sent a petition to Dr. Silverman asking him to close the baths and clubs administratively as a preferred alternative to the certain passage, if certified, of the Littlejohn initiative. This is unfortunate, as we think that our testimony, as the people most affected by the AIDS crisis, is important and necessary to vital AIDS decisions. We are asking that Dr. Silverman meet with People With AIDS before he makes any final decisions on the issue of baths and clubs.

We feel that closure of bathhouses and private clubs is not the real issue; rather, the issue is the education of gay men as to what specific sexual practices involve the exchange of bodily fluids and thus are "high-risk" for the transmission of AIDS, and to learn and practice low-risk, "safe-sex" techniques wherever and whenever they have sex.

We feel that if the baths and clubs are closed, some gay men who compulsively engaged in high-risk behavior at the baths and clubs will transfer their actions to public parks and streets of San Francisco, where hygenic facilities and educational materials are unavailable, and where police arrest is likely.

We feel that, unless the educational issue is addressed satisfactorily, that closing bathhouses and private clubs will not significantly reduce the incidence of AIDS and will not save lives.

We feel that bathhouses and private clubs should make structural and functional changes to encourage and facilitate low-risk, safe-sex practices. These could include closing areas, such as "orgy rooms", that encourage high-volume, high-risk sexual practices, making easily available educational materials and items such as condoms, and providing increased and adequate lighting in all areas. We understand, further, that owners of baths and clubs in San Francisco have agreed to make these and other changes.

We feel that the proposed closure of baths and private clubs is mostly symbolic, and will have many long-term, long-range, nationally detrimental effects on how gay men view themselves and how we are viewed by society. We feel that municipalities and states accross the country will see only that the City and County of San Francisco, at the request of some gay people, closed gay baths and clubs, and will not understand that this was a political shellgame to avert a more restricitve initiative petition. We anticipate that such cities and towns might on their own close down all gay establishments within their borders, for reasons of "public health". Thus, we anticipate increased discrimination against gay men lesbians and in general and people with AIDS in particular.

We feel that the Littlejohn initiative, which would submit homosexual sex practices to a public vote, is the worst possible approach to the AIDS crisis. Some have argued that it may be more expedient politically for Dr. Silverman to close the baths and clubs on his own, which decision could be easily reversed later, than the passage of the Littlejohn initiative.

We who have AIDS, however, are on record as opposing the Littlejohn initiative, as well as any attempt to close the baths and clubs, as a shallow, cosmetic, dangerous, and ultimately ineffective symbolic gesture.

Bobbi Campbell RN

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April 2, 1984

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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AIDS Behavioral Research Project
HOSPITALS AND CLINICS - A 405

SAN FRANCISCO, CALIFORNIA 94143
731-7468

TO: Mervyn Silverman, M.D.

FROM: Leon McKusick, M.S.
Steve Morin, Ph.D.

DATE: April 3, 1984

SUBJECT: Bathhouses and Public Policy

The issue of closing bathhouses in San Francisco has produced a debate which seems to us has lost track of data that could reasonably be used to make a public policy decision. Frequently discussions have moved from medical issues to political or rights issues without an examination of medical, behavioral and epidemiological data. The following are some thoughts.

Medical Issues

The proper policy question to be directed to medical advisors is: What is the most probable means of AIDS transmission? The medical consensus regarding AIDS transmission appears to be leaning toward the following: (1) blood to blood, e.g. transfusion cases; (2) semen to blood, e.g. cluster studies of sexual contacts; and (3) viral agent, e.g. SAIDS retrovirus model.

In that public policy decisions on bathhouses must be based on the medical issue of sexual transmission, a very high consensus that AIDS can be transmitted from semen to blood would be needed. Public policy decisions would follow directly from this medical consensus.

Behavioral Issues

If semen to blood transmission is widely accepted by the medical advisors, then certain target behaviors could be identified with prevention efforts directed toward lowering the incidence of AIDS transmission, e.g. frequency of anal intercourse, receptive without condom. The proper question to be directed to behavioral science advisors is: Does the environment at bathhouses promote an increased frequency of high risk sexual behaviors (semen to blood transmission)?

McKusick, Horstman & Carfagni (1984) conducted a study comparing men recruited from bathhouses to those recruited from bars, couple networks, and newspaper

Behavioral Issues (continued)

advertisements for those who did not attend bars or baths. Some of the following findings are relevant to public policy determinations:

Disease transmission: Men sampled from bathhouses were significantly more likely than other groups to have had hepatitis B. Those sampled from bathhouses and bars were more likely than the other two groups to have had either gonorrhea or syphilis in the last year.

Number of sexual partners: Men sampled from the bathhouses demonstrated a higher frequency of sexual partners than the other groups. Sixty-one percent of the men sampled in the baths reported 5 or more sexual partners in the last month; 32% reported 10 or more partners.

High risk activity: Men sampled from bathhouses and bars were more likely than the other two groups to demonstrate high risk sexual behaviors. Forty-four percent of the bathhouse respondents reported anal intercourse, receptive without condoms with a new or secondary partner in the last month; 11% reported this behavior with 5 or more partners in the last month.

Have Educational Efforts Been Successful?

One argument that is frequently used by those opposing bathhouse closure is that gay bathhouses offer an opportunity to prevent the spread of AIDS through public education. However, the data collected on men sampled from bathhouses indicates a very high level of awareness regarding AIDS transmission. In this sample there was a 92% agreement with the statement that "AIDS is transmitted through body fluids." There was a 95% agreement with the statement "reducing the number of sexual partners overall helps reduce AIDS risk." These data suggest that men attending bathhouses have a very high recognition of risk reduction guidelines even though there behaviors do not conform to these recommendations.

Would Closing or Altering the Baths Make a Difference?

There appears to be strong belief (possibly a myth) on the part of many people that closing the baths would not change high risk sexual behaviors. This argument to some extent ignores the issue that many behaviors are situation specific and that people behave in different ways in different environments. High risk and high frequency sexual behaviors are directly related to environmental factors which support such behaviors.

The American Association of Physicians for Human Rights (AAPHR) has released a statement on baths indicating "There is no evidence, at this time, that closing bathhouses would reduce the risk or incidence of AIDS." It is unclear whether the behavioral data above have been considered.

Further, the AAPHR statement indicates "attempts at legislating sexual behavior have only changed locations of that behavior, not curtailed it." Although this statement may have validity regarding statutes, it is not relevant to the current issue for determination.

Going back to the McKusick, et. al. data, respondents of who do attend bathhouses (n=281) were asked if there were no bathhouses how their sexual behavior might be expected to change. They responded as follows:

Would probably have the same kind of sex somewhere else	47%
Would stop having the sex he now has in bathhouses	7%
Would reduce the kind of activity he now has in a bathhouse but would still have some of this behavior elsewhere	28%
Other changes	19%

Self-report data on those attending bathhouses thus indicate that 53% would make significant changes if there were no bathhouses.

Given the high probability that the number of behaviors such as multiple partners is easier in bathhouses and the opportunities as well as social skills necessary to engage in the same type of activities elsewhere may not be a part of the person's current social skills, the 45% who would not predict changes in their sexual behavior may be overestimating other options. To a large extent the policy issue of closing/altering bathhouses depends upon whether or not frequency of sexual partners and high risk activities are situation specific. The above data would suggest that they are.

Conclusion

This memo was prepared in part to refute the notion that there are no data indicating that the closing of the baths would reduce the incidence of AIDS. The above medical, behavioral and epidemiological data can be interpreted to suggest that closing or altering bathhouses could have a major impact on reducing high risk sexual behaviors and therefore the incidence of AIDS transmission. High risk and high frequency sexual behaviors appear to be situation specific. Current bathhouse environments appear to promote high volume and high risk behaviors.

Most public policy decisions are made with far less data than are available on this issue. Although these data do no dictate one particular decision over another, they are are brought to your attention to help focus the public policy debate.

City and County of San Francisco **Department of Public Health**

April 9, 1984

PRESS STATEMENT

SAN FRANCISCO HAS BEEN FACED WITH ONE OF THE MOST COMPLEX HEALTH CARE PROBLEMS IN ITS HISTORY. THE TRAGIC DISEASE OF AIDS HAS HIT OUR CITY MORE SEVERELY THAN ANY OTHER IN THE UNITED STATES EXCEPT FOR NEW YORK. APPROXIMATELY ONE YEAR AGO, THE GAY COMMUNITY IN COOPERATION WITH THE DEPARTMENT OF PUBLIC HEALTH SET ABOUT TO DEVELOP A PROGRAM TO DEAL WITH THIS DISEASE THAT WAS TAKING THE LIVES OF MANY OF OUR YOUNG MEN. THIS PROGRAM HAS BECOME A MODEL FOR THE UNITED STATES. MEMBERS OF THE GAY COMMUNITY HAVE JOINED TOGETHER WITH AN UNPRECEDENTED SENSE OF PURPOSE TO BRING ABOUT SIGNIFICANT CHANGES IN RESPONSE TO THIS CRISIS.

IN CONJUNCTION WITH THE AIDS FOUNDATION, SHANTI PROJECT AND MANY CONCERNED INDIVIDUALS, WE HAVE ESTABLISHED A CONTINUUM OF SERVICES RANGING FROM EDUCATION AND INFORMATION, SCREENING, OUTPATIENT SERVICES, INPATIENT SERVICES, COUNSELING, IN-HOME SERVICES, AND MANY OTHER ACTIVITIES ALL DIRECTED TOWARDS PREVENTING, TREATING AND, HOPEFULLY, FINDING A CURE FOR AIDS. IN THE PAST YEAR ALONE, HUNDREDS OF THOUSANDS OF PIECES OF INFORMATION HAVE BEEN DISTRIBUTED TO BOTH THE GAY AND THE GENERAL COMMUNITY. HUNDREDS OF WORKSHOPS, TRAINING SESSIONS AND FORUMS HAVE BEEN PRESENTED AND, AS A RESULT OF ALL THIS ACTIVITY ALONG WITH THE MEDIA COVERAGE OF THIS EPIDEMIC, UNHEALTHY SEXUAL BEHAVIOR HAS BEEN CHANGING. THIS IS DOCUMENTED IN THE PLUMMETING FIGURES FOR OTHER SEXUALLY TRANSMITTED DISEASES IN THE GAY COMMUNITY. UNFORTUNATELY, OVER THE LAST FEW MONTHS, THESE NUMBERS HAVE FLATTENED OUT.

WHAT HAS MADE DEALING WITH THIS DISEASE SO DIFFICULT HAS BEEN THE ABSENCE OF RESEARCH-PROVEN INFORMATION ON THE EXACT IDENTITY OF THE CAUSE, THE EXACT MODE OF TRANSMISSION, AND THE ABSOLUTE CURE. THERE IS BASIC AGREEMENT, HOWEVER, AMONG RESEARCHERS AND OTHER EXPERTS IN THE FIELD INDICATING THAT AIDS IS SPREAD THROUGH BLOOD AND SEMEN, AND THAT THOSE GAY AND BISEXUAL MALES THAT INDULGE IN MULTIPLE SEXUAL ENCOUNTERS ARE AT THE HIGHEST RISK. LOCATIONS WHICH PARTICULARLY FOSTER THIS BEHAVIOR INCLUDE THE BATHHOUSES, SEX CLUBS AND THE BACK ROOMS OF CERTAIN BOOKSTORES.

THE QUESTION OF HOW TO DEAL WITH THESE FACILITIES IS ONE THAT I HAVE BEEN STRUGGLING WITH FOR OVER A YEAR. DURING THAT TIME I HAVE MET WITH HEALTH EXPERTS, BOTH LOCALLY AND NATIONALLY, IN AN ATTEMPT TO ASCERTAIN THE COURSE OF ACTION THAT WOULD RESULT IN A REDUCTION IN THE SPREAD OF AIDS. ONE MESSAGE HAS BEEN LOUD AND CLEAR - THAT CERTAIN TYPES OF SEXUAL BEHAVIOR AMONG HOMOSEXUAL AND BISEXUAL MEN WOULD HAVE TO CHANGE IF WE WERE TO BE SUCCESSFUL.

LAST WEEK I MET WITH A PANEL OF NATIONAL, STATE AND LOCAL AIDS EXPERTS AND ASKED THEM FOR THEIR RECOMMENDATIONS. AFTER SIX HOURS OF DELIBERATION CONCERNING ALL AVAILABLE OPTIONS, IT WAS THE OPINION OF THIS GROUP THAT ALTERING THE BEHAVIOR IN THESE BATHHOUSES, SEX CLUBS AND OTHER FACILITIES COULD HAVE AN IMPORTANT EFFECT ON THE INCIDENCE OF AIDS. IT WAS THE UNANIMOUS POSITION OF THIS GROUP THAT ALL SEXUAL ACTIVITY BETWEEN INDIVIDUALS BE ELIMINATED IN PUBLIC FACILITIES IN SAN FRANCISCO WHERE THE TRANSMISSION OF AIDS IS LIKELY TO OCCUR. IT WAS RECOGNIZED BY THIS GROUP OF EXPERTS THAT THIS ACTION, IN AND OF ITSELF, WOULD NOT COMPLETELY SOLVE THE PROBLEM OF THE TRANSMISSION OF AIDS, BUT THAT IN CONJUNCTION WITH THE STRONG EDUCATIONAL CAMPAIGN PRESENTLY UNDER WAY, IT WOULD HAVE A SIGNIFICANT IMPACT.

THERE ARE FEW PRECEDENTS TO THIS ACTION AND I THEREFORE CALL UPON ALL MEMBERS OF THE GAY COMMUNITY TO WORK WITH US AS WE MOVE THROUGH THESE UNCHARTED WATERS TOGETHER. MANY HAVE ALREADY TAKEN THE LEAD IN A COURAGEOUS AND CREATIVE MANNER.

I WANT TO REITERATE THAT THE ACTION WE ARE TAKING HERE TODAY, WITH THE SUPPORT OF AIDS EXPERTS AND GAY LEADERS, IS BUT ONE PART OF A PROGRAM TO REDUCE THE INCIDENCE OF AIDS. BY NO MEANS IS IT A PERFECT ANSWER OR A COMPLETE SOLUTION BUT, HOPEFULLY, WITH THE SUPPORT OF THESE INDIVIDUALS AND MANY, MANY OTHERS IN THE COMMUNITY, WE CAN MORE EFFECTIVELY BATTLE AND EVENTUALLY CONQUER, THIS DREADED DISEASE.

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City and County of San Francisco **Department of Public Health**

PRESS RELEASE

APRIL 9, 1984

FOR IMMEDIATE RELEASE

CONTACT: ZOHN ARTMAN
861-4794

DPH RELEASES LATEST AIDS STATISTICS

AIDS cases reported to the San Francisco Department of Public Health rose to 471 cases as of the end of April, up from 448 at the end of March. Reported deaths increased to 174 from the previous months total of 161.

Nationally, the total of AIDS cases reported is 3,899 compared with 3,646 at the end of March.

New AIDS cases in San Francisco continue to be reported at the rate of about 1 per day.

While AIDS does not pose a threat to the public at large or to the lesbian community, those in the highest risk group -- gay and bi-sexual males -- need to be aware of the need to prevent AIDS transmission. Information on AIDS prevention can be obtained by calling (415)863-AIDS.

San Francisco AIDS Cases
By Age Group
April 2, 1984

Age Group	Number of Cases	Percent of Total
under 20	0	0
20–29	68	14%
30–39	253	54%
40–49	115	24%
over 49	35	7%
Total	471	

San Francisco AIDS Cases
By Race/Ethnicity
April 2, 1984

Race/ Ethnicity	Cases	Percent of Total
White, not Hispanic	426	90%
Black, not Hispanic	20	4%
Hispanic	20	4%
Asian	2	.4%
Other	1	.2%
Unknown	2	.4%
Total	471	

Reported AIDS Morbidity and Mortality
National, California and San Francisco
April 2, 1984

	United States	California	San Francisco
Cases	3,899	1,020	471
Deaths	1,702	*	174
Percent Dead	44%		37%

* Information not received from State.

GOLDEN GATE METROPOLITAN COMMUNITY CHURCH

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California Hall
San Francisco, California 94102

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TTY: (415) 474-0315

April 10, 1984

Dr. Mervyn Silverman
Director of Public Health
City of San Francisco
101 Grove Street
San Francisco, CA 94102

Dear Dr. Silverman:

I am disturbed by several statements you made at the news conference yesterday. I understand my concern is shared by others who attended the meeting with you on Sunday.

While I cannot speak for others, it was my understanding that both bath houses and other establishments would be allowed to develop creative programs that were erotic in nature and that sexual activity not involving the exchange of blood and semen would be encouraged. Indeed, such a policy would be consistent with the information your own office has distributed in your educational program. I understood that sex with multiple partners in an "orgy" situation and sex between individuals which are at odds with safe sex techniques would be forbidden.

If there is a misunderstanding about this, it needs to be clarified with the opportunity for both you and those attending Sunday's meeting to re-evaluate our position. If it is simply a mistatement under the pressure of the press conference, please say so and I am sure all will understand. If you changed your opinion from Sunday to Monday and didn't inform us, you should know you have placed many of us in support of policies we can not support. You will also have undermined the faith and position of several of us. The result, I feel, will be a tragic drop in our support.

I want you to know I believe in your ethics and motives. Please clarify this issure for us. I realize you wanted to avoid discussing specifics about sex allowed. However, your statement seemed to state in very strong language that all sex will be prohibited. This was not my understanding. Other than doctors, M.C.C. ministers are most involved with AIDs patients. We minister to them and their families and we see them die. Accordingly, we will support any reasonable course to combat this disease.

However, some of us are among the early supporters of gay liberation. We will not support anything that diminishes our rights, our institutions, or our life styles.

On a positive note, your strong and positive statement about the co-operation and leadership of the gay community and the real change in habits in the gay community was appreciated.

Sincerely,

Reverend James E. Sandmire

The Reverend James E. Sandmire

c.c. Various members of the Sunday Meeting
Members of the meeting of April 1 at Golden Gate M.C.C.

JES/vlm

Dr. Paul Volberding

City and County of San Francisco **Department of Public Health**

September 13, 1984

Statement of Mervyn F. Silverman, M.D., M.P.H.
Director of Health

There have been a number of comments by others indicating a course of action to be taken by the Director of Health with regard to AIDS. As I have made no public statement indicating that a specific decision has been reached, I would like to summarize my present position:

(1) I have conferred with my panel of AIDS experts and a number of city officials, but feel it is inappropriate to discuss the details of those meetings.

(2) I am considering three options:

(a) Continue to pursue a regulatory course through the licensing mechanism . These proposed regulations were drafted by the City Attorney and sent by me to the Chief of Police last May, and represented the unanimous judgement of the assembled AIDS experts as the most effective action to take. Due process required that they move through various levels of government outside the Health Department. During that process, political considerations prevented these regulations from being adopted and implemented.

(b) Encourage the affected community to take action with regard to sex clubs, bathhouses, and other establishments which facilitate unsafe sexual behavior . To some extent, the community has begun to change as a result of alterations in individual behavior, and several establishments have closed as a result of reduced patronage. However, concerted efforts by the gay community to close all remaining facilities which foster unsafe sex practices would have significant impact extending beyond the objective of closure itself. Such action would be far-reaching, extending and reinforcing the changes that have already taken place.

(c) Close those facilities which encourage multiple anonymous sexual contacts among high-risk groups. Individual rights are an important consideration in this process. However, we consider health to be the uppermost priority and it is important that our actions not be reversed by the Courts. To ignore this as a possibility would be folly, because the ultimate goal is to effect a reduction in the spread of AIDS, not just to make an empty gesture.

(3) Although a great deal of attention is being focused on sex clubs and bathhouses, the major issue has been, is, and will continue to be, individual behavior. Through the provision of relevant education and information, we continue to have the best opportunity to prevent the further spread of this tragic disease.

(4) Because of the sensitive and complex nature of this issue, I shall not comment further until I make my decision public.

As Director of Health, I will continue to base my decisions and actions solely on public health considerations.

MFS:cc

DECLARATION OF PAUL A. VOLBERDING, M.D.

I, Paul A. Volberding, M.D., do hereby make the following declaration in support of the Application for a Temporary Restraining Order and Order to Show Cause Re: Preliminary Injunction:

1. I attended the University of Minnesota School of Medicine from 1971 to 1975, and received my M.D. degree from that institution in 1975. From 1976 to 1978, I did an internship and residency in Internal Medicine at the University of Utah. From 1978 to 1981, I had a Hemotology/Oncology Fellowship at the University of California at San Francisco ("UCSF"), and thereafter joined its faculty. From 1981 to 1982, I was the medical oncology consultant to the Malignant Melanoma Clinic at UCSF.

2. I am currently an Assistant Professor of Medicine at UCSF and Chief of Medical Oncology at San Francisco General Hospital ("SFGH"), and have been so employed since July 1, 1981. In addition, I am Director of the Acquired Immune Deficiency Sydrome ("AIDS") Clinic at SFGH and Co-director of the Kaposi's Sarcoma Clinic at UCSF. I serve on the Boards of Directors of the American Cancer Society/San Francisco and the AIDS & KS Research and Education Foundation. Over the past several years, I have written or participated in the writing of numerous professional articles on AIDS and Kaposi's Sarcoma. My curriculum vitae, which includes a complete list of my

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publications, is attached hereto as Exhibit 1 and incorporated herein by reference as though fully set forth.

3. In my capacity as Chief of Medical Oncology and Director of the AIDS Clinic at SFGH, my major responsibility is to oversee the diagnosis and treatment of all patients at SFGH with AIDS, herein defined to refer to patients meeting the criteria of the Center for Disease Control ("CDC") in Atlanta (which includes the presence of diseases considered diagnostic of an underlying immune deficiency such as Kaposi's Sarcoma, central nervous system lymphoma, or infections such as pneumocystis pneumonia). I also treat patients, supervise six full time physicians, six nurses and approximately thirty clerical and other staff members, and supervise the training of medical students in the treatment of patients. At the present time, I have approximately 300 patients with AIDS or AIDS-related diseases.

4. The first contact that I had with AIDS was in July, 1981, when I commenced my employment at SFGH. The week before I began, the first patient with Kaposi's Sarcoma was admitted to that facility. In the course of obtaining a medical history, the patient related that he previously had been employed at a gay male bathhouse, where he had had numerous sexual contacts with patrons. Attached as Exhibit 2 hereto is a picture of the patient taken approximately two months after his admission in July, 1981. He died in October, 1981. Kaposi's Sarcoma normally does not affect people until they are in their 70's or 80's.

During my medical school training, residency and oncology fellowship, I had never seen a patient with Kaposi's Sarcoma. Therefore, it was striking to me to see a 22-year old man with a very aggressive form of this disease. That same week, the CDC had just published its first report alerting physicians to the possibility of a new disease affecting homosexual men associated with Kaposi's Sarcoma, and I became very interested in further studies of the syndrome. Over the next two to three months, I saw several more patients with Kaposi's Sarcoma at SFGH.

5. In my capacity as a medical oncology consultant to the Malignant Melanoma Clinic at UCSF, I met Dr. Marcus Conant in September, 1981. I mentioned to him that I had several patients with Kaposi's Sarcoma. He took me to see several of his Kaposi's Sarcoma patients at UCSF. On the basis of our experience and the reports that had been published suggesting that this was a new disease affecting homosexual men, we realized that we would be seeing more cases because of the large number of risk group members in San Francisco. Therefore, we started a Kaposi's Sarcoma Clinic at UCSF, which I believe was the first facility devoted to AIDS in the entire country.

6. Over the next year, Dr. Conant and I saw ever increasing numbers of patients affected by Kaposi's Sarcoma, and became very alarmed when we saw that the disease was extremely aggressive and rapidly fatal. We quickly realized that we would be better able to study the treatment of Kaposi's Sarcoma in AIDS in a more controlled fashion if patients were referred to a

single facility. Because of my special interest in the syndrome, we decided that all patients with Kaposi's Sarcoma would be referred to the Oncology Clinic at SFGH for protocol therapy, where there would be controlled treatment with careful follow-up and the use of both conventional and experimental drugs.

7. Based on the clinical appearance of patients with AIDS and the concentration of the disease in specific risk groups, AIDS researchers suspected from the start that the disease was caused by an infectious agent, most likely a virus. The findings of numerous published investigations strongly suggested an infection and destruction of the cells in the immune system. Recently, investigators in both the United States and France identified a new viral agent in patients with AIDS or in AIDS risk groups. The current view is that this virus, variously termed LAV or HTLVIII, causes AIDS by preferentially infecting and damaging T-lymphocytes (cells of the immune system). The infection of the cells is chronic, but viral shedding of the infected cells may be intermittent. Thus, after exposure to the virus, outcomes for the infected person may include the development of AIDS, the development of immunity to AIDS, or a chronic carrier state. In those infected individuals who develop AIDS, the breakdown in their immune system causes an increased susceptibility to a wide variety of clinical problems, including infections and cancers, most of which ultimately are fatal.

The form of AIDS I personally have been most involved with is a common malignancy, Kaposi's Sarcoma ("KS"). This disease is

a tumor of the cells lining the lymphatic vessels. These vessels normally function to drain fluids from body tissues. KS, unlike most cancers, does not have a primary site with secondary sites of involvement. Rather, it can affect many regions of the body simultaneously. Prior to the AIDS epidemic, KS generally affected elderly men and was rarely fatal. In AIDS patients, however, the disease is much more aggressive and disseminates rapidly. The median age of patients affected by KS is now 35 years and almost all are homosexual men. KS causes many clinical problems, but the most evident is the rapid progression of pigmented skin tumors affecting any part of the body. Patients usually do not die directly from KS, although this does occur in about 10 percent of patients with pulmonary involvement. More often, patients with KS die of a wasting illness or from secondary opportunistic infections such as pneumocystis pneumonia.

AIDS leads to numerous infections. These are classified as opportunistic infections because they are caused by organisms in the environment which only affect persons with damaged immune systems. These include parasitic, viral, fungal and bacterial organisms. The most common infection seen in AIDS patients is pneumocystis pneumonia, which is caused by a parasite present in the lungs and is reactivated in AIDS. Pneumocystis pneumonia does not affect healthy individuals. Before AIDS, the majority of the cases of this pulmonary infection were in children with acute leukemia undergoing chemotherapy or in patients following kidney transplantation.

Another clinical problem caused by AIDS is a diffuse enlargement of the lymph glands. AIDS experts estimate that this problem is ten to twenty times more common than CDC-defined AIDS. We have studied a number of patients in our clinics with diffuse lymphadenopathy. Dr. Donald Abrams, working in my clinic, has estimated that approximately 5 percent of these patients will progress to AIDS within two years.

8. Since July, 1981, the number of patients with AIDS and AIDS-related diseases at the UCSF and SFGH clinics has escalated alarmingly. At the end of 1982, we were seeing approximately ten patients per week for follow-up; by the end of 1983, we were seeing approximately 150 per week. We currently record nearly 300 patient contacts per week, including patients with AIDS, patients with AIDS-related conditions, and risk-group members who are concerned that they might have AIDS. At present, approximately two new cases of AIDS are being diagnosed in San Francisco each day. To date, over 700 male homosexuals in San Francisco have been diagnosed with AIDS, with a mortality to date of nearly 50 percent. The number of persons with AIDS-related conditions is estimated to be ten to twenty times higher.

The existence of an AIDS epidemic in San Francisco has been confirmed by a study conducted in 1984 by the CDC and released on October 4, 1984. It is now possible to test persons for exposure to the AIDS virus. This testing is performed on serum and detects antibodies which confirm prior infection. The proportion of homosexual men tested in San Francisco who have antibody to

the AIDS virus is alarming. Serum collected from homosexual men visting San Francisco's Venereal Disease Clinic show as many as 66 percent with AIDS virus antibody. In contrast, a study in 1978 on the same individuals showed less than 1 percent had been infected by the virus.

9. I personally have been involved in the care of well over 50 percent of the AIDS patients in San Francisco and have participated in the care of at least 300 patients with AIDS. Of these patients, greater than 97 percent have been sexually active homosexual men. The exceptions include one person with AIDS acquired as a result of hemophilia, two patients who were exposed to AIDS as a result of intravenous drug abuse, and one person for whom risk factors could not be identified. In the case of homosexual males, AIDS is transmitted through contaminated semen or other body fluids such as blood or saliva. Homosexual men are more commonly affected by AIDS because of direct innoculation of the AIDS virus into the bloodstream facilitated by trauma incurred during rectal intercourse.

10. In my opinion, AIDS represents a major health problem to the country and especially to the cities most affected by the epidemic, including New York, Miami, Los Angeles, and San Francisco. San Francisco, with the highest per capita rate of AIDS in the country, has been especially affected by this disease. AIDS is almost uniformly fatal and is always irreversible. Although some patients have survived several years, the majority of patients die within the first two years

following the diagnosis. I know of no patient who, once diagnosed with AIDS virus, has experienced spontaneous remission. One patient that I treated told me that as a result of successful treatment of his KS, he could return to a sexually active lifestyle because his partners would not realize he had AIDS. Several other patients of mine with AIDS have developed rectal gonorrhea. This, occurring months after the diagnosis of AIDS, is clear evidence of ongoing non-protected anal sexual intercourse. I recall that at a meeting in May, 1984 at the SFGH AIDS Clinic with owners of gay bathhouses, one owner commented: "Let's face it - we both make money from these guys; we make money from their sex, you make money when they're sick."

11. The care of patients with AIDS is difficult medically, emotionally and financially. These patients are generally in their 30's and highly educated about their illness. They usually face a rapidly progressing series of medical problems for which in many cases there is no effective therapy. Death occurs after a prolonged illness which requires multiple lengthy hospitalizations. The cost of such care is not precisely known, but I estimate it to be between $60,000 and $70,000 per patient from the time of diagnosis to death.

It is tempting to predict that with widespread publicity and public education concerning AIDS earlier diagnoses can be made at a time when treatment is more effective. However, this has not been the case. In fact, at the present time there is no effective therapy for the underlying immune deficiency and our

treatment of the associated problems has not progressed significantly during the past three years. AIDS patients today, as they did three years ago, face a relentlously progressing course in all but a small fraction of cases.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct

Executed on October ____, 1984, at San Francisco, California.

Paul Volberding

PAUL VOLBERDING, M.D.

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