

I am honored tonight to present Being Alive's Spirit of Hope Award to Dr. Mark Katz. I would even be more thrilled if I were Mark's first choice as presenter, but I'm not. You should know that (Mark wanted) Elizabeth Taylor to present the award to him personally. Due to a scheduling conflict, Ms. Taylor was unable to be here tonight. I have, however, doused myself with PASSION perfume in the hopes that this would compensate for any deficiency. I now smell like Liz. Alluring, right?

Dear Dr. Katz: Congratulations on receiving Being Alive's Spirit of Hope Award. Your tireless work on behalf of the AIDS crisis and five years of service as a medical consultant to Being Alive certainly merits this recognition tonight. For your responsibility, your caring, your efforts and all your hard work, I thank you from the bottom of my heart. Much love, Elizabeth Taylor.

I thought I would open with some vital statistics about Mark which some of you may not know. Mark was born in Queens, N.Y. His childhood is self-acknowledged as being a rather reclusive one. A childhood spent mostly in his room reading books. And tonight we suffer the consequences of ever letting him out of that room.

Our good luck in having Mark here in L.A. is probably due in part to his having spent his young adulthood in snowy upstate New York, taking his undergraduate degree at Cornell and his M.D. at the State University of New York in Syracuse. He completed his residency in Internal Medicine in Madison, Wisconsin. While in Wisconsin he performed a daring operation involving two cheeseballs and a beef jerky. It was then he knew he belonged in emergency room medicine.

I was very much relieved during this banquet to know that there is at least one person in this room qualified to perform the Heimlich maneuver.

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Mark has had numerous influences in his medical career. None more important than Dr. Seuss. While in medical school Mark authored the seminal AIDS research paper entitled "GREEN EGGS AND AZT."

Dr. Mark Katz is now the Regional HIV/AIDS Physician Coordinator for the Kaiser Permanente Medical Group. Kaiser, of course, named after the roll. Permanente, of course, describing his salary cap working in a hospital and not a private practice. When questioned about why he had not "cashed in" and gone into the private practice of medicine, Mark demurely questioned, "You mean, you can really do that?"

As you know Mark provides an invaluable community volunteer service. Once a month he presents a televised medical workshop wherein he translates medical jargon into layman's terms. These monthly meetings have become so popular in fact that Mark has decided to charge a cover and two drink minimum.

I had the opportunity to attend a number of Mark's updates and I must tell you that as a physician I was amazed by the dexterity with which he answered the most complex questions. I was even more amazed when he suggested to someone in the audience to "put the lime in the coconut and then drink it all up, put the lime in the coconut then you feel better."

You may not be aware that Mark is encyclopedic in his knowledge of older rock and roll trivia. This has leaked into his professional life as it is rumored that he often makes emergency room patients challenge him in a game of Jeopardy before administering treatment to them. I'll never forget that heart patient who almost flatlined before managing to wheeze out "The Ronettes." Lucky for him it was a correct answer and Mark administered CPR.

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As you can all see Mark is a handsome and very GQ kind of a guy. He told me before this dinner that he would gladly trade any awards he will receive to be on the cover of the next issue of the International Male Catalogue.

What's so apparent to anyone who has met Mark is his upbeat enthusiasm. He overflows with so much positive-ness it once caused Howard Stern to tell him to "Shut the fuck up."

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With this roast tonight we hope to both honor and humble Mark. Yes, he does have a little bit of an ego. When Mark first heard of the Broadway play "CATS" he thought it was about himself. "DOCTOR KATZ, THE MUSICAL."

Lest anyone in the audience take this roast with anything other than love manifesting in a humorous way, you all should know that Mark has a well-developed sense of humor.

Mark has said that he got his sense of humor from his mother - and if he doesn't get it back to her by midnight tonight he of course turns into --- an intern.

Although wonderfully modest, Mark is no stranger to awards. He received the Kaiser Permanente Physician Excellence Award in 1991, the Being Alive Arthur Robbins Memorial Award in 1989, the Shanti Foundation County Citation Award in 1990 and the Stuart Gurman Humanism in Medicine Award in 1975.

In one way or the other he has been a major player in the activities of Being Alive, Shanti, the Plus Seminars, Nechama, Search Alliance, Pacific Center, the GLCSC and the L.A. County AIDS Commission.

Since 1989, he has presented 60 Being Alive Medical Updates, provided the medical overview at 35 Plus Seminars, and over 60 outside lectures. I stand in awe of his energy and dedication to his profession and his community.

His work has been vital in keeping hope alive in often trying times. On behalf of all of us who are in this together, and with the gratitude of tens of thousands of people living with HIV and AIDS in Southern California, it is my great honor to present to you, Mark, the 1993 Being Alive Spirit Award.

✓
OF HOPE

Ron,
I thought you might be
interested from an
editorial perspective.
Mike

REMARKS BY MICHAEL GOTTLIEB, MD
WEDNESDAY, JUNE 2, 1993
AIDS FORUM
THE INSTITUTE
FOR
ADVANCED STUDIES
IN
IMMUNOLOGY AND AGING
GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

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OTHER SPEAKERS HAVE TOLD YOU WHAT IS
HAPPENING ON THE RESEARCH FRONT.

MY ASSIGNMENT IS TO TELL YOU ABOUT SOME
OF THE THINGS WE ARE LEARNING ON
ANOTHER FRONT -- IN THE TRENCHES
OCCUPIED BY DOCTORS AND PATIENTS.

ONE OF THE THINGS WE'VE LEARNED IS THAT
WHEN DEALING WITH A NEW DISEASE WHICH
HAS SO ^{UNKNOWN} ~~MANY UNANSWERED~~ QUESTIONS, AS
~~WITH HIV,~~ THE INFORMATION TRANSFER
BETWEEN DOCTORS AND PATIENTS MUST BE A
TWO-WAY STREET. PATIENTS FREQUENTLY
ARE THE ONES TO PROPOSE NEW IDEAS TO
DOCTORS, INCLUDING INFORMATION ON
ALTERNATIVE THERAPIES. AIDS HAS
CHANGED MY VIEWS ON THIS SUBJECT.

I BELIEVE THAT PEOPLE WITH A LIFE-
THREATENING DISEASE MUST HAVE THE
FREEDOM, WITHIN REASON, TO SEEK OUT THE
TREATMENTS THEY FEEL THEY NEED. AS
THEIR DOCTOR, I WANT MY PATIENTS TO
TELL ME WHAT THEY ARE DOING TO TREAT
THEIR HIV CONDITION. IN THAT WAY I CAN
LEARN ABOUT NEW APPROACHES AND TRY TO

COORDINATE THEM WITH WHAT I AM
PRESCRIBING.

I WONDER IF ANY OF YOU HAVE EVER THOUGHT
ABOUT HOW IT FEELS TO BE A PERSON WITH
HIV AND TO READ AND HEAR THE NEWS
COVERAGE AND RESEARCH DEVELOPMENTS?

ONE OF MY PATIENTS GAVE ME A CARTOON WHICH
DESCRIBES THIS EMOTIONAL SITUATION
BETTER THAN ANYTHING I'VE SEEN. IT
SHOWS A MAN WALKING ALONG A SIDEWALK
WITH A SAD FACE AND EYES DOWNCAST AS HE
APPROACHES A SIGN IN HIS PATH WHICH
READS "ABANDON HOPE." JUST A FEW FEET
BEYOND HIM IS ANOTHER SIGN WHICH SAYS
"RESUME HOPE."

MANY PEOPLE WITH HIV ARE LIVING THEIR
LIVES ON A LOSE HOPE-GET HOPE CYCLE,

EXPERIENCING ALTERNATING FEELINGS OF
HOPELESSNESS AND FANTASIES OF AN
IMMINENT CURE. IT IS A ROLLER COASTER
PROPELLED IN PART BY THE WAY NEWSMAKERS
RELEASE THEIR FINDINGS AND THE MEDIA
COVERS THEM. DOCTORS SUCH AS MYSELF
DEAL WITH THE FALLOUT.

WORD THAT THE VIRUS IS SEQUESTERED IN
LYMPH NODES, OR THAT THE CONCORDE STUDY
DOUBTS AZT'S USEFULNESS, CAUSES PEOPLE
TO LOSE HOPE. COVER STORIES IN
NATIONAL NEWS MAGAZINES ABOUT A YOUNG
HARVARD RESEARCHER'S ERADICATION OF THE
VIRUS WITH A TRIPLE WHAMMY COMBINATION
FUELS THE FANTASY THAT A CURE IS
IMMINENT.

THAT OPTIMISM QUICKLY CRUMBLES AND TURNS

TO FRUSTRATION AND HOPELESSNESS WHEN PATIENTS LEARN THERE IS ONLY A SMALL CHANCE THEY CAN PARTICIPATE IN EARLY TRIALS, AND THAT THE THIRD DRUG WILL NOT BE MADE AVAILABLE THROUGH THE FDA'S EXPANDED ACCESS PROGRAM. WE WONDER WHY MORE DRUGS CANNOT BE MADE AVAILABLE THROUGH THIS PROGRAM?

WHILE THERE ARE MANY PROBLEMS REMAINING, I CAN SAY WITHOUT QUALIFICATION THAT DOCTORS HAVE BETTER MEDICAL TREATMENTS TO OFFER THE PERSON WITH HIV THAN WE DID FIVE YEARS AGO.

I FOR ONE DO NOT THINK THAT THE CONCORDE STUDY REPRESENTS THE LAST WORD ON AZT. TOO MANY SERIOUS PROBLEMS WITH ITS DESIGN AND ANALYSIS. FOR PATIENTS TO

ABANDON AZT NOW IS VERY RISKY BECAUSE THE FINAL VERDICT ON WHETHER THE DRUG PROLONGS SURVIVAL MAY TAKE ANOTHER FIVE TO TEN YEARS.

COMBINATION ANTIVIRAL THERAPY IS NOW WIDELY USED IN CLINICS ACROSS THE COUNTRY, COMBINING AZT WITH ITS FDA-APPROVED COUSINS-- DDI AND DDC.

ANOTHER COUSIN OF THESE DRUGS, D4T, IS AVAILABLE THROUGH EXPANDED ACCESS WITH VERY FAVORABLE INITIAL EXPERIENCE IN MY PRACTICE.

DRUGS NEWLY APPROVED FOR TREATMENT OF THE OPPORTUNISTIC INFECTIONS ARE WELCOME ADDITIONS.

ATOVAQUONE AS A BACKUP TREATMENT FOR PNEUMOCYSTIS PNEUMONIA, AND RIFABUTIN

AS A PREVENTATIVE AGAINST MYCOBACTERIUM
AVIUM INFECTION.

GROWTH FACTORS ON THE MARKET DEPENDABLY
REVERSE WHITE AND RED BLOOD CELL
DEPLETION CAUSED BY AIDS OR OTHER DRUG
TOXICITIES. UNFORTUNATELY, MANY
INSURANCE COMPANIES SET DANGEROUSLY LOW
LIMITS FOR BLOOD COUNTS BEFORE AGREEING
TO REIMBURSE FOR THESE EXPENSIVE
PHARMACEUTICALS.

YET MAJOR GAPS REMAIN. THERE IS NO
EFFECTIVE DRUG FOR CRYPTOSPORIDIUM, A
DEVASTATING INTESTINAL PARASITE. OR
FOR THE WORRISOME TB THAT IS RESISTANT
TO STANDARD DRUGS.

SOMETIMES WE WORRY AND ASK DOES THE DRUG
INDUSTRY HAVE SUFFICIENT INCENTIVE TO

AGGRESSIVELY FIND DRUGS FOR THESE
DISEASES?

DESPITE WIDESPREAD DESIRE BY PATIENTS TO
PARTICIPATE IN IMMUNE BOOSTING
TREATMENTS AND THERAPEUTIC VACCINES,
THE PROSPECTS FOR PARTICIPATING ARE
SLIM.

YOU HEARD EARLIER ABOUT RESEARCH TESTS
WHICH MEASURE THE AMOUNT OF HIV IN THE
BLOOD TO SEE IF RESISTANCE TO
ANTIVIRALS HAS DEVELOPED, AND TO TEST
WHETHER A MORE DAMAGING STRAIN OF HIV HAS
EVOLVED.

NONE OF THESE TESTS ARE AVAILABLE TO
DOCTORS AND THEIR PATIENTS ON A ROUTINE
BASIS TO HELP GUIDE THERAPY. WHEN
MODIFYING ANTIVIRAL DRUGS, DOCTORS ARE

MAKING A BEST GUESS AS TO WHAT WILL BE
EFFECTIVE. WE WOULD PREFER TO BE ABLE
TO MAKE DECISIONS BASED A LITTLE MORE
ON SCIENCE THAN INTUITION.

DOCTORS AND THEIR INCREASING NUMBER OF
WOMEN PATIENTS, NEED GENDER-SPECIFIC
INFORMATION ON HORMONAL AND OTHER
CHANGES THAT HAPPEN AS A RESULT OF HIV
OR AS A RESULT OF MEDICATION USED TO
TREAT THE VIRUS AND COMPLICATING
OPPORTUNISTIC INFECTIONS. THIS IS
INFORMATION THAT CAN ONLY BE GENERATED
BY GREATER AFFIRMATIVE ACTION IN
SMOOTHING THE ACCESS FOR WOMEN TO
CLINICAL TRIALS.

WITH RESPECT TO CHILDREN, WE UNDERSTAND
MORE ABOUT THE COURSE OF HIV, BUT

PROBLEMS REMAIN IN THE AREA OF
TREATMENT.

PHARMACEUTICAL COMPANIES REMAIN RELUCTANT
TO COMMIT RESOURCES TO TEST TREATMENTS
FOR AIDS IN CHILDREN, AND TO
MANUFACTURE FORMULATIONS OF THEIR DRUGS
THAT CAN BE STUDIED WITH KIDS.

HIV DISEASE IN CHILDREN IS A PROBLEM OF
THE POOR, AND RESOURCES TO MAKE
TREATMENTS AVAILABLE SADLY ARE LACKING
AT MANY OF THE PUBLIC HOSPITALS WHERE
THEY ARE CARED FOR.

IN PAST YEARS AS THE HIV PROBLEM HAS
BECOME MORE COMPLEX, MANY AMERICANS --
RESEARCHERS, POLITICIANS, ACTIVISTS --
HAVE JOINED TOGETHER TO URGE MORE FUNDS
FOR AIDS RESEARCH AND A STRONGER

ACKNOWLEDGEMENT FROM THE WHITE HOUSE OF
THE SCOPE AND SERIOUSNESS OF THIS
PROBLEM.

TWO YEARS AGO WHEN I CAME TO ADDRESS THE
NATIONAL PRESS CLUB ON THE 10TH
ANNIVERSARY OF THE EPIDEMIC, I PROPOSED
THE APPOINTMENT OF A WHITE HOUSE-LEVEL
ADVISOR ON AIDS TO OVERSEE THIS
COORDINATION.

THE NEW ADMINISTRATION GAVE PEOPLE
REAL HOPE THAT THIS WOULD HAPPEN. THE
FACT THAT IT HAS NOT HAPPENED CAUSES
PEOPLE TO LOSE HOPE. I URGE PRESIDENT
CLINTON TODAY TO MOVE TOWARD THIS
OBJECTIVE AS SOON AS POSSIBLE.

THANK YOU.

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IT IS VERY EXCITING FOR ME TO BE HERE WITH YOU ON THIS SPECIAL DAY---
WORLD AIDS DAY. THIS IS A DAY ON WHICH PEOPLE ALL AROUND THE WORLD
FOCUS POSITIVE ENERGY ON AIDS, THE DEVASTATING EPIDEMIC THAT HAS
RAVAGED HUMANITY FOR THE LAST DECADE AND A HALF.

IT IS A PARTICULAR PLEASURE TO VISIT THE ALMA MATER OF LINUS
PAULING, ONE OF MY HEROES IN SCIENCE.

AIDS REMAINS A FRIGHTENING THING TO MANY PEOPLE.
THE NATURAL RESPONSE IS TO AVOID ANYTHING TO DO WITH AIDS....TO
DRAW AWAY FROM SOMETHING SO TERRIBLE AS THIS VIRUS WHICH
DESTROYS THE IMMUNE SYSTEM....

SO WHEN I WAS ASKED TO SPEAK TODAY SOME 1000 OR SO SMILES FROM MY
HOME, I THOUGHT TO MYSELF "WELL, HERE ARE SOME BRAVE PEOPLE WHO
HAVE PUT AIDS ON THEIR AGENDA--I HAD BETTER GO TALK TO THEM".

I COME HERE TONIGHT WITH 3 OBJECTIVES.

THE FIRST IS TO TRY AND HELP YOU UNDERSTAND WHY HIV HAS BEEN SO
SUCCESSFUL IN STOPPING US FROM RESPONDING EFFECTIVELY TO IT'S
SPREAD.

A SECOND RELATES TO THOSE OF YOU WHO MAY BE LOOKING TOWARD
CAREERS IN HEALTH CARE. I HOPE THAT I CAN LIGHT A FIRE UNDER SOME OF
YOU TO WORK IN AIDS RESEARCH, TREATMENT OR PREVENTION.

AND THE THIRD IS TO IMPRESS UPON THOSE OF YOU WHO ARE YOUNG ADULTS HOW TO AVOID BECOMING STATISTICS OF THE EPIDEMIC.

I FIRST GOT INVOLVED WITH AIDS SOME FIFTEEN YEARS AGO WHEN I WAS DOING RESEARCH IN IMMUNOLOGY AT THE UCLA MEDICAL SCHOOL.

I WILL SPEND A FEW MINUTES TONIGHT ON A BRIEF HISTORY OF THE EPIDEMIC FROM MY PERSPECTIVE.

I BEGAN TO SEE SOME PATIENTS WITH UNUSUAL ILLNESSES IN LATE 1980. BY THE MIDDLE OF 1981 I HAD STUDIED 5 OF THEM.

ALL WERE HOMOSEXUAL MEN IN THEIR 20'S AND 30'S.

ALL HAD LUNG INFECTIONS CAUSED BY A BUG CALLED PNEUMOCYSTIS.

SEVERE INFECTION WITH PNEUMOCYSTIS ONLY HAPPENS TO PATIENTS THAT DOCTORS CALL IMMUNOCOMPROMISED HOSTS...INDIVIDUALS LIKE THE BOY IN THE PLASTIC BUBBLE...PATIENTS WHOSE IMMUNE SYSTEMS ARE DEFICIENT

NOW AROUND THE TIME WHEN I WAS FIRST EVALUATING THESE PATIENTS A NEW TECHNOLOGY USING MONOCLONAL ANTIBODIES BECAME AVAILABLE WITH WHICH TO COUNT THE NUMBER OF T CELLS OF THE IMMUNE SYSTEM.

ALL OF THEM HAD SEVERE DEPLETION, IN FACT AN ALMOST COMPLETE ABSENCE OF A TYPE OF T CELLS CALLED HELPER CELLS, ALSO CALLED CD-4 CELLS.

I REPORTED MY FINDINGS TO THE CENTERS FOR DISEASE CONTROL IN ATLANTA WHICH PUBLISHED THEM ON JUNE 5, 1981.

BY THE END OF 1982 THE SAME IMMUNE DEFICIENCY SYNDROME HAD BEEN FOUND IN IV DRUG USERS, HAITIANS, BLOOD TRANSFUSION RECIPIENTS, AND HEMOPHILIACS.

INTERVIEWS OF THE FIRST CASES IN LA REVEALED THAT WHILE THEY DID NOT KNOW EACH OTHER, MANY RECALLED HAVING SEXUAL CONTACT WITH A STRIKINGLY HANDSOME CANADIAN AIR STEWARD NAMED GAETAN DUGAS.

THE FINDING OF A CLUSTER OF CASES LINKED TO AN INDEX CASE GAVE CREDENCE TO A SEXUALLY TRANSMITTED INFECTION AS THE CAUSE OF THE IMMUNE DEFICIENCY.

GAETAN DUGAS, NOW LONG DEAD, WAS IMMORTALIZED AS "PATIENT ZERO" IN RANDY SHILTS EPIC ACCOUNT OF THE FIRST FIVE YEARS OF AIDS TITLED "AND THE BAND PLAYED ON"

IN 1983 A WOMAN SCIENTIST AT THE PASTEUR INSTITUTE NAMED FRANCOISE BARRE SINOUSSE ISOLATED A VIRUS FROM THE ENLARGED LYMPH NODE OF A PATIENT WITH AIDS.. SHE AND HER MENTOR PROFESSOR LUC MONTAGNIER NAMED IT LAV.

WHAT HAPPENED AFTER THAT BETWEEN THE MONTAGNIER TEAM AND AN AMERICAN TEAM LED BY DR. ROBERT GALLO IS A LONG AND COMPLICATED

STORY ABOUT WHICH TOO MUCH HAS BEEN SAID AND WRITTEN. SO I WON'T ADD TO IT.

THE END RESULT WAS THAT THE VIRUS WAS RENAMED HIV-1 BY AN INTERNATIONAL COMMISSION OF VIROLOGISTS APPOINTED TO SETTLE THE SQUABBLE. HIV STANDS FOR HUMAN IMMUNODEFICIENCY VIRUS.

HIV-1 IS A RETROVIRUS.

IT HAS THE ABILITY TO SPLICE IT'S GENES INTO THE GENES OF HELPER CELLS, AND SLOWLY SPREAD FROM ONE CELL TO ANOTHER EVENTUALLY KILLING THE CELLS.

WE NOW UNDERSTAND THAT HIV NEVER BECOMES DORMANT. IT IS ALWAYS REPLICATING...MAKING COPIES OF ITSELF LIKE A XEROX THAT NEVER STOPS

APPROXIMATELY ONE BILLION PARTICLES OF VIRUS ARE PRODUCED EVERY DAY

THE IMMUNE SYSTEM PUTS UP A GOOD FIGHT. NEW HELPER CELLS ARE PRODUCED.

BUT THE VIRUS BY MUTATING IN WAYS THAT ALLOW IT TO EVADE THE IMMUNE DEFENSES.

ULTIMATELY AFTER 5-15 YEARS IN MOST PATIENTS THE IMMUNE SYSTEM LOSES THIS WAR OF ATTRITION AND COLLAPSES.

THIS COLLAPSE LEAVES THE PATIENT SUSCEPTIBLE TO SERIOUS INFECTIONS WHICH ULTIMATELY PROVE FATAL.

WHEN THE IMMUNE SYSTEM REACHES THIS THRESHOLD WE SAY THAT A PERSON WITH HIV HAS PROGRESSED TO BECOME A PERSON WITH AIDS.

HERE IN OREGON AS OF THIS WEEK THERE WERE 3371 PEOPLE DIAGNOSED WITH AIDS. 2014 HAVE ALREADY DIED. 192 OF THE TOTAL WERE WOMEN. 103 OF THOSE ACQUIRED THE INFECTION THROUGH HETEROSEXUAL CONTACT.

WE KNOW QUITE A BIT ABOUT HIV AS AN STD, A SEXUALLY TRANSMITTED INFECTION.

PEOPLE WHO HAVE MULTIPLE SEXUAL PARTNERS IN THE SAME TIME PERIOD OR EVEN THOSE WHO HAVE SERIAL MONOGAMY WITH FREQUENT CHANGES IN SEXUAL PARTNER ARE AT INCREASED RISK FOR ALL STD'S INCLUDING HIV.

IT SPREADS MORE EASILY FROM MEN TO WOMEN THAN FROM WOMEN TO MEN.

ANAL SEX IS CARRIES THE HIGHEST RISK OF TRANSMISSION.

VAGINAL SEX WITH AN HIV POSITIVE MALE CARRIES A HIGH RISK OF TRANSMISSION.

ORAL SEX IS NOT 100% SAFE.

A PERSON INFECTED WITH HIV CAN TRANSMIT IT AT ANY TIME AFTER INFECTION, ALTHOUGH PATIENTS WITH ADVANCED INFECTION ARE MORE INFECTIOUS THROUGH THE SEXUAL ROUTE.

YOUNG PEOPLE UNDER THE INFLUENCE OF ALCOHOL AND DRUGS OFTEN MAKE FLAWED DECISIONS ABOUT SEX THAT PLACE THEM AT RISK FOR STD'S INCLUDING HIV.

THE SPREAD OF HIV AS WELL AS OTHER SEXUALLY TRANSMITTED VIRUSES (INCLUDING HTLV-1, HTLV-2, TYPE B AND TYPE C HEPATITIS) CAN BE PREVENTED BY CONDOM USE.

I WOULD NOW LIKE TO TURN FROM THE VIRUS ITSELF TO OUR RESPONSE TO IT.

FRANKLIN ROOSEVELT'S WELL-KNOWN STATEMENT "WE HAVE NOTHING TO FEAR BUT FEAR ITSELF" APPLIES VERY WELL TO AIDS.

AND THAT'S BECAUSE IT IS FEAR OF AIDS ... IT'S ASSOCIATION WITH MULTIPLE NO-NO'S ...SEX, HOMOSEXUALITY, DRUGS, BLOOD, DEATH... THAT GRABS US AND HOLDS US BACK FROM RESPONDING RATIONALLY TO THE THREAT OF HIV.

ON AN INTELLECTUAL LEVEL I KNOW THAT THIS VIRUS IS AN UNTHINKING HUNK OF RNA AND PROTEIN...YET EVERY ONCE AND A WHILE I LAPSE INTO ANTHROPOMORPHIC THINKING, INTO BELIEVING THAT HIV IS A CLEVER

PLAYER ON THE OTHER SIDE OF A CHESSBOARD....OR EVEN WORSE SOME KIND OF DOOMSDAY MACHINE.

I STAND BACK AND WONDER AT THIS VIRUS' UNCANNY ABILITY TO PLAY TO OUR UNCONSCIOUS, IRRATIONAL CAPACITY TO AVOID DEALING WITH IT

INDEED THE MOST PROMINENT LESSON OF THE LAST FIFTEEN YEARS HAS BEEN OUR PRODIGIOUS CAPACITY TO DENY IT'S RELEVANCE TO US INDIVIDUALLY AND TO THE HUMAN SPECIES AS A WHOLE

THE MAJOR WAY IN WHICH WE DO THIS IS TO THINK OF AIDS AS SOMEONE ELSE'S PROBLEM

FROM THE START WE CATEGORIZED AIDS AS A HOMOSEXUAL DISEASE. WELL, IT ONLY HAPPENS TO PEOPLE WHO HAVE ANAL INTERCOURSE, AND I DON'T. THIS NOTION LINGERS ON TODAY AMONG BOTH MEN AND WOMEN DESPITE THE FACT THAT ONLY A VERY SMALL PERCENTAGE OF THE WORLD'S HIV POSITIVE POPULATION IS HOMOSEXUAL.

FACED WITH UNDENIABLE DATA ON THE RAPID SPREAD OF HIV AMONG WOMEN, IV DRUG USERS, AND THEIR SEXUAL CONTACTS, THE NON-POOR CATEGORIZE AIDS AS A DISEASE OF AN UNDERCLASS....WE LUMP IT IN WITH OTHER PROBLEMS THAT WE WOULD RATHER NOT ADDRESS SUCH AS POVERTY, HOMELESSNESS, AND DRUG USE.

FACED WITH THE REALITY THAT IN CENTRAL AFRICA ALONE 20 MILLION ARE INFECTED, WE LUMP HIV INTO THE SET OF UNCONTROLLED DISEASES AND

ECONOMIC AND SOCIAL PROBLEMS OF AFRICA FOR WHICH WE HOLD OUT
LITTLE HOPE

WHEN WE SEE THE PROJECTIONS THAT UPWARDS OF 40 MILLION WILL BE
INFECTED BY THE YEAR 2000 AND THAT THERE WILL BE GENDER EQUALITY
...EQUAL NUMBERS OF MALES AND FEMALES INFECTED, WE CONSOLE
OURSELVES WITH THE KNOWLEDGE THAT ONLY ABOUT 1.5 MILLION
AMERICANS CARRY HIV

AIDS IS A BIT LIKE COMEDIAN RODNEY DANGERFIELD WHO IS KNOWN FOR
SAYING "I JUST DON'T GET ANY RESPECT"

NO OTHER EPIDEMIC GETS LESS RESPECT

TERRIFIED OF AIDS, AND ANGRY ABOUT IT'S INTRUSION INTO THE MOST
PERSONAL ASPECTS OF OUR LIVES WE PREFER TO PUT IT DOWN

THE EPIDEMIC OF EBOLA WHICH RECENTLY KILLED SEVERAL HUNDRED PEOPLE
IN AFRICA GOT MORE PRESS THIS YEAR THAN AIDS WHICH HAS KILLED
400,000 IN AMERICA ALONE. IN OUR COUNTRY 92 PEOPLE DIE OF AIDS EACH
DAY. IN 5 STATES AND 64 CITIES AIDS IS THE #1 KILLER OF YOUNG MEN
SURPASSING ACCIDENTS, CANCER, AND HEART DISEASE.

THESE ATTITUDES OF DENIAL TOWARD AIDS GAVE THE REAGAN AND BUSH
ADMINISTRATIONS PERMISSION TO GET AWAY WITH SAYING AND DOING
LITTLE OR NOTHING ABOUT IT.

AND AT LEAST FOR THE PRESENT THE CLINTON ADMINISTRATION IS HAMSTRUNG ON AIDS BECAUSE ANY MORE PROGRESSIVE EFFORTS IN A POLICY AREA PERCEIVED AS CONTROVERSIAL WOULD EXPOSE IT TO ATTACKS FROM THE RIGHT

AMERICA IS FOR ALL INTENTS AND PURPOSES PARALYZED WITH RESPECT TO EDUCATION FOR RISK REDUCTION.

YOUNG PEOPLE IN AMERICA STILL GET SEX EDUCATION ON A CATCH AS CATCH CAN BASIS IF THEY GET IT AT ALL.

PEOPLE WHO GET ON THEIR MORAL HIGH HORSE AND STYMIE SEX EDUCATION ARE RESPONSIBLE FOR THE PAIN, SUFFERING AND EVEN DEATH OF YOUNG PEOPLE WHO ARE AT RISK OF CONTRACTING A GROWING LIST OF SEXUALLY TRANSMITTED DISEASES ABBREVIATED AS STD'S.

THESE INCLUDE GONORRHEA, SYPHILIS, CHLAMYDIA, TYPE B HEPATITIS, TYPE C HEPATITIS, AND THE HUMAN RETROVIRUSES HTLV-I AND HTLV-2 AS WELL AS HIV.

FOR THE MOST PART THOSE WHO INSIST THAT SEX EDUCATION TAKE PLACE IN THE HOME PROVIDE THEIR CHILDREN WITH LITTLE OR NO INFORMATION RELEVANT TO STD'S.

I'M NOT TALKING ABOUT SHOWING SEXUALLY GRAPHIC CARTOONS TO YOUR KINDERGARTENERS. AND ABSTINENCE SHOULD BE PRESENTED TO TEENS AS AN OPTION. BUT LET US ALL AT LEAST RECOGNIZE THAT RELIABLE TEENS

SURVEYS INDICATE THAT ROUGHLY 50% ARE HAVING SEX BY AGE 15.

SOME PARENTS WILL PROBABLY DISPUTE THESE FIGURES AND SAY "THAT'S NOT THE CASE HERE IN CORVALLIS" OR "NOT MY KID"

BUT WHETHER THE 50% FIGURE APPLIES TO AGE 15 OR AGE 19 SHOULDN'T KIDS BE TOLD ABOUT THE HAZARDS OF STD'S, RISKY SEXUAL PRACTICES SUCH AS ANAL INTERCOURSE, AND MEASURES LIKE CONDOMS WHICH CAN PREVENT THESE ILLNESSES?

I THINK THAT MOST OF US WOULD AGREE THAT IF WE KNOW THAT SOMEONE HAS SERIOUSLY THREATENED ANOTHER PERSON'S LIFE WE HAVE A DUTY TO WARN THAT PERSON. CARRYING THIS THOUGHT A LITTLE FURTHER "DON'T WE HAVE A SIMILAR DUTY TO PROVIDE YOUNG PEOPLE WITH PRACTICAL INFORMATION ABOUT SEX AND STD'S?

INSTEAD OF PROVIDING A NATIONAL PROGRAM OF PREVENTIVE EDUCATION OF ANY CONSEQUENCE, WE HAVE SPENT MUCH OF THE FIRST 15 YEARS WASTING OUR TIME AND RESOURCES ON SIDE ISSUES. WE'VE BURNT DOWN HOMES OF PEOPLE WITH AIDS, SPAT ON HIV INFECTED KIDS GOING TO SCHOOL, WORRIED INCESSANTLY ABOUT AIDS AND MOSQUITOS, BANNED WORDS LIKE CONDOM IN GOVERNMENT FUNDED PAMPHLETS, ARGUED ABOUT WHETHER HEALTH CARE PROFESSIONALS ARE A THREAT, AND NOW WE DEBATE THE FAR-FETCHED THEORIES OF SCIENTISTS WHO CLAIM THAT HIV DOESN'T CAUSE AIDS. ISN'T IT ABOUT TIME WE CONFRONTED THE CENTRAL ISSUES EFFECTIVELY.

THERE ARE MANY OTHER LESSONS OF THE AIDS EPIDEMIC.

WE KNOW NOW THAT IT IS DIFFICULT TO PERFORM STANDARD METHODS OF EPIDEMIC PREVENTION IN PEOPLE WHO PERCEIVE THEMSELVES TO BE OPPRESSED AND AT RISK FOR ADDITIONAL DISCRIMINATION. IN SOME CASES POLITICAL CONSIDERATIONS DID PREVAIL OVER PUBLIC HEALTH. WAS THAT RIGHT? NO. BUT NEITHER IS THE FEAR OF DISCRIMINATION THAT LED TO THE SEEKING OF POLITICAL PROTECTIONS IN THE FIRST PLACE.

THE AIDS EPIDEMIC DID PROVIDE EVIDENCE THAT THE SPIRIT OF COMMUNITY ACTIVISM WAS ALIVE AND WELL IN AMERICA. GRASS ROOTS COMMUNITY ORGANIZATIONS SPROUTED MAINLY WITH GAY SUPPORT WHEN IT BECAME CLEAR THAT THE GOVERNMENT WAS GOING TO TAKE ITS TIME RESPONDING. TODAY ACROSS THE COUNTRY THEY PROVIDE IMPORTANT EDUCATION AND SUPPORT SERVICES.

ACTIVISM BY THOSE MOST AFFECTED PAID OFF WITH ACCELERATION OF THE FDA REVIEW PROCESS FOR NEW DRUGS. IN RECENT WEEKS 2 NEW DRUGS WERE APPROVED FOR AIDS WITH THE PROMISE OF MORE TO COME NEXT YEAR. THIS ACCELERATION OF THE REVIEW PROCESS WORKS TO THE BENEFIT OF PATIENTS WITH ALL DISEASES AS WELL AS THE PHARMACEUTICAL INDUSTRY.

IN THE AREA OF RESEARCH AIDS ACTIVISTS WERE SQUEAKY WHEELS AND DID THEY EVER GET THE GREASE. THIS DID NOT GO UNNOTICED BY OTHER

DISEASE CONSTITUENCIES. NOW PEOPLE SPEAK UP REGULARLY FOR MORE FUNDING FOR RESEARCH ON BREAST AND PROSTATE CANCER, ALZHEIMERS DISEASE AND OTHERS. AND WHY NOT? WE HAVE THE ECONOMIC RESOURCES AND THE BIOTECH KNOW-HOW TO SOLVE THESE PROBLEMS

ANOTHER SOBERING LESSON IN ALL THIS IS THAT MAN IS NOT NECESSARILY THE DOMINANT SPECIES ON THIS PLANET.

BUGS LIKE HIV REPRESENT SERIOUS COMPETITION.

NEWLY RECOGNIZED INFECTIONS INCLUDE HANTAVIRUS, LEGIONAIRES DISEASE, EBOLA, HTLV I AND HTLV II, TYPE E HEPATITIS A NEW HERPESVIRUS ASSOCIATED WITH KAPOSÍ'S SARCOMA.

OTHERS ARE OUT THERE WAITING TO BE DISCOVERED FOR THOSE OF YOU ENTERING CAREERS IN BIOLOGY-KEEP LOOKING.

A COROLLARY OF THIS LESSON IS THAT IT IS SHORTSIGHTED TO REDUCE OUR COUNTRY'S CAPABILITY FOR EARLY DETECTION OF EPIDEMICS.

OUR CENTERS FOR DISEASE CONTROL IN ATLANTA IS THE BEST EQUIPPED ORGANIZATION ON THE PLANET FOR INVESTIGATING DISEASE OUTBREAKS. JUST LOOK AT ANY NEWS REPORTS ON ANY EPIDEMIC IN ANY COUNTRY OF THE WORLD WILL SEE THAT CDC IS INVARIABLY CALLED IN.

IF AIDS TEACHES US ANYTHING IT IS THAT WE NEED AN EARLY WARNING SYSTEM FOR EPIDEMICS AND THE ABILITY TO RESPOND RAPIDLY.

THE RESPONSE TO AIDS IN THE EARLY 80'S WAS A BEST EFFORT BUT IT FELL SHORT BECAUSE OF INADEQUATE FUNDING.

I BELIEVE THAT IT IS SHORTSIGHTED TO CUT FEDERAL SPENDING FOR BASIC SCIENCE RESEARCH. TODAY SUPERBLY TRAINED SCIENTISTS ARE STRANDED HIGH AND DRY WITHOUT THE GRANT FUNDING TO SUPPORT THEIR RESEARCH PROGRAMS AS A RESULT OF THE EFFORTS TO CURB THE DEFICIT.

SPENDING MONEY ON A PROBLEM DOES NOT NECESSARILY SOLVE IT. BUT UNFORTUNATELY WE HAVE NO ALTERNATIVE. WE KNOW MORE ABOUT HIV TODAY THAN ABOUT MOST OTHER VIRUSES LARGELY AS A RESULT OF RESEARCH PAID FOR BY THE AMERICAN TAXPAYER.

AND YET STILL A GREAT MANY UNKNOWNNS REMAIN.

AFTER THE 1994 INTERNATIONAL AIDS MEETING IN JAPAN, GWEORGE LUNDBORG, EDITOR OF JAMA PREDICTED THAT THERE WILL BE NO CURE OR VACCINE FOR HIV UNTIL THE END OF THE NEXT CENTURY.

I AM SURE THAT SOME OF YOU MIGHT THINK HIS VISION OF THE FUTURE ALARMIST. YOU MAY HAVE MORE FAITH THAT SCIENCE WILL BAIL THE WORLD OUT.

BUT LET'S FACE FACTS THAT HIV HAS PROVED TO BE AN ELUSIVE ENEMY. IT'S PHENOMENAL MUTATION RATE LEADS TO RAPID RESISTANCE TO ANTIVIRAL DRUGS. VACCINE CANDIDATES ARE DROPPED AS IRRELEVANT EVEN BEFORE THEY ARE TESTED IN FIELD TRIALS. FEDERALLY FUNDED

RESEARCH IS SHIFTING BACK TO BASIC SCIENCE.

IN CLOSING I HOPE THAT ALL OF YOU YOUNG PEOPLE WHO ARE NOT ALREADY INVOLVED WILL MAKE A RESOLUTION ON THIS WORLD AIDS DAY TO DO SOMETHING CONSTRUCTIVE ABOUT THE AIDS EPIDEMIC. UNFORTUNATELY IT LOOKS LIKE THIS BATTLE WILL BE GOING ON FOR SOME TIME. THE LEADERSHIP WILL BE LEFT IN THE HANDS OF YOUR GENERATION.

THANK YOU.

INTERVIEW WITH HARRY HAVERCOS

February 1, 1995 - 3:30 p.m. - Washington, D.C.

(Gottlieb): Let me start by asking you what you were doing at the start of AIDS. Refresh my memory on what positions you had and when you moved onto what.

(Havercos): My first experience to AIDS was actually in December of 1980. I was an IV fellow at the University of Pittsburgh and I saw a man who had pneumocystis pneumonia who I was counseled on actually after they did the open lung biopsy. I had actually done some research on open lung biopsies reviewing our series at the University of Pittsburgh. When I saw the case I was sure that this represented a man with lymphoma. I can remember telling a third year medical student, felt some lymph nodes, you do a little reading about the diagnosis when you have it microbiologically. This guy, I remember was December 30th and I just got back from Christmas vacation and this was my first experience. I knew very little about his sexual history. I ran across this patient about six months later and I had gone to a CDC and it started that somehow we hooked up one of his physicians and he knew I was there and so I went down to see him. By then I knew more about sexual behavior in the gay life style and some other things. Where as the first time I am sure I was very technical. I started at CDC in July of 1981. I just finished my fellowship in Pittsburgh a week earlier.

(Gottlieb): Did your patient have any ties to Gatton Dugas.

(Haverkos): Not that I am aware of. I didn't know anything about him until about a year or two later and I was still at CDC.

(Gottlieb): In retrospect, your patient, had they already been seeing patients in New York City or had they ever seen another patient like that before in Pittsburgh.

(Haverkos): We discussed that patient several times at medical rounds, at infectious disease rounds. Pittsburgh was a big megalo virus situation. Monto Ho was my mentor and so we were sure that this was some atypical CMV immunosuppressive kind of situation. It was until the CDC piece came out. I had to go down to interview at CDC in April to go down and they have this matching system. So I mentioned this patient to Myra Schultz, the head of Parasitology. His way of interviewing was to ask you about any parasitic disease that you had seen and then talk about a case. I remember I talked about this patient, I talked about a patient with anasciosis and I think a patient with malaria and he would grill you on what you knew and what you didn't know about parasitology. I ended up matching with him. Right before I went down on June 5th, the article that you were involved in in MMWR came out and I remember somebody wanted me to actually present grand rounds the anaschiosis case and I said no, I had finished service, I really was in response just trying to clean things up so now I am going to work

on this disease.

(Gottlieb): So when you talked to the guy in April he was still unaware that the article was in the works for the June 5th MMWR or he didn't say anything about it anyway.

(Haverkos): They did talk a little bit, Sandy Ford was there and at that time they were putting something together, but Myra Schultz didn't necessarily put it together and alert Dennis Geranik, it was still evolving at that time so it became more an intellectual exercise that we talked about this patient and that it did anything to help understand what was going on in Los Angeles and other places. I was assigned to parasitology and actually I was not very happy with that assignment. I figured I would row up and go back to the midwest and be an infectious disease academic (Cincinnati). I thought parasitology; how many parasitologist are in the midwest. That was my fifth choice. When I got to CDC it turned out to be the break of my life as far as working scientifically in many ways. My second day Kern was interviewing EIS officers to pick one and there were three of us in the running. Ida was clearly the front runner. She had seen a number of cases. Henry Mazure from Cornell was in attending for a year. Martha was a pediatrician and I happened to have seen the case which Jim Kern then put together and aside gee this is not just in New York, San Francisco and Los Angeles. When I interviewed with them it turned out that he and I both went to college at Notre Dame. So Henry Mazure was telling

Ida not to talk too much about this because they were going to publish in December so Ida antagonized Kern a little bit because she wouldn't tell him everything she knew. It was only my second day at CDC.

(Gottlieb): So he took you on as an EIS officer working with him on AIDS.

(Haverkos): I was detailed then I did two jobs my first year. I was still on parasitology and still was assigned to do the Pumanodine request so I got used to rotate the beeper. Since everybody was calling for Pumanodine I would get the beeper Monday through Friday and then on the weekends we would rotate. I did that with parasitology and some other activities. So I went to the course to learn, to look under microscopes and all that stuff for the parasites and then would actually have two offices my first year. I worked with Kern and Jaffee and then after my first year, parasitology called me at Crown North facility dealing with some of the early patient cases and Myron Schultz actually got displaced by, I can't remember his name. But anyway he called me and said what do you want to do; to continue to work on AIDS or do you want to come and work full time in parasitology. I said I was going to work in AIDS. I still continue to do some of the putatamy for them.

(Gottlieb): Now in Randy Schultz's book he says that some of the

early epidemiologist in retrospect wandered how AIDS entered the United States and looked back to the tall ships arriving in New York harbor in 1976. Schultz sort of muses and says "All those sailors". Did you ever participate in discussion about the sailors and bicentennial.

(Havercos): I don't recall any. I remember the Legionnaire's disease occurring about the time of the bicentennial. That was Philadelphia. We didn't know about African disease until late 1982 and 1983. There were fairly early Haitian connections. I think we got our first inklings about Haitians in the fall of 1982 from a guy named George Hensley. We were just overwhelmed. We didn't get down to Miami until the fall of 1981. People were just calling us from everywhere. I probably spent 4-6 hours a day just on the telephones talking to clinicians. Hensely was a pathologist at Jackson Memorial Hospital. He started seeing some cases in Haitian immigrants with what they initially thought was unusual tuberculosis. One of the early hypotheses was the Fire Island connection in New York City. There were a number of men dying or sick who travelled or new each other from spending time on Fire Island.

(Gottlieb): After all these years what do you make of the Haitian connection.

(Havercos): I think they clearly had AIDS earlier than some other

parts of the world but later than others. I think it should have been our first clue that heterosexual transmission occurred, some of the Haitians were women. It was very hard to get sexual history and drug histories of people they were mainstream Americans and clearly there were a number of issues and immigration and all kinds of things. But clearly you would talk to their physicians who were also Haitian, they weren't gay or drug users. They didn't have hemophilia. They should have been our first clue.

(Gottlieb): Do you think the Haitian's AIDS cropped up simultaneously with AIDS in Americans or do you think one predated the other.

(Haverkos): That is the debate who took it where. It is really hard to say. I don't we will ever know where it started. I think there are connections between countries and cities and persons. Who the first were I think we will have the same debates they had about syphilis. Even though our science hopefully is several hundred years ahead of when syphilis was found in Europe by, I'm not sure that we are going to be able to answer that question.

(Gottlieb): What is your read on some of those so-called early cases, serum specimen from Namius in 1959 as being containing antibodies of HIV 1.

(Haverkos): If you go back and read the literature you could find

cases that are consistent with what we call AIDS today. From the blood samples that have been looked at I can't comment on as much, I am not a virologist and don't know what time does to blood and antibodies. It is likely that the disease started with a mutation from some related virus and got into some human somewhere and it may have taken years or decades to go from that one person to where it is today. Central Africa is one of the possibilities. I don't know, you could argue that it started somewhere in the United States as well. If you look at just absolute number of patients. You don't know what repetitive of spread was.

(Gottlieb): The diversity of the virus is greater in Africa than it is here.

(Haverkos): I guess I am sensitized to the fact that some people do, or are concerned about implications and do we really want to recreate the old spanish/italian.

(Gottlieb): The fact of the matter is that monkeys as HIV 2 in Africa, it seems that there was a crossover from certain monkey mangobey species that the humans have HIV 2 and it looks like the HIV 1 is most similar to the Chimp virus. Since we don't have monkeys here.

(Haverkos): I have heard people describe various retroviruses that could have been, the smallpox vaccine have been used for vaccine

preparation, keeping viruses alive. You do various things to vaccine preparation, could that have led to some mutation and then inoculated into a human. Could it be simian virus and picked up even through some kind of contact between monkeys and man by sexual contact, cuts of some kind. People talk about other bestiality between man and animals. They talk of sheep virus.

(Gottlieb): What is your gut reaction as to how long it has been around.

(Haverkos): I would think from one person to hundreds of people it may have taken 10-20 years, so when people talk about these cases in the 50s and 60s it is possible. I think the first case we can call AIDS at the CDC from my early years there were diagnosed in the fall of 1978.

(Gottlieb): Beatrice Hahn says that if it was a monkey it happened in the course of slaughtering the monkey and a little cut. The Africans were doing that to monkeys for several hundred years. The question is it seems likely that if monkey viruses were going to occur it would have happened a long time ago. On the other hand Jerry Myers says it looks like evolution has been very recent. What do you think about the Manchester sailor. Did you ever review that case?

(Haverkos): I didn't review it in detail. The one case I did

review in detail was the case of a Haitian immigrant to New York City diagnosed with pneumocystis in 1957 or 1958. There was no tissue, but we actually went up to the hospital and talked to the author of the paper.

(Gottlieb): Did you have anything to do with the boy in St. Louis? (NO) - I don't think anybody from CDC went out and talked to those people. I think they talked on the phone. It was a big news item in 1983 or 1984. Apparently it is not clear, the virological evidence is soft. IN coming into this conversation with people I had assumed that this was a for real case. A sporadic for real case in which HIV sequences had been definitely found and it turns out it was not. Even Harold and Barbara, virologists at Stoneybrook thought it was a fact. A couple of other things. Gaton Dugas, was he really patient 0, did you ever get involved in Darrow and Hauerbach in the cluster.

(Haverkos): Yeah I actually brought him into Atlanta. It was about that time we were convinced it was a virus and we were trying to find patients that we thought might have high levels of the virus. In fact we had one of your patients, remember that blood/donor recipient pair. I said look we have to get viruses on these two people. So we had a number of cases like that and Gaton Dugas because he had been linked through Darrows study I was asked to call him up and invite him to Atlanta. I remember I went over to the Sheritan across the hall. He ate breakfast and I turned him

over to the lab people.

(Gottlieb): Some people say that he continued to be highly sexually active when he was covered by KFs.

(Haverkos): I think Bill Darrow and the authors on that paper did a more detail. Basically my role was to get him to Atlanta and try to get some blood on him. I didn't really do an extensive sexual history at that time. He was actually based out of Van Couver, but he did a lot international extensive flying for some airlines.

(Gottlieb): Is Darrow now in Florida and retired? Have you talked to him and is he a friend?

(Haverkos): He is working at Florida International University of Miami. Harold is a very close friend with Bill Darrow. I think Bill introduced Harold to his second wife and worked together quite closely for a number of years. I talked to Bill about a year ago when I was at CDC for a meeting and at the time he was preparing to retire.

(Gottlieb): Who do you think are key people that I should talk to in terms of who might know something more about this that is published or who are reliable people and have maybe strong feelings or views.

(Havercos): I would certainly talk to the people who found the virus early on. I would talk to Gallow and people from his group. I have talked to Jay Leavy and people from his group. I talked to Paul Fureno. I think those are people that I would get some of their thoughts and some of the people who understand the virology.

(Gottlieb): What do you think?

(Havercos): I think it is clearly some related virus, there is several candidate viruses and I mentioned simian and I mentioned the Bovine and I mentioned Visnop and I mentioned the other two previous human retroviruses HTL V 1 and 2 and somehow those viruses got into humans, mutated and then were spread. I'm not sure we will know. I guess you do startle them a little bit when you talk about bestiality that it raises all these different possibilities, but no one then pursues with me with which one do you like. I don't do as much talking about AIDS as I did early on, but you could count on someone asking where did that come from.

(Gottlieb): Do you think it is a worthy question to ask, scientifically worthwhile or valuable question to try and retrace where this came from.

(Havercos): It might give us insights into some future diseases or how do epidemics get started and could it be one of if not the largest epidemics of all times. I am not so sure that we are going

to be able to sort it out because we are looking at viruses that now exist in 1995 unless some of the technology allows us to feel comfortable with the stored samples and I don't know the technology well enough to comment on that.

(Gottlieb): Do you think that there is a downside to trying to investigate this. Do you think from political, I am sure you have heard various countries over the years critique CDC or whomever for putting Haitians on the list and Africans, but in the aftermath of the Soviet collapse and the collapse of communism is it now time to put that worry behind us. The Soviet created misinformation about the source of AIDS that a lot of the third world still believes.

(Haverkos): We will probably never put the end of that speculation by someone, I don't know I guess I am sensitive being part of the whole Haitian situation being one who visited them. I was one of the CDC players there, I mean a country that is poor to begin with to raise questions about origins of some disease spread person to person I am sure had detrimental impact on their economy and tourism and other things. Retrospectively it was an epidemiology enthusiast thing, gee this important to learn as much as we can but then you know wondering if some of the things you may have done might have had, whether it was me or someone else, I am a little cautious I guess on the impact.

(Gottlieb): But you might have saved some tourist that might have

had a bike accident and could have had a blood transfusion from getting AIDS.

(Havercos): We thought maybe the Haitians would get better medical care because people would be able to recognize what they were dealing with and start with the therapies, but that may have been zeal and naivety on the part of some of us. Clearly we are involved in something new and is very deadly.

(Gottlieb): Do you give any credence to lab accident theories.

(Havercos): I think I give the Bovine leukemia could be just of the fetal calf serum happened to be infected with Bovine leukemia virus and then altered and mutated and what you do for a vaccine and inoculating someone is one potential hypothesis, somehow a virus somewhat related to Bovine is a lot farther away than simian. I can see where people might pick on that one. Cliff went down to Haiti with me the first time. When I went down I went down with Dick Crowsey who was then the Head, Tom Quinn, AL Saw, Cliff Lane and CDC was concerned they might get scooped on this, and they had to send somebody and I was probably the most expendable epidemiologist they sent me. They put us up in a very nice hotel. It as very interesting trip. We went down to basically get some research started, what we thought would better understand this disease. They really had us down to try to tell us that we should remove the Haitians form the risk group. So being the CDC

representative I of course was the target of much of the discretion. We were treated very well on our entry and not quite as well on our exit. They were just cool and dropped us off at the airport and let us fend for ourselves.

End of Interview

Waser/Burg

(Gottlieb): Let me tell you what I am up to. I have always marvelled at the fact the disease which I think is an African disease was detected by myself and others in West Los Angeles, California. One of the most glittery, unlikely place to find a new disease, a new virus, or to detect the entrance of a new virus into the Continental United States and 15 years later I have begun to focus on the question of where the AIDS epidemic came from and especially the early years, the early cases, the early purported cases just what is known about that, because there is a great deal of confusion and misinformation out there. What I would like to do is write a scholarly, truthful, but readable book to the lay public on the origin of the AIDS epidemic and the method would be to talk to people like yourselves who have been part of this for a long time and try to get what, in the context of your own work and in the context of what you have seen what you think happened. It is politically sensitive but I will be very careful to not create World War III in Africa. Knowing who is actually doing science I think can really do it, because if you are funded by Feds it is going to be hard to really take this on. It is a question that everybody asks me in the lay public, because as much as you talk about HIV, where did it really come from. I was wondering what your thoughts are individually, together, I assume that you have had conversations about this over the years, where to start.

(Barbara): Actually we had not discussed this for awhile and we just discussed this again in the setting of this new book called "The Hospital". Have you read this?

(Gottlieb): I have read this and indeed is one of the things that got me going because of his assertion about the western shore of Lake Victoria, the Isle of Plagues, monkeys, human transmission.

(Barbara): It is not just that. The whole idea actually that not only HIV but other viruses and related viruses, it was a personal but fabulous book I thought and I recommend it very highly to Harold and everybody else in the lab, first of all because it is enjoyable and secondly because I think it does shed light on HIV and I do not, I don't think he presents enough data to pinpoint the emergency of this virus from this particular place that he names. No data at all, he just asserts that.

(Gottlieb): I wrote to him and received no reply, approximately 2-3 months ago through his publishers.

(Harold): This is supposed to be a film right?

(Gottlieb): This was supposed to be Redford and Jodie Foster and they backed out and now they have to recast it, but they never started shooting.

(Barbara): In any case I do believe that the data are excellent to suggest that the virus did originate in Africa and that it was in Africa and the virus is more advanced in Africa and the epidemic is more advanced in Africa than it is in either Europe or the United

States and I think the evolutionary data that Jerry showed support. Also the idea that people look at the stage of disease, how many people actually have full blown AIDS, you look at the rate of transmission of women to their children. All this suggests that the epidemic was entrenched in Africa, at least it led us by a number of years and also there was supposedly, and I can't remember the exact data, but supposedly there was a person in Kamchatka, I think who was looking at cryptococcus meningitis and had kept a record in a diary of how many kids with cryptococcus meningitis a year he had and through the early 70s it would be one or two a year and suddenly in the late 70s he had 10, 15, 20 cases and that is a few years ahead. It strongly supports that it was in Africa before it was in the United States.

(Harold): There is one issue related to the African question was it a simian virus that was transferred. There are _____ in the Indian subcontinent and it is conceivable that it was in those as well but for whatever reason it didn't really pick up in India as far as we know. The epidemic is only now getting underway in Indian as far as we know.

(Gottlieb): There are Macaque(?) but do you think there was an animal to human transmission in India.

(Harold): Is this a _____ virus? It was in the Indian _____ and the African _____, more likely just in Africa but I think

that what we are seeing here is very much a consequence of changes in human behavior. We take the view that epidemics caused by infectious organisms are a product not only of the organism but of the social commissions and that the greatest acute epidemic of the century was the influenza epidemic following the first World War and that the social disruption of a war facilitated the transition. I think that it is likely that the social changes in the third world and maybe particular in Africa as opposed, it is possible that the virus was in the Indian _____ but it is also possible that Indian customs were different than African customs in terms of butchering the monkeys or in terms of sexual practices. I have no information about the Indian situation other than the fact that there are Indian _____.

(Barbara): We were joking about this yesterday, there is a _____ in Thailand.

(Harold): When we worked on the Thai/Cambodian border in 1980 one of the women who worked in the emergency room of our thatched roof emergency room had a _____ helping her prepare lunch, cutting vegetables.

(Gottlieb): What were you doing there?

(Barbara): We were taking care of Cambodian refugees and it was part of the Cornell University Medical School program. We took

care of the patients who were shot.

(Harold): We were in a trajectory of the shells and we were afraid that one of them was going to misfire, hit the camp and burn the whole camp down in an hour, because it was very dusty and a lot of wind.

(Gottlieb): Was there any HIV there in 1980.

(Barbara): Not that we new of. Right before we left Henry Masor had presented the first New York case. It was a Jacobi guard. That was the first New York case.

(Gottlieb): Why do you say _____ rather than Mangabeys or pseudi-Mangabeys

(Harold): We are being imprecise. Monkey, nonprimate, not chimpanzees but monkeys.

(Gottlieb): I understand that the HIV-1 and the HIV-2 are virtually identical.

(Harold): Very close.

(Gottlieb): That one could make a good case that the women or men for that matter who butcher the pseudi-Mangabeys in the meat market

on the West Coast of Africa cut themselves and apparently has data that they have women who butcher the monkeys have a higher rate of HIV-2 infection.

(Barbara): The other point that Harold was making about human behavior, I think that comes in here is that this is a tone of great social and economic upheaval in Africa, and with a lot of men leaving their families to go to the City to make money and a lot of men earning their living by building roads, truck routes, and there was a tremendous before HIV, as infectious disease people we knew that there was a tremendous rate of conventional STDs in this population. I remember people who were really interested in really learning about sexually transmitted diseases seeing vast numbers of cases would go to work in STD clinics in Africa because you would see numerous cases of the old fashion STD, syphilis, gonorrhea, new within the last 15 or 20 years. Tony Cunningham is an infectious disease internist and virologist in Australia.

(Harold): He has worked on the nonprogressive from the blood transfusion in Australia. His patients are nonprogressive and the viruses are being studied.

(Barbara): Hill McFee among other people presented some neutralizing antibody which shows that actually again that most of them are still doing well. One died of lupus, one died of cancer unrelated to HIV and the others are completely well and do not have

appreciably measurable neutralizing antibody.

(Gottlieb): There is that little girl in Chicago apparently who repeated efforts can't retrieve virus.

(Harold): We have had some trouble getting virus but we seem to have less trouble than others. We can generally grow it.

(Barbara): There is a heterogeneous group of nonprogressive. Probably there are many ways to become a nonprogressive.

(Gottlieb): Jumping back for a moment. The cut monkey theory.

(Harold): I think that this is not just a lot of propaganda. I think it is reasonable in that the conditions had to be right for it to spread. It may have been in the monkeys a long time, it may have been in humans a long time without the conditions right for spread. In terms of the conditions being right for spread, as you know, there was a student at Washington University or some young gay man who ended up at Barnes Hospital in the late 60s who essentially died of AIDS and had an autopsy and I believe that HIV has been identified in him.

(Gottlieb): Until yesterday I believed what you believe. There was nothing published and Jerry Myers tells me that there is no

evidence of HIV recovered from that boy and that there is no tissue available.

(Harold): There was a guy from 59', he travelled around the world and he had HIV.

(Gottlieb): I talked to David Hoe and he says he is working on that case, on some materials. So there is the Manchester seaman, the Danish surgeon, there is a Norwegian family that David mentioned to me, I hadn't heard about that.

(Harold): Let me tell you some data that we really know, that is not hearsay, that it is stuff we can work. This doesn't go back as far, but it is very solid. I think we probably have the longest infected person documented anywhere. We have a woman who is infected and still alive and I can call her up right now. She was infected in 77' or before. We know this because she gave birth to a girl who became infected. We looked at her sequences. We published this five years ago. Jerry Myers worked on it as well. This was the close contact case that formed the basis for the Florida dental case, because this was the case that established how much diversity evolves when there is a transmission between close contacts because we identified a family in which a woman who used to use intravenous drugs in New York City in the mid-70s transmitted vertically to her daughter and horizontally to her male partner, who died. We looked at all their viruses and the

recipients of her virus, namely her daughter and the male partner truly had no other risks, so we know they got the mother's virus. The daughter got the virus at birth. December 1977. The child lived to be 13 years old. She was Asymptomatic until she was 12 and then she developed PML. She was written up three times.

(Barbara): This woman was somebody we started following in Stoneybrook. She moved to Florida with her child and the child died and she moved back and we are still in contact with her. We looked at the girl and it confirmed the epidemia. The history on this woman is that she started using drugs in New York City in 1975. She was married to another drug user. In 1977 she became pregnant, she broke up with that guy and cleaned up her act as far as the drugs were concerned. She had this child in 1977, moved back to Long Island where her proper mother is in real estate and met this other guy, whom she began living with. They had another child in 1982 and they were living happily ever after in St. James until the man became sick with essentially failure to thrive and extremely pseudier psoriasis. He was admitted to our service and I said look at this and he supposedly was no risk until we delved a little more deeply and found out that his wife was a former drug user in New York City. We then tested the whole family and the whole thing gelled. It turns out that the woman was positive but asymptomatic with a CD4 count in the 140s. This was in 1988. Her husband was symptomatic but without an OI yet. He essentially had wasting and this horrible pustular. The child was asymptomatic but

had a little thrush. She had a CD4 count of 30. Nobody believed it.

(Gottlieb): So you are citing this case as evidence in the United States in 1977, what is it that makes this woman a long term survivor.

(Harold): There are different types of long term survivors. There are those who maintain low CD4s and most are able to survive with low CD4s.

(Gottlieb): She became infected in the first year of the epidemic or how long do you think the epidemic was in the drug users in New York.

(Barbara): We will also tell you that one of other patients, Norman, whom we have followed for a very long time is guy we started following when we were at Stanford who we started following in 1983, he had lived previously in New York and L.A.

(Harold): He was lover of AIDS patient No. 26 in the L.A. cluster, who died at Cedars-Sinai Christmas of 1981. In March of 1981 Bill Darrow from CDC investigated him and bled him and we got the serum and he was positive in 1982.

(Barbara): He gave a history of having 10,000 sexual partners. By

the time we took his history in 1983 he had a history of 10,000 sexual partners.

(Harold): He used to go a bath house and have 50 partners, do it 20 times a year, 1,000 partners a year and started in the mid-60s. As far as his lover, the name Wellborn comes in but I don't know if that was his lover at the end.

(Barbara): He stopped having all these partners and started a monogamous relationship with another guy. First of all this was wonderful guy. He had been in a circle of gay men in New York City in the late 70s who were also using IV drugs.

(Barbara): He was not, but others were in that group, so that confirmed our idea that in the late 70s in New York City the virus was already there. When I was a house officer at Bellview in the late 70s I was probably already working on IV drug users who were in infected because in 1980 and 1981 they started dropping.

(Harold): The interesting thing also is the sequence, if you look at the sequence of the woman her sequence was very close to LAV. Very close, it is essentially an MN sequence, so is Norman, they were infected very early and one possibility is that that was really the essential sequence.

(Barbara): We have discussed this before with Nancy Hayward who

did the sequencing on Norman and another long term nonprogressive. Norman remained a long term nonprogressive for approximately 10 year and then in 1991 his CD4 had a rapid crash, he lost 400 CD4 in one year and he developed 2 OIs. He was very very interesting. I think he is the most interesting long term nonprogressor that has been identified. Because as we know Derosier is using the idea that the long term nonprogressors are an experimentative nature to show that an intenuative virus could be a vaccine. He had such a virus until suddenly in 1990 he lost 400 CD4 cells like that. I know it happens but it not supposed to happen in long term survivors. So their viruses may not be a good idea to put into people.

(Gottlieb): What about Randy Schultz, what were you going to say?

(Barbara): What I was going to say is that I have no evidence but Randy Schultz suggests in his book "And The Band Played On" that the virus may have been brought by semen.

(Gottlieb): Do you think that it is mythological or poetic license, did he talk to somebody? In his book does he have any knowledge.

(Barbara): I actually do believe that it very logical to say and it s certainly believable and the data we have now is consistent with the idea that the virus originated in an animal in Africa,

that it got into the human population that way, that it then was sexually transmitted very rapidly and there are other sexually transmitted diseases which have proliferated in Africa now and in the last 10 or 20 years and that somebody who was travelling and also with the sexual freedom of the 70s, the gay population.

(Harold): When we were talking to you on a more regular basis we used to joke around and say that the epidemiology in the early to mid-80s showed the gay men flew nonstop coast to coast. They didn't stop off in the midwest.

(Barbara): And they went to Haiti. The other question is whether the virus came directly from Africa to Paris to New York or how it came. Tom Quinlin was the first one who showed that the virus was the first person to present the data to us would show that the virus was very prevalent in Zaire, that it was a one-to-one male to female ratio and that if you look at the flights leaving Zaire they go to two places, Brussels and Port Au Prince Haiti and of course there is one of the first sites in which HIV was recognized was also in Haitian immigrants to the United States. It is also known that gay men enjoyed vacationing in Haiti.

(Gottlieb): Is there data on New York gay men or recollections of men from the early 80s.

(Barbara): That is a good question to ask some of our patients,

but I will also say that there is so much poverty in Haiti that a lot of men who do not consider themselves to be homosexual or bisexuals do prostitution just for money and certainly would be a way so if it was introduced sexually into the heterosexual population from Africans who went back and forth, apparently with political upheavals, there were a lot of people moving back and forth from Zaire to Haiti so it could have been introduced into the heterosexual population and then some of these men could have transmitted it to gay men who came from New York, who then went back up to New York.

(Harold): I think that is possible and could also have been both Zaire/Haiti and Zaire/Brussels at the same time.

(Gottlieb): Who should I talk to about Haiti? Jean Paup, I have written to him.

(Barbara): If you were here I would introduce you to a very good guy. He is a black man, Haitian and trains at Cornell.

(Harold): You should also go to Tom Quinn because he has project in Haiti.

(Gottlieb): I did talk to Tom here and he was a little less free with the information than you guys are.

(Harold): Our information is soft. We don't want to make any claims. The truth is we are not epidemiologist and a lot of what we are telling you is our processing of what we have heard, processing for our believability, so it is our opinion.

(Gottlieb): Tom will talk to me, he encouraged me to read his papers first. He is making a presentation in another month and is going to update things and I will look at what Tom has done.

(Harold): Hopkins has a unit in Haiti. There is an HIV strain group, headed I think by Quinn in Haiti. Neil Halsey who is also at Hopkins. The other guy at Cornell is Warren Johnson.

(Gottlieb): What about Gatton Dugas. The patient you described is as promiscuous as he was.

(Harold): I heard that the CDC had his specimen, blood or something and that they were supposed to be working n up for the sequence. I don't know him but I heard that. I heard that there is a guy at CDC who got me the 1982 serum on Norman. A guy named C. Robert Horsburgh. I don't know if he is still there and he was one of their doctors and he is published in the AIDS field. I recently checked him out because I actually wanted to give him an acknowledgement in this paper we are writing on this guy and I just wanted to check the spelling of his name and when I contacted him about five years ago for this serum we had a discussion and he said

that he was under the impression that CDC had the Gaton Dugas sample.

(Gottlieb): David Hogue told me that CDC has his virus.

(Harold): Our sequences are in Jerry's data base.

(Barbara): The other thing is that Mike Lang said he would give us some serum from some very early patients from 1980, people who were long term survivors who he started following in 1981, 1982. You could do reverse transcription. You can get virus out of serum. You can pellet the virus. You can't culture it usually, but you can pellet the virus, you can reverse transcribe into DNA and then you can add PCR amplify.

(Harold): We do a lot of PCR and we are just getting into sequencing.

(Gottlieb): What about serum surveys? Apparently Nomias has a 1959 Zaire serum, lab work done at Essex's labs suggesting a positive serum back in 1959.

(Barbara): I think it fits.

(Gottlieb): Peter Peot apparently knows the African story real well. He has been in and out of there. Joe McCormick is probably

is a pretty good person to talk to. He was one of the bad guys in the book. David says that Haiti is linked to the U.S. In other words the same subtype B is present in B as is present in Europe and America. Do you think that would tend to diminish the Zaire, Tom Quinn story. There is no subtype B in Africa.

(Harold): I think that is strong piece of data against the Africa to Haiti transfer and it is probably more consistent with Haiti being infected by Americans.

(Gottlieb): How long has HIV been around. You have heard that discussion between Beatrice and Jerry. Do you think that all this divergence stuff that, do you think that says anything about when it evolved, when it jumped from primate.

(Harold): I think a lot, Jerry was hinting that there is more to driving diversity than just immune pressure. We used to have regular discussions with Jerry when we were doing this family because he really needed that very badly and he kept saying that the diversity was epidemic driven and he was eluding to that today as well and I think that that plays a role that that is the more opportunities for transmission and the more transmission and the more infection the more there is going to be and it is just mad because you have people essentially getting into contact with people with more divergence and you see this with AZT resistance. The AZT resistance is a good marker for spread of virus. There you

have a nice narrow marker and AZT was introduced a few years ago and now according to the Walter Reed group close to 20% of new infections are AZT resistant. That is because what is in the population and this is not looking at geometric spreads, not asthmatic spreads and so I think that when we talk about Africa or wherever it started there was a very small pool with not much contact, not much sex perhaps, relatively victorian. I think that one of the keys to his is to really talk with some anthropologists who know what the scene in Africa is and epidemiologist not physicians but anthropologists. What was going on in 1930, 1940, 1950 and 1960 in Africa. I haven't got a clue.

(Gottlieb): If you talk to the old hands who were in Africa in the 60s and 70s, the American doctors, they will say, of course they were at the University Centers, they will say we haven't seen AIDS.

(Harold): That is not what I am asking. I am talking about sexual behavior. We know it is not IV drugs in Africa. You look at what was going in colleges in America in 1920, 1930, 1940, 1950, 1960, 1970, 1980, things change, well what was going on in Africa in the sexually active communities. I think there is two questions. There may have been a really flat lag space. It could have been going on for a very long period of time, but the conditions weren't right. It may have been in the community, but it may not have been able to take off.

(Barbara): It may have been introduced more than once. What is very interesting there may have been at least four different times in which the transition jumped. Jerry at one point said he thought there were four major groups.

(Gottlieb): Beatrice said well the way your data suggests that there were two jumps and I think he agreed.

(Barbara): I think that may well be true and that again is consistent with the mind set that is actually is presented in the book "The Hospital" and if you think about this stuff the idea that there were these tiny isolated communities and again presented in this book is the idea that people can have horrible, terrible disease and they are so isolated that some just die in a few days and maybe there were people who were incubating HIV in tiny isolated villages. So a person or two persons and a child would die in some isolated villages before passing it. It was only after the sexual revolution reached critical mass.

(Harold): There is one other pressure that is going on which is that the virus was changing in African people, that its possible that they started out with something like SIV or HIV 2 which is at least overall somewhat less pathogenic or less rapid than HIV 1 and maybe that was really just smoldering there and that maybe, this is all just speculation.

(Barbara): The evolutionary truth suggests that there was a break, that there is a common ancestor.

(Harold): You should also talk with Vanessa Herst. She is based at the NIH and she is an expert on SIV and evolution and she has done excellent work. Beatrice does refer to her work. She worked with Mullins and on her own. She has her own lab now. Have you spoken to Murray Gardner. Murray has been to Central African Republic and I would think that Murray would be an excellent person to talk to.

(Gottlieb): It could also have jumped species way out in the bush, it might have been initially a rather benign infection in the first person. It might not have gone crazy and killed him, so somebody could have been incubating it out there and passing it onto the next person and then in that person or could have been sort of the real patient 0.

(Barbara): That is another thing we have to remember is that the incubation for this disease is so long.

(Harold): I just think that there is one aspect of this that we are not looking at and that is the anthropologic aspects of African life. What was the death rate with childbirth in African villages in 1950. That is if a man were infected, transmitted it to his wife, she gets pregnant, she dies in childbirth, I don't know what

the conditions are, the conditions may have essentially controlled it. It may have been under some sort of population quarantine control. So that even if it were in there, is it possible that contusions in Africa improved so much between 1930 and 1960 that the life span of people was enlarged so that you could see.

(Barbara): I doubt very much in 1930 that people were dying in the prime of life and the whole thing about this epidemic it is killing young people. I think they would have noted that people in their 20s were all becoming extraordinarily ill and dying.

(Gottlieb): What about needle spreading. Do you think that the polio vaccination had anything to do with it or do you think that the vaccine itself or the needles used to inject the vaccine may have contributed to the spread of HIV in Africa.

(Harold): The question that was asked before was there some other monkey virus in it and this was the monkey virus. I read these articles, there were articles in nature on this and I thought that they had really nailed it down. I think that the final nail down was the impression that I got was that HIV won't grow in monkey tissue culture, it is not a permissive system for retro-viruses, at least that was the implication in the article.

(Gottlieb): I am going to get back to you on this if I can, once you are home, I may want to sit down with you again, two or three

more times. Let me ask you one more question today and that a couple of years ago Jonathan Mann when asked by someone about the origin of the AIDS epidemic dismissed that saying it is unimportant. Why don't people talk about the origin of the HIV epidemic, do you think there is interest among scientist, is it an interesting question and if it is an interesting question why don't people talk about it more at meetings like this. We talk about it in a veiled way.

(Barbara): I think there is tremendous interest and I think there has been a lot of work done on this. There are a lot of nature papers on finding the monkey virus that is most like a human virus and that sort of thing. I think that one question that has come up is that I may be mistaken but I think that there are Africans who are sensitive about it, who feel that this would inadvertently reflect poorly on them and do not want to be seen by ignorant people for the terrible epidemic or that sort of thing. I think that people have to believe that people who don't want to discuss it publicly are trying to be sensitive to the people in the third world.

(Harold): The other thing that makes it misguided is that people seem to be ready to blame the source but not the spread. The real danger is from the spread, not from a hysteric source, the real danger is from the spread. The idea should be to interrupt the spread not to quarantine the historic source.

(Gottlieb): If you don't look and learn from history and try to identify the source then what does that bode for the future on epidemic diseases.

(Barbara): Absolutely and I again think again that this comes out of the book "The Hospital". There is a lot of discussion about over-development and destroying the rain forest and viruses. The author brings up in that book that the possibility that some of these viruses are now emerging and entering the human population because their original hope has been greatly - that is theologic - that is true but in any case it made me think it is an important question.

(Harold): This whole issue of emerging viruses is a very important issue and I think that attempts to limit scientific inquiry and to try to avoid basically searching for the truth are always misguided. They may have superficially good intentions but it doesn't work. Active attempts to divert people from meaningful truths is always a bad idea no matter how good the intentions and I think that it is similar to the idea of HIV testing people. I think it is important that people find out if they have HIV and I think efforts need public health efforts need to be made to control the epidemic.

(Gottlieb): There is denial whether they have it, countries are in denial.

(Harold): I think that these efforts to put in a closet and do not look are misguided.

INTERVIEW OF 22? Harold Jaffe, CDC

(Gottlieb): I want to start by asking you about something that Randy Schultz wrote in his book and that he starts with the tall ships going into New York harbor in 1976. It is kind of vague and he says something like when the first cases were described in the early 80s the epidemiologists in New York sat around and talked about the tall ships in 1976 for the bicentennial and all those sailors.

(Response): I don't know where he got that.

(Gottlieb): Then he goes on to I think the Danish surgeon and I wanted to ask you who would know about that case. Do you know?

(Response): No I wouldn't know. The Danish surgeon who worked in Europe to work, I forget where he had gone.

(Gottlieb): Then he goes onto Gaton Dugas who I understand from conversations here that he was a patient of Alvin _____, I didn't know that. When did you first hear about Gaton Dugas.

(Response): We found about him as part of the investigation of this cluster of related cases in southern California. The first information that I got about it was from David Haurerbach who was the CDC/EIS officer assigned and he is a person you want to talk to. He was at UCLA in pulmonary. I think he had been contacted by

some people from the gay community center in West Hollywood and was told that some of these patients knew each other and were probably sexual partners of each other and we discussed it over the phone and I discussed it Bill Darrow who is another person you should talk to. He is no retired in Miami. He is research sociologist about how to approach this and Bill's feelings was that we should approach this in the way you would look maybe at a cluster of syphilis cases where he would interview these men and ask them about their sexual partners. Bill went out and spent time with Dave going around interviewing these people and within a day several of them had named Gaton guys.

(Gottlieb): I never appreciated this, that there was a link to the L.A. cluster.

(Response): That is where it started and Bill started tracking it across the country and ultimately he was able to find 40 patients that he could link together with Gaton sort of a defender of this. I think Gaton's role has misinterpreted, because when this information first came out and he was called patient 0 simply because there was a chart that indicated him as 0 people said well he was the source. The chart was a figure in an article that Bill published in the American Journal of Medicine. People saw that and they said well he is a flight steward, he had sex all over the world, he is the person who brought it into the U.S. and Bill never meant to say that. Bill's point was there were probably a number

of Bill like Gaton, people who travelled a lot and who were highly sexually active and who would have been the kind of person who could have spread the disease quickly, so there were probably lots of Gatons, he just happened that he was the one we found.

(Gottlieb): There are certain assumptions that yes he would be the kind of likely person, he had the means to do it. It was kind of like the same things that are said about the Manchester sailor. That a sailor would be a likely person to be a traveller.

(Response): Right. A traveller and somebody who would be likely to be sexually active and then Bill actually contacted Gaton and started talking to him about his partners and was able to get Gaton name about 70-75 of his partners of whom at least 10% were known AIDS cases at the times. It is interesting that Gaton also told Bill that he had a diary that name of hundreds of his partners which Bill tried very hard to get and was never able to get. I think if he had gotten that we would have found the names of lots of other AIDS cases.

(Gottlieb): So you think that there is something to Gaton as a vector.

(Response): Gaton represents the kind of person who contributed to the rapid spread of the disease in gay men.

actually asked David is that the sequence looks like a contemporary

(Gottlieb): Was there any data with respect to whether he had travelled to any suspect area.

(Response): You would have to ask Bill that. I believe that he did travel to the Caribbean. I don't know if he went to Africa or Haiti or not. Bill has a marvelous memory. He would know all of that.

(Gottlieb): In terms of _____ surveys which was one tool to try and track or date onset what is your read on the earliest reliable serum.

(Response): Earliest one I know about was a serum sample that Andy Nomi has had and Andy is at this meeting. I believe it was collected as part of a measles survey in Africa in 1959 and I don't know who tested it but it was supposedly positive. We isolated HIV out of a urine sample that was collected in 1976 and that is the earliest isolate that I know of. A serum sample and its is now Isolate V something or another.

(Gottlieb): Do you know anything about a Norwegian family? The Manchester sailor.

(Response): David Hogue has sequenced samples to the Manchester sailor but what I have been told unofficially, I have never actually asked David is that the sequence looks like a contemporary

Caly V virus which I guess people think doesn't make sense. It is not what they would have expected and I think David is worried that it might be a contaminate or something and he has never published it. People have known for several years that David had those samples and were just waiting to see the results and they never came.

(Gottlieb): The St. Louis case.

(Response): I don't know much about that. I read about it in JAMA?. I think at the time we tried to get some specimens from that case and never were able to so I don't know anything more about it other than what was published. We called them and I don't remember the story but we were never able to get materials from them.

(Gottlieb): What is your sense? Was that a case or not?

(Response): It seems very odd because it was a young boy about 14, he was living in a place that was certainly not an AIDS hot spot by a long shot. I think there was some suggestion in the story that maybe he had engaged in male prostitution, but if you would have to guess who would be an early case of AIDS I wouldn't guess a 14 year old boy in St. Louis.

(Gottlieb): Do you think that data support a progress of the virus

from New York to Haiti or Haiti to New York or somewhere to Haiti.

(Response): I don't think we know. Negallo used to always shows these slides in these talks with arrows going back and forth between Haiti and Africa and the U.S. and I think it was probably in Haiti earlier than in the U.S. It seems clear from interviews that we did at the time that Haiti was considered a good vacation spot by gay men in the United States. It was a place that was relatively inexpensive, where there was a lot of sex available. I don't know how it got into Haiti but I think the gay men who went to Haiti for sex probably spread it there and brought it back.

(Gottlieb): So you think there is something to support it being in Haiti prior to the U.S.

(Response): There weren't cases reported from Haiti any earlier but when we first started sending people to Haiti and talking to Haitian physicians which was around 1982 it seemed to us that there were cases that probably had been occurring there for some time. It is also interesting that there was a lot confusion about it at the time but I think in retrospect it is clear that most of the early Haitian cases were bisexual men, where it is now a predominately a heterosexual disease, so I think a lot of these early cases were men who were turning tricks with American gay men.

(Gottlieb): So you don't put much stock in the Haitian/Zairian

connection.

(Response): I don't know. There are certainly ties between Haiti and West Africa. I don't know anything about the movement of people between the two places.

(Gottlieb): Most people say that when Zaire became independent that they needed French speaking people who could read and write, be civil servants, they brought in Haitians. But I don't know if anyone has ever looked to document yet 1,000 Haitians worked as civil servants in Zaire.

(Response): I heard the same thing but I have no proof of that.

(Gottlieb): One of the interesting things about the subtypes is that apparently there is no subtype B in Africa and subtype B is prevalent in Haiti which seems to make a link to the U.S. Assuming things are going in Haiti and still there is a major problem.

(Response): There is still a major problem there. There is several U.S. sponsored teams still working there. Warren Johnson from Cornell, Neil Halsey from John Hopkins.

(Gottlieb): The animal connection, do you think there is a missing link between an animal species and humans with respect to HIV 1.

I think humans it certainly has a strange way of spreading it by

(Response): To my knowledge there is still not an identified animal virus that is very close to HIV 1. I think the closest one is the Chimpanzee virus. On the other hand it is obvious that the more you look for these viruses in animals the more you find and it is certainly conceivable that somebody will find a virus that is closer and this gets back to the part of the question if you assume that the origin was animal which I think you have to assume and it crossed over into humans, when did it do that. Did it do it 5,000 years ago or 40-50 years ago and how many times did it do it. We know now that there is whole separate group of viruses in West Africa which are subtype Os and really aren't close to the other HIV ones at all, which would seem to suggest an independent origin. The HIV 2 story which Beatrice was probably the world's expert on is very integral and HIV 2 looks like a monkey virus that is in humans. You can buy monkey in the market. You can ask Kevin about it. This is much easier to imagine for HIV 2 than HIV 1. HIV 2 just looks like this virus that got into people by accident, doesn't really like being in humans. It is not as African as HIV 1 - it doesn't transfer as easily. You get the sense it wants to be in monkeys. Kevin published on that. HIV 1 likes being in humans.

(Gottlieb): It seems to me although this evolution of it, it certainly, we think of people as wanting to be stable and a stable relationship would be a good host to parasite relationship. If HIV 1 likes humans it certainly has a strange way of showing it by

evolving the way it does.

(Response): You could say if it really liked humans it would be non-pathogenic and that way it would survive as long as possible, but it certainly likes to kill people.

(Gottlieb): Who is responsible for this Chimpanzee virus in Gabon and Cameroon. Do you know who the worker is that is the expert on it.

(Response): There is woman at this meeting named Myro McClure who, I spent a year in Robin White's lab and she was there, knows a lot about these viruses. She would be a good person to talk to her.

(Gottlieb): I would like to talk Chauketman about the Dugaw isolate in terms of where it fits in. If he is sequencing it he ought be able to compare it i terms of the diversity thing and see if it is the very early one. IT probably is.

(Response): I know he has some sequence made. I don't know to what extent, filed genetically, whether Jerry Myers has ever looked at it.

(Gottlieb): Do you know this guy Guilkes, a British Tropical Disease Specialist who says there is early malaria research in which blood computes mangobeys and macaques were injected into

human volunteers? (No) Just to backtrack a little bit in terms of what we talked about over there, was there something that went unnoticed before because of whatever the situation was in terms of medical care in Africa and movement of the people.

(Response): First of all it was clearly a new disease at least in an epidemic form in the United States. We looked very hard retrospectively for cases, reviewing Putamidine requests by reviewing cancer registries and we really could not find cases earlier than about 1978. Now it is certainly possible that there were sporadic cases that were simply unrecognized but there could not have been a lot of cases. In Africa I think the situation is much different. Again Kevin is the expert, but it seems to me that in cities like Kinshasa cases that in retrospect were AIDS were starting to occur in the mid-70s. I think the introduction of the virus hints to large population areas in Africa was earlier than the United States but not all that early. The question is where was it before then. One possibility is if it has been in rural Africa for a long time and that when people became infected they would show up maybe in a missionary hospital with a fever and meningitis and they would die and nobody would make anything out of it. That with the population movements that occurred in Africa in the 60s and 70s related to independence, civil unrest and so on a lot of people came in from the countryside into the city often with no skills, women would have to prostitute themselves to eat, people who would not have been very sexually active in their villages

became very sexually active almost by necessity so that lets say in one scenario is the virus has been in rural Africa for a long time at a relatively low level and the ingredient to transmit it rapidly simply weren't there. Those people then get pu into a totally different situation. They are pushed out of their villages by war or economic necessity and move into a city, women start to prostitute themselves to support themselves and it starts to spread. It takes an introduction into the right kind of population to spread rapidly and that is what happened in the United States. The analog was dropping the virus into highly sexually active gay men who travelled who could spread it. It could have been out there but it took those kinds of population movement and development to get it into the population where it would spread rapidly.

(Gottlieb): What is the value of asking this question of trying to trace ancestry?

(Response): It is obviously an intellectually interesting question. Everybody wants to know where it came from. I think there could be lessons for the future in it. For example I think it makes us think a lot more about animal reservoirs of disease. What other viruses are out there in animals that we could become exposed to. Also by doing the kind of work that Jerry Myers does, kind of working backwards in the molecular revolution of HIV might give us some idea of where it is going. For example, people

speculate, Is HIV going to become more or less severe over time or will it stay the same. Will it adapt in some way to humans that it has not adapted now. I don't think we know that but may be that by looking back we will get some clues about where HIV will go in the future.

*Address to Nat Press Club***DRAFT****There Is Nothing Manageable About AIDS*****The Clock Is Ticking*
~~When You Are Dying of This Disease~~****By Michael Gottlieb, MD**

After 12 years of dealing with perhaps the worst pandemic illness ever known to mankind, there still are worrisome signs of floundering national leadership in dealing with AIDS. On the occasion of World AIDS Day, being observed December 1, we should be reflecting on our nation's management of this growing crisis.

Specifically, my concerns are statements made by federal government officials who have portrayed HIV as a "manageable disease."

It is hard to believe anyone who has had significant experience with AIDS patients could in any way portray it as manageable.

Medicine has made great strides in managing some diseases. Diabetics have insulin, ulcer patients have the H2 antagonists and heart patients often can avoid bypass surgery with medication, exercise and diet.

But to someone suffering with AIDS, to say that disease is manageable is like saying we can manage ocean tides. Yes, we can erect jettys, build our homes high on the beach and anchor boats at the appropriate moorings. But the tides will come and there is nothing any man can do to stop their inevitable rise and fall.

So it is, for the foreseeable future, a certainty that AIDS is not survivable, a fact all those who suffer with it must face.

Through both hard work and happenstance I was the first physician to diagnose the new disease that would come to be called Acquired Immune Deficiency Syndrome or AIDS. It was a case of being at the right place at the right time.

The place was the UCLA School of Medicine and the time was 1981. I was treating five gay men who manifested the same symptoms with alarming characteristics. And there also were startling differences in their immune systems that really could not be explained.

On June 5, my report on these men was published in the Center for Disease Control's "Morbidity and Mortality Weekly Report," entitled "Pneumocystis Pneumonia - Los Angeles."

There is much, much more to this story than my small part in it. There is Robert Gallo and Luc Montagnier, Rock Hudson and Randy Shilts, Liz Taylor and Larry Kramer, Magic Johnson and Mary Fisher, the Ray children and Ryan White, Arthur Ashe and Elizabeth Glazer, C. Everett Koop and Kimberly Bergalis.

There are the thousands of victims of AIDS, thousands of care-givers, and multiple thousands of loved ones, relatives and friends who have suffered the losses of the past and who will suffer losses yet to come.

These are the real heroes, both sung and unsung, of the AIDS years.

If we could look ahead to the end of this second decade of AIDS, it would be wonderful to think that we might be able to sing the praises of persons who had found

either a cure and/or a vaccine for AIDS.

But, at this point I'm still not sure the world really understands how desperately a coordinated push for a vaccine, a cure, preventive education and more understanding of the far-reaching social and economic devastation of AIDS, is needed.

If you don't understand why we are in a crisis situation, I want to list just a few statistics. You may have heard some of this before, but this is what we are dealing with:

- There are an estimated 10 to 11 million people who **already** are HIV infected globally. Moreover, it is estimated that there are at least two million children orphaned worldwide, a figure expected to reach 10 million by the end of the decade.

- Last year, the Global AIDS Policy Coalition, which is based at Harvard, estimated that by the year 2000 as many as 120 million people will be HIV infected with the minimum expectation set at 40 million.

- In this country 1 million people **already** are infected with HIV. That is 1 in every 100 men and 1 of every 800 women.

- To date in the United States, we have lost more people to AIDS than almost twice the number of those killed both in the Korean and Vietnam wars -- more than 190,000. In five states and 64 of our cities, AIDS and related illnesses are the No. 1 killers of young men between 25 and 45 -- surpassing accidents, cancer and heart disease.

This gives you an abbreviated statistical view of where we've come from and where we're going, but in this country that is only part of the problem.

Two years ago in a speech at the National Press Club in Washington and in testimony before Congressman Waxman's health subcommittee, I proposed that President Bush name a top White House advisor to coordinate an accelerated effort to control AIDS. One of the people I suggested for the so-called White House AIDS czar post was Dr. David E. Rogers of Cornell University Medical College, who was then serving as vice chair of the National Commission on AIDS.

Dr. Rogers earlier this year listed five major problem areas in the fight against AIDS, problems which reflect my own concerns as well as those of others:

Problem No. 1. We have no national plan for dealing with the epidemic. True, mobilization against AIDS involves coordination of multiple agencies dealing with research and health care, but it also deals with drug abuse treatment, immigration, housing and education.

Under President Clinton we now have a White House AIDS czar ostensibly to coordinate a national plan, but I would not want to embarrass any group of people, physicians included, by asking for a show of hands of those who could name this individual.

Problem No. 2. We have no national prevention program of any consequence. Young people still get AIDS preventive information solely on the basis of catch as catch can -- if they get any at all. Instead, over the last 12 years, there has been no shortage of hypocrisy, ambiguity, and general ineptness on AIDS prevention.

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Substance Abuse at Columbia University, has said by the end of this year the cost nationally will be \$10 billion and the cost for treating one single newborn who is drug exposed, and with HIV infection, is \$5,000 a day.

The significance of these dollar figures to me is to project them into some other framework of our national health care needs.

For example, earlier this year President Clinton went out to the Washington, DC, suburbs for a photo opportunity on the high cost of vaccinations as one of the nation's health care problems that needs fixing.

With the \$10 billion that Joe Califano says will be spent on AIDS this year, and at the estimated cost of \$200 to vaccinate each child, it takes no White House budget genius to see we could inoculate all newborn children and then some.

Problem No. 3. We have not built an adequate medical care program or social system to care for the many impoverished and even homeless victims of this epidemic. This is the high risk group and, as Dr. Rogers has noted, **"failure to help those who use illicit drugs has significantly increased the speed and scope of the spread of this fatal disease."**

Problem No. 4. Discrimination against gay men and the high-risk lower income population still dominates AIDS policy here and almost everywhere in the world.

Problem No. 5. We have spent much of the first 12 years of the Age of AIDS wasting our time and resources on side issues. We've burned down homes of AIDS victims, spat on AIDS infected kids going to school, worried about AIDS and mosquitoes, banned words such as condom in government-funded brochures, and

debated whether health care professionals should be tested or not tested for HIV.

I think Congressman Waxman summed up these problems in one of his statements from which I quote:

"Our society has failed to deal with the epidemic, in part because (its) statistics are so incomprehensible. In larger part, however, we have failed because we have not found a way to deal with what AIDS is really about: It is about sex. It is about drugs. It is about poverty. It is about ignorance. It is about fear. It is about a failed health system. It is about failed compassion."

No one who has been in the trenches in the war against AIDS would claim there is anything simple about it. The politics, the economics, the social and ethical aspects are as ever-changing and undefined as the virus itself.

Our natural instinct is to draw away from something so awful. But, ironically, for society to "not give a damn," to watch passively from the sidelines, has been one of the deadliest of mistakes.

I speak as a veteran of this battle -- a veteran with combat scars as well as combat ribbons.

It is generally agreed that my report in June, 1981, was the first to identify AIDS as a new disease. At the time I was an Assistant Professor at the UCLA Medical School.

My initial report, published by CDC, was informing the Center of five cases of a previously rare pneumonia called pneumocystis in homosexual men. But the definitive

helper T cells associated with it, was published on December 10, 1981, as the lead piece in the New England Journal of Medicine. It became one of the most quoted scientific publications of the last dozen years.

The Journal came close to rejecting the paper, probably because the syndrome I was writing about seemed off-the-wall and just generally perplexing. At that time there also seemed to be a widespread view in medicine that all the diseases of mankind already had been described. It is safe to say that after Legionnaires disease, AIDS, and now the hantavirus, that viewpoint was slightly off the mark.

In the early days, there was literally a handful of politically powerful people who cared about AIDS. Contrast that to the present common sight of superstar entertainers, professional athletes, politicians and others who wear the red lapel ribbon symbolizing AIDS awareness.

At the relatively young age of 45, being one of the grandfathers of AIDS allows me a unique historical perspective. In addition, it gives me a bully pulpit to offer a report card on how we in both medical and lay society have responded to the tremendous challenge of somehow seeing that the Global AIDS Policy Commission's dire predictions for the Year 2000 do not come true.

AIDS is not just any disease, not just a medical phenomenon. Because of its links with homosexuality, sexual practices, intravenous drug use, and tainted blood, the emergence of AIDS into our collective conscious could have been predicted to be cataclysmic.

Some years ago in a conversation with Admiral James Watkins, who chaired

several important task forces on AIDS and then went on to be Secretary of Energy, I asked him what it would take for the average American to feel some compassion for those inflicted with HIV.

He said he thought it would take every American knowing some person or some family in which AIDS had taken a life or threatened to take a life.

As the circles are getting smaller, more and more people are touched by this tragedy. Prejudices are perceptively softening -- a striking contrast from 1988 when the Ray children with hemophilia and AIDS had their house in Central Florida fire bombed.

Now, I want to mention some of the crucial events which are highlights for me and relate some personal impressions of them.

1981 -- The year of the discovery. I recall the euphoria of finding some new disease, and then the realization that it was not only horrible but it was going to be common.

1982 -- AIDS is officially named by the Centers for Disease Control, and the case count starts. The disease is reported in children, drug users, Haitians and transfusion recipients.

1983 -- In June I attend a conference convened to discuss the epidemic in Naples, Italy, at the Castel del Ovo, a 10th century fortress shaped like an egg protruding into Naples harbor. Scientists working for Luc Montagnier at the Pasteur Institute present their findings on a virus isolated from a French AIDS patient -- a virus which selectively destroys CD-4 helper T cells in test tube experiments. Their virus,

which they call LAV, destroyed the very same cells I had found missing in my patients at UCLA. I say to myself, "This is amazing. It's only been two years since the disease was described, and these guys have found the cause."

1984 -- In many respects, 1984 fails to fulfill George Orwell's dire predictions. But, in the field of AIDS, 1984 is a pivotal and key year.

With a nationally televised news conference, U.S. Secretary of Health and Human Services Margaret Heckler joins with Dr. Robert Gallo of the National Cancer Institute to announce that the cause of AIDS had been found, and that a test would soon be available to insure the safety of transfused blood. In one of the most fantastic real-live science stories of all time, the Gallo and French viruses are found several years later to be one and the same. The French virus has been sent to Gallo's lab and somehow is mixed up with his own cultures.

1985 -- Actor Rock Hudson, one of my patients, asks me to announce that he has AIDS. For the average American, this finally puts a face on this strange disease. Congress responds and begins appropriating funds for AIDS treatment research.

1986 -- AIDS Clinical Trial Groups, or ACTGs, get funded by the National Institutes of Health to test promising drugs in patients.

1987 -- AZT is approved for AIDS treatment. It clearly postpones symptoms of the disease, but whether it prolongs life span is still controversial.

1988 -- Dr. Tony Fauci is named NIH's AIDS czar and the first case of HIV02 in the U.S. is reported in New Jersey. The infamous Koop booklet on AIDS is mailed to every household in the nation.

1991 -- Magic Johnson of the LA Lakers announces he is HIV positive, and the world has another 8.0 point Richter Scale shock.

1992 -- Both the Democrat and Republican National Conventions feature major speakers who are HIV positive.

1993 -- President Clinton elevates the status of AIDS at the White House and appoints Kristine Gebbie, RN, to be AIDS czar. The White House budget recommendation for AIDS programs for 1994 is 28 percent higher with an increase in funds for research, care and prevention.

In looking to the future of AIDS, we can view it as either a glass that is half full or half empty.

Being an eternal optimist, this is what I see in our glass that is half full.

One, the new disease was diagnosed, the new virus identified, and the blood-screening process developed in unprecedented time. This contrasts with the 50 years that elapsed in the search for the polio virus.

Two, AZT, originally developed in 1964 to treat cancer, was found to be useful and was approved. Other treatments have been found and expedited approval by the FDA has come about. Other potential AIDS treatments and vaccines are in trials, and there is cause for some hope there.

Three, while slow to act at first, Congress now is providing the National Institutes of Health with more than \$1 billion for AIDS research each year, and our total federal government commitment is more than \$2 billion annually.

Four, we have a president in the White House who, for the first time, is not

afraid to say the words HIV and AIDS, and to acknowledge the threat of AIDS to our country and the world.

The late United States Senator from New York, Robert Kennedy, often used a quote that I think fits our future with AIDS.

"Some people see things as they are and ask, ' Why?' I dream of things that could have been and ask, ' Why not?'"

Why can't we, with all our marvelous minds and marvels of information transfer, do a better job of convincing people -- especially our younger people -- that if they get AIDS it will surely kill them?

Why can't our president and other world leaders enlist our national hearts and minds in a crusade to limit the forces of discrimination, sexism and classism that promote the spread of this deadly virus?

Why can't we get our private sector research capabilities more involved and integrated with federally-funded efforts in a Manhattan-style project aimed at answering central questions? And I find it hard to believe that this idea is as impractical as we are led to believe by its detractors.

Why can't we find more compassion for all AIDS victims? For, as we say, there but for the Grace of God, go I.

And, there they go, those infected with HIV, in numbers now beyond comprehension.

Until a treatment or vaccine is available, what is needed from our national leadership are realistic statements about this terrible disease which is moving through

our land like a silent hurricane that leaves nothing in its path.

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