

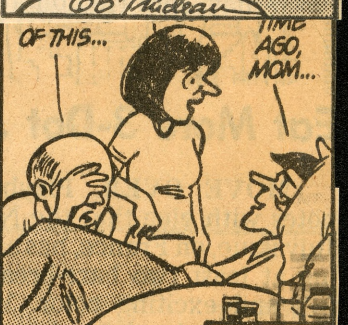
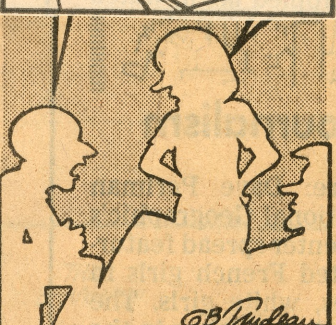
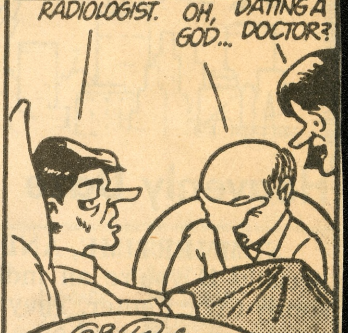
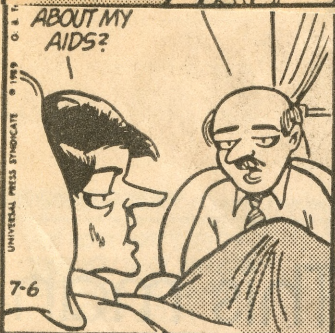
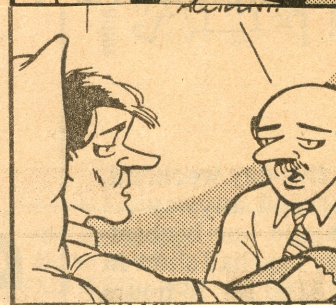
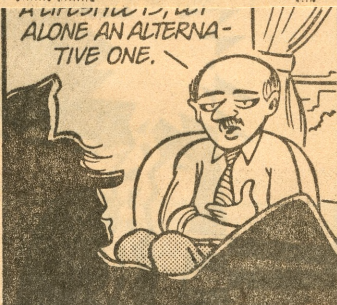
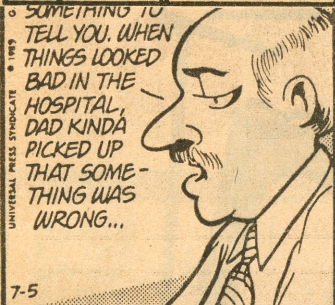
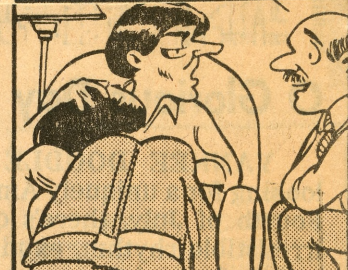
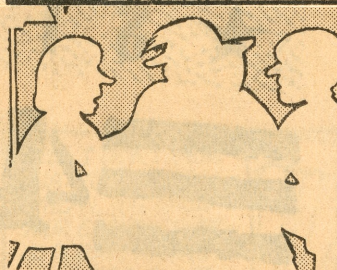
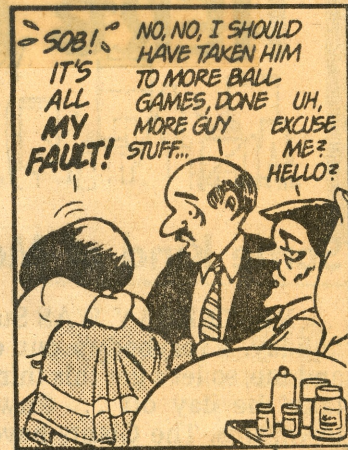
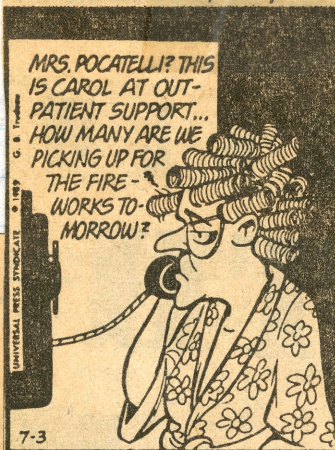
Muslim Rejects AIDS Death Call

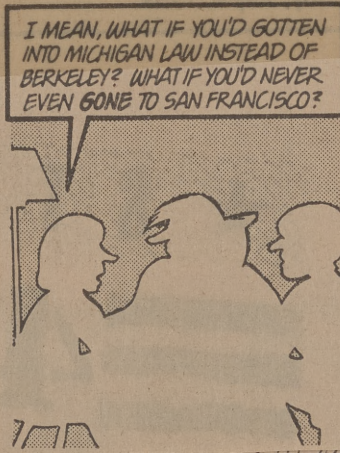
Egypt's top Muslim authority yesterday rejected a fellow cleric's statement that AIDS victims should be killed.

Grand Mufti Sayed Tantawi, Egypt's state-appointed senior authority on Islamic rulings, told reporters the religion did not allow the killing of AIDS-patients, even in hopeless cases.

Abdullah al-Mashad, head of a committee at Cairo's al-Azhar University charged with issuing opinions on religious issues, said Monday that AIDS patients should be denied food, water and medical treatment.

"We must purge society of the AIDS patient and those like him because his existence causes public harm," said Mashad, who ranks below the Grand Mufti in Egypt's Islamic hierarchy.





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ANDY, I HAVE
SOMETHING TO
TELL YOU. WHEN
THINGS LOOKED
BAD IN THE
HOSPITAL,
DAD KINDA
PICKED UP
THAT SOME-
THING WAS
WRONG...



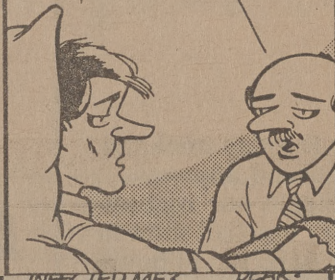
7-5

WELL, I DIDN'T KNOW
WHAT TO SAY TO HIM.
I MEAN, YOU KNOW
YOUR GRANDFATHER—
HE DOESN'T KNOW WHAT
A LIFESTYLE IS, LET
ALONE AN ALTERNA-
TIVE ONE.



SO?

SO I TOLD
HIM YOU DIED
IN A BOATING
ACCIDENT.



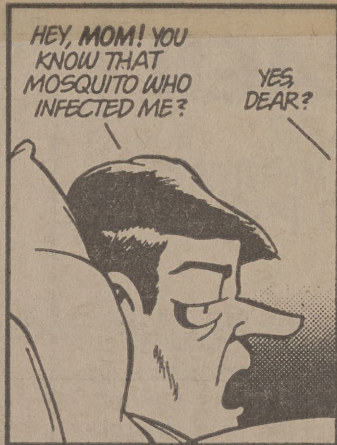
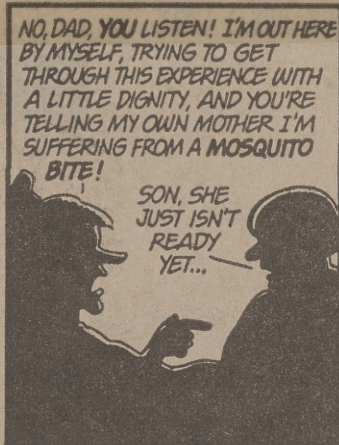
YOU
WHAT?

IS THAT
OKAY? HE
DOESN'T
SUSPECT
A THING.



G.B. Trudeau

RADIOLOGIST ON DATING A



UNIVERSAL PRESS SYNDICATE © 1987 G. B. Trudeau

YOU HEAR THAT, LLOYD? I
TOLD YOU THAT YOU CAN'T
GET AIDS FROM AN
INSECT BITE!



7-7

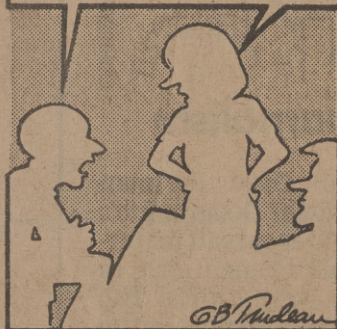
I WAS
JUST
TRYING
TO...



SO WHERE'S
THIS DOCTOR HE
FRIEND OF YOURS MOVED
NOW? BACK TO
BOSTON.
I HAVEN'T
SEEN HIM
SINCE
1982.

1982?

HIV CAN LIE
DORMANT FOR
YEARS, LLOYD.
DON'T YOU READ?



G.B. Trudeau

I CAN'T
TAKE
ANY MORE
OF THIS...

A DOCTOR!
WAIT'LL I
TELL MY
BRIDGE
CLUB!

IT WAS
A LONG
TIME
AGO,
MOM...





Ideas & Trends

Judging the Perils Of Official Hostility To Scientific Error

By STEPHEN JAY GOULD

WE all learned that Galileo discovered some of the moons of Jupiter and the phases of Venus. Few people realize, however, that he made a gigantic goof about Saturn. His telescope, scarcely better than a modern toy, did not resolve the rings well — and rings, in any case, were then so far beyond the conceptual bounds of permissible features for a planet that even a clear view might not have produced a good mental resolution. In any case, Galileo thought that he saw a central sphere tightly surrounded by two smaller spheres too big and too close to be ordinary moons.

Following the custom of his day, and in order to establish priority without revealing his results, Galileo sent a complex Latin anagram to Johannes Kepler, announcing his discovery in code.

Kepler never resolved the message (and actually misscrambled the anagram as a statement about Mars). Galileo later revealed his true intent: *Altissimum planetam tergeminum observavi* — I have observed that the most distant planet is threefold (the planets beyond Saturn, invisible to the naked eye, had not yet been discovered).

Under Arrest

We also all learned that Galileo was later convicted of heresy for defending and teaching the Copernican system, and that he spent the rest of his life under house arrest. We continue to deplore Galileo's fate and rank him first in the noble army of scientific martyrs. And yet, in the light of recent developments in Washington, I'm not so sure that Galileo might not be in more trouble today. Several Congressional committees have been investigating scientific misconduct and some seem ready to view error as a cause for investigation into the misuse of Federal funds. On this model, the Medicis of Florence might consider prosecuting Galileo for his misreading of Saturn.

"Scientific misconduct" is the subject under scrutiny by Representative John D. Dingell, Democrat of Michigan, and his Oversight and Investigations Subcommittee. The cause célèbre, a paper written by David Baltimore and colleagues, has been placed under the forensic equivalent of an electron microscope. The paper contains some errors, and some evidence of poor record keeping. The more public charge of fraud cannot be sustained.

Fraud and error are as different as arsenic and apple pie. The first is a pathology and a poison, the second an unavoidable consequence of any complex human activity.

(Of course, not all error is blameless as an epiphenomenon of creativity. Some errors may arise from serious carelessness; others from precipitous grandstanding prompted by the allure of fame or fortune. But most errors, a great majority by far, are honorable. They belong in the category of honest effort, not in the domain of duplicity.)

Taxonomy, or the study of classification, is

Since the days of Senator William Proxmire's Golden Fleece awards, often given to laboratory projects he considered a waste of taxpayers' money, scientists and politicians have found themselves on opposite sides of a fundamental issue: how much control should government have over the research it pays for? The debate has become particularly bitter since last spring, when a Congressional committee investigating "scientific misconduct" enlisted Secret Service agents to examine the notebooks of Thereza Imanishi-Kari, a scientist who collaborated with David Baltimore, a Nobel laureate in medicine, on a paper describing immunology experiments at the Massachusetts Institute of Technology. In this essay Stephen Jay Gould, a Harvard geology professor, gives his view of the issue.

generally accorded low status among the sciences — as an exercise in mere ordering, fit only for bookkeepers, and roughly equivalent to pasting stamps in prearranged spaces in nature's album. This attitude is both arrogant and false. Nature is full of facts, but any "album" for their arrangement must record human decisions about order and cause. Thus, taxonomies represent the height of human creativity, and embody our most fundamental ideas about the causes of natural order.

Taxonomies also channel our thinking into fruitful paths when a classification properly captures causes of order, but often into ludicrous or vicious error (older racial taxonomies, for example) when we mistake thoughtless prejudice for objective truth.

False taxonomies are most dangerous when we mistake them for an obvious "right way" and don't even question their underlying theory of order. The implied taxonomy of "scientific misconduct" falls into this category of worst cases.

Legislators and journalists seem to acknowledge that true fraud, as the worst expression of misconduct, must be rare and therefore difficult to study. They therefore envisage a continuum shading away from fraud toward less severe forms in the same category of misconduct — finagling, cover-up, sloppiness and error, for example. Since types of misconduct become more common as their severity decreases, error may be the most practical subject for study. Two aspects of this conceptual scheme are desperately wrong.

First, while we all accept that any beneficiary of Federal funds must be subject to the

scrutiny of benefactors, what could possibly be more chilling to creativity than an office of censorship (it would have another name, but the effect is what counts) trying to impose the impossible and the inhuman — freedom from error in thought and deed? We might as well rule that any orchestra receiving a penny in state funds must employ an umpire to tap the conductor on the shoulder every time the principal French horn plays a sour note.

Second, the implied taxonomy of "scientific misconduct" is wrong in the worst way. The supposed continuum, shading away from fraud to less serious but more common forms of the same phenomenon, is backwards. Fraud and error belong on opposite sides of any proper dichotomy.

A Matter of Trust

Fraud is a pathology. I doubt that non-scientists realize how concerned all scientists are to purge any detected incident. The reason for our loathing is not widely understood, and its basis is not abstractly moral. Science must be based on trust. We cannot easily identify most cases of fraud; only the careless, the unbalanced and the foolishly daring leave palpable tracks. We cannot hover over all our colleagues at their workbenches, any more than the Internal Revenue Service can monitor every trip to the bank or call to a stockbroker.

We must believe that the publications of our colleagues are presented in good faith, for only then can we analyze their work to discover errors. Fraud is the worst of all offenses — a violation of community standards that must be respected and internalized, lest the community die.

Fallibility and Creativity

Error, on the other hand, falls into the category of unavoidable side consequences to commendable activity — like a pitcher's sore arm after a shut-out. Lord knows we try our damndest to cut down and eliminate these consequences, for they are embarrassing and personally harmful (just as pitchers have been trying various nostrums from prayers to whirlpool baths to changes of delivery, from time immemorial in the field of dreams).

But we cannot completely eliminate the consequences without compromising the main activity. (I could pitch batting practice all day, but I'd never make the bigs.) In any proper taxonomy of scientific activity, error belongs in the category of proper procedure — for three major reasons:

1. People work this way. We are fallible creatures. Ambiguity defines the richness of our intellectual lives. Computers frustrate us because they display the inhuman property of shutting down when faced with any error or ambiguity; we have had to establish an en-

tire profession — debugging — to mediate between our two opposing styles.

2. Work of intellectual daring carries the danger of increased error, in both frequency and consequence. If they wished to avoid all possibility of error, Galileo would have trained his telescope on the next building, and Darwin would have stuck with pigeons. Intrusive regulation by nonscientists is most frightening for this reason; innovation and chanciness will die. Error is the flipside of great discovery. Together they form one coin, and their common currency is brilliance.

3. Error is a spur to correction. Errors promote good science, if only because one-upmanship seems as intrinsically human as error itself. "False views, if supported by some evidence, do little harm, for every one takes a salutary pleasure in proving their falseness," Darwin wrote, in one of his most famous lines.

Great intellectuals have always understood this principle, and have been accepting of honorable error and fiercely intolerant of fraud.

The economist Vilfredo Pareto wrote of Kepler, who contributed a thing or two to human knowledge, though he never unscrambled Galileo's anagram: "Give me a fruitful error any time, full of seeds, bursting with its own corrections. You can keep your sterile truth for yourself."

July 20, 1989

Mr. William W. Waybourn
President
AIDS Resource Center
3920 Cedar Springs
P. O. Box 190712
Dallas, Texas 75219

Dear William:

Thank you so much for your warm letter inviting me to Dallas to speak.

While my schedule is very hectic, I would be happy to visit Dallas to do whatever I can to help you in your battle to light a candle deep in the heart of Texas.

In truth, I despair that we will be able to do anything in Texas since even bright and sophisticated Texans seem to feel that anti-intellectualism makes them more acceptable to their peers.

If you could arrange a speaking engagement with a medical society or, since I am a dermatologist, a dermatological society in Dallas, you may find that Burroughs Wellcome Company would be willing to pay me a handsome honorarium to talk about treatment of patients with AZT. I could then couple that scientific presentation with a presentation to the AIDS Resource Center.

I have served the past year as co-chair of the California AIDS Leadership Committee with the Director of Health Services, Dr. Ken Kizer. In that position, he and I have written an AIDS response plan for the state of California. Interested legislators in Texas might want to take that plan and modify it to serve the needs of your state. If you could arrange a meeting with legislators and legislative aids, I would be happy to explain the plan to them and suggest how they can begin implementing it in Texas.

Finally, we need a quantum leap in thinking if we are to reach the mainstream of Texas political thought. Perhaps an interactive forum of two to three hundred mothers who are

William W. Waybourn
July 20, 1989
Page Two

concerned about their kids acquiring AIDS in the next generation would prove an opportunity to discuss the spectre of a sexually-transmitted, fatal disease.

I look forward to working with you and hearing from you.

Sincerely yours,

Marcus A. Conant, M.D.

MAC/mlh

● Quick Release of AIDS Drugs

In response to lobbying by patients, U.S. health officials agree to distribute experimental AIDS drugs before testing for effectiveness is complete; "parallel track" to be ready by the fall

THE HIGH COMMAND in the war against AIDS filed into Representative Henry Waxman's (D-CA) health subcommittee hearing room on 20 July to make a public concession.

You can't run a war without troops, they acknowledged, and their own troops—the AIDS victims who serve as volunteers in drug testing clinics—are in revolt over the tight federal rules that limit who gets new AIDS drugs and when. The patients want faster access to drugs as they come off the laboratory bench, before they go through time-consuming "Phase II clinical trials" that test their effectiveness.

The nation's top health officials say they are ready to yield on this point and that they will relax the rules in a significant way this fall. The plan is to make drugs more widely available before Phase II tests, a major shift in policy that could have long-term consequences in the research and pharmaceutical communities. If exceptions are made for AIDS, the same arguments would hold for cancer and other currently incurable diseases afflicting millions of people.

Some researchers and clinicians have been calling for just such a policy shift for years. Others are skeptical, fearing that this will make clinical data harder to interpret and slow down the ultimate licensing decisions.

Several scientists who run AIDS studies worry that if experimental drugs are distributed early to people outside the clinic, this could make it impossible to control the patients' medication. This, they argue, will make it difficult, if not impossible, to determine whether a new drug is in fact responsible for clinical improvements.

The AIDS activists' response: too bad. Jim Eigo, a leader of the New York gay advocacy group ACT UP, told Waxman that AIDS victims are not in awe of the "strange and abstract god, clean data." Eigo claimed that, contrary to what researchers fear, patients will be more likely to comply with clinical test requirements if they perceive the rules as fair—which is not the case today. Martin Delaney, founder of Project Inform,



Changing the rules. AIDS activists Jim Eigo (right) and Martin Delaney argue that drugs in clinical trials should be widely available.

an advocacy group in San Francisco, says, "I argue that it is the FDA restrictions that are polluting the clinical trials," because patients desperate to get access to drugs lie about their medical history. With more lenient rules that would not happen.

The specific concession the activists want, and will get this fall, according to U.S. health officials, is a new structure for distributing experimental drugs called the "parallel track." It means essentially that an AIDS patient will be able to receive the latest drugs that appear safe, whether or not they have been licensed for sale, without having to be part of a clinical trial. Normally, a drug that is not approved for sale by the Food and Drug Administration (FDA) cannot be obtained except by people in an FDA-sanctioned test. In the past, FDA has allowed case-by-case "compassionate" or "emergency" exceptions. It also permitted a broader exemption (called "group C" drugs) for some cancer patients. But what is being proposed now is a much bigger reform.

The new procedure "could change ground rules on research, clinical care markets, and insurance," Waxman said. "If it works, it could revolutionize drug development," but if it fails, it could "cripple AIDS research."

The parallel track will open a kind of

second supply window, providing experimental drugs routinely to "persons for whom there are no satisfactory alternative drugs or therapies available . . . and who for some reason are not eligible for or not able to participate in a clinical trial." So declared James O. Mason, the assistant secretary for health of the Department of Health and Human Services, the top health official at Waxman's hearing. Mason was flanked by Anthony Fauci, chief of the National Institute for Allergies and Infectious Diseases, Samuel Broder, director of the National Cancer

Institute, and Frank Young, commissioner of FDA, all of whom spoke in favor of the reform.

However, before the new plan can go forward, Mason said, critical details must be worked out. He has asked Young to assemble an advisory committee quickly and submit a report no later than 21 August. Among other duties, the committee will define procedures for identifying toxic effects among patients not in clinical trials, review liability issues and develop standards for informed consent. Young hasn't decided who will sit on the new committee as yet, but he may use an existing FDA advisory group that reviews antiviral medicines.

The FDA has been broadly criticized by the activists for its slowness in making new drugs available. (See comments of Vincent DeVita, former Na-

tional Cancer Institute director, p. 346.) But Young argued that it was FDA that began the reform in June 1987 when it proposed a "fast track" for drugs that may alleviate serious illnesses. Young claims FDA was denounced in Congress at the time for moving too fast, then, 1 year later, for moving too slowly.

At the hearing, Delaney of Project Inform blamed the FDA's staff, not its chief, for delay. An innovation of last year designed to



Anthony Fauci: "We can be humanitarian and do good science."

Drug Availability Is an Issue for Cancer Patients, Too

If AIDS activists have done nothing else, they have sensitized the public and the medical research establishment alike to the need to give people with life-threatening diseases faster access to experimental drugs. But AIDS is not unique in this regard. "Many of the issues that have been rediscovered have been important concerns to the cancer institute since the early 1970s," says National Cancer Institute director Samuel Broder.

That does not mean that those issues have been resolved, however. The recent flare-up of a controversy among top cancer researchers over a new drug therapy for colon cancer provides a case in point.

Two clinical trials have indicated that treatment with a combination of the drugs levamisole and 5-fluorouracil can delay or prevent colon cancer recurrences in certain patients who have had their original tumors removed surgically. Having such a therapy would be a major advance, a victory in the "war on cancer," if anyone still thinks in those terms. Colon cancer is the second leading cause of cancer deaths in the developed countries. It will claim an estimated 44,000 lives this year in the United States. And efforts to develop chemotherapeutic regimens to prevent the metastases that take the vast majority of those lives have been unavailing—until now.

So why not help colon cancer patients beat the odds by giving them early access to the levamisole-5-fluorouracil therapy? The main argument, as with AIDS drugs (also see p. 345), centers around the question of when an experimental therapy should be made available to patients with a life-threatening illness. Or in other words, how firmly do safety and efficacy need to be established under those conditions? Charles Moertel of

the Mayo Clinic in Rochester, Minnesota, who is the principal investigator on both colon cancer trials, puts the dilemma more starkly.

"Should we continue with sound scientific method or yield to the activists?" Moertel asks. "Scientists are being displayed as sitting in an ivory tower without any compassion. I strongly object to the idea that good science is not compassionate for the patient." He maintains that the levamisole-5-fluorouracil results are not yet firm enough to recommend widespread clinical application of the therapy.

Others disagree—vehemently—with this position. Among these is Vincent DeVita, who was NCI director from 1980 until he left at the end of last year to become Physician-in-Chief of Memorial Sloan-Kettering Cancer Center in New York City. DeVita, who is familiar with the levamisole-5-fluorouracil studies from his NCI days, says, "You could save 12,000 lives per year with this therapy. Why wait?"

At the crux of the dispute is the question of what constitutes a positive result in a cancer drug trial. Moertel holds out for the ultimate "hard" end point—increased survival. The first of the two studies he led, which included a total of 400 patients, indicated that either levamisole alone or the levamisole-5-fluorouracil combination can delay the recurrence of colon cancer and increase survival, especially in patients with "Dukes' C" disease. Such patients, whose tumors have already spread to nearby lymph nodes but not to distant sites in the body, have a poor prognosis. About 75% relapse within 5 years and die.

Although the results of the first colon cancer study were encouraging, Moertel points out that the 15-year history of levamisole cancer trials has been notoriously checkered. "One investigator would do a study and find miraculous things. Another would do a more careful study and find nothing," the Mayo researcher explains.

In any event, a second, more extensive test of levamisole, both alone and with 5-fluorouracil, as a therapy for colon cancer was begun

just about 5 years ago, with the last of 1300 participants entering the study in 1986. The patients have not yet been followed long enough, Moertel says, to determine whether the drugs have had any impact on their 5-year survival. Moreover, he notes, the levamisole-5-fluorouracil therapy is too toxic—one patient has died of the side effects—to administer without proof of efficacy.

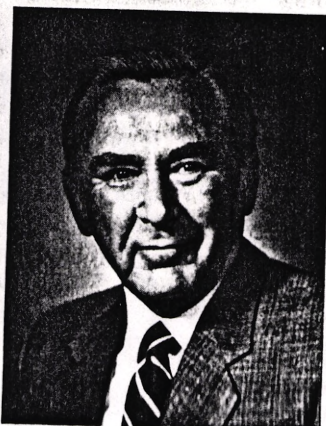
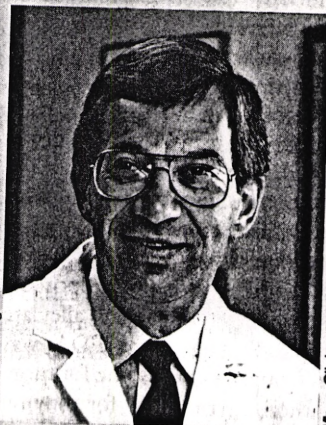
In any large clinical study, however, the data are continuously monitored to see if a treatment is turning out to be either better or worse than expected. And in this case, the monitoring shows that the levamisole-5-fluorouracil combination is having a marked effect in delaying colon cancer recurrences in Dukes' C patients. The effect is so significant, DeVita says, it will certainly be reflected in an increased survival rate when those data are in. By his view, Moertel is being much too conservative.

The Mayo researcher was sufficiently optimistic, however, about the eventual outcome of the levamisole-5-fluorouracil study to suggest to officials of the U.S. Food and Drug Administration and NCI that the therapy be given "group C" status, a step which the FDA took in May of this year. The group C classification, which applies only to cancer drugs, means that physicians can now prescribe the experimental therapy for patients with Dukes' C colon cancer even though it has not yet been approved by the FDA. The levamisole will be available through NCI.

Moertel went to the FDA, he says, because levamisole has not been approved for human use in this country and he wanted to set in motion the regulatory machinery needed to make the drug available should its efficacy be demonstrated. An estimated 25,000 patients would be eligible for the treatment every year in the United States.

DeVita, who 10 years ago was instrumental in moving the FDA to set up the group C designation, would have gone further in this case. He thinks that the NCI should also have issued a "clinical alert" to make physicians aware of the levamisole-5-fluorouracil data and recommend that they consider administering the therapy to their Dukes' C colon cancer patients. "I feel badly that I didn't push the clinical alert before I left NCI," DeVita says.

But Moertel "absolutely" opposes issuing such an alert at this time, and Broder says, "We would not make the data available in a clinical alert without the approval of the clinical investigator." Neither of the colon



Cancer drug controversy. Sloan-Kettering's Vincent DeVita (left) thinks a new colon cancer therapy should be made available to patients now. The Mayo Clinic's Charles Moertel disagrees.

cancer trials has been published, although a report of the first has been accepted by the *Journal of Clinical Oncology*.

The cancer institute has taken another step with regard to the levamisole-5-fluorouracil data, and it touches on an issue, namely the use of placebo controls, that is no less sensitive in cancer research than it is in AIDS research. NCI is now requiring that its grantees tell any colon cancer patient who is considering participating in one of their clinical trials about the promising levamisole results.

The idea is to give them the opportunity to opt for the levamisole-5-fluorouracil treatment, instead of entering a new study, especially if that study is comparing an experimental therapy with an inert placebo. "If it were me I would demand to know all the information, and I would be madder than a hornet if the information hadn't been explained," Broder asserts.

DeVita thinks that placebo controls are no longer justified in colon cancer studies and that any new therapy should be compared to the levamisole-5-fluorouracil combination. He suggests that Moertel is reluctant to announce the results of the levamisole-5-fluorouracil studies because this might interfere with the recruiting of patients for a placebo-controlled trial that he is conducting on another drug combination, Leucovorin and 5-fluorouracil.

Moertel takes strong umbrage at that suggestion. "We're trying to defend that study because we feel it is in the best interest of cancer patients," he maintains. The Leucovorin combination has already proved effective in prolonging the survival of patients with advanced, recurrent colon cancer, and Moertel thinks it may hold even greater promise than the levamisole combination as an adjuvant to colon cancer surgery. In any event, Broder says, the informed consent form for the Leucovorin trial is in compliance with the requirement to inform prospective participants about the levamisole results.

The dispute over the levamisole therapy has a positive side. It carries a strong implication that cancer researchers are at last beginning to make headway against a major killer, even if they do not agree over the current status of the research. Equally apparent, however, is the conclusion that the long-standing issue of when to make experimental drugs available to people with life-threatening illnesses is not likely to be resolved anytime soon. ■ **JEAN L. MARK**

allow greater access to investigational new drugs or INDs—called "Treatment IND"—was judged a failure by Delaney because the staff made little use of it. Delaney charges that the FDA has not delivered on promises made by Commissioner Young.

It was Fauci who gave the latest bureaucratic innovation—the parallel track—its notoriety. He endorsed it publicly on 23 June at a San Francisco meeting on AIDS treatment. (Fauci coordinates a national effort to test new AIDS drugs and talks often with AIDS activists.)

Events added urgency to the proposal. As Fauci, Young, and the AIDS activists were discussing the parallel track this spring, the Bristol-Myers Company revealed that its new compound DDI is less toxic than existing AIDS drugs and is proving reasonably effective for patients in clinical trials (see story this issue, p. 353). AIDS patients will want to use it as soon as possible, which could be in September, if the parallel track is working by then.

Fauci said during the hearing that he recognizes that some AIDS patients could be "disenfranchised" from the benefits of DDI under the traditional research rules. Distribution of the drug would be limited to people in clinical trials, and the trials would randomly give participants either DDI or AZT, an older AIDS drug. The catch is that AZT is quite toxic and has a limited period of usefulness (about 2 years). Patients who have gone beyond that limit, or who cannot take it for other reasons, would be excluded from the trials. Yet, as Eigo and Delaney point out, "AZT-intolerant" people most desperately need the new drug.

Fauci told the committee, as he told his own clinical research chiefs, that "we can be humanitarian and do good science" as well. Mason echoed the sentiment: "We have a responsibility to be compassionate," and the parallel track "might even enhance our ability to get people to participate" in clinical trials.

On the other hand, some researchers worry that the parallel track will be unmanageable. Several who spoke with *Science*—Martin Hirsch of Harvard, Douglas Richman of the University of California at San Diego, and Lawrence Corey of the University of Washington, Seattle—have such concerns. One question is whether the benefits of this new approach will outweigh the risks, even in the short term. Toxic effects not apparent in small Phase I reviews could surface when the drug is distributed on a wider scale, doing unexpected harm. Second, as each new drug appears, there may be a faddish tendency for patients to begin taking it in place of or in addition to those in a clinical trial. Some clinicians say this will make it

hard to control the research data.

Finally, because the parallel track will be open to patients who live far from a test clinic, some researchers worry that this geographical exemption will divert patients from major medical centers, adding to the growing problem of recruiting patients for trials.

Similar criticism, though with a different slant, came from Ralph Nader's Health Research Group. Speaking across town on 20 July as a witness before a meeting of the presidential advisory panel on AIDS and cancer drugs, director Sidney Wolfe said the parallel track could create "an extraordinary conflict between researchers and patients." Wolfe and a senior attorney of the group, William Schultz, worry that a fast track plan

The parallel track could create "an extraordinary conflict between researchers and patients."

will jeopardize the conduct of more rigorous clinical trials. "Nothing will happen [in validating therapies] if science isn't applied" to the proper testing of an experimental drug, Wolfe said. "The parallel track is fraught with that possibility."

In addition, Wolfe argues that manufacturers should be required to show that a drug has some efficacy before it is allowed into the parallel track. However, defining a minimal threshold of effectiveness will be difficult. A year ago, many AIDS patients were scrambling to buy dextran sulfate, which had shown biological activity in test tube experiments. The drug was only available in Japan, so AIDS patients formed buying clubs and used a Canadian clearinghouse to purchase it overseas. Scientists soon discovered, however, that dextran sulfate wasn't even absorbed by the body. One way to discourage quack therapies in the future, Wolfe said, would be to prohibit a manufacturer from making a profit on a drug while it is distributed under the fast track system. No guidelines have yet been developed on matters of profit or liability.

Many things remain undefined, and this is what makes the clinic directors so nervous. Richman puts it this way: "People say, here's the concept; we'll fill in the blanks later. But what you put in the blanks will determine whether it succeeds or not."

■ **ELIOT MARSHALL**

With reporting by Marjorie Sun.

PLEASE REPLY TO:

☐ SACRAMENTO ADDRESS:
STATE CAPITOL, ROOM 3063
95814
(916) 445-3353

☐ DISTRICT OFFICE ADDRESS:
1074 EAST AVENUE
SUITE N
CHICO, CA 95926
(916) 343-3546

☐ 650 IMPERIAL WAY
SUITE 103
NAPA, CA 94559
(707) 253-7212

☐ 50 SANTA ROSA AVENUE
SUITE 305
SANTA ROSA, CA 95404
(707) 571-1909

☐ 2400 WASHINGTON AVE.
SUITE 120
REDDING, CA 96001
(916) 225-2201

California State Senate



JIM NIELSEN

Senator

Fourth District

Butte, Colusa, Glenn, Lake, Napa, Shasta and
Tehama Counties and a portion of Sonoma County

July 21, 1989

COMMITTEES:

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SIERRA CASCADE
KLAMATH WATERSHED
SENATE RURAL CAUCUS
VICE CHAIRMAN
STATE ALLOCATION BOARD

Honorable John Vasconcellos
State Capitol, Room 6026
Sacramento, California 95814

Dear John:

As we deliberate on the problems of unwed teen pregnancy, abortion, AIDS, and other sexually transmitted diseases, we have, at times, underestimated one solution: sexual abstinence. I would like to invite you to a presentation by a unique, all-teen organization dedicated to the restoration of the ethic of sexual abstinence prior to marriage.

The presentation has been scheduled for Tuesday, August 29, from 12:45 to 1:45 p.m. in Room 113 of the Capitol. I am hoping this time period will fall during the lunch break of whatever committees are meeting that day.

The group is called Clean Teens U.S.A. Clean Teens was organized in Modesto and now has over a dozen chapters nationwide. They have received over a thousand requests for membership from every state in the union and a half dozen foreign countries. Leaders of Clean Teens have spoken to more than 35,000 of their peers, parents, and other concerned citizens and the response has been overwhelming. Locally, and across the nation, in health classes, youth groups, civic clubs, and legislative forums, the response has been the same: Pre-teens and teens are tired of the pressure to be sexually active and leaders such as ourselves are tired of programs that encourage social and casual sex.

The goals of Clean Teens are simple: (1) To inform young people, their parents, and the general public of the necessity of sexual abstinence prior to marriage; (2) To provide peer support and professional referral services; (3) To train young people for present and future leadership roles and as role models; and (4) To develop educational materials and tools to better equip themselves and their peers to carry out the above.

net on computer 8/29/89

*cc. mail
C. Nielsen
not done*

July 21, 1989
Page Two

On August 29, leaders of Clean Teens will be here to present themselves, their documentary video, and a synopsis of their teen-led four-hour public school curriculum. You will find these projects to be especially effective because they feature TEENS TELLING TEENS.

I strongly encourage you to set aside time on your busy calendars for this important presentation. You'll find it to be an interesting and uplifting experience. Please contact Lois Draper in my office if you plan to attend.

Sincerely,

A handwritten signature in cursive script, appearing to read "Jim", with a long, sweeping underline that extends to the left and then curves back under the name.

JIM NIELSEN



TEENS TELLING TEENS

CLEAN TEENS U.S.A. is currently charting its course for the future and establishing goals for today and tomorrow. It's a long, tough road ahead, but we are prepared to do all that is necessary to replace the myth of safe sex with the truth of abstinence. We have a deep desire to help the hurting souls in our world today and bring a fresh perspective on teen sexuality to America that preserves personal security and protects public health and safety.

We thank Morality in Media of New York and all the members of C.L.E.A.N. (Citizens Leading Effective Action Now), our parent organization, for their generous support, and also all the members of CLEAN TEENS U.S.A. for the bold stand they have taken. Youth are the leaders of today and the youth of CLEAN TEENS U.S.A. are making a difference in their community and the nation. People everywhere are excited about CLEAN TEENS U.S.A.'s statement advocating sexual abstinence before a monogamous marriage.

In an age that is threatened by the AIDS epidemic, sex has become not just a private issue, but also a public one. Even those in non-high risk groups are affected by the deadly virus. Along with astronomical rates of teen pregnancy, and abortion, sexually-transmitted diseases, AIDS has forced us to look seriously at sexuality and its impact on our everyday lives. Safe sex (promoting condom use to protect oneself from AIDS) is medically unsafe; abstinence is the only 100% proof-positive way to avoid AIDS.

Time is running out; now is the time for us to make a difference. The shattered lives and heartaches can be avoided as teens begin to understand the truth about sexuality.

Teens started free love during the sexual revolution of the sixties, why not teens starting sexual restraint and healthy relationships in the nineties? HOW BEST TO COMMUNICATE THIS MESSAGE THAN,

TEENS TELLING TEENS

CLEAN TEENS U.S.A. Explodes Nationwide!

A newsarticle by syndicated columnist Michael McManus brought hundreds of letters from around the U.S. regarding CLEAN TEENS U.S.A. In addition, a rally with over 1,000 in attendance launched the organization which now has over 500 Modesto teenagers in its membership. President Kirk McCall has addressed two national conventions, one for Morality in Media in Florida and another for the National Coalition Against Pornography in Ohio. As our first newsletter goes to print, public schools are preparing to receive our speakers, and several states have begun the process of national chapter organization. WHY? Many people throughout the nation believe that teenagers can change the moral trend in society from sexual promiscuity to sexual abstinence before a monogamous marriage. The positive arguments need to be explained and promoted by teenagers on campuses, in schools, and even in churches. CLEAN TEENS U.S.A. has accepted that challenge. This is a battle for the lives and future of thousands of young people in the communities around the nation. Please consider joining with us.

"TEEN TALKS"

Are you interested in talking with other people about tough questions concerning sexuality? If so, come to weekly Teen Talk. These are informal rap sessions designed to give teens an opportunity to share with one another and find answers to tough questions. These sessions are open to anyone who wishes to learn and offer encouragement.

What CLEAN TEENS U.S.A. Believes

OUR STATEMENT:

CLEAN TEENS U.S.A., which represents many American teenagers, believes that the survival of the traditional family and ultimately of America as a nation, depends on the restoration of the ethic of sexual abstinence prior to marriage. CLEAN TEENS U.S.A., believes that sexual promiscuity and pornography have created more social problems in America than in any other nation in world history. These tragedies facing teenagers today include divorce, teenage pregnancies (unwed), abortion, the AIDS epidemic, other sexually transmitted diseases, prostitution, rape, incest, molestation and runaway/throwaway children.

OUR GOALS:

- To inform young people, their parents, and the general public of the necessity for sexual abstinence prior to marriage.
- To provide education for the development of healthy relationships.
- To provide peer support.
- To provide professional referral services.
- To provide credible, responsible role models.
- To train and support young people for present and future leadership positions.

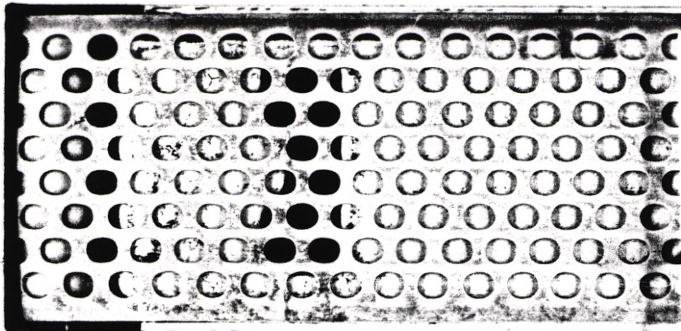
OUR STRATEGY:

To unite and organize teenagers toward our goals through public forums, media campaigns, civic and church activities, discussion groups, speakers, counselling, and newsletters.

To develop a large membership that will influence present and future generations and promote traditional values which offer the solutions to the problems facing America.

YOUTH STATISTICS

- Every 31 seconds an adolescent becomes pregnant (*National Center for Health Statistics*).
- By age 20, 80% of today's unmarried males and 67% of today's unmarried females have had sexual intercourse (*Guttman Institute*).
- It has been reported in an adult control group that the 5 year failure rate of the pill in preventing pregnancy is as high as 44%.
- University of Miami researchers report that over a 24 month period the failure rate of condoms in preventing AIDS may run as high as 31% in a control group of husbands and wives.
- In yet another study the 5 year failure rate is said to run as high as 68% in preventing AIDS.
- There will be over 1,100,000 teen pregnancies this year in the U.S. (*Parents and Teenagers*).
- The cost of supporting a 15-year old mother and her baby for just one year is over \$18,000 (*National Research Council*) - it is estimated that teen pregnancy will cost our nation over \$100 billion in the next 20 years (*The Private Life of the American Teenager*).
- 400,000 teen pregnancies end in abortion. (*Orlando Sentinel*).
- At least 33,000 people will contract a sexually transmitted disease (STD) today in America (*U.S. News and World Report*).
- A Baltimore Health Clinic reported that 51% of its teen patients were hospitalized due to sexual activity - abortions, births, STDs (*Orlando Sentinel*).



- Over 20 million Americans have incurable herpes - approximately one out of every ten people in our country.
- 100 million people will be infected with the AIDS virus by 1992 (*World Health Organization*).
- More than half of today's marriages will end in divorce.
- Teens whose parents are divorced or separated are much more likely to have had intercourse than those whose parents are married or widowed. On the extremes, the gap is almost a two to one margin (*Sex and the American Teenager*).
- Some experts estimate that as much as 70% of all pornography ends up in the possession of children and teenagers.
- Over 25% of coeds have been raped or sexually attacked since age 14 (*Journal of Consulting and Clinical Psychology*).
- In the past 20 years the teen suicide rate has gone from ten out of 1,000 to eighty out of 1,000 (*Dallas Morning News*).
- Between a million and 1.3 million teens runaway yearly - about one youngster in three is a throwaway (*Parade Magazine*).
- There may be as many as 600,000 child prostitutes in our nation (*National Committee for the Prevention of Child Abuse*).
- Each year, at least one American child out of ten is sexually abused (*Newsweek*).

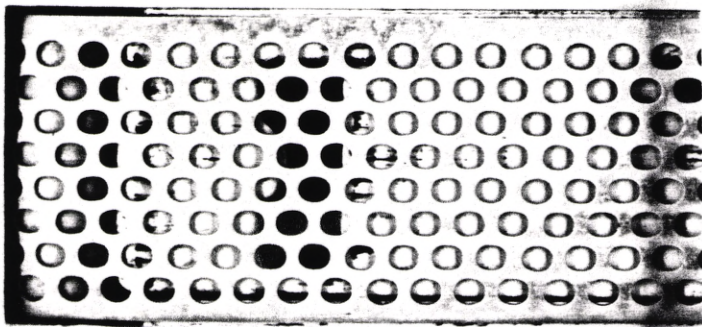
GETTING INVOLVED

If you are interested in becoming a member of CLEAN TEENS U.S.A., please send us \$1.00 and you will receive our newsletter for one year. If you wish to start a chapter in your area, write to us and accompany your request with \$10.00. We will mail to you a printed packet of material including details of "what" and "how" to form a chapter. You will be placed on our mailing list and provided with newsletters, flash bulletins, and information valuable to your effort.

NOW IS THE TIME TO UNITE WITH US
AND MAKE THE DIFFERENCE!

CLEAN TEENS U.S.A. is a non-profit, non-sectarian, national organization, P.O. Box 918, Modesto, California 95353 or contact John Evans (209) 394-4000, ext. 139, 4918 Taylor Court, Turlock, CA 95380.

Affiliated with Morality in Media of New York, New York and C.L.E.A.N. of Modesto, California.





Treatment Awareness Week June 21 — 25, 1989

Sponsors

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Suite 500
44 Montgomery Street
San Francisco
California, 94104
415/955-2666

July 3, 1989

Marcus Conant, M. D.
350 Parnassus, Suite 808
San Francisco, CA 94117

Dear Dr. Conant,

Thank you so much for your assistance in making HIV Treatment Awareness Week a success! The comments regarding the symposiums have been overwhelmingly positive.

There is no doubt that your investment of time and energy will have an impact on the lives of those who attended the meetings, and those they come in contact with. We are at an important point in this disease, and our message, that there is something that can be done, is vital. There are many who will owe there lives and health to you for getting this message to them!

We will be closing down the phone lines for HIV Treatment Awareness Week in the next few weeks. There have been numerous request to have this event held again, which we will probably do. In the event that you need to get in touch, I am enclosing my card with my office phone number.

Again, thank you for caring and for your commitment to treatment awareness!

Cordially,

Michael S. Cullen, CFP

MSC/br

REPLY TO:
ROOM 5087
STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814
(916) 445-5788
720 SUNRISE AVENUE
SUITE 110-D
ROSEVILLE, CALIFORNIA
95661
(916) 783-8232



Senate

California Legislature

JOHN T. DOOLITTLE
First District
Chairman, Senate Republican Caucus

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SIERRA/CASCADE/
KLAMATH WATERSHED
CHAIRMAN
SELECT COMMITTEE ON
SMALL BUSINESS
ENTERPRISES

July 5, 1989

TO: Members of the Legislature

FM: Senator John Doolittle

RE: Co-author request

Next week I will be introducing legislation which urges the Governor and the Legislature to reject the California AIDS Leadership Committee's Plan to combat the AIDS virus entitled "California's Continuing Response to HIV Disease: A Strategic Plan."

The AIDS Leadership Committee's Plan represents an ill-conceived and irresponsible approach to combating the AIDS virus in California. The plan also ignores the AMA's recommendations regarding prison transmission and mandatory testing. Additionally, the committee's plan fails to address the cries of our constituents to responsibly deal with the AIDS crisis, to protect them from infection and to control the spread of the disease.

Please join me in co-authoring this important legislation. If you have any questions contact Bishop Bastien in my office at 5-5788.

Yes, I would like to co-author your legislation regarding the California AIDS Leadership Committee's Plan to combat the AIDS virus.

Signature

Print Name

Return to: Senator John Doolittle, Room 5087,
by July 14, 1989.

7/7/89
Stan H -
FYI -
SA

FROM SENATE OFF SAC

7.13.1989 15:08

P. 1

REPLY TO
ROOM 5087
STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814
(916) 445-5788
720 GUNRISE AVENUE,
SUITE 1100
ROSEVILLE, CALIFORNIA
95661
(916) 763-8232



Senate

California Legislature

JOHN T. DOOLITTLE
First District
Chairman, Senate Republican Caucus

COMMITTEES:
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SELECT COMMITTEE ON THE
SIERRA/CASCADE/
KLAMATH WATERSHED
CHAIRMAN
SELECT COMMITTEE ON
SMALL BUSINESS
ENTERPRISES

7/7/89
Stan H -
F.I.
SA

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Signature

Print Name

Return to: Senator John Doolittle, Room 5087,
by July 14, 1989.

I HAVE to GO.

ENJOY MICHIGAN!

I'LL TALK to YOU ABOUT THIS STUFF ON
YOUR RETURN. THERE'S NOTHING
WE CAN DO RIGHT AWAY ACCORDING
TO STAN + KATHRYN.

BYE,

Pam

Why Brave Men Fear AIDS

Marcus A. Conant, M.D.
Clinical Professor of Dermatology
University of California San Francisco

July 1, 1989

Why Brave Men Fear AIDS

--Brave men are not afraid of death.

--Brave men fear loss of respect, loss of friends & family, loss of prestige, and loss of self image if they become infected with HIV

--It is not AIDS that brave men fear catching. It is the stigma of homosexuality they fear.

"The coward dies many times before his death. The valiant never tastes of death but once. Of all the wonders that I yet have seen, it seems to me most strange that men should fear seeing that death, a necessary end, will come when it will come." --Julius Caesar to his wife on the morning of March 15th, 44 B.C., Julius Caesar by William Shakespeare

A few years ago, a young 28-year-old patient was dying in the last stages of the Acquired Immune Deficiency Syndrome (AIDS). Years before, he had left his mother and stepfather in one of those predictable midwestern cities which are ideal for having barbeques and raising children, particularly ideal if you are concerned your children might have original ideals. Our hero, after much soul searching, emigrated to San Francisco to start a new life which would include an affirmation of his homosexuality as an integral part of who and what he was. Little did he or anyone else know that, about the same time he moved west, another immigrant, the

AIDS retrovirus (HIV-1) had also chosen San Francisco as a place most favorable to its lifestyle. The two met in 1981, and their lives became inseparably entwined for the remainder of their existence.

Shortly before his death, this patient's mother called me, as his attending physician, to inquire about his health and to ask what she, as a loving mother, could do to provide support for her son and reduce his pain. I assured the timid voice on the other end of the line that the single most positive thing that she could do for her son would be to travel to San Francisco and visit him, even if only for a short period, in the few weeks before his death. He had often spoken to me of his estrangement from his family, who did not approve of the child that they had produced and raised, and who had expelled him from their home with the same sort of resolve that one returns a gift after Christmas to Macy's with when it ceases to please.

The suggestion of a visit to San Francisco was met with immediate resistance, and in exploring the mother's apprehension, I learned that she knew enough about AIDS to realize that she would not be contracting the disease if she were to visit her dying son. The issue was far more complex. The boy's stepfather had absolutely forbidden any visit by the boy's mother to the bedside of her son for fear that she would pick up the AIDS virus, bring it home, and infect him.

This was not to be the only irrational and self-imposed quarantines that we were to see. In numerous subsequent cases, I have had the opportunity to begin the process of dissecting the anatomy of this irrational and seemingly inhuman cowardice. When I have met men such as my patient's stepfather face to face, I have usually found that they are successful, amicable, and assertive, the kind of guy you'd like to be seated next to on a transcontinental flight, who will listen respectfully while you tell him who and what you are, and who will entertain you with stories of his successes and failures. After a few drinks, you may exchange cards with promises to write or call when next in the other's home town, both knowing that this is more of a formality than a promise. The man usually begins by telling you that both he and his wife have done all that they can to understand their son's sexuality, but that he had such great promise, and he used to date such nice girls, and all of his teachers said that he was such a wonderful boy that they just don't understand how he could have let those people in San Francisco corrupt him into "one of those." These discussions are usually painful and interspersed with half-finished sentences, rhetorical questions, and long and uncomfortable pauses. At this point, I usually direct the interview to a discussion of the man's fear of death. Frequently, he will recount that he served in Korea or Vietnam, that he faced death many times, and, that while he was in no hurry to die,

he had no morbid fear of death itself. This revelation, of course, leads to the ultimate question: if he has no fear of death, why does he fear contracting AIDS? If he has no fear of death, why does he, even when he understands intellectually that AIDS is not transmitted casually, have a morbid fear of contracting AIDS from his dying son or from his wife who may visit and comfort the boy. There is usually a long pause, punctuated by a statement such as, " I could not bear what people would think."

Brave men do not fear death. Brave men do not fear death from AIDS. Brave men fear that, if they contract AIDS, their friends, their families, and their neighbors will assume that they have been struck down by this loathsome disease because they are in some way loathsome themselves. These men do not fear death. These men fear the brand of homosexuality. This reaction is homophobia, pure and simple. Pointing out the depth of fear, loathing, and hate which is projected onto the victims of AIDS, and the terror of most men in our society that if inflicted with this disease, they would be immediately stigmatized with the same stereotype and humiliated by the same social revulsion and discrimination that they themselves have spent their lifetimes perpetrating on victims of their homophobia.

When Shakespeare observed that the coward dies many times before his death, I am sure that he was thinking of the

coward quaking in fear of the pain immediately preceding the ultimate immortality. We have cowards dying on the cross of discrimination -- a discrimination against their own children -- which they themselves have created.

FROM THE DESK OF

MARGARET ANN STORKAN, M.D.

June 22, 1989

Dear Colleague,

Please send a letter of support for the nomination of Marcus Conant for the Clark W. Finnerud Award, Dermatology Foundation for 1989.

This award is presented to the individual who has devoted extraordinary time and talent as a part-time teacher and clinician.

Marc, as a dermatologist has truly given unstinting efforts to the study and treatment of the human immunodeficiency virus infections.

Let's recognize his work!

Sincerely,

mas

Margaret Ann Storkan, M.D.

by June 30:
Finnerud Award
Dermatology Foundation
1563 Maple Avenue
Evanston, IL 60201

copy

Marcus Augustine Conant M.D.

A PROFESSIONAL CORPORATION
DERMATOLOGY
(415) 661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 20, 1989

Dr. Margaret Ann Storkan
Dermatology Foundation
1563 Maple Avenue
Evanston, IL 60201

Dear Margaret:

Just a note to tell you how touched I was that you have taken the effort to nominate me for the Clark W. Finnerud Award.

Those of us working with this new disease have felt blessed that we can use our creative talents to make a real difference for our patients and our society. Recognition of our efforts by our friends and colleagues makes us understand that we are twice blessed.

I look forward to seeing you in December.

Sincerely yours,



Marcus A. Conant, M.D.

MAC/hjl

Marcus Augustine Conant M.D.

A PROFESSIONAL CORPORATION
DERMATOLOGY
(415) 661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 6, 1989

Ms. Eileen Growald
Institute for the Advancement of Health
16 East 53rd Street
New York, New York 10022

Dear Eilene:

I write to say that I hope you, Paul, Adam and Daniel are having a wonderful summer and to urge that the Institute consider a review of all of the papers on the mind/body connection that were presented at the 5th International AIDS meeting in Montreal.

Tom Coates and Ron Stall presented an outstanding paper which documented something we had all suspected for a long time. Namely, that the serious illness or death of a loved one accelerates disease progression in the survivor.

I am sure that the readers of your digest would welcome a review of all the papers presented at the 5th International AIDS meeting and I would bet that Tom Coates could be persuaded to write that for you.

Look forward to seeing you in the Fall.

Sincerely,

Marcus A. Conant, M.D.

MAC/hjl

Marcus Augustine Conant M.D.

A PROFESSIONAL CORPORATION
DERMATOLOGY
(415) 661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 20, 1989

Ms. Joyce Goldstein
Square One
190 Pacific at Front
San Francisco, CA 94111

Dear Joyce:

I was delighted that Time Magazine discovered what I
have known for years; that you are one of the greatest chefs
in the country.

I am so pleased that you received the recognition so
richly deserved. As a friend, I am proud of your
accomplishments.

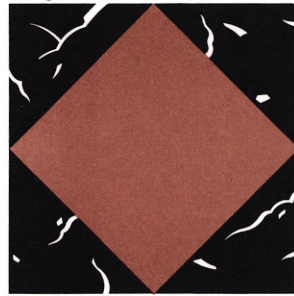
Fondly,



Marcus A. Conant, M.D.

MAC/hjl

S Q U A R E O N E



Dear Friend of SQUARE ONE,

My mother is going to be embarrassed by this. However, I am really proud of her. So despite her feelings about not tooting her own horn, I'm going to send you a copy of this recent TIME Magazine article anyway. Read it, but don't tell her I sent it.

I have some really exciting news for you about our renovation plans. In the fall we will be tearing down the wall that separates the Caffè from SQUARE ONE and we'll be expanding our bar. Instead of the small waiting area, look for an exciting new space, light lunch menu, fabulous hors d'oeuvres in the evening, and my new and expanded wine list. More details to come.

Have a wonderful summer.

Evan Goldstein

When Women Man the Stockpots

After ages laboring in the kitchen, females are earning the title of chef

BY MIMI SHERATON

Men are chefs. Women are cooks. Or at least that was once the conventional view. No longer. Now, whether in their own restaurants or as employees, women across the U.S. have earned their toques as chefs: the leaders of kitchen staffs, not merely cooks who work at their own stations. To suggest a woman as chef even ten years ago would have prompted laughter. Women, went the old calumny, are not creative enough to be chefs. And anyway, how could they lift those hot 60-qt. stockpots? "Very carefully," says Joan Woodhull, 20, a recent graduate of the Culinary Institute of America in Hyde Park, N.Y., where 25% of the 1,850 students are women.

Slowly and after considerable struggle, this band of feisty and talented women, mostly in the U.S. but also in France and England, have wrested for themselves the full title of chef. To be sure, female cooks in restaurants have a long and honored history. They were the keepers of the flame who always produced traditional dishes without deviation, both in American mom-and-pop eateries and especially in France, where the *cuisine de femme* (woman's cooking) was celebrated by Escoffier.

But these women were accorded little status precisely because they never altered dishes. Top honors went to the male chefs, who had undergone long classical training either as apprentices or in professional schools, and who were celebrated for their creativity and inventiveness with new dishes. A case in point: La Mère Blanc in Vonnas, France, was long a famous *cuisine de femme* restaurant, but it earned Michelin's three-star rating only after Georges Blanc took over from his mother and began to dream up nouvelle haute cuisine.

As in other arenas, women seeking full status in the kitchen have had to prove themselves by beating men at their own game. Most neither requested nor accepted help along the way. Mary Sue Milliken, who with her chef-partner Susan Feniger owns the Mexico-inspired Border Grill and the Oriental-eclectic City Restaurant in Los Angeles, recalls that in earlier kitchen jobs, "I insisted on hand-whisking 80 quarts of hollandaise sauce made with two cases of egg yolks."



LYDIA SHIRE: serving green-curry lobster soup and a lobster-salad sandwich at Biba in Boston

No one paid heavier dues than tiny, 5-ft.-tall Anne Rosenzweig, who during her first unpaid apprenticeship was made to lift all the stockpots alone, even though men in the kitchen helped one another. "The European chef there was miserable and kept saying that women had no strength, no stamina and no concentration," says Rosenzweig, who went on to become the controversial vice chairman at Manhattan's exclusive "21" Club, as well as chef-partner at her own New

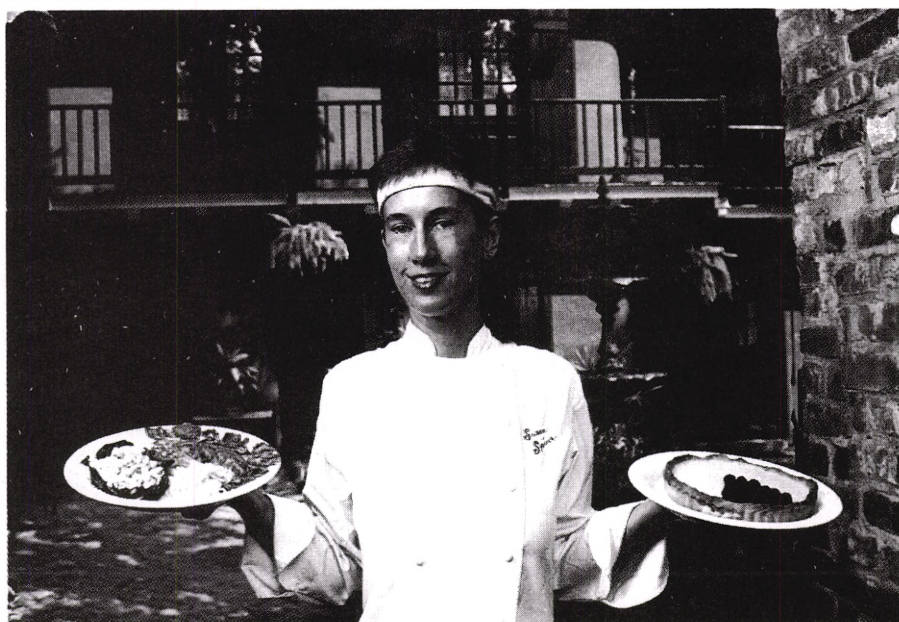
York City restaurant, Arcadia. Overprotectiveness, not abuse, was what almost undermined Leslie Revsin, a chef at the Barbizon Hotel in Manhattan. She recalls that men rushed to help her with any heavy task, even when she didn't need help. Revsin managed, however, and in 1972 became the first female "kitchen man" and then chef at the Waldorf-Astoria, an event that prompted headlines in local newspapers.

Many women chefs have discovered exquisitely simple solutions to problems that arise because of their lack of the male's physical strength. Culinary Institute graduate Woodhull's is possibly the most obvious. "It's more stupid to do something dangerous in the kitchen than to ask for help. And asking for help doesn't mean you're not a good cook," she points out. On the other hand, advises Lynn Sheehan, a student at San Francisco's California Culinary Academy, where nearly half the 400 students are women, "if you feel you need more upper-body strength, go work out." Elizabeth Terry, the chef-owner of Elizabeth on 37th in Savannah, advises the women in her kitchen: "If you can't handle the garbage can when it's full, empty it when it's half full."

If physical weakness has not prevented women from becoming bona fide chefs, what about their al-

JOYCE GOLDSTEIN: offering Russian soup and Korean steak at Square One in San Francisco





SUSAN SPICER: displaying crayfish-scallop salad and lemon tart at the Bistro in New Orleans

leged lack of creativity? Judging by the menus of prominent women chefs around the U.S., pure tradition has gone the way of hand-rolled dough. For though most draw upon certain ethnic and regional influences, all feature the new American cooking, with its free association of international dishes and ingredients and its basically French cooking techniques. Whether such food is prepared by men or women, it is most successful when the surprise of novelty is tempered by a sense of familiarity, a feeling that though the dish is recognizably new, it evokes past flavor associations.

Few chefs have shown more culinary flair than Rosenzweig. Among her classic dishes: chimney-smoked lobster glossed with tarragon butter and buttressed against a crisp cake of threadlike Chinese noodles; roast quail with rhubarb bedded down on dandelion greens; and homespun corn cakes topped with caviar and crème fraîche. Similarly, Joyce Goldstein, chef-owner of the stylish Square One in San Francisco, creates an aura of flavor unity on a menu that may offer crusty Italian bread, Russian mushroom soup, pungent Korean steak and a very American spiced persimmon pudding.

Beginning with Alice Waters, the first female chef to gain national renown—in 1971 after opening Chez Panisse in Berkeley, where she gives a light, decorative California interpretation to the dishes of Provence and Italy—the best women chefs have stayed away from traditional mamma fare. Newcomer Caprial Pence combines Oriental condiments with European dishes and local products at Fullers in the Seat-

tle Sheraton Hotel; Hong Kong-born Jackie Shen, chef-owner of Jackie's in Chicago, decks out fillet of fish sautéed with papaya, avocado and orchids.

In nearby Evanston, Ill., Leslee Reis at her enchanting Café Provençal underlines sautéed foie gras with mango puree and cushions roast pheasant on mushroom ravioli. The menu at Lydia Shire's Boston restaurant, Biba, which is due to open this month, will feature dishes as stylistically diverse as Thai green-curry lobster soup, salad of rock crab and sashimi, and lambs' tongues with fava beans and cilantro. Even in New Orleans, where locals still favor their own Creole-Cajun kitchen, Susan Spicer, of the Bistro at Maison de Ville,

JOAN WINTERS: showing off Italian-American desserts at New York City's Duane Park Café



has won converts with her Provençal improvisations.

Judging by the food one samples around the U.S., there is little difference in the performance of male and female chefs discernible to the eye or palate. Badly conceived culinary high-wire acts are as unappetizing when practiced by men as by women, as are slowness, uneven pacing of courses and sloppy presentation. "I hate this whole question," says Los Angeles' Milliken, "because it emphasizes differences, and women can only really succeed if there are none."

But some still do discern shadings of difference. "I find men tend to be more classically trained and are less flexible about trying new techniques," says San Francisco's Goldstein. "Women are less academic in their approach and so are more flexible." Observes Evanston's Reis: "Men are more aggressive about putting forward their ideas and suggestions. Women tend to be shy about speaking up." Shen feels that women let their personal problems interfere with their work and are therefore not as useful to her. "Men seem better able to keep their private lives separate."

Chefs and educators all seem to agree that women have more patience with minute detail, especially in pastry work, a startling finding when one considers that the two most inspired pastry chefs in the U.S. are Albert Kumin and Dieter Schorner, both obviously men with patience enough to produce cakes that are intricate works of art. But perhaps their female counterparts will emerge as more women wield whisks and pastry tubes. There are already two in New York City who show considerable promise: Joan Winters, whose confections reflect an

Italian-American down-home blend at the Duane Park Café; and Susan Lantizus, who does stylish Italian innovations at San Domenico.

Whatever the merits of the male-female debate, women chefs seem to have no difficulty handling male crews. Waters puts it quite crisply. "I can do more than they can," she says. "I can fire them." Even so, despite the years of sex discrimination, these women seem to forgive if not totally forget. "I love men so much," says Milliken. "I forgive them their attitudes toward women. It's only what their grandmothers and mothers brought them up to believe."

It is inevitable and encouraging that women have joined the list of culinary creators. But it also raises questions: Who will be the keepers of the flame? Or will our beloved traditional dishes, ignored by creative chefs, simply disappear?

—Reported by
JoAnn Lum/New York, with other bureaus

Marcus Augustine Conant M.D.

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(5) 661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 20, 1989

Mr. William W. Waybourn
President
AIDS Resource Center
3920 Cedar Springs
P. O. Box 190712
Dallas, Texas 75219

Dear William:

Thank you so much for your warm letter inviting me to Dallas to speak.

While my schedule is very hectic, I would be happy to visit Dallas to do whatever I can to help you in your battle to light a candle deep in the heart of Texas.

In truth, I despair that we will be able to do anything in Texas since even bright and sophisticated Texans seem to feel that anti-intellectualism makes them more acceptable to their peers.

If you could arrange a speaking engagement with a medical society or, since I am a dermatologist, a dermatological society in Dallas, you may find that Burroughs Wellcome Company would be willing to pay me a handsome honorarium to talk about treatment of patients with AZT. I could then couple that scientific presentation with a presentation to the AIDS Resource Center.

I have served the past year as co-chair of the California AIDS Leadership Committee with the Director of Health Services, Dr. Ken Kizer. In that position, he and I have written an AIDS response plan for the state of California. Interested legislators in Texas might want to take that plan and modify it to serve the needs of your state. If you could arrange a meeting with legislators and legislative aids, I would be happy to explain the plan to them and suggest how they can begin implementing it in Texas.

Finally, we need a quantum leap in thinking if we are to reach the mainstream of Texas political thought. Perhaps an interactive forum of two to three hundred mothers who are

William W. Waybourn
July 20, 1989
Page Two

concerned about their kids acquiring AIDS in the next generation would prove an opportunity to discuss the spectre of a sexually-transmitted, fatal disease.

I look forward to working with you and hearing from you.

Sincerely yours,

Marcus A. Conant, M.D.

MAC/mlh

AIDS Resource Center

A Community Outreach Project of the Dallas Gay Alliance
and the Foundation for Human Understanding
3920 Cedar Springs, P.O. Box 190712, Dallas, Texas 75219, 214-521-5124
24 Hour Hot Line 214-559-AIDS

July 12, 1989

Marcus Conant, M.D.
250 Parnassus - Suite 808
San Francisco, CA 94117

Dear Dr. Conant:

I was so taken by your presentation at the New York conference that I wanted to write and ask you if you are available for speaking engagements, specifically in Dallas. Your comments are exactly what we need to awaken an incredibly complacent Dallas patient population and medical establishment.

I think it goes without saying, Dallas is the Calcutta of AIDS research. It seems that there has been a conscious effort to avoid AIDS research here, and it continually perplexes me that physicians would want to sit out on the epidemic of the century.

We face almost insurmountable odds of changing the system here, but we sued Parkland Hospital and now more than 450 persons are aerosolized pentamidine and there is no longer an AZT waiting list. We will continue to act as an advocate on behalf of patients, and now we are about to embark upon a research endeavor that will bring research components to Texas.

But we need outside help. I don't know what your schedule is like, but we would be willing to accommodate you at almost any time. Please let me know of your fee, travel expenses or other important information we would need to get you to come to Dallas.

Sincerely,

DALLAS GAY ALLIANCE



William W. Waybourn
President

cc: John Thomas, Executive Director, AIDS Resource Center
Dan Barbaro, M.D., Medical Director, Nelson-Tebedo CRI
Gloria Goodwin, R.N., Coordinator, Nelson-Tebedo CRI

The Truth About AIDS.

Pass it On!

Marcus Augustine Conant M.D.

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(415) 661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 20, 1989

Dr. Robert M. Wachter
Program Director
Sixth International Conference on AIDS
University of California San Francisco
Box 1505
San Francisco, California 94143-1505

Dear Bob:

Thank you so much for your letter. I look forward to hearing favorably that I can participate in the program for the Sixth International Conference in a meaningful way.

The issue of patient driven research has been much in the news in San Francisco in the past few weeks. The problems this initiative raises are legend, but include:

1. Do these patients truly have informed consent?
2. Is it coercive if the patient actually pays for their own research?
3. What are the values of the Human Experimentation Committee in preventing abuse?
4. What is the value of a food and drug regulatory body in preventing abuse?
5. What is the standard for investigators regarding publication and disclosure of their results from these studies.

An afternoon forum devoted to discussing these issues would go a long way toward decreasing some of the stress between the community and academic based investigators.

I would suggest a program composed of an academic based clinical research scientist, a representative from a human experimentation committee, a representative from a regulatory board, an ethicist, and a community activist.

Dr. Robert M. Wachter
July 20, 1989
Page Two

Obviously I am interested in this subject and would be happy to facilitate the session or participate in any way that would be useful.

Sincerely yours,

Marcus A. Conant, M.D.

MAC/hjl

cc: Dr. John Ziegler
Dr. Paul Volberding
Dr. Donald Abrams

JUN 27 1989

SIXTH INTERNATIONAL CONFERENCE ON AIDS

SAN FRANCISCO, CALIFORNIA USA ■ 20-24 JUNE 1990

June 23, 1989

Marcus Conant, M.D.
350 Parnassus Avenue, Suite 808
San Francisco, CA 94117

Sponsor

University of
California
San Francisco

Dear Dr. Conant,

Thank you for your suggestions regarding the program of the 6th International Conference on AIDS. These ideas have been shared with the meeting co-chairs, Drs. Ziegler and Volberding, and the relevant Track Committee chairs.

Co-Sponsors

World Health
Organization
City and County
of San Francisco

American
Foundation for
AIDS Research
International
AIDS Society

As you can well imagine, we are receiving exciting program ideas from many fronts, from San Francisco to Singapore. We will be considering all these ideas over the next six months or so. Final decisions regarding the program will be made by the meeting co-chairs and myself only after extensive consultation with the Local Organizing Committee, the International Steering Committee and the relevant Track Committees.

Once again, we thank you for your interest and input.

*Local Program
Office*

University of
California
San Francisco

Box 1505
San Francisco
California
94143-1505
USA

Telephone
415-550-0880

Telefax
415-550-0886

Sincerely,



Robert M. Wachter, MD
Program Director

cc: John Ziegler, M.D.
Paul Volberding, M.D.
Donald Abrams, M.D.



Tacoma's needle exchange makes its point

By Kim Severson
The News Tribune

Tacoma's needle-exchange program is approaching its sixth-month birthday.

In that time, the numbers of needles handed out in the name of stopping the spread of AIDS has jumped from 35 a day to almost 600 a day.

The government-sponsored operation has moved from a card table on Pacific Avenue to a spiffy new van

that parks on Commerce Street six days a week. In addition to orange-tipped syringes, the program dispenses condoms, bleach, food and lots of health advice to the people on Tacoma's streets.

David Purchase, the man hired by the Tacoma-Pierce County Health Department to run the exchange program, has traveled thousands of miles to tell other cities about what Tacoma has done.

The former drug counselor, who has become an international celebri-

ty in AIDS prevention circles, has offered information to health workers in eight other cities that since have started exchange programs or plan to by the end of the summer.

Most importantly, Tacoma health officials said, is that the exchange is working.

"It looks like the program is a winner. It's doing what we want it to do, and that's reduce HIV (the virus that causes AIDS) infection," said Terry Reid, head of the Tacoma-Pierce County Health Department's

AIDS programs.

Reid will pass that message to the Board of Health at a meeting scheduled for 3 p.m. today in the basement of the Burlington Northern West Credit Union, 3633 Pacific Ave.

The Board of Health has asked for regular updates on the exchange program, which has proven to be the most controversial public health effort ever undertaken by the Health Department.

When the exchange began, down-

town merchants and area homeless shelter administrators said the exchange caused an increase in criminal activity and was drawing addicts to the downtown corridor.

The exchange since has moved to a less obvious location, and health officials continue to work with Tacoma police to keep the area safe.

The exchange also has been challenged legally. Although a formal opinion from the state attorney general is pending, an informal opinion issued in April ruled that such pro-

grams were illegal under an anti-drug law that prohibits the sale of hypodermic needles for any purpose other than medical needs.

Health officials believe that law is pre-empted by the 1988 AIDS-prevention bill passed by the Legislature.

Public concern over giving needles to drug users and other AIDS prevention tactics is still alive. At a board meeting last

Please see **Needles**, B2

Needle exchange wins U.S. honor

Pierce County's innovative but controversial effort at stopping the spread of the AIDS virus is the best new public health program in the country, according to the National Association of County Health Officials.

The AIDS prevention program designed by the Tacoma-Pierce County Health Department received the J. Howard Beard Award this week for its efforts at stopping the spread of the blood-borne virus.

The national award is given each year to one program deemed the best and most innovative in any area of public health.

The county AIDS prevention program features educational and outreach efforts, a public service campaign promoting the use of condoms and a needle exchange program.

The needle-exchange program, now in its sixth month of operation and exchanging almost 300 dirty needles for clean ones daily, was the first of its kind in North America. Health officials said earlier the program involved the exchange of 600 needles daily, but Wednesday they corrected that figure to 300 daily.



David Brandt/The News Tribune

Program director David Purchase meets with health official Ardythe Fleener at the needle exchange location on Commerce Street.

Needles

Continued from B1

month, a petition bearing more than 500 signatures was presented in hopes that the board would stop public service announcements about condoms and safe sex as well as the needle give-away.

Kim Anderson, a retired teacher and mother of two, led the petition drive. She said she and other residents who think the needle exchange promotes drug use will be at the meeting today to try to influence the board to stop the programs.

Reid said data collected from his department show that the exchange actually helps stop drug use. Since the program began, 150 of Pierce County's estimated 3,000 to 5,000 intravenous drug users have been referred for drug treatment. Half of those people have followed up by entering a methadone treatment program, Reid said.

Reid said research done by Health Department workers shows that the needle exchange efforts don't increase drug use but do increase needle hygiene among addicts.

The results of that six-month scientific study done in cooperation with Pierce County and New York health officials were released at the Fifth International Conference on AIDS in Montreal in May.

Nationally, the blood-borne AIDS virus is spreading fastest among intravenous drug users and their children. About 20 percent of the estimated 90,000 AIDS cases in the country are among IV drug users, according to the Centers for Disease Control in Atlanta.

In Washington, only about 5 percent of the 1,263 AIDS cases diagnosed since 1982 are directly related to intravenous drug use.

Marcus Augustine Conant M.D.

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661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 20, 1989

Brother Tolbert McCarroll
Starcross Community
P. O. Box 14279
Santa Rosa, CA 95402

Dear Brother Bobby:

Thank you so much for your warm letter. Attached please find all of the abstract presentations from Montreal, many of which talk to the efficacy of needle exchange and the fact that this program does not increase IV-drug abuse.

If I can furnish you additional information or help in any way, please do not hesitate to write.

Sincerely yours,

Marcus A. Conant, M.D.

MAC/hjl

STARCROSS
community

Annapolis, California 95412
(707) 886-5446

MAILING ADDRESS:
P. O. BOX 14279
SANTA ROSA, CA 95402

June 19, 1989

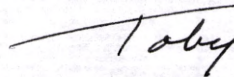
Marcus Conant, M.D.
350 Parnassus Ave.
San Francisco, CA 94117

Dear Marcus:

It was an honor to meet you at last. I have a number of heroes in this epidemic, and you are one of them. Thank God you have been here. Driving home I could see the wisdom in your suggestion of my working on Jim Nielsen. I will do so and have made contact.

It would help for the present problem if you could get me more details, studies or statements supporting needle exchange - including anything you have written. Thanks.

With best wishes,



Brother Tolbert McCarroll

6/22/89 De Francis you
Abstract, for VI Internat'l



U.S. Department of Justice

Immigration and Naturalization Service

425 Eye Street N.W.
Washington, D.C. 20536

CO 234-C

20 JUL 1989

Marcus A. Conant, M.D.
Co-Chair, California
AIDS Leadership Committee
Suite 808
350 Parnassus Avenue
San Francisco, CA 94117

Dear Dr. Conant:

Thank you for your letter of April 17, 1989 concerning the admission of temporary visitors to the United States who are infected with the human immunodeficiency virus (HIV).

The Immigration and Nationality Act enumerates 33 classes of individuals who are ineligible to receive visas and are excludable from admission to the United States. These classes have evolved through the years in response to Congress' desire to preserve and protect the health, safety and welfare of United States citizens and those lawfully admitted to reside permanently in the United States. Among the groups of individuals who are excludable from admission are those who are "afflicted with any dangerous contagious disease." In 1987, Congress passed specific legislation to insure that HIV infection be included as a disease considered "dangerous and contagious." Those who are HIV positive are therefore inadmissible to the United States by law. The Immigration Service cannot change or amend this law by policy or regulation.

The statute does allow for exceptions to these exclusion clauses at the discretion of the Attorney General for individuals coming temporarily to the United States. In 1987, the Service implemented policies in deciding these exceptions, or waivers, in individual cases involving people infected with HIV. There are three areas considered in making these determinations: concern about the public health and safety of United States citizens; concern about possible spread of the disease; and concern about potential financial burdens on United States taxpayers.

Since these policies were implemented, much has been learned about HIV infection. United States citizens have become much more aware of the causes and effects of this disease. Medical studies regarding the effects and methods of transmission of the disease have provided much valuable information.

With these advances in mind, the Service employs a balancing test on a case-by-case basis in determining whether the discretionary authority to waive exclusion should be exercised. The risk of harm to United States citizens must be balanced

against the nature of the individual's reasons for wishing to enter the United States. On May 25, 1989, the Service clarified its position as to how this balancing test should be applied to short term visitors to the United States who are HIV infected. Absent any other relevant factors, a waiver should be granted to a short term visitor (30 days or less) when the individual can establish that entry into the United States would confer a public benefit which outweighs the risk such entry would engender to the public health.

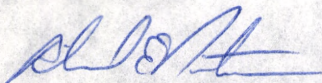
A sufficient public benefit can include a showing that the short term nonimmigrant will be attending academic or health related activities (including seeking medical treatment), or conducting temporary business in the United States. A sufficient public benefit can also include the applicant establishing that he or she will visit close family members in the United States. Entry into the United States essentially for tourism reasons alone does not constitute the requisite public benefit to overcome the risk.

Notwithstanding the instances described above, the risk to the public health may outweigh the public benefit claimed by the applicant, as for example in the case of an applicant for whom there is reason to believe that he or she will spread the human immunodeficiency virus while in the United States. Consistent with the criteria outlined in this instruction, temporary waivers may be granted subject to the district director's discretion on a case-by-case basis.

The implementation of this clarified instruction reaffirms the continuation of the basic policy while assuring that reasonable exceptions have been and will be considered. Furthermore, it allows the Service to accomplish its goals, yet continue to maintain the statutory and regulatory mandate to exercise discretion in an orderly manner, on a case-by-case basis.

Thank you for expressing your views on this issue.

Sincerely,

A handwritten signature in blue ink, appearing to read "R. E. Norton", is written above the typed name.

Richard E. Norton
Associate Commissioner,
Examinations

Marcus Augustine Conant, M.D.

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(415) 661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 28, 1989

Rev. Canon William H. Barcus III
1839 - 15th Street, #359
San Francisco, California 94103

Dear Bill:

Just a note to tell you that I see you are being honored by Shanti at their annual awards dinner on August 26th.

I can think of no one who deserves recognition more than you. I write to tell you once again of my great admiration for all that you have accomplished.

Fondly,

Marcus A. Conant, M.D.

MAC/hjl

COMMUNITY RESEARCH INITIATIVE (NEW YORK)
and
COUNTY COMMUNITY CONSORTIUM (SAN FRANCISCO)
Conference on:

**ORGANIZING COMMUNITY BASED
CLINICAL TRIALS:
MODELS FOR THE AIDS EPIDEMIC**

July 7-9 Columbia University, New York, NY

CONFERENCE CO-CHAIRS:

Donald I. Abrams, M.D.
County Community Consortium (SF)

Michael Callen
Community Research Initiative (NY)

ADVISORY COMMITTEE
(List In Formation):

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Stephen Holzemer, R.N.
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FROM COUNTY COMMUNITY CONSORTIUM
James Campbell, M.D.
Carroll Child, R.N.
David Feigal, M.D., M.P.H.
Thomas Mitchell, M.P.H.
Zach Weingart

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(Affiliations for Identification
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Carol Braun Trapnell, M.D.
Food & Drug Administration

Lawrence S. Brown, Jr., M.D., M.P.H.
Urban Resources Institute/
Harlem Hospital

David Corkery
American Foundation for AIDS Research

Lawrence Deyton, M.D.
National Institutes of Allergy &
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Barbara Park
McKinsey & Co.

Marie Saint Cyr
Women & AIDS Resource Network

James Sampson, M.D.
Oregon AIDS Task Force

Melanie Thompson, M.D.
Santa AIDS Research Consortium, Inc.

CONFERENCE STAFF:

Debbie Levine, Coordinator
Mark Harrington, Consultant

July 17, 1989

Marcus Conant, M.D.
350 Parnassus, Suite 808
San Francisco, CA 94117

Dear Dr. Conant,

On behalf of Dr. Donald Abrams and Michael Callen, I would like to thank you for addressing the first conference on "Organizing Community Based Clinical Trials: Models for the AIDS Epidemic." The interest and energy generated by the conference has been far-reaching, and your contribution to making the conference a success has been invaluable. I hope that we can continue to use you as a resource to strengthen and develop community based research organizations, and that you will continue to stay in touch with me, at AmFAR, and with the individual groups to provide comments and criticism on the work that we all are undertaking.

I will continue to provide you with any information collected by our loosely formed network of community research organizations, and let you know about all future conferences.

Thank you again for participating as a speaker at the conference. Personally, I found your speech to be one of the best, incisive critiques of the system. I'm sorry I did not get a chance to speak to you at length. Please keep in touch.

Regards,



Debbie Levine
Conference Coordinator

Marcus Augustine Conant, M.D.

A PROFESSIONAL CORPORATION
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(415) 661-2613

*350 Parnassus Avenue, Suite 808,
San Francisco 94117*

July 28, 1989

Mr. Jim Brown
U.S. Public Health Service
200 Independence Avenue, S.W.
Room 717H
Washington, D.C. 20201

RE: Dr. Deborah Greenspan

Dear Mr. Brown:

I am pleased to write to support the nomination of Dr. Deborah Greenspan by the Assistant Secretary for Health for the 1989 Dentist's Award. *JS*

Dr. Greenspan distinguished herself as early as 1982 by becoming actively involved in the evaluation and treatment of patients infected with the AIDS virus, HIV. With her husband, John Greenspan, she described a new oral lesion, hairy leukoplakia, seen in this population of patients and she has given untiringly of her time in educating physicians and dentists in our community and throughout the nation in the evaluation and compassionate care of patients with AIDS.

I can recommend Dr. Greenspan to the Assistant Secretary without reservation.

Sincerely yours,

Marcus A. Conant, M.D.

MAC/hjl

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MEDICAL ANTHROPOLOGY PROGRAM
CENTER FOR SOCIAL AND BEHAVIORAL SCIENCES

1350 Seventh Avenue, CSBS-317
San Francisco, California 94143
(415) 731-1880

July 15, 1989

Marcus A. Conant, M.D.
350 Parnassus Avenue, Ste. 808
San Francisco, CA 94117

Dear Dr. Conant:

I am a doctoral candidate in Medical Anthropology at the University of California, San Francisco. My dissertation research focuses on press coverage of the AIDS epidemic between June 1981 and December 1986 in selected mainstream and gay newspapers.

The study uses methods of content analysis of news articles and interviews with editors, reporters, and news sources in order to identify key variables related to the newsmaking, scientific, and political processes that may have influenced the ways in which AIDS was covered in the press. I am particularly interested in the ways in which sources may have tried to influence how AIDS was reported. As someone who was quoted frequently in press reports during the first years of the AIDS epidemic, your experience and perspective would be invaluable to my research.

The enclosed consent form describes the study in more detail. If you agree to be interviewed, I hope that we might arrange an appointment sometime this month. I would need to talk with you for about one and one-half hours, at your convenience. The interview could be split up into two sessions, if you prefer.

I will call your office in a couple of days to arrange an appointment. In the meantime, if you have any questions or concerns about my study, please don't hesitate to call me at 752-5514. I very much look forward to talking with you.

Sincerely yours,

Karen S. Heller, M.A., Ph.D. (cand.)
Medical Anthropology Program
University of California,
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Encl.