Regional Oral History Office
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Berkeley, California

The San Francisco AIDS Oral History Series

THE AIDS EPIDEMIC IN SAN FRANCISCO: THE MEDICAL RESPONSE, 1981-1984

Volume I

Selma K. Dritz, M.D, M.P.H. — CHARTING THE EPIDEMIOLOGICAL COURSE OF AIDS, 1981-1984

Mervyn F. Silverman, M.D., M.P.H. — PUBLIC HEALTH DIRECTOR: THE BATHHOUSE CRISIS, 1983-1984

Introduction by James Chin, M.D., M.P.H.

Interviews Conducted by
Sally Smith Hughes
in 1992 and 1993

Since 1954 the Regional Oral History Office has been interviewing leading participants in or well-placed witnesses to major events in the development of Northern California, the West, and the Nation. Oral history is a modern research technique involving an interviewee and an informed interviewer in spontaneous conversation. The taped record is transcribed, lightly edited for continuity and clarity, and reviewed by the interviewee. The resulting manuscript is typed in final form, indexed, bound with photographs and illustrative materials, and placed in The Bancroft Library at the University of California, Berkeley, and other research collections for scholarly use. Because it is primary material, oral history is not intended to present the final, verified, or complete narrative of events. It is a spoken account, offered by the interviewee in response to questioning, and as such it is reflective, partisan, deeply involved, and irreplaceable.

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It is recommended that this oral history be cited as follows:

To cite the volume: The AIDS Epidemic in San Francisco: The Medical Response, 1981-1984, Volume I, an oral history conducted 1992-1993, The Bancroft Library, University of California, Berkeley, 1995.

To cite an individual interview: [ex.] Selma K. Dritz, M.D., M.P.H., "Charting the Epidemiological Course of AIDS, 1981-1984," an oral history conducted in 1992 by Sally Smith Hughes in The AIDS Epidemic in San Francisco: The Medical Response, 1981-1984, Volume I, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1995.

Copy no. 1

Cataloguing information

THE AIDS EPIDEMIC IN SAN FRANCISCO: THE MEDICAL RESPONSE, 1981-1984, VOLUME I, 1995, xv, 276 pp.

Selma K. Dritz (b. 1917), epidemiologist, San Francisco Department of Public Health, 1967-1984; enteric disease in gay community; early cases of AIDS: etiology, diagnosis, risk groups; San Francisco General Hospital's Kaposi's Sarcoma Clinic; transfusion AIDS; Medical Advisory Committee on AIDS formed; June 1982 meeting, New York City, on AIDS opportunistic infections; San Francisco bathhouse issue; discussion of funding, AIDS drugs, AIDS in women. Mervyn F. Silverman (b. 1938), director, San Francisco Department of Public Health, 1977-1986; health department links with San Francisco's gay community; AIDS education strategy, programs; hospital admission of AIDS patients; the San Francisco model of AIDS care; the bathhouse issue; AIDS testing, and AIDS drugs; AIDS and the media and the federal government response; funding for AIDS. Appendices include AIDS Chronology, 1981-1984, list of key participants, documents from interviewees.

Introduction by James Chin, M.D., M.P.H., Clinical Professor of Epidemiology, School of Public Health, University of California, Berkeley

Interviews conducted 1992 and 1993 by Sally Smith Hughes, Ph.D for the San Francisco AIDS Oral History Series. The Regional Oral History Office, The Bancroft Library, University of California, Berkeley.

ACKNOWLEDGEMENTS

The Regional Oral History Office wishes to express deep gratitude to Evelyne and David Lennette of Virolab, Inc., for their financial support of this project, incisive conceptual contributions, and sustaining interest and enthusiasm.

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PREFACE--by David A. Lennette, Ph.D., and Evelyne T. Lennette, Ph.D.

As two young medical virologists working in Pennsylvania, we experienced first hand some of the excitement of medical detective work. We had our first glimpse of how personalities can shape the course and outcome of events during the swine influenza and Legionnaires' disease outbreaks.

On our return to California, we were soon embroiled in another much more frightening epidemic. In 1981, our laboratory began receiving samples for virologic testing from many of the early San Francisco AIDS patients--whose names are now recorded in Randy Shilts' book *And the Band Played On*. Our previous experience with the legionellosis outbreak had primed us for this new mystery disease. While the medical and scientific communities were hotly debating and coping with various issues during the following three years, we were already subconsciously framing the developments in an historical point of view. In San Francisco, dedicated junior physicians and researchers banded together to pool resources and knowledge out of necessity, and in doing so, organized part of the local medical community in a very unusual way. Once again, we were struck by how the personalities of each of these individuals shaped the course of events. Even before HIV was discovered, we knew we were witnessing a new page in the history of science and medicine.

The swine flu and legionellosis outbreaks were both very local and short lived. We now speak of them in the past tense. The AIDS epidemic, sadly, is still spreading unimpeded in much of the world. We know that it will be with us for a long time and that it is very unlikely that either of us will live long enough to read the closing chapter on AIDS.

Future generations will some day want to know how it all got started. The existing scientific reports and publications provide depersonalized records of some of the events, while newspaper articles and books give glimpses as summarized by observers. What are missing are the participants' own accounts and perspectives.

It is now more than a dozen years after the recognition of the AIDS epidemic in the United States. So much has happened and changed--already, some of the participants in early events have retired, records are being discarded and destroyed, and memories of those days are beginning to fade. We felt their oral histories had to be recorded without delay.

We had previously sponsored oral histories on virology with Dr. Edwin H. Lennette, David's father, and Dr. Harald N. Johnson, and were

familiar with the methods and work of the Regional Oral History Office. We met to talk over the recording of the AIDS epidemic with Willa Baum, head of the office, and Dr. Sally Smith Hughes, medical history interviewer. After some discussion, we agreed that the events from 1981-1984 needed to be documented and we would fund it. This was a time when many crucial decisions on the clinical, public health, social, and political issues pertaining to AIDS were made with little scientific information and no precedents to rely on. The consequences of many of these decisions are still being felt today. With the discovery of HIV, however, the framework for decision making shifted to different ground, and a pioneering phase was over. Once we decided on the scope of the project, it was a simple task to identify prospective interviewees, for we worked with many of these individuals during those years.

Dr. Sally Hughes has shared our enthusiasm from the beginning. We are pleased that her efforts are now coming to fruition.

David A. Lennette, Ph.D.
Evelyne T. Lennette, Ph.D.

November 1994
Virolab, Inc.
Berkeley, California

SERIES INTRODUCTION--by James Chin, M.D., M.P.H.

As the California state epidemiologist responsible for communicable disease control from the early 1970s to the late 1980s, I had the privilege and opportunity to work with all of the participants who were interviewed for the San Francisco AIDS Oral History Project. I consider it an honor to have been asked to provide a brief introduction to the role that these individuals played in the history of AIDS in San Francisco during the early years. Before I begin, the following quote from Dr. James Curran, in a December 1984 issue of the *San Francisco Chronicle* sums up what has happened to all of the participants in this oral history project:

> I'd like to sound more upbeat about this, but there are some unavoidable facts we need to face. AIDS is not going away. Gay men don't want to hear that. Politicians don't want to hear that. I don't like to hear that. But for many of us, AIDS could well end up being a lifelong commitment.

The first recognized cases of AIDS were reported in the *Morbidity and Mortality Weekly Report (MMWR)* on June 5, 1981. I recall this report vividly. A few months earlier, the Centers for Disease Control (CDC) had begun sending an advance copy of the *MMWR* text to state health departments. The advance text of the June 5 *MMWR* had a lead article on the sudden and unexplained finding of five apparently unrelated cases of *Pneumocystis carinii* pneumonia in five young gay men from Los Angeles. The *MMWR* text was received in my office just before our weekly Tuesday afternoon staff meeting was to start. I handed the text to Tom Ault, who was responsible for the state's venereal disease field unit and asked him to have some of our federal- or state-assigned staff in Los Angeles assist in the investigation of these cases. I remember saying to him that it may not turn out to be much of anything, but it may be the start of something. I never imagined that that something would eventually develop into a worldwide epidemic of disease and death.

In the ensuing weeks and months, it became apparent that the mysterious illness reported from Los Angeles was also present among gay men in San Francisco. From 1981 to 1984, the numbers of AIDS cases reported from San Francisco rose almost exponentially--from a handful in mid-1981 to well over 800 towards the end of 1984. The impact that AIDS has had in San Francisco is unequaled on a per capita basis anywhere in the developed world. If the AIDS prevalence rate of about one AIDS case per 1,000 population that was present in San Francisco at the end of 1984 was applied nationally, then there would have been about a quarter of a million AIDS cases nationwide instead of the 7,000 that were actually

reported. During the first few years of what was initially referred to as GRID (gay-related immune deficiency), there was general denial of the severity of this newly recognized mystery disease even in San Francisco. The enormity of the AIDS problem was first fully accepted by the gay community in San Francisco, and physicians and researchers in the city rapidly became the leading experts in the country on the medical management, prevention, and control of AIDS. In contrast to Los Angeles and New York, which also have had large concentrations of AIDS cases, the gay community in San Francisco has been more unified and organized in developing political and community support for the treatment and care of AIDS patients.

The epidemiology of AIDS, namely, that it is caused primarily by a sexually transmitted agent, was fairly well established by 1983, well before HIV was eventually isolated and etiologically linked to AIDS in 1984. Public health investigations in San Francisco, spearheaded by Selma Dritz in 1981 and 1982, provided much of the key epidemiologic data needed to understand the transmission and natural history of HIV infection. The more formal epidemiological studies of AIDS among gay men in San Francisco were carried out by Andrew Moss at San Francisco General Hospital (SFGH) and Warren Winkelstein at the University of California at Berkeley. All of these studies were helpful to Mervyn Silverman (who during this period was director of the San Francisco Department of Public Health) to support his decision in October 1984 to close the San Francisco bathhouses. Selma Dritz retired from her position with the health department in 1984, and Mervyn Silverman has moved on to become the premier HIV/AIDS frequent flier in his current position as president of the American Foundation for AIDS Research, which is now supporting studies internationally.

Jay Levy was an established virologist when AIDS was first detected and reported in 1981. His laboratory isolated and characterized a virus which he initially called ARV--AIDS Related Virus. He continues to play a prominent role in the quest to better understand the pathogenesis of HIV. Herbert Perkins was the scientific director of the Irwin Memorial Blood Bank in San Francisco during the critical period around 1982-1985 when data began accumulating to indicate that the cause of AIDS might be an infectious agent which could be transmitted via blood. Under his direction, the Irwin Memorial Blood Bank in May 1984 was the first blood bank in the country to begin routine surrogate testing of blood units for the AIDS agent using a hepatitis B core antibody test. He retired as director of Irwin Memorial in April 1993, but remains very much involved in defending the blood bank from legal suits arising from transmission of HIV via blood transfusions during the early years. Don Francis did not work in California during the early 1980s, but directed epidemiologic and laboratory studies on AIDS as the first head of the AIDS laboratory at CDC in Atlanta during this time period. Following his request to become more directly involved with field work and HIV/AIDS program and policy

development, he was assigned to work in my office in Berkeley in 1985. Don took an early retirement from CDC in 1992 and continues to actively work in the San Francisco Bay Area as well as nationally and internationally on the development of an AIDS vaccine.

The clinical staffs of San Francisco General Hospital and the University of California at San Francisco established the two earliest AIDS clinics in the country, and in 1983, Ward 5B at SFGH was set up exclusively for AIDS patients. In the early 1980s, Don Abrams and Paul Volberding were two young physicians who found themselves suddenly thrust into full-time care of AIDS patients, a responsibility which both are still fully involved with. As a result of their positions, experience, and dedication, both are acknowledged national and international experts on the drug treatment of HIV and AIDS patients. Merle Sande, John Ziegler, Arthur Ammann, and Marcus Conant were already well established and respected clinicians, researchers, and teachers when AIDS was first detected in San Francisco. Their subsequent work with HIV/AIDS patients and research has earned them international recognition. The Greenspans, Deborah and John, have established themselves as the foremost experts on the oral manifestations of HIV/AIDS, and Constance Wofsy is one of the leading experts on women with HIV/AIDS. There is rarely a national or international meeting or conference on AIDS where most, if not all, of these San Francisco clinical AIDS experts are not present and speaking on the program. The number of HIV/AIDS clinicians and research scientists from San Francisco invited to participate in these medical and scientific meetings usually far exceeds those from any other city in the world. All of these individuals have made tremendous contributions to the medical and dental management of HIV/AIDS patients in San Francisco and throughout the world.

As of late 1994, more than a decade since the advent of AIDS in San Francisco, Jim Curran's remark in 1984 that "...for many of us, AIDS could well end up being a lifelong commitment" has been remarkably accurate for virtually all the participants in this San Francisco AIDS Oral History Project.

James Chin, M.D., M.P.H.
Clinical Professor of Epidemiology
School of Public Health, University of California at Berkeley

September 1994
Berkeley, California

SERIES HISTORY--by Sally Smith Hughes

Historical Framework

In 1991, Evelyne and David Lennette, virologists and supporters of previous Regional Oral History Office (ROHO) projects in virology and horticulture, conceived the idea for an oral history series on AIDS. They then met with Willa Baum (ROHO director), and me to discuss their idea of focusing the series on the medical and scientific response in the early years (1981-1984) of the AIDS epidemic in San Francisco, believing that the city at this time played a particularly formative role in terms of AIDS medicine, organization, and policy. Indeed San Francisco was, with New York and Los Angeles, one of the three focal points of the epidemic in the United States, now sadly expanded worldwide.

The time frame of the oral history project is historically significant. Nineteen eighty-one was the year the epidemic--not until the summer of 1982 to be officially christened "AIDS"--was first recognized and reported. The cause, human immunodeficiency virus (HIV), was reported in 1984, and by early 1985, diagnostic tests for HIV were being marketed. These achievements signaled a turning point in the response to the epidemic. Its science shifted from a largely epidemiological approach to one with greater emphasis on the laboratory. As soon as the virus was isolated, scientific teams in the United States and Europe raced to characterize it in molecular terms. Information about the molecular biology of HIV was in turn expected to transform AIDS medicine by providing a basis for treatment and prevention of the disease through new drugs and vaccines.

San Francisco continued to make important contributions to combating the epidemic, but by early 1985 it had lost its pioneering role. The AIDS test showed that the epidemic reached far beyond the three original geographic centers and involved large numbers of symptomless HIV-positive individuals, who were not identifiable prior to the test's advent. AIDS funding increased; the number and location of AIDS researchers expanded; research interest in the newly identified virus took center stage. San Francisco's salient position in the AIDS effort faced competition from new players, new research interests, and new institutions. The first phase of the epidemic was history.

Project Structure

Within the limits of funding and the years of the project (1981-1984), the Lennettes suggested eight potential interviewees whom they knew to play important medical and scientific roles in the early years of the San Francisco epidemic. (Both Lennettes have close connections with the local AIDS research community, and Evelyne Lennette was a scientific collaborator

of three interviewees in this series, Jay Levy and Deborah and John Greenspan.) I then consulted Paul Volberding, an oncologist at San Francisco General Hospital with an international reputation as an AIDS clinician. He and others in the oral history series made several suggestions regarding additional interviewees, expanding my initial list to fourteen individuals.[1] My reading of primary and secondary sources and consultation with other authorities confirmed the historical merit of these choices.

The series consists of two- to ten-hour interviews with fourteen individuals in epidemiology, virology, public health, dentistry, and several medical specialties. By restricting phase one to San Francisco's early medical and scientific response to the epidemic, we aim to provide in depth documentation of a major aspect, namely the medicine and science it generated in a given location, at a given time, under near-crisis conditions. Like any human endeavor, medicine and science are embedded in the currents of the time. As these oral histories so graphically illustrate, it is impossible to talk about science and medicine without relating them to the social, political, and institutional context in which they occur. One of the strengths of oral history methodology is precisely this.

This concentration on physicians and scientists is of course elitist and exclusive. There is a limit--practical and financial--to what the first phase of a project can hope to accomplish. It was clear that the series needed to be extended. Phase two of the oral history project, a series with AIDS nurses, is underway and serves to broaden the focus. The long-range plan is to interview representatives of all sectors of the San Francisco community which contributed to the medical and scientific response to AIDS, thereby providing balanced coverage of the city's medical response.

Primary and Secondary Sources

This oral history project both supports and is supported by the written documentary record. Primary and secondary source materials provide necessary information for conducting the interviews and also serve as essential resources for researchers using the oral histories. They also orient scholars unfamiliar with the San Francisco epidemic to key participants and local issues. Such guidance is particularly useful to a researcher faced with voluminous, scattered, and unorganized primary sources, characteristics which apply to much of the AIDS material. This

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[1] A fifteenth was added in 1994, when the UCSF AIDS Clinical Research Center provided partial funding for interviews with Warren Winkelstein, M.D., M.P.H., the epidemiologist directing the San Francisco Men's Health Study.

two-way "dialogue" between the documents and the oral histories is essential for valid historical interpretation.

Throughout the course of this project, I have conducted extensive documentary research in both primary and secondary materials. I gratefully acknowledge the generosity of Drs. Arthur Ammann, Marcus Conant, John Greenspan, Herbert Perkins, Warren Winkelstein, and John Ziegler in opening to me their personal documents on the epidemic. Dr. Frances Taylor, director of the Bureau of Infectious Disease Control at the San Francisco Department of Public Health, let me examine documents in her office related to closure of city bathhouses in 1984. Sally Osaki, executive assistant to the director of the health department, gave me access to documents from former Mayor Dianne Feinstein's papers on her AIDS activities. I am grateful to both of them.

Dr. Victoria Harden and Dennis Rodrigues of the NIH Historical Office assisted by sending correspondence and transcripts of a short telephone interview with John Ziegler, which Rodrigues conducted.[1] I thank Dr. James Chin for his introduction to this series, which describes his first-hand experience of the epidemic as state epidemiologist at the California Department of Health Services where he was responsible for communicable disease control. I also thank Bill Walker, archivist of UCSF's AIDS History Project and the San Francisco Gay and Lesbian Historical Society, for his assistance in accessing these rich archival collections.

The foregoing sources have been crucial in grounding the interviews in specifics and in opening new lines of questioning. A source to be noted, but untapped by this project, is the California AIDS Public Policy Archives, which is being coordinated by Michael Gorman, Ph.D., at San Francisco General Hospital.

Of the wealth of secondary historical sources on AIDS, the most pertinent to this project is Randy Shilts' *And the Band Played On*.[2] Although criticized for its political slant, it has been invaluable in providing the social, political, and ideological context of early AIDS efforts in San Francisco, particularly in regard to San Francisco's gay community.

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[1] Telephone interview by Dennis Rodrigues with John L. Ziegler, M.D., January 5, 1990. Tapes and transcripts of the interview are available in the NIH Historical Office, Bethesda, MD.

[2] Randy Shilts. *And the Band Played On: Politics, People, and the AIDS Epidemic*. New York: Penguin Books, 1988.

Oral History Process

The oral history methodology used in this project is that of the Regional Oral History Office, founded in 1954 and producer of well over one thousand archival oral histories. The method consists of background research in primary and secondary sources; systematic recorded interviews; transcription, editing by the interviewer, and review and approval by the interviewee; deposition in manuscript libraries of bound volumes of transcripts with table of contents, introduction, interview history, and index; cataloging in national on-line library networks (MELVYL, RLIN, and OCLC); and publicity through ROHO news releases and announcements in scientific, medical, and historical journals and newsletters.

Oral history as an historical technique has been faulted for its reliance on the vagaries of memory, its distance from the events discussed, and its subjectivity. All three criticisms are valid; hence the necessity for using oral history documents in conjunction with other sources in order to reach a reasonable historical interpretation.[1] Yet these acknowledged weaknesses of oral history, particularly its subjectivity, are also its strength. Often individual perspectives provide information unobtainable through more traditional sources. For example, oral history in skillful hands provides the context in which events occur--the social, political, economic, and institutional forces which shape the evolution of events. It also places a personal face on history which not only enlivens past events but also helps to explain how individuals affect historical developments.

The foregoing criticisms could be directed at the AIDS oral history series. Yet this series has several mitigating characteristics. First, it is on a given topic in a limited time frame with interviewees focused on a particular response, namely the medical and scientific. Thus although each interviewee presents a distinctive view of the epidemic, multiple perspectives on the same events provide an opportunity for cross-checking and verification, as well as rich informational content. Furthermore, with the exception of Dr. Selma Dritz who retired in 1984, each interviewee continues to be actively engaged in AIDS work. Hence, the memory lapses resulting from chronological and psychological distancing from events discussed are less likely to occur than when the interviewee is no longer involved.[2]

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[1] The three criticisms leveled at oral history also apply in some cases to other types of documentary sources.

[2] I discussed some of the advantages and disadvantages of oral history conducted with interviewees "in the heat of the battle", that is, while still engaged in the event being discussed, in an unpublished paper presented at the annual meeting of the Oral History Association, November, 1993.

An advantage of a series of oral histories on the same topic is that the information each contains is cumulative and interactive. Through individual accounts, a series can present the complexities and interconnections of the larger picture--in this case, the medical and scientific aspects of AIDS in San Francisco. Thus the whole (the series) is greater than the sum of its parts (the individual oral histories), and should be considered as a totality. To encourage this approach, we decided to bind several oral histories together in each volume.

Another feature of an oral history series is that later interviews tend to contain more detailed information because as the series unfolds the interviewer gains knowledge and insight from her informants and from continued research in primary and secondary sources. This was indeed the case in the AIDS series in which the later interviews benefited from my research in private document collections made available to me as the project progressed and by the knowledge I gained from the interviews and others connected with the AIDS scene.

A feature of this particular series is its immediacy, a characteristic less evident in oral histories conducted with those distanced from the topic of discussion. These are interviews with busy people who interrupted their tight schedules to look back, sometimes for the first time, at their experiences a decade or so ago. Because many have not had the luxury of time to contemplate the full meaning of their pasts, the oral histories could be criticized for lacking "historical perspective." But one could also argue that documents intended as primary historical sources have more scholarly value if the information they contain is not filtered by the passage of years and evolving personal opinions.

The oral histories also have a quality of history-in-progress. With one exception, the interviewees are still professionally engaged in and preoccupied by an epidemic which unhappily shows no sign of ending. The narrators are living the continuation of the story they tell. Neither they nor we can say for sure how it will end.

Other Oral History Projects Related to AIDS

Oral history projects on other aspects of the San Francisco epidemic are essential for full historical documentation and also mutually enrich one another. Unfortunately, not enough is currently being done in this regard. Two local projects are Legacy, directed by Jeff Friedman, which focuses on the Bay Area dance community tragically decimated by AIDS, and Clarissa Montanaro's AIDS Oral History Project, which interviews people with AIDS. An installation, "Project Face to Face", directed by Jason Dilley and using excerpts from interviews with people with AIDS, was exhibited around the San Francisco Bay Area and in 1991 was part of the inaugural exhibit at the Smithsonian's Experimental Gallery.

AIDS oral history projects outside San Francisco include documentation by Victoria Harden, Ph.D., and Dennis Rodrigues of the NIH Historical Office of the contribution made by NIH scientists, physicians, and policymakers to the AIDS effort. The New Jersey AIDS Oral History Project, sponsored by the University of Medicine and Dentistry of New Jersey, interviews faculty and staff involved in the epidemic and representatives of organizations providing AIDS support services. Rosa Haritos, Ph.D., at Stanford relied substantially on oral history in her dissertation on the controversy between the Pasteur Institute and NIH over the discovery of the AIDS virus.[1] In England, Virginia Berridge, Ph.D., co-director of the AIDS Social History Programme at the London School of Hygiene and Tropical Medicine, employs oral history in her research on AIDS policy in the UK.[2] And Maryinez Lyons, Ph.D., at the University of London, uses interviews in her work on the political economy of AIDS in Uganda.[3] In France, Anne Marie Moulin, M.D., Ph.D., Director of Research at INSERM, Paris, has relied on oral history in some of her work on the epidemic in France. The anthropologist, Paul Farmer, used interviews heavily in his work on AIDS in Haiti.[4]

Emerging Themes

What themes can be extracted from these oral histories? What do they convey about the medical response to AIDS in San Francisco? Was it unique, or are there parallels with responses to other epidemics? What do these interviews tell us about the complex interweaving of factors--social, political, economic, and personal--which shaped reactions to this epidemic, in this city, in these years?

The short answer is that it is too soon to attempt definitive answers. This is the first volume in a lengthy series, and most of the oral histories

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[1] Rosa Haritos. Forging a Collective Truth: A Sociological Analysis of the Discovery of the AIDS Virus. Ph.D. dissertation, Colubmia, 1993.

[2] See: Virginia Berridge and Paul Strong, eds. *AIDS and Contemporary History*. Cambridge: Cambridge University Press, 1993.

[3] Maryinez Lyons. AIDS and the Political Economy of Health in Uganda, paper presented at a conference, AIDS and the Public Debate: Epidemics and their Unforeseen Consequences, sponsored by the AIDS History Group of the American Association for the History of Medicine, Lister Hill Center, NIH, Bethesda, MD, October 28-29, 1993.

[4] Paul E. Farmer. *AIDS and Accusation: Haiti and the Geography of Blame*. Berkeley: University of California Press, 1992.

are not completely processed nor has the information they contain been fully assessed.

Furthermore, there is an inherent danger in reaching definitive conclusions on the basis of oral histories with only fifteen individuals. Obviously, this is not a statistical sampling. On the other hand, because these fifteen have been at the front line of the epidemic and in a city hit hard by the epidemic, their voices "count" more than their numbers might suggest. They also "count" because these individuals helped devise organizations and policies that have served as models for AIDS programs across the country and around the world. Thus, if used in conjunction with the traditional documentary sources, these oral histories "count" as rich historical sources on several levels.

Remembering these caveats, I will make some tentative suggestions about a few of the many themes which come to the fore as I put the first volume together. My thoughts will doubtless be modified and extended as I examine the oral history collection as a whole and assess it in the context of the existing literature on AIDS history.

--Professional and personal "preparation" for the epidemic:

Narrators invariably mentioned how their prior education and professional training and experience had prepared them for participation in the epidemic. Their training as oncologists or epidemiologists or infectious disease specialists "fitted them" in a deterministic sense to take notice when the epidemic was first recognized in San Francisco. Their interest piqued, they chose to become engaged because their professional knowledge, experience, and responsibility placed them in a position to contribute. How then to explain why others with similar backgrounds chose not to become involved? The interviews indicate that psychological makeup, humanitarian concerns, career ambition, absence of prejudice, and simply being needed and on the scene also played a role.

--Organizing for the epidemic:

The oral histories describe at length, in detail, and on many levels how the medical profession in San Francisco organized to respond to the epidemic. The focus is on physicians, but the oral histories show that it is impossible to talk about the medical response without at the same time mentioning its interconnections with the nursing, psychiatric, and social service professions, the gay community, and volunteer AIDS support organizations. Discussion of the coordinated medical system created in the early years of the epidemic, capsulized in the so-called San Francisco model of comprehensive AIDS care, permeates the oral histories. The complex process by which a community organizes to diagnose, investigate, and treat a newly recognized disease is detailed here, as are the spinoffs of these activities--the foundation of two AIDS clinics, an AIDS ward, and a specimen

bank; funding efforts; education and prevention programs; epidemiological and laboratory studies; political action at the city, state, and national levels; and so on.

--The epidemic's impact on the professional and personal lives of physicians and scientists:

A strength of oral history is its personal voice; its facility at putting a human face on history. The personal dimension makes history come alive and also helps to explain why events took the course they did. Its subjectivity is also an object of criticism. Hence the scholar's imperative to use oral history only in conjunction with the written documentary record.

Surprisingly, despite the flood of AIDS literature and the centrality of the medical profession in the epidemic, there are few accounts by physicians of the epidemic's professional and personal impact.[1] The physicians' voices which speak--at times poignantly, but always with immediacy--through these oral histories are a small corrective to the impersonality of most of the literature on AIDS.

On a professional level, the narrators describe commitment, concern, cooperation, camaraderie, and conflict as attributes of their engagement in the epidemic. Clinicians and epidemiologists confronted by what they perceived as a medical emergency described the prevailing sense of urgency and dedication of the epidemic's early years--to stop the insidious spread of disease, to discover its cause, to devise effective treatments, to establish community care arrangements. Narrators talked of concern for an articulate, informed, and youthful patient population, with whom some identified and for whom most felt great sympathy. They also spoke of the camaraderie and cooperation of the physicians, nurses, social workers, and community volunteers assembled at UCSF and San Francisco General to run the AIDS clinics and ward. But they also mentioned conflict--personal and institutional rivalries, funding problems, and run-ins with the university administration, city politicians, and gay activists.

On a personal level, the interviews recount the epidemic's impact on individual lives--of fear of a devastating and lethal infection, of stigma and homophobia involved in dealing with socially marginal patient populations, of exhaustion and burnout, and of growth in human experience and insight.

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[1] A few personal accounts by physicians do exist. See, for example: G. H. Friedlander. Clinical care in the AIDS epidemic. *Daedalus* 1989, 118, 2:59-83. H. Aoun. When a house officer gets AIDS. *New England Journal of Medicine* 1989, 321:693-696.

--The epidemic as a social and cultural phenomenon:

These oral histories describe the complex interactions between disease and its social and cultural context. They indicate how the unique circumstances of San Francisco in the early 1980s--its large and vocal gay community, its generally cooperative medical and political establishments, the existence of a city budget surplus--shaped the response to the epidemic.

AIDS, like all disease, reflects social and cultural values. Implicit and explicit in the oral histories are evidence of stigma and homophobia, the politicization of the AIDS effort and those associated with it, and the tension between individual rights and social welfare.

The foregoing themes are but a few of those inherent in these oral histories. I hope that scholars will be persuaded to explore these further and to discover and research those unmentioned. To serve as a rich, diverse, and unique source of information on multiple levels is after all a major purpose of this oral history series.

Locations of the Oral Histories

The oral history tapes and bound volumes are on deposit at The Bancroft Library. The volumes are also available at the National Library of Medicine, UCLA, and other manuscript libraries.

Note Regarding Terminology

In this series, both interviewer and interviewee occasionally use the term "AIDS" to refer to the disease before it had been officially given this name in the summer of 1982. "AIDS" is also used to refer to the disease which in recent years has come to be known in scientific and medical circles as "HIV disease." In these oral histories, the term "AIDS" has been retained, even when its use is not historically accurate, because it is the term with which readers are most familiar.

Sally Smith Hughes, Ph.D.
Project Director

February 1, 1995
Regional Oral History Office
The Bancroft Library
University of California, Berkeley

LIST OF PARTICIPANTS IN THE SAN FRANCISCO AIDS ORAL HISTORY SERIES

VOLUME I

Selma K. Dritz, M.D., M.P.H, Epidemiologist, San Francisco Department of Public Health

Mervyn F. Silverman, M.D., M.P.H., Director, San Francisco Department of Public Health

IN PROCESS

Donald I. Abrams, M.D., AIDS Internist at San Francisco General Hospital

Arthur J. Ammann, M.D., Pediatric AIDS Physician and Administrator, UCSF

Marcus A. Conant, M.D., AIDS Physician and Political Spokesman

Donald P. Francis, M.D., D.Sc., Epidemiology and Virology at the Centers for Disease Control

Deborah Greenspan, D.D.S., D.Sc., Oral Manifestations of AIDS

John S. Greenspan, D.D.S., Ph.D., AIDS Specimen Bank, UCSF

Jay A. Levy, M.D., Virologist, UCSF: Isolation of the AIDS Virus

Andrew A. Moss, Ph.D., Epidemiologist at San Francisco General Hospital

Merle A. Sande, M.D., AIDS Activities at San Francisco General Hospital

Paul A. Volberding, M.D., AIDS Oncologist at San Francisco General Hospital

Warren Winkelstein, Jr., M.D., M.P.H., The San Francisco Men's Health Study, UC Berkeley

Constance B. Wofsy, M.D., Authority on *Pneumocystis carinii* Pneumonia and Women with AIDS, San Francisco General Hospital

John L. Ziegler, M.D., AIDS Oncologist at the Veterans Administration Medical Center, San Francisco

Regional Oral History Office
The Bancroft Library

University of California
Berkeley, California

The San Francisco AIDS Oral History Series

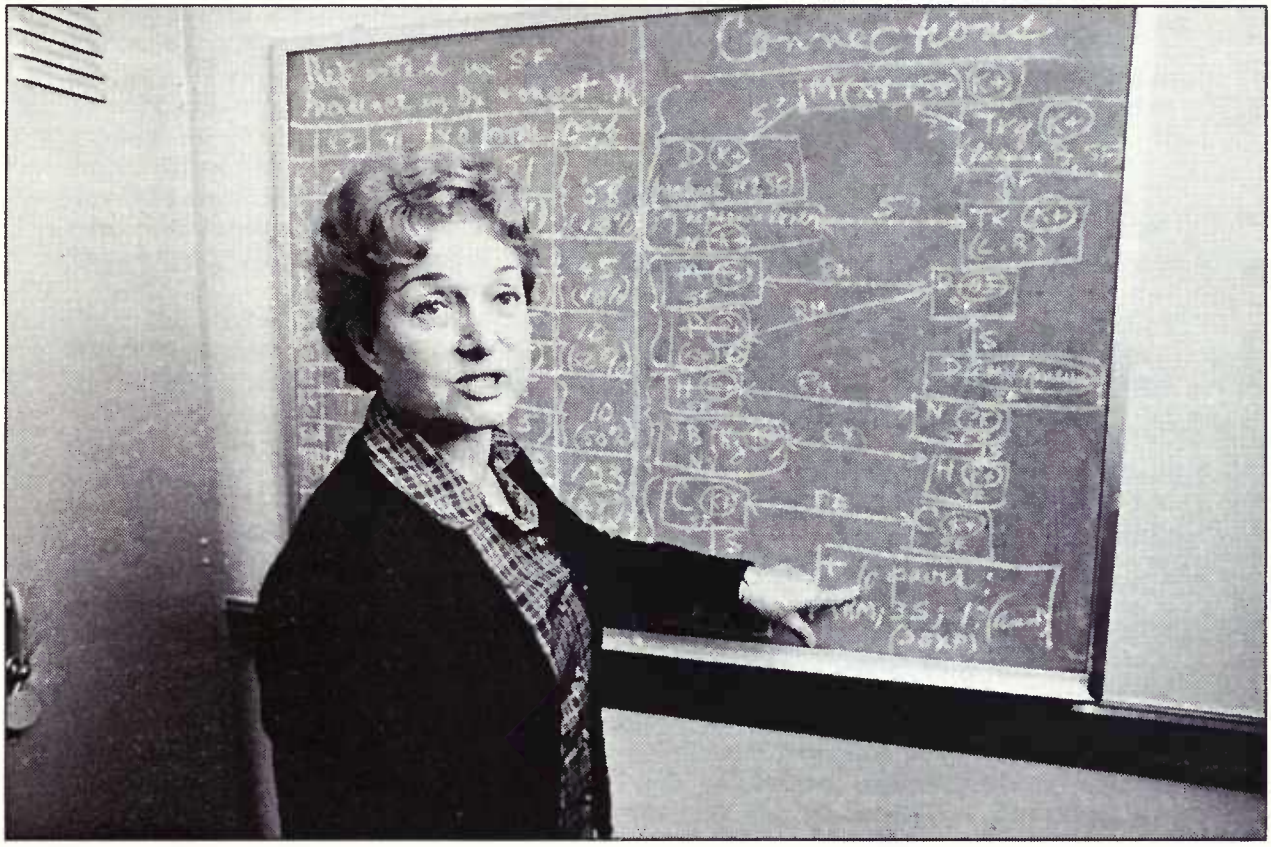
THE AIDS EPIDEMIC IN SAN FRANCISCO: THE MEDICAL RESPONSE, 1981-1984

Volume I

Selma K. Dritz, M.D, M.P.H.

CHARTING THE EPIDEMIOLOGICAL COURSE OF AIDS, 1981-1984

Interviews Conducted by
Sally Smith Hughes
in 1992



Selma K. Dritz, M.D., M.P.H., 1982

Photography courtesy San Francisco Chronicle

INTERVIEW HISTORY--by Sally Smith Hughes

This oral history with Selma K. Dritz, M.D., M.P.H., is the first in the San Francisco AIDS Oral History Series: The Medical Response, 1981-1984. Dr. Dritz was interviewed because she played a seminal role in the early years of the AIDS epidemic in San Francisco. As assistant director of the Bureau of Disease Control of the San Francisco Department of Public Health, she tracked cases of what by mid-1982 was known as "AIDS," collaborated with the Centers for Disease Control and the University of California, San Francisco [UCSF] in helping to establish the etiology and epidemiology of the disease, and worked tirelessly to educate the gay and straight communities about AIDS recognition and prevention. She also tells of her long-standing working relationship with the gay community, ties which she utilized when the epidemic broke in San Francisco in the summer of 1981. She also talks about the commitment and confusion of the early days when various theories competed as the explanation for the devastating infectious diseases appearing in previously healthy young men. Her dedication to combating the epidemic and obvious sympathy for those tragically affected underlie the interviews.

This oral history is also important as a reflection of the health department's role in the epidemic. Dr. Dritz and Dr. Mervyn Silverman, director of the department until his resignation in December 1984, are the two voices in this series representing it. Both address the department's official role as coordinator of San Francisco's medical response to the epidemic. Yet the content of the two interviews differs significantly. Dr. Silverman focussed on the controversy regarding the bathhouses as sources of AIDS transmission, a wrenching episode resulting in his decision in October 1984 to order them closed.

Dr. Dritz's account, while certainly not without conflict and strong opinion, is more one of collaboration and cooperation, at least at the local level. She describes the health department's interrelationships with a complex web of city, state, and national institutions--physicians and epidemiologists at UCSF and San Francisco General Hospital, local hospitals and private practitioners, gay political organizations and City Hall, and, further afield, health officials in Oakland, Los Angeles, and at the Centers for Disease Control in Atlanta. She became visibly agitated while discussing the federal governments slow and inadequate response to funding needs for AIDS research and the crippling effect the delay had on epidemiological research in particular.

Her agitation is reflected in her penciled annotations on the AIDS chronology I composed to assist the interviews. When she returned it, I found she had written at the top: "After reading these notes, perhaps you'll think I'm not sufficiently impartial for your project. I would understand." My response was--and is--that one strength of this oral history series is that it represents a range of perspectives, all necessarily subjective, all requiring assessment against other sources, but all contributing to a picture of why the response to AIDS in San

Francisco evolved the way it did. Dr. Dritz's voice is essential to this history.

Others have already indicated that they agree. In September 1993 Dr. Dritz attended the Los Angeles premier of the television serial, "And the Band Played On." The celebration with Randy Shilts, author of the book on which the videodrama is based, and Lily Tomlin, who portrayed Dr. Dritz, was tempered by forewarning of Shilts' death to AIDS five months later on February 17, 1984.

The Oral History Process

Four interview sessions were conducted with Dr. Dritz in June and July 1992. The setting was her modest home near the San Francisco Zoo where she has lived since 1949 and raised three children. The living room contains the grand piano testifying to her reputation as a near-concert level pianist. A more recent interest in clay sculpture is relegated to a portion of her basement.

Our preliminary meeting on June 9, 1992 set the stage for the subsequent recording sessions: coffee at the kitchen table, documents within ready reach in the file cabinet in the adjoining room, animated conversation with this engaged and engaging woman.

At Dr. Dritz's suggestion, I brought a projector to the second session so that she could show slides used in past AIDS talks. With me, she used them as starting points to describe her role and that of the health department as AIDS cases in the city escalated. The meticulous records which she kept were destroyed after she retired from the health department in 1984. Her oral history stands as a partial corrective to this loss of historical documentation.

Feisty, alert, and looking far younger than her seventy-five years, she spoke forthrightly and at times passionately of the turbulent period when the cause of the epidemic and its transmission patterns were being worked out. (Dr. Dritz's retirement occurred in the same month as the announcement of the discovery of the AIDS virus, in April 1984.) The edited transcripts of the interviews were mailed to Dr. Dritz, who edited them lightly. The finished product not only describes the contributions of a key figure in the medical response to the AIDS epidemic, but also provides glimpses of an efficient and experienced epidemiologist and a compassionate human being.

Sally Smith Hughes
Interviewer/Project Director

September 1994
Regional Oral History Office
The Bancroft Library
University of California, Berkeley

Regional Oral History Office
Room 486 The Bancroft Library

University of California
Berkeley, California 94720

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name Selma Kaderman Dritz, M.D.

Date of birth 29 June 1917 Birthplace Chicago, Ill.

Father's full name Paul Harris Kaderman

Occupation deceased Birthplace Russia

Mother's full name Pearl Rosenberg Kaderman

Occupation deceased Birthplace Russia

Your spouse Harvey Fred Dritz, M.D.

Occupation deceased Birthplace Chicago, Ill.

Your children Ronald A. Dritz M.D.; Alice Eileen Mussma;
Deborah Dritz Lieuwes

Where did you grow up? Chicago, Ill.

Present community San Francisco CA

Education U. of Illinois Medical School, 1941, M.D.
U. of California Berkeley 1967, M.P.H.

Occupation(s) Physician, Epidemiologist
Retired in 1984.

Areas of expertise Pediatrics, Public Health,
Preventive Medicine -
(Concert pianist to 1937, before medical school)

Other interests or activities Marble sculpture since
retirement; anti nuclear violence (prevention,
elimination of conflict). Environment.

Organizations in which you are active Physicians for Social
Responsibility, San Francisco Chapter -,
2) Various AIDS medical groups.

I EDUCATION AND EARLY CAREER

[Interview 1: June 24, 1992] ##[1]

Education

Hughes: Please tell me where you were born and educated.

Dritz: I'm a middle westerner, born in Chicago [June 29, 1917], parents of Russian origin. Medical school, class of 1941, University of Illinois College of Medicine. Intern at Cook County Hospital [1941-1942]. Pediatrics residency at Cook County Hospital [1942-1944], all in Chicago. Chief resident of the Cook County Contagious Disease Hospital.

Early Career

Pre-San Francisco

Dritz: Then private practice in pediatrics, Gold Coast practice, if you please, in Chicago, during World War II. Then two years as pediatric consultant to the Illinois State Health Department [1946-1947], retired at that time to raise my children. I had been married during my residency. Came to San Francisco, remained retired until my children were in their mid-teens. Went to the School of Public Health at UC Berkeley, took a master's in '67 in public health.

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[1]## This symbol indicates that a tape or tape segment has begun or ended. A guide to the tapes follows the transcript.

I immediately joined the San Francisco health department in '67 and worked there until '84 as Assistant Director of Disease Control, in charge of all infectious disease epidemiology except classic venereal disease--now we call it sexually transmitted disease--and tuberculosis. Those were two separate-standing clinics.

The work in infectious disease at first was the usual standard chasing down of measles, mumps, whooping cough, making sure that children in school had their proper immunizations, tracing down an occasional outbreak. For a time, I did occupational health, too, and industrial safety for the department [as chief of the Division of Occupational Health]. Then I was asked to take purely infectious disease as the city population grew and as new disease outbreaks appeared, particularly in our increasing population influx from the Pacific Rim.

[tape interruption]

Hughes: Why did you leave private practice?

Dritz: My husband came back from overseas service in the navy in World War II, and we realized that this was the time that we wanted to start to raise a family. We had delayed for five years during the war in order to be sure that our children would not find that they were suddenly growing up without a father. So I retired. It worked out quite well. I felt that, as a pediatrician, I had a duty to other people's children, but my children had only one mother. There were other pediatricians for other people's children, so I stayed home and took care of my own children.

Hughes: Did you like private practice in pediatrics?

Dritz: It was interesting at that time, but by the time I was ready to come back to pediatrics, it was no longer of interest to me as such. In the early years, we were still challenged with polio. We didn't have a vaccine for polio; we didn't have the MMR [measles, mumps, and rubella] vaccines. It was a real challenge to take care of children.

By the time I came back, most of those diseases had been relatively conquered, and the main interest was in neonatology--treatment of premature infants--whom I had cared for when I ran the preemie service at Cook County Hospital in pediatrics. But neonatology as such I didn't find too fascinating. The other aspect of pediatrics then was diseases and emotional problems of adolescence, and that too just wasn't what I wanted.

A third factor was the fact that San Francisco, by the time I was ready to go out into private practice, was a different city. If I had to go out on a call at night alone in Chicago, I had driven with a heavy monkey wrench on the seat next to me. Now, since my husband was also a physician and we might both be out of the house at the same time at night, it just didn't do.

So when I had my master's in public health, I joined the health department here. I could have an eight-to-five job, unquote--it ran more than that--but I could be assured that I would not be out when my children were at home at night.

Hughes: Was that the main motivation for the master's in public health?

Dritz: No. I had been pediatric consultant to the state health department in Illinois before I retired, and I found that it was the public health aspects of the work that were more interesting than the actual clinical aspects. In clinical medicine, I could help one patient at a time. Two patients at a time. Maybe even save a life. We didn't save them too often. But in public health, I could affect the health of many people at the same time. So I found that much more absorbing, and that was why I went for my master's in public health.

Hughes: Is there anything you care to say about the program in public health?

Dritz: It was a good program, but most of what I learned about public health, I learned on the job. You learn theoretically in a school of public health how to draw up a budget; you learn theoretically how to do health education, as two examples. Out here, when you do public health education, you have to first find yourself an interpreter for Korean, Tagalog, Vietnamese, Thai languages. You have to learn how you speak to people of other cultures without insulting them. You have to learn to think of diseases like, say, clonorchiasis--Chinese liver fluke disease--which you didn't see in San Francisco, but you see it now; people come in from the China Sea.

You have to learn on the job how to write a budget, not according to the books, but according to how much you think you can get away with now, and still leave yourself an opening to go for a supplemental budget six months from now when what you're getting now isn't going to be enough and you know it isn't going to be enough, but you can't say it isn't going to be enough.

Epidemiologist, San Francisco Department of Public Health, 1967-1984

Dritz: So I learned on the job. I learned that a good deal of public health--I suppose a good deal of most city occupations--is political. And in seventeen years on the job, I guess I must have been a pretty good politician, because I survived until I retired.

Hughes: Is public health chronically underfunded?

Dritz: Almost every department in this city is underfunded now, because the tax base is too low. The city has roughly 720,000 people here. Only about half of them really pay taxes. The big businesses pay taxes, I suppose, but they have lots and lots of write-offs. Maybe a third of the population is under the poverty level. There just isn't enough money, especially as new immigrants come in from the Pacific Rim and from Mexico. We have more Hispanic people from Guatemala and Colombia than we have from Mexico *per se*. That's different than Los Angeles.

Immigrants are hindered by their poverty level, their language difficulties, and their educational lacks for the kind of service jobs we have here, where they can't run a computer and they can't handle typewriters. Men are eager to work but they're often just not qualified for the kinds of jobs we have. Older men now of the immigrant type are taking jobs at places like McDonald's at minimum salary simply to get food for people.

Now, in San Francisco real estate is up; rents are <u>enormous</u>. I think next to New York, it's the most expensive city to live in. When you have a large population of below-poverty-level people, and rent and food and housing and everything else that you can think of is so terribly expensive, there are great lacks that welfare and mental health and injection drug services and health and Medicare all have to supply. There just isn't enough dollar pie to go around. In the health department, you were always fighting for a bigger slice of the pie. It was interesting.

Hughes: Was Mervyn Silverman director when you first joined the department?

Dritz: No, Ellis Sox was director when I was there for the first year or two. After he left, Francis Curry, who had been chief of the TB clinic, became director. About seven years later, must have been about '76 or '77 [1977], Mervyn Silverman became director after Frank Curry reached retirement age. We still had a sixty-five year retirement age then.

Hughes: Were there policy shifts every time a new director came in?

Dritz: Under Ellis Sox, everything was sort of free and easy. If there was a problem, you went in to talk with him about it, and he said, "Well, what do you want to do about it?" And that was it. You could do what you felt you wanted to do about it.

Frank Curry was a good, conscientious health director. I think his major interest was in the TB group in the Chinese community because he had run the TB clinic. But he was fair and he knew his business. He was highly respected.

Merv Silverman was more an organization man. He knew contracts; he knew management. He was very, very interested and devoted to the public health and to getting services, and he knew how to get that aspect of the work done through good health officers under his direction. I would have liked to see him continue; he was a good man, but he got caught in that awful can of worms of the battle between the gays and the City Hall and the bathhouse owners. Nobody could have survived that.

Hughes: Did he give you free rein when it came to the AIDS crisis?

Dritz: Yes. Well, we had an AIDS advisory council [Medical Advisory Committee on AIDS, San Francisco Department of Public Health]. I have a chart on that from the health department staff. San Francisco General, University of California at San Francisco, Bay Area Physicians for Human Rights, and several other groups: we all met regularly to discuss major problems and try to come to some consensus on how to handle them. Silverman was ready to listen to everybody. He asked very, very good questions, and then he made up his own mind. But it always seemed to be a pretty fair approach to the various views that had been presented.

The work in AIDS was very difficult because we didn't know where we were going. We were blind people in a dark room, and if we had seen the light, we didn't know if we would recognize it.

Enteric Disease in the Gay Community

Hughes: Well, maybe before we actually get into AIDS *per se*, we should talk about the work that you had done with the gay community on enteric diseases. I think that sets the stage, both in terms of some of the disease patterns, and also in establishing your relationship with the gay community.

Dritz: It certainly did. Back in '74, the board of supervisors in the city, under what pressure I don't know, ruled that acts in private between consenting adults were no affair of the police. That meant that there would be no more raids on baths, bars--there really weren't too many in the way of baths at that time. The action was in the back rooms of the bookstores, the back rooms of the bars, out in the bushes of Buena Vista Park when the weather permitted.

With the passage of that ordinance, the population of the gay community in San Francisco just exploded. Police had estimated that originally we might have between thirty and forty thousand gay men in the city--I just use the word gays; it's easier. By '75-'76-'77, they were estimating 120,000. People came from every city in the country where they were being harassed, from New York after the Stonewall battle; from Moscow, Idaho--the university was said to have a large gay group there; from Humboldt County, California; from Texas; the cowboys out in Arizona and New Mexico who had to use what they called "tea rooms" for their contact, public bathrooms and so on, a lot of them came to San Francisco.

Hughes: Was San Francisco unique in having that sort of an ordinance?

Dritz: San Francisco was unique in a different way. It's a compact city. It's just fifty square miles; it's a square seven miles on each side. We can't spread anywhere without getting our feet wet, except down the peninsula, which is an enclave of mostly wealthy residential areas on the west, and some high crime and drugs on the Bayshore [Freeway] to the east. The compactness of the city made it possible for us in the health department, police department, fire department, to know practically everybody active there. Seven hundred thousand population. I think it dropped to about 680,000 at one time.

Knowing the population there, knowing the neighborhoods, we were able to see that the Castro area and the Polk Street area north of that were developing more and more concentration of gay men. Now, for us it was simply a fact at that time, but for the gays it meant--I'm generalizing now, of course--they could recognize each other more readily, they could make contacts more readily, and they didn't have to hide in a crowded bar or bookstore back room. They developed the baths.

The baths were not so much places for swimming or washing yourself. They were large establishments. One of them, the Club Baths, was four stories high, I think. They had cubicles where the doors could be closed and where there was simply a bunk with a mattress and a jar of Crisco. There were also large what were called "orgy rooms," which were dark, a lot of music going on. It

was possible for men to make contact with each other--sexual contact, I mean now--even standing up, without seeing each other's faces, and some of them actually told me later, "I don't know who he was. I never saw his face." I'm not trying to be funny about it, but these were places where a man could go in and make ten, fifteen, twenty contacts in the night, depending on how much energy he had.

With that, we began to see an increase in diseases in the city. Not AIDS--this was long before AIDS appeared. The VD clinic began to see much more syphilis and gonorrhea. Of course, that didn't bother anybody; one shot of penicillin and you were cured. And they began to be coming in with severe diarrheas. And then the reports began to come in from physicians in the community. See, by law, physicians were supposed to report all cases of enteric disease, diarrheal disease, shigella, amebiasis, salmonella--almost any cause of diarrhea. This is because for the food processing and food serving industries, waiters, cooks had to be free of diarrheal disease. So any doctor who had a case of diarrheal disease in a man or a woman by law had to report it.

We began having reports that were changing. Previously, let us say in '69, we would have reports of 100 cases in the course of a year, and they would be more or less evenly divided between males and females, and the age range would go from a few months of age to eighty-five years.

By '76, '77, I was seeing a complete change.[1] For one thing, it went from 100 cases to 500 in the same period. It went from half-and-half male and female to--on a sheet of twenty names, there would be eighteen males and two females. And the ages almost exclusively ranged between twenty-five and forty-five years of age. I looked again, and they were all shigella, either *S. sonnei* or later *S. flexneri*. But they were not just shigella. The cases were being reported by doctors who I knew had primarily gay patient populations, and by clinics that served a concentration of gay population.

So we knew now that gay activities, the increasing gay population, the increasing gay contacts, and the baths, were contributing to transmission of a tremendous lot of enteric disease. Now, why enteric disease? Enteric means your guts, your stomach, intestines. And enteric disease ordinarily is a disease that is caused by swallowing the organism from contaminated food or contaminated water.

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[1]See: S. K. Dritz. Medical aspects of homosexuality. *New England Journal of Medicine* 1980, 302:463-464.

Now, these cases weren't coming from eating establishments. They were in men who were ingesting the bacteria or the hepatitis A virus in the oral-anal techniques that they were using for their gay sex contacts. As we developed more and more of these cases, we not only had an increase of hepatitis A, which is an enterically transmitted disease, but a lot of cases of hepatitis B. Now, that last shouldn't have happened, because hepatitis B has to be transmitted into the bloodstream, usually by a needle or a cut or a scratch, especially in a third-world country.

Here, though, some of the traumatic anal techniques that the gays were using caused breaks in the mucosa and in the blood vessels in the anus and the rectum, and in the mouth, too, I suppose. And ingestion of fecal material from the anus of the passive partner into the mouth of the active partner produced hepatitis A; or injection of semen of the active partner into a broken blood vessel in the rectum of the passive partner with hepatitis B virus, meant that they were being injected parenterally. So we had a large increase in all of these diseases.

Now, my job was to find out where these diseases were coming from, stop the source--that was a good job--find out who had it, and make sure that they didn't pass it on to anyone else. So I did intensive interviews. I was able to reach about 70 percent of the shigella and hepatitis and amebiasis patients, by phone or in person or through interviews with their physicians. In almost every case, I found that it had to be oral-anal or anal-genital contact.

But in investigating this, I had to make contact with members of the gay community, the officers of their various political clubs--there was the Alice B. Toklas [Gay Democratic] Club, the Stonewall [Gay Democratic Club], the Harvey Milk [Memorial Democratic] Club, the Tavern Guild, which was the association of gay bar managers and owners--and try to pass on word to them how the gays were getting these diarrheas and the fact that we could cure them. But the next time they went out, they would catch them again, because there was no immunization for them then.

Hughes: Were they receptive to your suggestions?

Dritz: Many of them were, because they found that we were not being antagonistic or punitive. I tried to make it clear that my job was to stop the diseases, and I didn't care what they did in bed, in the bushes, or anywhere else. My job was simply to see that they didn't catch them again. I didn't want them to get sick. They responded to a sympathetic approach, maybe because they had so little of it; I don't know.

The gay community found that the health department was helpful, that we wanted to be helpful, and the private doctors that were curing them--treating them, anyhow--told them that we were trying to help, too.

As a matter of fact, once one of the doctors sent in reports from his private office lab that just didn't make sense at all. It looked like something was going crazy in the lab. I couldn't accept those reports, so I called the doctor and asked him, did he mind if we sent one of our lab technicians in? The city had the microbiology lab, the reference lab of the health department; we worked together all the time. I asked him if we could send in one of our technicians just to review his lab technicians' work. He agreed. Our lab tech reported back they had big mistakes in what they were doing, and corrected it all, and my reports began to come through as they should be. The physician was very happy about it.

A gay physician would call in perhaps and say, "I think I've got a Rocky Mountain spotted fever case. I just don't understand it." And I offered our lab as an additional check on his lab. We confirmed it. I called him back, I said, "Tom, that was a good diagnosis. It <u>is</u> Rocky Mountain spotted fever." He'd say, "Thanks a lot, Selma," that sort of thing. So we were on a one-to-one basis, a first-name basis, with many of the gay physicians. As a matter of fact, it bothers me now to know that seven of those that I knew have died of AIDS. They were good doctors, and there are still some really good ones practicing there.

So I had rapport with the gay community, I had rapport with their political and social organizations, I had rapport with their doctors. Because they trusted us, they reported in, in spite of being afraid of the confidentiality problems. So we knew better what was happening, and how it was happening, why it was happening. Until AIDS hit us. And then we didn't know from beans.

II THE AIDS EPIDEMIC

Early Cases of AIDS

Kaposi's Sarcoma

Hughes: When were you alerted to the fact that something unusual was happening in the gay community?

Dritz: Actually, not in our gay community, but among the gay population in the country, the first thing was the publication of Michael Gottlieb's article in the *MMWR*.[1] It was in June of '81.

[tape interruption]

Dritz: We [in San Francisco] didn't get our first cases until late July, early August. Those were not cases of *Pneumocystis* [PCP]. The first one was a case of Kaposi's sarcoma [KS] reported by Dr. Jim Groundwater in a man called Ken Horne. Jim was very excited about it, because we had already known that Kaposi's sarcoma was being reported from New York by Linda Laubenstein. Dr. Groundwater suspected that it must be part of this same outbreak. Ken Horne lasted about two years, I think; that's all.

After that first case, we had three or four other cases of Kaposi's in a row, within a week or two. Then we began to get a sprinkling of *Pneumocystis* pneumonia and Kaposi's sarcoma. By the end of the first month, we had a little over twenty cases, and two had already died.

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[1]M. S. Gottlieb, H. M. Schanker, et al. *Pneumocystis* pneumonia--Los Angeles. *Morbidity and Mortality Weekly Report* 1981, 30:21, 250-251. (June 5, 1981)

At this time, in our health department, we had a coordinating office for gay and lesbian health services. We met every week in the office of that group. Members of the various gay clubs, Tavern Guild, independent gays--anybody who was interested--came in. Each week, I would report to them how many more new cases there were, how many more new deaths. And it became ominous, week after week. I would tell them, "There were twenty-two cases; now there's a total of twenty-six cases; we have four deaths already."

Patients at the time they were diagnosed had been sick a long time. They would come to the doctor after whatever they tried to do themselves for "these spots", unquote, on their skin, didn't work, and then doctors might use one ointment after another. Finally, they would take a biopsy. Now, some of the doctors did biopsies right away, but in general they would take a biopsy and it eventually came back with [the comment], "Good Lord! Kaposi's sarcoma! What's that doing here?"

We knew then that Kaposi's sarcoma is a disease of old men in the Mediterranean littoral or in North Africa. Lesions on their lower limbs become ulcerous, perhaps after a few years, but they're slow-growing; they're indolent. The men last for eight, ten, twelve, fourteen years, until they die of something else. Unless they would get a terrible infection, such as septicemia, and die from that source, KS usually didn't kill them.

These young men, though, were not Mediterranean old men. They had the lesions all over them, and internally, too. The lesions were working fast, and the men died in a few months. And we didn't even know if they were dying of the Kaposi's sarcoma, or something else. And we didn't even know they had the KS before the lesions showed up. We didn't know what caused it, except in Africa it was related we thought to the cytomegalovirus. So it was a great puzzle. Why is this African disease of old men suddenly appearing so virulently in San Francisco and New York in the gay community? It raised big questions.

Pneumocystis carinii Pneumonia

Dritz: Then the *Pneumocystis* organisms began to show up. Now, there it could easily be missed, and it probably was missed at first until we became aware that there was such a disease as an active *Pneumocystis carinii* pneumonia. Ordinarily this organism can be found in the lungs of some normally healthy people and it's just either living there in symbiosis or as the organisms come in

they're killed by our immune system responses. In this case, it caused a violent bronchopneumonia, and they died of the pneumonia.

Now, first of all, we had to find out that it was *Pneumocystis* pneumonia. Then we had to find out how to treat it. Centers for Disease Control [CDC] had a drug called pentamidine, which they distributed to doctors at the doctors' request when the doctors sent in to CDC in Atlanta proof that they had a case of *Pneumocystis* pneumonia.

Hughes: Why was the drug so carefully controlled?

Dritz: It might have been very expensive; I don't know. It may have been to track presence of a very rare infection. CDC's prime job was infection control.

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Dritz: Those patients who needed pentamidine almost invariably had had a renal transplant or were on chemotherapy or on radiation for cancer--kids with leukemia, persons whose immune systems had been depressed in order to keep them from rejecting the transplant. Without an immune system, the *Pneumocystis* could cause pneumonia. Two or three times a year, you'd have a case of *Pneumocystis*. Dr. [Oscar] Salvitierri up at the kidney transplant unit at UCSF reported a couple of cases like that. I had talked with him about it.

Now, we were finding *Pneumocystis* in apparently normally healthy young men, twenty-five, thirty, forty years old. These people shouldn't be getting it. So we began wondering, was something wrong with their immune systems? But we didn't have any evidence.

A paper on that came out sometime later, I think it was in the *New England Journal of Medicine*, proving that the T4 cells, what are now called the CD4 cells, the helper cells, are depressed below a critical level of 200 T cells/mm^3 in these patients.[1] A normal level for a healthy person is around 1000. When a person gets, let's say, severe pneumonia or flu, the immune system may be temporarily depressed a little bit. And as he recovers it rises again.

We began to think that maybe these gay men, since they were getting one disease after another--shigellosis, amebiasis,

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[1]H. Masur, M. A. Michelis et al. An outbreak of community-acquired *Pneumocystis carinii* pneumonia: Initial manifestation of cellular immune dysfunction. *New England Journal of Medicine* 1981, 305:1431-1438.

hepatitis A, hepatitis B, syphilis, gonorrhea, lymphogranuloma venereum, one after another and in rotation, perhaps their immune systems were finally being depressed to a critical level below which they couldn't recover any more. Therefore, maybe it was just these repeated infections that were making them susceptible to *Pneumocystis* and Kaposi's sarcoma. We still didn't know what other reason there would be for their being susceptible to these diseases. We still didn't know about HIV [human immunodeficiency virus].

[tape interruption]

Kaposi's Sarcoma Study Group and Clinic

Hughes: The KS study group was organized in 1981. Do you remember exactly when?

Dritz: Well, it must have been right after the first cases appeared [in the summer of 1981]. I remember Marcus Conant showing us in his clinic the skin lesions on the heel and leg of Bobbi Campbell, a male nurse, who was the first case of KS that we saw in the clinic. I had come in from the health department, and some of Conant's residents, and some of the other doctors from dermatology and oncology were there, because this was such an interesting case.

After that, we began to meet every week or every two weeks, I think on alternate Tuesdays, as a grand rounds clinic to look at cases and to talk about things. Among us there were those who really became the core of the AIDS activities: me, Conant, Don Abrams, who is now the director of the San Francisco County Community Consortium which conducts trial therapeutic tests for various medications for AIDS. (The consortium demonstrated that inhalation of pentamidine would help prevent recurrence of cases of *Pneumocystis* pneumonia.)

There was John Conte from the UCSF infectious disease unit, there was Dave Altman of gastroenterology at UCSF, Jim Groundwater of dermatology at UCSF, Paul Volberding of oncology-hematology at San Francisco General Hospital, Jay Levy from virology at UCSF. If I've forgotten anybody, I'm sorry. Oh, and Paul Dague. Paul Dague was a Ph.D., I think, and he was in psychology. He was very, very anxious to help. He did a lot of work with questionnaires on gay patients, and he was dead within a year [January 1984].

[tape interruption]

Simon Guzman: An Early Patient

Dritz: One of the early patients was Simon Guzman, also a KS case. Now, he was characteristic of some of the patients who ran like crazy everywhere in the country and to Europe looking for a treatment, because the diagnosis was a sentence of death. Simon Guzman ran down to Mexico for therapy after Marc Conant diagnosed him, because the Mexicans were supposed to have drugs there that the Food and Drug Administration [FDA] wouldn't permit in the States.

It didn't work on him. He went to the Philippines right from Mexico for a highly touted bloodless hands-on surgery, which of course did nothing for him. He came back in worse shape; had to be hospitalized. Marc Conant put him into UCSF, and we worked for eight solid months and $200,000 later, when he died.

In the course of that, we learned a lot about AIDS, because his immune system went down just to nothing. He developed cytomegalovirus, he developed brain lymphoma, he developed *Pneumocystis* pneumonia, he developed cryptosporidiosis. Gallons and gallons of fluid poured out with the diarrhea. There was nothing we could do. We couldn't stop it. We gave what we call purely supportive therapy: Treat the symptoms. After eight months, he died. It was a pity that he lived that long, because he suffered.

This was the kind of thing that happened, and this was the kind of thing from which we learned. We learned what didn't work, not what worked.

Hughes: Were you thinking about a compromised immune system?

Dritz: When we had *Pneumocystis* pneumonia showing up, we had to think, "Maybe there's something wrong with their immune system," because we found that disease only in people whose immune systems had been deliberately suppressed for other reasons.

Hughes: So that was an idea that occurred to you--

Dritz: It was an idea, but we couldn't follow up on it. In the meantime, researchers were working on it back East, and it eventually came out in the literature.

Investigating the Etiology of AIDS

Possible Causes

Dritz: We were beginning to think, well, you suppress the immune system either by radiation or chemotherapy. Maybe some chemicals in the gay community are suppressing the immune system. So we began to look at the environment. All the gays--generalizing, of course--had plants in their house. What do you use on your plants? Plant food, plant chemicals, bug sprays. They all had dogs or cats or something. What do you use on your pets? What do you use to get a high? We sent two of my men into the Jaguar Bookstore and the Ambush, and they bought "poppers" under the counter. We sent them down to CDC in Atlanta and let CDC analyze them.

There's another part to that, too. The poppers turned out to be nitrites, but we found that almost all the gays were using the poppers. Why didn't all of them get this disease? Why did only a few? We didn't know at that time that most of them were already infected with it, because we didn't have a test for it. Why aren't they sick? So there was that question.

The CDC Questionnaire

Dritz: As we got to the point where we had about 100 patients, CDC worked out for us about a twenty-four page questionnaire that covered everything: Where were you born, where were your parents born, what do you do--all the lifestyle factors--what techniques of sexual communication do you use, what do you use in your house, what do you use in the way of drugs? Have you ever traveled? Did you serve in the armed services? Where did you serve, and what kind of materials do you use in your occupation? What are your hobbies, and do you use airplane glue? Everything we could think of.

Hughes: Was that questionnaire based on earlier questionnaires, or was it created for the AIDS epidemic?

Dritz: No, we put that together--it was creative. CDC called us down there to Atlanta. I was from San Francisco, there were two from New York, one from Texas, I believe, and I think one from Chicago.

Hughes: These were all public health people?

Dritz: Yes.

Hughes: Do you remember any names?

Dritz: No, I'm sorry. But Jim Curran and Harold Jaffe were there for CDC. I think maybe Bill Darrow, too. We did actual role-modeling, role-playing, with this questionnaire, to see how it would be used and how useful it might be, and where it might antagonize the person who is being interrogated.

I used the questionnaire on about 100 of the patients here. It took almost two hours to go through it in detail with each one. We gathered all the information and sent it all back to CDC, and it took them two years to do a computer analysis of it, twenty-four pages of questions. It took them about a year and a half to get budget enough to hire another statistician to do the job. Jim Curran was crazy; he was wild: NIH [National Institutes of Health] wouldn't give him the money.

See, the government wouldn't give CDC extra money. If they needed more money, it had to come from some other health department [Health and Human Services] budget. NIH also had not only NIAID, National Institute of Allergy and Infectious Diseases, but they also had the National Cancer Institute, and the other institutes. So to get money for the special AIDS project of CDC, they had to take it from somewhere else. Nobody else was going to give it up.

Hughes: I can imagine.

Dritz: When CDC finally got the money almost two years later for a statistician to analyze the questionnaires when we knew already that this had to be an infectious disease, they said, "The only thing that adds up here, the only thing that is significant, is type of sexual activity and amount of sexual activity." That was it. The poppers didn't come through, dog sprays didn't come through, food didn't come through, travel didn't come through. Even the previous diseases gays had--they all had those diseases. But the one thing that came through was the sexual--some person might use the word--promiscuity. It's as descriptive as anything else. But when a gay man reported three times a week, ten contacts each time in the baths or something like that, it's pretty active, if not promiscuous.

Now, some of them had quiet, monogamous relationships with monogamous partners, and they were closeted, and we didn't know about them. But those who were out, who called themselves the "Castro Clones," the very young, very slender, short haircut, moustache, tight jeans--the clothing stores on Polk Street didn't

carry a waistline in jeans bigger than twenty-four inches (mine is bigger than that)--they were the ones that were really out in the baths in force, night after night.

Suspicions of a Transmissible Agent

Dritz: Now, when you have so many people in close contact, so easily visible to each other, and the police aren't bothering you, there's a lot of [sexual] activity. If you have a transmissible disease, that's where it's going to be transmitted. We had proved that gays transmit the enteric diseases, so we were beginning to be almost certain that with this, too, we had a transmissible disease.

Hughes: How early do you think you could say that?

Dritz: Well, by the end of '82 we had the case of the baby at UCSF infected through a blood transfusion. That was sort of the nail in the coffin, as far as we were concerned, as proof that AIDS was a blood-transmissible disease. We didn't know <u>what</u> was being transmitted yet, but we knew something was being transmitted.

<u>Diagnosing AIDS</u>

[Interview 2: June 29, 1992] ##

Hughes: Dr. Dritz, I thought we should start with the changing definitions of HIV disease as the epidemic progressed. Could you start with how you were defining the disease in the very earliest days?

Dritz: The earliest cases were a series of Kaposi's sarcomas. They weren't diagnosed very quickly either, because we weren't looking for KS in young people in this part of the world. When cases of *Pneumocystis* appeared in San Francisco a little bit after Michael Gottlieb's report in CDC's *Mortality and Morbidity Weekly Report*, we realized that there must be some kind of connection between the two outbreaks. We were calling it simply "gay cancer," "gay pneumonia." The gay community objected to the "gay" label, of course, and we tried simply to call it pneumonia in members of the gay community. Later, gay patients preferred to call themselves "PWAs" or "Persons with AIDS."

After a while, though, we began to see other diseases beside the pneumonia and KS that we lumped under the terms "OI," opportunistic infections. We had cases of non-Hodgkins lymphoma. That was a very rare thing. It was DUNHL--diffuse undifferentiated non-Hodgkins lymphoma--massive increase in the size and inflammatory processes in the lymph glands. It was a lymphoma, it was a cancer, and it was appearing in the same population.

Then, we began to see in the next year Burkitt's lymphoma, which is an African lymphoma, which is the most virulent of them all with a doubling rate of twenty-four hours, seen usually in young boys in central Africa and related to the Epstein-Barr virus. So here again, we were looking for viruses. The cancer registry told us when we asked that they could expect two or three cases of Burkitt's lymphoma diagnosed in the course of maybe two years, in all of California. And we had eight cases in the course of nine months here. So Burkitt's lymphoma became part of our local diagnosis of AIDS.[1]

It wasn't until quite a good deal later that we got reports from the laboratories of bone marrow analyses that showed *Mycobacterium avium*, sort of related to tuberculosis but in the bone marrow, in young children and infants born of AIDS-infected mothers.

We began to see oral candidiasis. Francine Lozada, one of the professors in the [UCSF] dental school, diagnosed that for us.[2] Candidiasis--thrush--is a fungus, a yeast, in the mouth. It would grow down into the esophagus. It would get all the way into the intestinal tract. The patients had it in their rectum, the anus--horrible thing.

In the same type of patients--young, gay men--Francine was able to show us, and I have pictures of it, Kaposi's sarcoma behind the teeth in the mouths that were already infected with the candidiasis. We had a new diagnosis there. Then she found hairy leukoplakia--very rare.[3] It was a very zoo of infectious

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[1]For more on the AIDS-lymphoma association, see the oral history in this series with John L. Ziegler.

[2]F. Lozada, S. Silverman, Jr., et al. New outbreak of oral tumors, malignancies and infectious diseases strikes young male homosexuals. *California Dental Association Journal* 1982, March, 39-42.

[3]For more on hairy leukoplakia, see the oral histories in this series with Deborah and John S. Greenspan.

that do not cause serious disease generally in healthy persons with normal immune response.

We found in taking histories of these infected men that a lot of them had had herpes zoster--shingles--perhaps six months before their AIDS symptoms began to develop, before they were "sick"--the most devastating, damaging, herpes zoster that one could imagine. Now, herpes zoster is caused by the varicella virus, that is, the chicken pox virus, which many adults apparently seem to harbor quiescently in the neural ganglia. For some reason in some, usually elderly, people, it's activated--we don't know why--and causes shingles, following the nerve trunk on the chest or on the head. It doesn't happen in young men to the degree that we saw it. So this again became part of our diagnosis.

Then there were the violent diarrheas that were finally diagnosed in Simon Guzman as a cryptosporidiosis, a parasitic disease of sheep and goats. And we found later that sheepherders when they're tested are found to have antibodies to this disease. They've had it, but they didn't get sick with it. They hadn't any diarrhea; they didn't even know they had it. But these patients were pouring out two, three, four liters of fluid in twenty-four hours. So we had another diagnosis.

I could go down the whole list. There was PML--progressive multifocal leukoencephalopathy. It was another lymph gland problem, to put it very briefly. T cells--they're called T cells because they're produced in the thymus--act against invading organisms. The T cells are one part of the immune complex. But there were B cells, too. They're the cells that develop in the bone marrow and seem to proliferate in the lymph nodes. We saw later that when the lymph nodes became inflamed with AIDS virus, there was an overgrowth of B cells, and then they all died down.

Now, the B cells produce the circulating antibodies. Instead of attacking the invading organisms directly like the T cells do, they throw out antibodies to neutralize the chemicals in the virus. Except the virus was secreted in the white cells of the blood, and the antibodies couldn't reach it. That's why we thought, although we found high levels of HIV antibodies in the gay men, that they were still infected, and they still got sick, because the antibodies couldn't reach the virus.

Incidentally, a little aside is that an ordinary vaccine is actually a synthetic antibody to an invading organism, whether it is a bacterium or a virus or whatever. The antibody chemically hooks on to the invading organism. When it chemically hooks on to it, the two become a different chemical, a third chemical, and that third chemical doesn't cause the damage in the body.

But you couldn't use an antibody, or a vaccine if you wish, that would attack the HIV, even if we had one then, because it would have to get into the cell where the HIV is already secreted, which would destroy the cell, which we don't want to do. So what we're trying to do now is to find something that will interfere--AZT may do it to some degree, except it has side effects--with the reverse transcriptase enzyme which the virus needs to take over the mechanism within the cell to duplicate its own DNA at the expense of the cell's DNA.

I got off the track a little--but all of these various infections and damages to various parts of the body became part of our picture of what AIDS was, but it developed gradually. For a couple of weeks, it was only KS, and then PCP, and then later on we got more and more opportunistic infections, and the horror of the thing grew week by week.

Recognizing Immune Suppression

Hughes: At what stage did it become clear to you and others that there was an underlying immune problem?

Dritz: There was a publication in the *New England Journal of Medicine* which indicated that the T cells were way down in AIDS patients.[1] Now, before that, there was no good way to count and differentiate helper cells, the T4 cells, from the T8 cells, the suppressor cells--they're now called CD4 and CD8, or C4 and C8.

Since the lymph glands were involved in all these cases--a lot of patients had lymphadenopathy before they showed the other illnesses--the cells of the lymph glands were studied carefully. We found that the T4 cells are diminished. An ordinary healthy person would have, let us say, 900 cells/mm^3. In a person who has recently been quite ill, it might be down to 800, 700, 600, and it would recover in time.

In gay people, it went down below 500 cells, below 400, and approached 200 when they were actively showing symptoms of AIDS-complicating diseases. So then we knew that something was attacking the T cells, destroying them in the most severe cases to the point that we couldn't count them any more.

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[1]H. Masur et al. *Op. cit.*

More on Etiology

Dritz: Now, we knew then that we had to find some way to prevent this from happening, and in order to prevent it, we had to get into the cells. We didn't have the virus yet. However, knowing that the T cells were being destroyed, we couldn't rule out some chemical toxin which also destroys the cells. We couldn't rule out some previously unknown mechanism within the humoral system, the blood system. We couldn't rule out some new invader. We had ruled out every invader that we could test for, which didn't mean that we had ruled out every invader.

Hughes: You mean micro-organisms and viruses?

Dritz: Yes. An animal or plant life form--a yeast is a plant form--rather than an inert chemical toxin, which could also destroy things, but not as a living form. So we still didn't know. We were looking for chemicals in the environment, chemicals used in their occupation, chemicals used in their hobbies. People were sniffing glue, and they used airplane glue and so on.

A normal sexually active adult heterosexual male maybe would report as many as twenty-five heterosexual contacts per year. The gays could average sixty-five per year, and as high as 3,500 in a lifetime (and those lives were short!). We were looking at sexual stimulants--poppers--and the other chemicals they used. Poppers are amyl nitrites. We were thinking about what kind of sexual lubricants they used, whether on the penis or in the rectum, and the various chemicals which might have some effect if they were getting into the bloodstream through broken blood vessels in the anus. A lot of gays were using steroids to build up their muscles, and we do know that steroids do have a deleterious effect on the immune system.

Hughes: They're immune-suppressant.

Dritz: Yes. Then, besides chemicals, we were looking for a genetic factor. Why did some men get this virus and get sick quickly? Why did other men apparently remain immune? Now, they were infected, but we didn't know it yet. So why did they remain "immune?" Dr. Alvin Friedman-Kien in New York was testing the genetic factor, HLA-DR5. He thought he found, in the gay men he tested, statistically significant numbers who had some deficiency in their HLA-DR5, but eventually that wasn't confirmed by anybody else, and he dropped it. You must remember, much of the heterosexual population who were homophobic, if you wish, said that "there's something wrong with gays' genes; they're born

wrong." So this genetic factor of Friedman-Kien had to be looked at.

I told you that gay men had so many serial infections--sexually transmitted diseases, enteric diseases--any or all of which could depress their immune response. If they infections in rapid succession, it could be that the immune system never got back up to anywhere near normal before it was knocked down again. It could have been depressed below a critical level to the degree that it couldn't recover at all any more.

At that point, maybe whatever agency destroyed their immune response left them vulnerable to any invader that found them. We thought at that time that their serial infections must have been that agency.

Hughes: To put it colloquially, the straw that broke the camel's back.

Dritz: That's right. Then we were looking at bacteria, but everything we checked was negative. We looked at fungi and yeasts. Now, candidiasis is caused by a yeast, and some of the other AIDS infections are caused by a yeast. We looked at protozoa. PCP is caused by a relative of protozoa. We looked at parasites. A lot of them had round worms--*Ascaris*--surprisingly, which we don't see in this country unless somebody's come back from Mexico or perhaps an ashram in India. We worried about this.

And then the viruses, finally. We couldn't look at viruses without an electron microscope; the other bacteria and parasites we could inspect under a standard light microscope. Of all the viruses we could and did test for by biological methods, the herpes group was of most interest, because herpes zoster is one of the herpes group, cytomegalovirus [CMV] is the herpes group, Epstein-Barr virus [EBV] is the herpes group. EBV is related to Burkitt's lymphoma, and causes mononucleosis in he States. CMV is related to Kaposi's sarcoma in Africa. Both conditions are forms of cancer. Would solving this mystery bring us closer to an attack on the cancer problem, too?

Retrovirology

Dritz: Then we were looking for the HTLV, human T cell lymphotropic virus.

Hughes: Because of Robert Gallo's work?

Dritz: Gallo had previously reported identifying HTLV-1. It was the first time that a virus had been proved to be the cause of a human cancer. Now, that was HTLV-1. Before that, we knew tobacco mosaic virus was the cause of a tobacco plant tumor. Chicken sarcoma is caused by an identified virus. This was the first time that a human cancer, adult leukemia, was proved to be caused by a virus--a retrovirus. He deserves greatest credit for his discovery. This, though, didn't help us with AIDS, since the adult leukemia he had found was localized in a small area of southwestern Japan. There was no AIDS reported there.

Then Gallo identified HTLV-II, and Murray Gardner at the Primate Research Center at UC Davis found a monkey--it was a *Macacus rhesus*--that had the equivalent of human AIDS. He didn't find the virus, but he was able to prove by shifting monkeys from one cage to another and permitting the air to go from one direction to another--things that you can't do with humans--that it was a transmissible disease, that it had to be transmissible monkey-to-monkey, and that it didn't transmit through the air or through the food dish, but through cuts and scratches in fights. I don't remember if he did or didn't prove that infected female monkeys gave birth to infected infant monkeys. But he proved that this simian AIDS, if it truly was an AIDS like the human AIDS, was a transmissible disease. [Myron] Max Essex reported similar findings from Harvard University's primate research center. That was very exciting.

Hughes: It also provided an animal model, didn't it?

Dritz: No, it didn't, because it's only recently that we've found a monkey--just in the last few weeks, I think it is--that can develop true AIDS.

Hughes: The macaque.

Dritz: That's right. There are varieties of macaque. Until that discovery, only the chimpanzee was known to develop true AIDS. Jay Levy said he'd love to test it out, but $50,000 to purchase a chimpanzee?

Hughes: Wow!

Dritz: Somebody else said, "No, it's $15,000."

Hughes: A bargain.

Dritz: Yes. And there aren't that many. Of course, the animal rights people would have a very valid argument, too. People would raise fewer objections about macaques because there are so many more of

them, and they're not quite so closely related to humans. I'm not anti-animal rights, of course. Animals should be treated decently, sympathetically, humanely. But I still place human life at a higher level of priority than animals'. Somebody's going to throw a rock through my window for this.

Then the herpes group was out as a primary cause of AIDS, and the HTLV group we couldn't prove anything. Every new virus had come from Africa in the last half-century anyway: Lassa virus, African green monkey disease, Marburg virus, Eboli River virus--there may have been one or two others. And then African swine fever, which was found in Haiti. Since AIDS was found in Haiti, the question was raised, maybe it's caused by the African swine fever virus. Couldn't prove it. I don't know how many more viruses we considered. We probably had the virus of the week or the virus of the month.

So between all of these things, we had our own definition of AIDS that didn't fit exactly with CDC's.

Hughes: Now, when you say "our," do you mean the health department?

Dritz: Our office here, yes. I was tabulating Burkitt's lymphoma as cases of AIDS in late '82. CDC didn't accept that until months later.

Hughes: With other parameters? Burkitt's would have to be in young men to be classified as AIDS, wouldn't it?

Dritz: Well, my cases were. It was Burkitt's lymphoma, but they had the weight loss and the fever and the night sweats and everything else [characteristic of AIDS]. They had that history before all of the more definitive symptoms of AIDS appeared.

Warren Winkelstein's group's ongoing study[1] on San Francisco gay men found that if they went back a few years before the men they were interviewing had become overtly sick, they found, yes, a couple of months ago the men had what they thought was flu, but got over it, and maybe two months later they began to lose weight and so on.

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[1]The San Francisco Men's Health Study. For more on this study, see the oral history in this series with Dr. Winkelstein.

AIDS Progression

Dritz: Winkelstein's group finally characterized the disease. AIDS starts with an invasion almost like flu, and then you get well for a while, and then you begin to lose a little weight, and your lymph glands flare up, and then your lymph glands go down after a while, and you seem to be all right. That is ominous, we found later, because after the lymph glands die down, then a short time later, patients develop overt AIDS with one or another or a combination of the opportunistic infections.

Hughes: And the T-cell count is dropping all the time.

Dritz: That's right. Well, we learned to count the T cells, too, and that was finally part of our definition. Our lab had difficulty; it's a complex procedure and requires specialized equipment, which was just then becoming available to researchers, and we couldn't afford it in San Francisco then.

The first time the cell sorter was available was down at Stanford, I think. The Stanford group was using that equipment, on loan from one of the manufacturing companies [Beckton Dickinson], I believe. I didn't do any lab work myself; I knew what they were doing. I may have some details wrong here.

Hughes: Well, at this early stage, were you working under the assumption that this was a disease of gays?

Risk Groups

Dritz: No. We were working under the assumption that this was a disease that required multiple intimate contacts, by any persons, and it apparently had to be something that could get into the circulatory system. So it wasn't necessarily only gays. Now, the first few months, half-year maybe, we didn't even think in terms of intravenous drug users, but after a while, we realized that it didn't have to be gays only. Anybody who had unclean infected material introduced into the circulatory system from any source whatever, whether it be an IV needle from a drug user or the semen of an infected man going through the anus of a passive partner, any of these kinds of people could catch it.

And then, after we had the hemophiliacs being diagnosed with the disease and getting very sick very rapidly, we realized that it had to be something injected into the bloodstream.

Hughes: Well, the CDC, reported the first cases in heterosexuals in August 1981.[1]

Dritz: They also knew AIDS had to be sexually transmitted when CDC reported that a hemophiliac's wife was now infected with the disease.

Hughes: And yet, the popular image of the disease remained that of a gay disease. I question whether some of the physicians and researchers were not also trapped by that conception.

Dritz: Well, we had thousands of gay men sick with it. There were only a handful of the hemophiliacs.

Press Coverage

Dritz: The press wasn't terribly excited about AIDS until Rock Hudson developed the disease. In the meantime, here in San Francisco, the *Chronicle* was publishing on AIDS. Randy Shilts had difficulties getting his editors to publish his stories, especially if there was a big murder on the front page.

Hughes: What was the argument?

Dritz: People aren't interested in the gays. Now, Art Ammann's baby who developed AIDS from blood transfusion--that was news. In other words, something that will catch the reader's eye, because the newspapers have to build up their readership in order to sell advertising, which pays the bills. And that's business. I can't argue with it. But the press should be considered as a public agency, too, and therefore, they should feel some sense of responsibility for doing something just for the benefit of their readers. If there's something that the reader should know, even if it isn't very popular or profitable, they should print it.

The newspapers might have been thinking--I don't know, of course--that if they got too pro-gay, maybe readers would switch to the San Francisco *Examiner*.

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[1]S. M. Friedman, Y. M. Felman, et al. Follow-up on Kaposi's sarcoma and *Pneumocystis* pneumonia. *Morbidity and Mortality Weekly Report* 1981, 30:33, 305-307. (August 28, 1981)

Hughes: Do you think the perception of the disease as a gay disease, by at least some segments of the population, was a factor in the federal response, particularly in terms of dollars, to the AIDS epidemic?

Dritz: Oh, yes. Because we had a very, very ultraconservative administration, both in Washington and Sacramento. If you think of President Bush and Vice President Quayle talking about decent morality now, it was even more so before, because they were worried about the fundamentalist groups. Right now, there aren't so many fundamentalist ministers on the air raking in thirty, forty, fifty million dollars anymore, because they have lost much of their following.

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Dritz: The press was very, very cautious. If you angered somebody in the top administration, it was quite possible that you wouldn't get the hint that if you were around the department offices at ten o'clock on Sunday morning, there was going to be something interesting happening, and maybe if you were a good boy, you'd get the first crack at it and beat out the other reporters. Those things happen. So the press had to be a little bit cautious during those years when the fundamentalist religion was riding high. Some homophobia must have played a role, too.

Funding Problems

Hughes: Well, another aspect of the slow federal funding, and there are many aspects, was that the epidemic coincided with a cutback at the federal level in practically all areas of health care and scientific research, the philosophy of the Reagan administration being to shuffle as much of the responsibility--

Dritz: To the states, and the states shifted it to the counties and cities.

Hughes: Yes.

Dritz: They were using all of their budget for Pentagon purposes, and they felt justified at that time. Much of the population agreed with them. They were worried about the "Evil Empire." I was worried, too, every time a jet went overhead, whether they were going to drop something on my children. But at the same time, I was a doctor; I had a responsibility to our population here through the health department. I felt that the responsibility included caring for these people, not just telling them what they

were getting, and telling them to cut unsafe sex out so they wouldn't catch AIDS.

Now, the federal government's budget was geared to military, foreign affairs--I suppose they did something about roads, because they might have to run tanks across them. I'm a cynic. But they felt that health care should be the responsibility of the states. Now, the states passed the buck to the counties and the cities. The counties and the cities didn't have any money. The states said, "You are responsible for health care," but they didn't give them any money to do anything.

So things went downhill. There wasn't any money. For example, it took more than a year to find the money to hire a statistician who could analyze the twenty-four-some pages of questionnaire that we used on 100 of our patients, to see if we could find out what was different about these people as compared to healthy gay people. We didn't know most of the healthy gays were infected with HIV then, too.

Hughes: Was it not also true that the CDC was particularly affected by these budget cuts?

Dritz: Well, health money was given to the National Institutes of Health, which has the Public Health Service, under which is the CDC. It has the NIAID--National Institute of Allergy and Infectious Diseases. It has the National Cancer Institute, NCI. It has the National Heart, Blood, and Lung Institute, and a whole bunch of others. Now, they were given one bunch of money, one pie, and everybody had to compete.

CDC asked for more money for this AIDS outbreak, but there wasn't going to be any more just for CDC. It had to come from somewhere else. The cancer institute wasn't going to give it up. NIAID wasn't going to give it up. Heart, Blood, and Lung Institute was doing a lot of research for open-heart surgery. So it was a scramble, and CDC was the orphan. We didn't get it.

CDC's job was supposed to be, if there's a case of malaria in Louisiana, you go out there and clean it up. That's why they're down in Atlanta in the first place, because that was the place where malaria and the other deep South diseases were focused. CDC wanted to move to the Washington area, but they weren't permitted to.

If there was an outbreak of a disease, CDC would go out with their regular questionnaires. They ask a zillion questions; they find out what's different about it; they clean up the pools of

water where the mosquitoes are growing that produce the malarial organisms, and they stop the outbreak, and that's it.

Now, AIDS was a different story entirely. It wasn't a couple of cases or an outbreak of legionellosis--which got millions of dollars spent for it, because these were straight men, war veterans. Great. I'm glad they helped them. But there would be millions of people involved here, and AIDS is a disease that was killing them 100 percent. Sooner or later, it was 100 percent. It still is. At least it's later rather than sooner now, but that's about all you can say for it so far. The average time of survival from diagnosis to death was ten to twelve months a few years ago. Now it is about eighteen months.

So the CDC needed an awful lot of money, and couldn't get it. They were stretched so thin. There was Harold Jaffe running around all over the country. Jim Curran was running around talking. Don Francis was screaming. Bill Darrow was doing questionnaires. Dave Auerbach was circling the country. I think that's about all; five of them that I can think of [at the CDC]. Oh, and Mary Guinan. She was taking testimony everywhere and the CDC investigators were bringing it all in. Then it lay there waiting for the computer, because there wasn't any money for a statistician.

And the same way here in the city. Jay Levy is a top-notch virologist at UCSF. It's a state university, so the city couldn't offer any money. The state didn't have any money for him. He was trying to do tests to find out what was going on here, there, and everywhere, and he didn't have money for the equipment to do the testing, and couldn't get it. The money wasn't available, because it had to come down from the top. That was the point at which finally the gay community began to try to raise money. They twisted arms and they had cake sales and things, and raised a little bit.

More on the Kaposi's Sarcoma Clinic

Dritz: Marc Conant was able to get a $50,000 grant, which he used to hire Helen Schietinger as the nurse coordinator for the KS clinic. She made appointments, she ran around like crazy, and she did a marvelous job. Really killed herself for what salary she was getting.

Hughes: That $50,000 came from the American Cancer Society, I believe.

[tape interruption]

Dritz: After Marc had hired Helen Schietinger, we were able to do a little bit more with the KS clinic. Originally, it was chiefly dermatology weekly rounds. Since the first cases we had were KS, which is a dermatology problem, a skin cancer if you wish--it's not really a cancer; it's something different--Conant would bring in his KS cases for us to see. The usual clinic--all the doctors gather.

In that clinic, after a few weeks of these sessions on KS, we began to see that the patients also had *Pneumocystis* pneumonia, or we saw the scars on the forehead of a severe herpes zoster, and it became more than just a dermatology case, but they were coming through the derm clinic. Marc Conant at the same time was in private practice in dermatology. I believe some of these gay patients came to him as private patients after seeing him at the university, if they requested they didn't want to be a clinic case, they wanted a private doctor.

So the KS clinic gradually began to show us different kinds of cases, and it became finally the KSOI clinic--Kaposi's sarcoma and opportunistic infections. Then as some of the patients came in and had to be hospitalized, it became a hospital clinic, too.

Finally, those of us who were there--Dave Altman in gastroenterology, John Conte the UCSF infectious disease chief, Paul Volberding and Don Abrams as hematology-oncology, of course Conant, John Ziegler came from the Veteran's Administration Hospital, Francine Lozada from dental clinic, Jay Levy from virology, and once in a while one of the newspaper reporters would come in. Dave Perlman was very interested in AIDS and wrote very good, impartial articles. No patients' names, of course. Once in a while, we would meet with Charles Petit also. He usually does the physical sciences and is science editor for the *San Francisco Chronicle*, while Dave Perlman does the biological sciences.

We began to have good free-for-alls there: "What do you think is causing this and what do you think is causing that?" Leon McKusick would come in; he is a psychologist. Paul Dague was there before that; he was the psychologist, a Ph.D. Unfortunately, he died of AIDS in that first year [January 1984], so he didn't get to do too much. We realized that our interests were much wider than just dermatology and hematology/oncology.

Support from Community Groups

Dritz: The Kaposi's Sarcoma Research and Education Foundation went through some changes, and became the San Francisco AIDS Foundation in time. By that time, though, we were having input and cooperation and some funding from various AIDS organizations; one was the Shanti group. Jim Geary, the leader of the Shanti grief counseling group, was one of the people in that clinic. He's left Shanti since. Over a period of time--I'm not really clear on a single step here and there--the KS Foundation evolved into the AIDS Foundation, and then they became a fundraising group as well as a community service group. They were able to help Helen Schietinger put together some houses for those AIDS patients who had been thrown out of their homes, had no money, no place to go. They were on the street, and they weren't sick enough or eligible for hospitalization.

With city and AIDS Foundation funds, we rented or bought three Victorians, four bedrooms each, and we were able to house twelve of the sickest patients there, and arrange with VNA, Visiting Nurse Association, and other home health aides to come in and bathe patients. The Shanti group had lots of volunteers gradually trained to buy groceries, bring food in, support the patients.

Hughes: Was there any problem in the neighborhood where the Victorians were?

Dritz: I don't recall that there was that much, because the houses were in the gay area. It worked out very well, except the first man to die of a group of four just shattered all the others. So the program had mixed effects, but at least it took care of the men physically, and a little bit emotionally, because the Shanti group sent in volunteers to sit and talk with them, hold their hands. They had grief therapy.

Shanti had started simply as a grief management group, for persons who had friends who were dying of cancer, for instance. And when AIDS became the big problem in the city, Shanti became an AIDS support group. They did a wonderful job.

Hughes: Had it always had an association with the gay community?

Dritz: Not necessarily, but there were a lot of gay men involved in the Shanti organization. I'm generalizing, of course--a lot of gay men gravitated to the health professions. They were nurses, they were aides, they were hospital orderlies, but there were real estate agents and businessmen and lawyers and doctors and

engineers among them too. A large percentage of the male nursing personnel was gay men. Aside from Ken Horne who was Jim Groundwater's patient, the first AIDS patient we had with KS was Bobbi Campbell, who was a nurse.

When Rock Hudson was finally recognized as a case of AIDS and died of it, Elizabeth Taylor funded--with many millions--the beginning of AmFAR, the American Foundation for AIDS Research. Rock Hudson had been a friend and a colleague.

So there are now the two organizations. There's AmFAR, of which our former health director, Merv Silverman, is now the president, and there is the AIDS Foundation here locally in the city. AmFAR is a national organization.

Hughes: Is there competition between the two?

Dritz: I don't think so. The San Francisco AIDS Foundation raises most of its money here, and it does a wonderful job. It not only has housing for sick gay men, it has a food bank, and gay men who are mobile can come up once a week or every day and get food. They also have a sort of meals on wheels organization, which they developed. They deliver food to those who are home-bound. Otherwise, they would just die there.

Hughes: San Francisco is known for its extensive community-based system. It seems to be a network that is unique to San Francisco.

Dritz: That's right. It's unique in two ways. San Francisco has I think a higher per capita population of gay men than any other city--not in actual numbers, but per capita. Also, San Francisco is unique in that it's so compact. It's only fifty square miles in area; it's a square seven miles on a side.

The Health Department's Community Ties

Dritz: We know all our medical community people, and all the doctors know each other, the patients practically know each other--not only gay, but all the others. If something came up in the office, I'd just pick up a phone and say, "Tom, what's happening out there?" Or Tom would call in and say, "I've got this case here. Could you help me get a lab test on it?"

So the health department worked closely with our medical community. We knew the gay organizations--we knew the ones that hated us; we knew the ones that would work with us. We finally

realized that over these years of working first with the enteric diseases and now with AIDS, that gay men did trust our office, and they would cooperate. They came in and gave me confidential information, knowing that I wouldn't pass it on.

Knowing what the needs were, we in the health department were able to work out an education program for the health community, for the doctors, and the lay people working in health. We were able to work out an education program for the lay community, both gay and heterosexual. We were able to work out a program for health services, ancillary health services, if you wish. And we were able to work with the press and television, all of that. We worked with CDC, California Medical Association, the American Medical Association, the San Francisco Medical Society--their president, Glenn Molyneaux, was very supportive of us all through that period. I can't now remember all of the organizations we worked with.

Each time we found a new need, we tried to respond to it. Much of the time we didn't have the money for it, but we worked out something, and the community cooperated. The gay doctors would cooperate. They came in to clinics at private evening sessions to talk about cases, to talk about problems.

As we were able to work out our responses to as many of the problems as we could identify, other cities began to pick up some of our methods, for instance, housing for gay men who needed homes, certainly the food bank and the meals on wheels.

The gay parade in San Francisco is a good fundraiser. It's a raiser of sensibility for the population. Of course, it incenses a lot of people, too, but in general I think in San Francisco, we have become, if not accepting, certainly more tolerant of the gay lifestyle than we used to be. It shouldn't be necessary to be tolerant, even. People are people. My attitude was, what people do in bed is their own business--unless it transmits disease, which is what I'm getting paid to prevent. So in that case, it's a different story. Besides, I'm a doctor; I should prevent it.

Hughes: How did you weigh the pluses and minuses of the health hazard versus the civil liberties issues?

Dritz: We were always behind the eight ball. We were always chasing after a good answer, a good way to do it. But if we found that the actions of infected patients were hazardous to their [sexual] contacts, and we had told them what not to do and showed them why they shouldn't and they were still doing it, then I tried to crack down. You couldn't put them in jail, because you couldn't prove what they had transmitted. And you don't do that. But we got at

them any way that we could. We could threaten then, "We'll tell your friends that you're infected." We didn't do it. But once in a while, we had to use a little body punch just to keep them from killing somebody else.

Gaetan Dugas and the Cluster Study

Hughes: Well, maybe this is the time to introduce Gaetan Dugas, patient zero?

Dritz: Well, he wasn't really patient zero. He was the first one from whom we could more or less prove that it was a transmissible disease. Bill Darrow and Dave Auerbach from CDC were doing interviews in California on patients with AIDS. This was when we were still doing our large questionnaire and trying to find out, is AIDS a transmissible disease, or is it some chemical in the environment?

In their interviews, the CDC asked patients, "Well, whom did you have sexual contact with?" And have them name them. This was before confidentiality became a red flag, and justifiably, perhaps. You have to be politically correct here.

Hughes: Which comes hard, doesn't it?

Dritz: No, not really, but I have to be conscious of it.

So they kept asking about contacts from patients they were interviewing. Several in southern California mentioned that one of their contacts, among many, was this handsome Canadian air steward. They didn't get the name. After maybe thirty or forty interviews, they kept hearing something about a Canadian air steward. And then finally, one man they were interviewing pulled out his appointment book. He said, "Yes, there was this Canadian air steward, and he was here just on Thanksgiving--oh, wait a minute, I think I have his name in my book." And he pulled out the name. "Gaetan Dugas, that's his name."

Now, Dave Auerbach and Bill Darrow had heard the name Gaetan Dugas a long time ago from Linda Laubenstein in New York. She was a cancer specialist there and Dugas saw her for a small purple KS lesion then. Doctors will mention patients' names to each other when they won't use the names in public. It was an unusual name, and they both remembered it. Dave and Bill went back and found that the other two who had mentioned the Canadian steward said, "Oh, yes, that's probably his name." After that, by talking to

people who had slept with Gaetan Dugas, or who had slept with somebody who had slept with Gaetan Dugas, they were able to put together what they called their cluster study. I think Gaetan had direct sexual contact with about forty out of two hundred and something, and the others had had contact--second and third degree contact--with him.

So he was the first one for whom they were able to say, "Well, this man we know had AIDS. And these people slept with him"--or whatever they did with him--"and they also have AIDS." They were able to put together a connection. This looked now very, very suspiciously like something being transmitted from Gaetan Dugas to others.

Hughes: When did this happen?

Dritz: It would have been in '82.[1]

Hughes: Before Art Ammann's baby?

Dritz: Yes, that was before, because Art Ammann's baby then was the next nail in the coffin. (I shouldn't talk that way!)

Hughes: Please finish with Dugas, because you had some more dealings with him before he died.

Dritz: Bill Darrow and Dave Auerbach came back up to my office from southern California to talk to me, because I had a whole list of contacts listed on my blackboard there. You've seen pictures of that. Bill came in and he said, "Well, I've got a name now and a contact. Do you know any of these?" And he gave me Gaetan Dugas' name, and I had that name already. I showed him Gaetan Dugas had contact with Michael Maletta, a hairdresser from New York, and there was Dan Turk, who had a clothing store on Polk Street, and one or two other names. I would have to look back at the slides now to be sure. We're talking about almost ten years ago now. And they're dead now.

I knew that Gaetan Dugas was still in town. I couldn't get to him, but I put word out, "If you see Gaetan Dugas, let him know I want to see him." He came up. I told him, "Look, we've got proof now." I didn't tell him how scientifically accurate the information was. It wasn't inaccurate, but it wasn't actually

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[1]S. Fannin, M. D. Gottlieb, J. P. Wiessman et al. A cluster study of Kaposi's sarcoma and *Pneumocystis carinii* pneumonia among homosexual male residents of Los Angeles and Orange County. *Morbidity and Mortality Weekly Report* 1982, 31, 23:305-307. (June 18, 1982)

scientifically proven. I said, "We've got proof that you've been infecting these other people. You've got AIDS, you know. We know it's transmissible now, because you're transmitting it." He was the active partner in all this gay business, anal-genital sex. "You've just got to cut it out."

"Don't be silly, I won't cut it out. It's my life. I'll do what I want." I said, "Yes, but you're infecting other people." "I got it. Let them get it." I said, "You've got to cut it out!" "Screw you." He walked out. I never saw him again. It was a pity, because he was apparently an intelligent man, except on this one point. And he was very, very sexually active. He was a presumptive proof that AIDS was something transmissible from an infected person directly to the uninfected person.

Hughes: You mentioned your diagrams of transmission. Was he the first that reinforced the idea of a transmissible agent?

Dritz: I had a lot [of indication] that it looked like AIDS could be transmissible. There was all this contact among these men, and they all had the disease, one kind or another. On the other hand, all of these men were having other contacts, too, and we didn't know then that the incubation period was a long number of years in some cases.

Hughes: Right. And they were maybe using the same poppers or--

Dritz: Whatever, yes. And we didn't have the answer on the poppers yet, because CDC was still waiting for money for a statistician to run the computer analysis on the questionnaire. So the problem then was to test the rest of our theories about transmission, and that didn't happen until the end of '82.

Transfusion AIDS at UCSF

Hughes: With Art Ammann's baby.

Dritz: Let's go on to Art Ammann's baby, because that was where we knew we had an infectious disease. Well, we had the hemophiliacs, too--we knew something was being transmitted into the bloodstream.

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Hughes: You have spoken of Art Ammann's baby as the nail that sealed the coffin. Tell me why it was so conclusive.

Dritz: Well, we had Gaetan Dugas, presumptive evidence. We had hemophiliacs, presumptive evidence, although they were not in direct contact with gay men. They were not in direct sexual contact with anybody, except their own wives. They were not getting blood transfusions, but they were using Factor VIII and Factor IX, which are made from pooled human plasma, collected in plasmapheresis centers. The collecting organization pays men to donate their blood, the plasma is removed, the red cells are shot back into their veins, and they go off, for pay. Now, the people who will come into a plasmapheresis center--which were all in the drug-sex Tenderloin area or south of Market [in San Francisco]--will be those who are probably a high-risk population anyhow, if they sell their blood for money.

So we had plasma being concentrated down from maybe 20,000 donations into Factor VIII and Factor IX, and segments of the plasma being injected into hemophiliacs to prevent excessive bleeding, which is the characteristic of their disease, following trauma of some kind.

Factor VIII and Factor IX had not been used too many years before that. I don't remember exactly when. But just at about the time that the AIDS cases were beginning to appear here, New York was reporting one or two cases of hemophiliacs with AIDS. They were heterosexual; they had nothing to do with the gay community; they didn't even live in that gay area. They had no contact with this area. And yet they were getting AIDS. Now, why? The only thing that we, the scientific community, could see that was common with the hemophiliacs and the gay people who were apparently getting injected with the virus was that they must be getting it from plasma. So that was a presumptive, a very terrifying presumptive, suggestion that it was a virus in the bloodstream of infected persons.

Now, Art Ammann had the idea, and he has to get full credit for it. He wrote the paper; he's the prime author on it.[1] He said, "I've checked this baby back and forth for combined immune deficiency," which is the congenital form. The plastic-bubble baby was one of those. Well, "This one," he said, "isn't characteristic. The blood counts aren't characteristic. The cell counts aren't characteristic. And yet this kid is getting diseases one after the other. His immune system is down. Maybe it's like AIDS. He did have blood transfusions."

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[1]A. J. Ammann, M. J. Cowan, D. W. Wara, H. Goldman, H. Perkins, S. Dritz. Possible transfusion associated acquired immunodeficiency disease (AIDS). *Morbidity and Mortality Weekly Report* 1982, 31:652-653. (December 10, 1982)

The baby had an Rh factor condition in which the baby's blood is destroyed by antibodies from the mother's blood. That doesn't happen any more, because as soon as the mother's first baby is born, she can be immunized against the Rh factor, so she doesn't destroy the blood in the second baby.

The affected baby's blood simply has to be completely exchanged, which meant that in the course of the first week of Ammann's baby's life, its blood was exchanged with blood fractions from thirteen donors. Because Ammann thought it was AIDS and I was working the AIDS problem in the department, he called me. So I called the Irwin Memorial Blood Bank. Of course, they cooperated. We had worked a lot together on hepatitis B and hepatitis C, transfusion-mediated hepatitis, so we had rapport there.

We got the thirteen donors' names, and right in the middle of them was number seven, an AIDS patient in San Francisco, already dead. I can still see it on that yellow page that Herb Perkins sent me. I won't use the patient's name that I recognized from my AIDS case file. And the same birthdate; there wasn't any question that the donor was our AIDS patient.

So I called Art Ammann and I told him that the blood donor was an HIV case. This was November of '82. The man had already died, vehemently denying that he was gay. That was not true. We proved it later from his medical records. The interesting thing was that the date of onset of his symptoms was seven months after he had made the donation. He hadn't known he was sick then, and of course, the blood couldn't be tested for we didn't have a test for AIDS. It had been tested for hepatitis, and he didn't have that.

I called Herb Perkins at the blood bank. He was medical director of the Irwin Memorial Blood Bank. I told him what we had. He must have had a heart attack.

Hughes: What did he say?

Dritz: I don't remember what he said, but it might be something like, "Oh, my." He is a perfect gentleman, and wouldn't cuss.

Hughes: Because the significance must have hit both of you: AIDS was transmitted by blood.

Dritz: Oh, yes. Well, it hit Art Ammann too, because at UCSF they were transfusing a lot of babies with Rh factor problems. And transfused adults also had to be considered at risk.

Hughes: Right. And you already knew about cases of AIDS in hemophiliacs.

Dritz: That's right. So then I called CDC and told them this new development, and Harold Jaffe talked to me on the phone. He said, "Oh, Gads! We've been afraid of it." Because with the hemophiliacs getting it, we'd already been afraid. This was the end of November of '82, into December.

The Centers for Disease Control Blood Transfusions Workshop/Advisory Committee Meeting, January 4, 1983

Dritz: On January 4, 1983, the CDC convened a national meeting with all the health department people and the blood bank people. We met in Atlanta. CDC called me and they said, "Come in, we've got to have you here." After all, our office "discovered" the case [of the baby with transfusion AIDS], if you wish. I told him I'd be glad to fly to Atlanta, but I couldn't afford the money. The round trip was over $800 at that time, plus taxis and the hotel. Health department people don't get that much money. It's not like a neurosurgeon or a plastic surgeon.

Hughes: Decidedly not.

Dritz: So they said, "We haven't got the money, either." I asked the city--"No way." I called back and asked CDC, could they get it from the feds somehow? They couldn't get it. Finally, one of their finance officers called back. He said, "We've figured out a way. We can't pay for you to come here as an employee of the city health department. If you're an employee of the city health department, they have to pay for you. But we could categorize you as a medical consultant, an independent contractor, and for that we can pay for you to come." And that's how we worked it out.

This is what funding was in those days. And they gave me $1,100 I think to pay for the round trip, one meal, and one night in the hotel. I couldn't fly the red-eye in and spend the whole day at the meeting and then fly the red-eye back again. So they paid for one night in a hotel.

The money was a big problem at every stage. I was asked to come up to Eureka and Arcada in northern California to lecture. The fire department, police department, the EMT--emergency medical technicians--the ambulance people there were worried, "Will we catch AIDS by doing mouth-to-mouth resuscitation?" So I went up there to talk with them, and I brought them the prototype that our

fire department had worked out, a barrier so that they could give mouth-to-mouth without actually touching the skin of the patient.

I did that on my own money. I was able to use a city car to ride up there and back--six-hour drive each way--but I had to pay for my own gas. That's the way the city was. Well, you did those things. I wasn't flush, but you're a doctor. It was that way.

Hughes: Well, go back to the Atlanta meeting. Tell me what the atmosphere was like.

Dritz: It's hard to say that it was an atmosphere. If you think of a beehive with all the bees buzzing back and forth, it was that kind of feeling. People were tense. There was nothing calm or quiet about it. It wasn't a bunch of scientists sitting in their tweed jackets with a pipe in their mouth, talking. These were people who might have their careers or their organizations or their businesses at risk--great risk.

Hughes: Was the press there?

Dritz: The press was there, too. There must have been thirty of us at least, maybe more, sitting around a hollow square table, and along the walls were the press, lots of people there. For a while, I wondered, who were all of these observers? Then somebody mentioned it's the press. Herb Perkins was there with me. I recognized one or two of the men from the plasmapheresis centers. The New York Health Commissioner, David Sencer, was there, James Goedert was there, Aaron Kellner of the New York Blood Center, other New York people--hard to remember all of them. The Pharmaceutical Manufacturers' Association, the FDA [Food and Drug Administration], American Association of Blood Banks, the American Red Cross, the Hemophilia Foundation, and more.

Hughes: Who is Goedert?

Dritz: A physician at the National Cancer Institute who worked on AIDS. They played musical chairs from one NIH institute to another. I don't recall his exact title at that time. This took place ten years ago, now.

To begin with, it was just like any CDC convocation, if you please. CDC staff presented the materials first that we were going to be discussing, and their views of what the problems were. And then it was opened for discussion.

Hughes: Did Art Ammann's baby figure in their presentation?

Dritz: Well, we had proof here that the baby had been transfused with blood from a person who later had been diagnosed with AIDS and subsequently died. We still couldn't prove that that particular blood gave that baby AIDS, but it was as presumptive as it could be. The only way you could prove transfusion transmission would be if you took somebody known with AIDS and somebody known without AIDS and you injected the AIDS blood into the test subject, and later he came down with AIDS, and there were no other sources for him to get it.

Hughes: It would be an impossible experiment.

Dritz: That's right. Now, there was always the possibility--we didn't know it then yet--but when a person is infected with AIDS, there is a latent period--a couple of weeks to a month or two, maybe three--before the blood develops the antibodies to a degree where you can count them and recognize them. Now, during this period, a person could be infectious with AIDS and we wouldn't know it.

We didn't know whether the other twelve donors at that time maybe were incubating AIDS too. We checked back; none of them came down with AIDS. So again, it was pretty certain that this baby had not been infected by anyone else but the blood donor [with HIV]. The baby was in an incubator in a hospital--it could hardly get infected any other way. A hospital needle supposedly could be contaminated, but there were no AIDS cases known in the hospital at that time, certainly not in the nursery. And everything used there is sterilized. It wasn't due to multiple uses of a single needle. So it had to be from the infected donor. Where was I?

Hughes: You were talking about the CDC presentation.

Dritz: Oh, yes. So first, Jim Curran, the director of the AIDS unit at CDC, presented a number of cases--I'm a little vague on the exact details now.

Hughes: That had been transmitted through blood?

Dritz: No. This baby was the only case we knew that was transmitted through blood. The hemophiliacs maybe were getting it through pooled plasma. But he was presenting that, "We seem to have a problem with the blood supply now. There is this case that's been transfused, and there are hemophiliacs that have come down with AIDS for whom presumptively the only source was contaminated plasma, because it comes from a relatively high-risk population."

Then it went on to Harold Jaffe with some of the epidemiology. It went on to Tom Spira, the head of CDC's virology

department, who gave a run-down on the various tests we have available now for eliminating possible sources of infection of any kind in the blood. We have hepatitis B core antibody tests--that was new then. We had already hepatitis B surface antigen tests. We didn't have a hepatitis A test yet. We could test for malaria, rickettsia, legionellosis, tuberculosis, and others. But we couldn't test for an AIDS antibody or an AIDS virus, yet. We can now.

Spira had put together tabulations of the incidence of these positives in different populations, showing that in a gay you could expect higher levels of hepatitis B core antibody or hepatitis surface antigen. He said, "We don't have a test for whatever this infectious agent is." We weren't calling it AIDS then yet, I don't think.[1] No, we didn't call it HIV [human immunodeficiency virus] yet, because that wasn't until after Robert Gallo and Luc Montagnier had their two different names for the virus, which were changed later to HIV.

So he said, "We still don't have proof that AIDS is a virus. But it must be something like that, because it isn't anything else we have. We don't have any test for it, but if you use tests 1, 2, and 3 on every blood unit, maybe we'll have better presumptive evidence that this might be high-risk blood." However, his tabulations listed, among other things, hepatitis B core and surface antibody levels in gay AIDS patients, versus "healthy gays." We learned much later that many of the "healthy gays" were already infected.

The blood banks were already asking patients, "Have you ever been in the malaria areas? Were you in Vietnam? Were you in India? Have you ever had hepatitis? Have you ever had jaundice? Did you do a lot of drinking? Is your liver off?" And with all of that questioning, they tried to eliminate high-risk people without asking, "Are you gay?" Because that was the one thing we couldn't do--the confidentiality and civil rights issues.

The gay community and the liberal community were very, very adamant that you couldn't--what's the word?--"out" a gay person. And they had some justification for their fears, because they were losing their social contacts of every kind--their work, insurance, lovers, everything. On the other hand, the conservative population had justification for their fears, too, that if we

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[1]Some point to July 27, 1982 as the date when the CDC adopted AIDS as the official name of the new disease. (Bruce Nussbaum. *Good Intentions: How Big Business and the Medical Establishment are Corrupting the Fight Against AIDS*, p. 86.)

didn't identify these people, other people were going to die because this diagnosis of AIDS meant eventual death.

[tape interruption]

Dritz: So after Tom Spira finished his list of proposed surrogate tests, because we didn't have an actual test for HIV, then Don Francis got into the discussion. He said, "We've got to do something to prevent the use of contaminated blood. This disease is infectious." Now, he had been very, very essential in wiping out smallpox in Africa. He had led the World Health Organization fight against smallpox. If anybody killed smallpox, it was he. He's a fantastic, devoted health person. He said, "We've got to do something about cleaning up the blood supply and preventing the use of any more contaminated blood."

Then it was open for discussion. Some of the blood bankers I suppose were being responsible to the medical needs of the community. They didn't want to lose their blood supply, and they didn't want to have to do all this battery of surrogate tests, because the results wouldn't be definitive. They'd have to raise the price of blood transfusion, and that would make it more difficult for people to pay it. They'd have to get more technicians in, and it would cost them a lot more money.

They made the point repeatedly--they didn't convince us--that Ammann's baby was only one case, and it could have been a freak, and after all, we have ten million transfusions a year in this country, and this is the first one with the possibility of HIV contamination. Of course, we didn't know until '85 how many more cases were already incubating. There are several hundred known now in 1992.

Hughes: Were they factoring in the hemophiliac cases as well?

Dritz: That wasn't proved. You couldn't say, "This injection caused this AIDS in this person." It was all presumptive. And yet, we had to say the only way the hemophiliacs could be getting AIDS was from Factor VIII and Factor IX, which comes from high-risk plasma pools.

And the only way this baby could have got it was from its transfusion. But you couldn't prove it. They could have argued that maybe the donor didn't have AIDS when he gave blood to the baby, because he didn't get his symptoms until seven months later. Well, now we know there's a long incubation period. He was already infectious. His case proved AIDS can be infectious before symptoms develop. And we didn't have an HIV test then, so we couldn't prove it. Without the scientific proof--you inject it

here and it develops there, and then you take it from this one and you inject it in a third one and the third one gets it, then you prove it--Koch's postulates.

Hughes: One might argue that if something is significantly presumptive, why not err on the side of caution to protect the blood supply?

Dritz: That's what we were saying in Atlanta. It went round and round; the blood bankers--not all of them--were adamant. Some of them were just quiet. They didn't want to say, "Well, we ought to stop taking donations from high-risk persons." It might have been Francis--somebody at the table said, "Well, why don't we just not take donations from any gay people?" It wasn't a blood banker. Because Perkins told me that 5, 6, 7 percent of his blood bank donations were from the gay community. They were very, very good about donating. They were very socially conscientious people.

Hughes: To sum it up, the blood bank people were interested in preserving the volume of their donations?

Dritz: Well, preserving the volume of the donations and preventing the escalation of their cost base with all this.

And at the end, there was no consensus. I asked them, "Please, tell us what you want us to do. This is a national group, we're a medical consultant panel, what do you want to do? I have 700,000 people in my city. I have a population with a high percentage of gays. We have a bunch of big hospitals. We use a lot of transfusions. Our Irwin Memorial Blood Bank needs the blood." And Herb was sitting right next to me there. "What are we going to do?" And there was no consensus.

Testing Blood for Viruses

Hughes: So you went away not having any policy to follow?

Dritz: There wasn't any policy. They finally decided, well, maybe it would be a good idea to do a hepatitis B core antibody test [on donated blood], for which the equipment and the machinery was just beginning to come on the market. Maybe we should test gay blood against heterosexual blood for the hepatitis B core antibody. Spira had shown that he thought the antibody would be higher in the gay group than in the straight group. But when we checked it over, the difference was not statistically significant.

Hughes: If you did use the hepatitis B core antibody test, then that would mean discarding any positive blood.

Dritz: Yes. Up to this point, they'd been doing hepatitis B surface antigen tests. Any positive, they dumped the blood right away.

Hughes: I know the surface and core antibody tests are different, but aren't they testing for the same problem?

Dritz: No, because the surface antibody may disappear. The core antibody doesn't. Now, if the surface antigen has disappeared, you test for that, and the blood seems all right. The core antibody is still there and can be infectious. And we didn't have a test for that until just about that time [early 1983]. The test for hepatitis C has just become available. Until recently, we couldn't test for it. And so we still had transfusion-mediated hepatitis being reported into the city. Although we tested for A and we tested for B, this was hepatitis C, formerly called non-A, non-B, for obvious reason. Now we can test for that, too, so there won't be any more transfusion-mediated hepatitis due to the C agent. There may be a D; we don't know yet.

The New York and the San Francisco blood banks decided they would try to see whether there was a difference in the hepatitis B core antibody in gay versus heterosexual or in high-risk versus apparently low-risk populations. Of course, the apparently low-risk gay population were already heavily infected, too. Not every one, but the numbers were going up, and we didn't--couldn't--know it.

In '78, there were already 4 percent infected. When we went back retroactively and tested the bloods of the hepatitis B vaccine trials, 4 percent of them were already HIV positive. We didn't even know there was such a thing as AIDS then. By '84, 60 percent to 70 percent of a gay population was infected. Now, the general population of males in the city, by the time I retired [1984], was less than 1 percent infected. But among the gays, it was about 3 percent with AIDS. I retired in '84; the test wasn't licensed until March of '85. After they were tested, they found maybe 3 percent of them were sick with AIDS, or presumptively getting the symptoms, but over 60 percent of them were incubating it.

[Interview 3: July 6, 1992] ##

The Medical Advisory Committee on AIDS, San Francisco Department of Public Health

Purpose and Membership

Hughes: Dr. Dritz, when and why was the Medical Advisory Committee on AIDS at the San Francisco Department of Public Health formed, and who composed it?

Dritz: Well, it was formed because there was so much difficulty and confusion and splintering among all the parties who were involved in trying to get some answers to what was happening in the gay community. We already were quite certain that AIDS was an infectious condition, and therefore a transmissible disease. Therefore we had to find out how we could stop the transmission, which meant getting to the people at risk, getting to the people who could help those who were at risk.

Since there were so many different agencies involved--the city government, the health department as a fraction of that, San Francisco General Hospital as a treatment arm of the health department--it was different than most other big cities. The university, the pharmaceutical people, the researchers, the medical society, organized medicine, the gay community--there were so many factors entering into it, plus the press and the media, that we simply couldn't just go by fiat and say, "This is what the health department wants to do, and that's it."

So Dr. Silverman, as director of the health department, felt that he'd better have an advisory committee composed of representatives of as many of these different factions as was possible. I use the word faction advisedly, because a lot of them were fighting.

I represented the health department's Bureau of Communicable Disease Control for him, and I was unofficially his advisor on it. I was developing all the information that he later used. He was smart, though. He knew his business, too. There was Merle Sande. He was chief of medical services at San Francisco General Hospital, where the AIDS outpatient clinic was developing. I'm not sure if Ward 5B [the AIDS ward] had opened yet or not.

Hughes: It opened in July '83.

Dritz: I think that we started to meet in late '82.[1]

Then there were Bob Bolan and Rick Andrews, both physicians with large gay practices, representing the gay community and the BAPHR--Bay Area Physicians for Human Rights--which was the San Francisco branch of the American Physicians for Human Rights, a New York organization. And there was Dr. Glenn Molyneaux, representing the San Francisco Medical Society. I think he was the president at the time. Another member was Dana van Gorder, who was administrative aide to Supervisor Harry Britt, the one gay member of the San Francisco Board of Supervisors. He had replaced Harvey Milk, who had been assassinated at the same time that Mayor George Moscone was assassinated.

At intervals, Marcus Conant from UC dermatology came in. He had organized and was running our KS clinic. Occasionally, Dave Perlman from the *San Francisco Chronicle* would sit in, but that was all off the record.

Hughes: Did the committee insist that he keep information off the record?

Dritz: No, he reassured us that it would be off the record unless we said he could use it. Actually, we could have asked him, "How do you think the press will present this?" We were not thinking in terms of the press, but rather in terms of what we could do to get word out effectively to the population at risk about the things we thought they should do or not do to protect themselves from transmitting what we were practically sure now was a transmissible disease.

Giving Advice

Dritz: We came up with various suggestions--educating the community, working not to isolate but to give medical support to the people who were already sick and dying very fast, how to deal with a public who were afraid to ride a bus through the gay community, how to deal with the undertaking establishment which refused to prepare deceased AIDS patients for burial. They called in to say, "We're not going to do it. We can't embalm them because we could

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[1]In March, 1983, Mervyn Silverman established "an ad hoc medical advisory committee to my office" to "keep abreast of [AIDS] developments and present as consistent a response as possible to the public on matters relating to AIDS..." (Marcus A. Conant, KS Notebook, 1983)

stick ourselves." We couldn't tell them for sure that they wouldn't get infected.

There were nurses' representatives, and other health workers, who were worried about getting needle sticks. We had to find some way to talk to them, to clarify what we thought we knew about this question. We had to make it clear that whatever we were saying might change as the epidemic went ahead.

This was an advisory committee that eventually came up with general conclusions on the questions at the moment. Dr. Silverman accepted them or had his own reservations about some of those. He had major input, because he was a very, very experienced public health director. He had been with the U.S. Public Health Service. He had directed the Wichita, Kansas, health department. He knew his business very thoroughly, and so he would accept or change or take in toto what we had decided at any one of the biweekly meetings.

Sometimes, he would be overruled by City Hall, because there was an awful lot of politics in this. The input from the BAPHR representatives, for instance, and from the board of supervisors, was almost always purely political. BAPHR was represented by physicians, and they were concerned for their patients, just as any physician would be. At the same time, they also expressed the unique view of segments of the gay community [about the need to preserve civil liberties]. We could understand when they voiced it, but we couldn't present it ourselves, because we didn't think in those terms until we learned to understand what they were saying.

So it was medical, it was public health, it was preventive medicine, and it was a hell of lot of politics. The only term for it is a can of worms. No matter how you twisted it, some other factor came up. "Let's do this." "I think we can reach them in this way." "Yes, <u>but</u>--" And there was always a "yes, but--" No matter what you said, there were three objections for four different reasons from members of the committee. We tried to work cooperatively, and we did do a reasonable job.

The one thing the advisory committee did do was give Dr. Silverman a stronger hand for his arguments to City Hall, because he wasn't just saying, "This is what <u>I</u> think as a doctor," but "Everybody else has input. This is what we <u>all</u> decided, and this is what we think should be done." And the hand would come down in Room 200--that's City Hall--"<u>No</u>." I'm not naming names.

Hughes: Give me an idea of the types of issues that the committee would discuss.

The Bathhouses

Dritz: Well, number one was the baths, because we knew that was the main source of AIDS transmission. A gay man could pick up one or two partners in a bar, and they'd go off someplace to have their fun. There were back rooms in the bars, in the baths, too. They were called orgy rooms, where ten, fifteen, twenty, thirty, forty men were dancing around with almost no light, and of course, anything happened there. That explained to us why a gay man would say, "I don't know who I got it from. I never saw his face." That sort of thing.

The bars were not the best places to be, but at least, they would limit the amount of contact a man could have. In a bookshop, in a small sex club, out in the park--these places limited the contact. But in the baths... At a four-story bathhouse, Club Baths south of Market I think it was, 350 men would gather on a Saturday night at $10 a crack, and they got their $10 worth. And more. Including drugs in addition to poppers.

Would you permit a child with measles to go to school with a classroom of thirty other children? No! It's a transmissible disease. You exclude him, and if the whole room has been exposed, then you close that classroom--you discontinue that class and send the kids home. There was quarantine for these diseases at one time. In Africa, if one or two patients came up with smallpox, you isolated the village, and you vaccinated everybody. So after the smallpox was finished with that patient or those two patients, it had no place else to go.

We didn't have a vaccine for AIDS. We had the disease spreading wildly. We knew that the numbers were going up geometrically in those first two years. The numbers of new cases were doubling every six months. It was terrible.

Hughes: But times had changed. Society was putting much more emphasis on individual rights, particularly for minorities such as the gay population. It was no longer as acceptable for a government agency to do what some factions regarded as removing individual rights.

Dritz: That's right. It was not only civil rights and individual rights, but the federal government was also saying, "We have too much government now. Let's concentrate on the threat from the Evil Empire overseas." This epidemic was going to wipe us out, and they didn't even care about it.

Any physician who has any sympathy or sense of responsibility toward his patients, to the population, toward his own family, would say, "You don't waste money up in the sky on nuclear weapons against a theoretical threat, when you have the threat right here, right now, killing you, just as deadly as a bomb." Central Africa now we know is going to be wiped out by AIDS just as if they threw a couple of atom bombs in there.

The emphasis was not so much on civil rights as on fear in the gay community that if they were "outed," made known that they were gay, that they would lose jobs, friends, a place to sleep, insurance. All of these things made them resist closing the baths, because their incognito activities in a closed environment in the baths kept them from being known on the outside. Now, there were gay men who were aggressively out, the S&M, sadomasochist, men, the leather boys we called them, who walked up and down Market Street dressed in leathers with leather caps like the old Nazi men, and chains, and leather boots. But they were the ones that died fastest, because generally speaking, they used the most traumatic anal-rectal techniques, and got infected. They had been infected with many other sexually transmitted diseases before then, so they were in no shape even to postpone the activation of the AIDS virus after it hit them.

I can talk about the meeting we had when Dr. Silverman was about to announce that he was going to close the baths, then he didn't, because the mayor and he couldn't get together on it. I wasn't in on that session between the two of them, though, so I can't give you all the details.

Many members from the gay community were at that meeting. Bobbi Campbell, who was already infected with AIDS, was standing at the back. I remember at least three members of the gay community, nude, just with towels around them, holding signs that said, "Today the baths; tomorrow the ovens." They meant that, if we let you close the baths on us, next thing you'll quarantine us, then we'll be in jail, then you'll destroy us, like a Hitler. It was very, very extreme.

Now, through Rick Andrews and Bob Bolan, we could perhaps get through to some of the other members of the medical community dealing with AIDS patients, so that they could all put out the message in comparable terms to their different patients, "Don't do this risky sex practice." But of course, if the men were patients, they were already sick.

Hughes: It was too late.

Dritz: We had to reach those that weren't infected yet. We didn't know that by '83, or even late '82, we already had about 10, 12 percent of the gay community infected. We didn't find that out until we ran the hepatitis B follow-up study later, with Winkelstein's report.[1]

So we were working partly in the dark. We were shedding as much light as we could on the people we were trying to reach. Marc Conant was backing us on trying to close the baths, because he saw from his own patients at UCSF and what he heard from the gay community that too many things were going on that simply would spread the thing beyond anything that we'd ever seen. Well, the Black Death, the plague in the Middle Ages, wiped out one-third of European population over a period of a couple of years. This epidemic eventually is going to wipe out that much of the general as well as gay population unless we can get a vaccine for it and medical treatment.

Fear of Infection

Dritz: There was the treatment issue: how do you treat them? Merle Sande was screaming, "We need money for the San Francisco General Hospital. We've got a[n] [AIDS] clinic here. We've got Paul Volberding, we've got Don Abrams, we've got maybe a couple of interns. And the nurses, a lot of them are very devoted. And some of them just don't want to have anything to do with AIDS patients. We have a lot of aides who are justifiably afraid, because we can't assure them 100 percent that they won't catch anything, although we're pretty sure they won't."

We knew it didn't go through the air, because AIDS patients who were sick at home did not produce cases of AIDS in their immediate intimate daily household contacts. We were pretty sure it was blood-transmitted, needle-transmitted, cut-transmitted, something like that.

So Sande needed money for better infection controls, for better equipment at the hospital, for better management, for more dedicated nurses. They actually did manage to give nurses the

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[1]W. Winkelstein, D. M. Lyman, N. S. Padian, R. Grant, M. Samuel, J. A. Wiley, R. E. Anderson, W. Lang, R. Riggs, J. A. Levy. Sexual practices and risk of infection by the human immunodeficiency virus: The San Francisco Men's Health Study. *Journal of the American Medical Association* 1987, 257:321-326.

option to transfer to the AIDS clinic and the AIDS ward at San Francisco General Hospital, and some of them did that. It was marvelous.

On the other hand, there were concerns--the nurses' concern, physicians' concern for the health workers' safety, our inability to tell them how safe or unsafe a specific job might be, and the medical unions' objections too, and the fact that a nurse or an aide might get AIDS and die of AIDS and the family could sue the city for $100 million for not protecting them. All of that. There were financial considerations to that, too.

San Francisco Medical Society

Dritz: The medical society simply wanted to be cooperative, and it was. There were some reactionary physicians in the medical society, just as there are reactionary persons in any population. But the majority of them were only admirable.

Hughes: How did they help?

Dritz: Well, when we wanted word spread among the physicians of the medical society about the new things we were learning--it took maybe six months for a paper to get published, to be read--they would transmit that information. Silverman or Sande could talk at a meeting of the medical society. I didn't talk there, because they were superior to me in the department.

We needed advice from members of the medical society: "How do we get this information to doctors who are dealing with patients in the Fillmore [District]? What's the best way to talk to people about this without turning them off?" The Fillmore at that time was primarily black, strongly criminal, and a high drug-using area. You'd talk about AIDS to some of the doctors, and they'd say, "I don't want anything to do with it. I won't treat those patients." Just as some doctors will say, "I won't have anything to do with Medicare. I don't want anything to do with socialized medicine." There are reactionaries among us.

San Francisco Board of Supervisors

Dritz: We needed the input from the board of supervisors, because some of them could influence the other members of the board--I forget if

there were nine or eleven members at that time--and that too could influence the action of the mayor. The mayor couldn't override the board of supervisors short of a two-thirds override on a veto, but she could say, "Next time you want something passed here, you must listen to what we think is the best way to do it for all the population,"--politically correct words.

Hughes: Did Harry Britt transmit the information to the committee which you wanted transmitted?

Dritz: Not only transmitted, but he gave us a lot of input of the thinking of the gay community, too.

Health Department Relationships with Other Agencies

Local, State, and Federal Agencies

Hughes: The next step is to talk about the agencies that were involved with the AIDS epidemic in San Francisco. I'm thinking of the slide that you showed me of the relationship between the San Francisco Department of Public Health and various institutions and groups. [see appendix]

[tape interruption]

Dritz: We had developed step by step, over the period of those first three years, our own complex program for handling the different aspects of this outbreak, even though we didn't have an answer to controlling it yet. This program that we had worked out was actually later a pattern for AIDS control in other cities. They used San Francisco as their model. There was City Hall on the top, because all the health department money came through City Hall, from the budget, which was approved by the controller but it was under the hand--sometimes the fist--of the mayor's office.

The San Francisco Department of Public Health got its funding from City Hall, and therefore couldn't just say, "Nuts to you; we're going to do what we want. We'll use the money the way we want to." It's a line item budget, so anything that we had down for, say, typewriters in an office, we couldn't change to medication in the [AIDS] clinic [at San Francisco General]. At that time, we were beginning to fight for program budgeting, which would have given us more freedom. I don't know if they ever got it. They didn't have it when I left in 1984.

The Bureau of Communicable Disease Control then had two arms: the separate VD [venereal disease] and TB [tuberculosis] clinics, and the Bureau of Disease Control. My chief of the bureau was in charge of the VD and the TB clinics. They were free-standing clinics, and I had all the rest of the infectious disease. So my part of the work covered the AIDS epidemic.

The San Francisco health department had relationships with UCSF, where Conant had the KS clinic. His clinic also communicated with CDC directly. Between his clinic and the KS [Research and Education] Foundation, we had put together our epidemiology group. That's the inclusive group [the KS Study Group] I told you about where we met every two weeks and talked about the latest things we knew about the disease.

Then the department itself worked directly with the state health department, the California Department of Health Services, because we had to report communicable diseases to it. It got its information from us directly. We worked directly by phone with CDC, reporting in cases and getting from them reports, for instance, on the latest numbers of new cases in northern California or in Atlanta, or the latest theories coming from the men working in New York City. CDC had that; they were a transmitting agency as well as a research organization.

Hughes: How did they release information?

Dritz: We worked by telephone. It was very informal. Anything they wanted to, they printed in *MMWR*, but that would take maybe two, three, four weeks to come out. When we got Ammann's baby, I telephoned them that we had strongly presumptive proof that AIDS was transmitted through transfusion. They had that in the very next *MMWR*, which comes out weekly.[1] So they could work it fast.

Then, I worked with Shirley Fannin in L.A. by phone. She was [deputy] director of infectious disease for Los Angeles County. Or through CDC with L.A. We worked together, and I found out what was going on there with them.

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[1]A. J. Ammann, M. J. Cowan, D. W. Wara, et al. Possible transfusion-associated acquired immune deficiency syndrome (AIDS)--California. *Morbidity and Mortality Weekly Report* 1982, 31:48, 652-654 (December 10, 1982).

The News Media

Dritz: We also worked with the press and the broadcast media. The radio stations called in several times a day for the latest statement every time something new came out. My clerks became very, very blasé about the TV people coming in with their lights and cameras to take whatever we had to give them. Randy Shilts, David Perlman, Charles Petit from the *Chronicle*; John Jacobs from the *Examiner*; and a reporter occasionally came from the gay papers, the *Advocate* and the *Sentinel* [*San Francisco*]. I've forgotten the names.

Hughes: Did you feel in general that their reports were balanced?

Dritz: If I read their reports and found they weren't, I told them, "Don't come in again." The big press, the *Chronicle* and the *Examiner*, did exemplary work. They were very careful. Sometimes they would call back and say, "Did I understand this right?" So they got it right. On the other hand, if we said, "This is off the record," they observed off the record.

Hughes: Did you have to tell some of the press not to come back?

Dritz: I called one, I remember. I don't remember if it was the *Advocate* or the *Sentinel* or the *Bay Area Reporter*. I told him that he had something wrong, and I'd like a correction please, and I got a snooty reply. So I said, "Just don't come back." Which wasn't really the best thing to do, because we needed newspapers that reached the gay community more than the *Chronicle* or the *Examiner*. But we had access to the *Advocate* and the *Sentinel*, and they were quite responsible. Now, the New York gay paper, the *New York Native*, was a great one, but they didn't deal with us at all. You know, in New York, the West Coast is the Hudson River.

Private Physicians and Other Health Departments

Dritz: We also worked with the independent physicians of the community, such as members of BAPHR, Bay Area Physicians for Human Rights. There were the individual gay physicians, the general physicians, the other departments of public health in the Bay Area.

Alameda County health department worked with us a lot, because it was beginning to get a lot of AIDS cases in Oakland among the sailors in the Alameda Naval Air Station. There were a couple of gay bars there that were helping disseminate the disease. Dr. Bob Benjamin was the head of infectious disease--I

think he still is--and he worked with us in the early days, finding out what we were finding out and adapting it to his needs, because his numbers of AIDS cases were much lower than ours originally.

Then we worked with the individual hospitals. Ralph K. Davies Hospital, for instance, right off the Castro, had a lot of patients from the Castro as some of the physicians had their offices in the Davies Medical Center. There were also clinics there.

San Francisco Coroner's Office

Dritz: And then we had a lot of dealings with the San Francisco coroner's office. Boyd Stephens worked with us by phone a lot. The gay community had doctors and lawyers and real estate men, but it also had hookers and dishwashers and homeless people--we didn't call them homeless at that time--and people that were just found dead, who were brought into the coroner's department. Or they were coroner's cases, or they died under suspicious circumstances, or they were found dead in their home and there was no doctor present, so it automatically became a coroner's case.

We were able to establish a modus operandi so that if Boyd Stephens suspected that AIDS was a factor in a death, even if he couldn't prove it because we didn't have a blood test for it yet, he would give us the information in case it could help us make a contact with some other case. This was all confidential, of course, because among doctors you don't give the information out except to those that are involved in the particular case.

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Dritz: We shared anonymous data among doctors, among the gay community, among the health workers.

Confidentiality

Dritz: Many of the gays were "out." They were known to be gay, and they didn't make any bones about it. If we asked them, "Who was your contact?" and if it was somebody they knew was "out," then they would tell us if they could.

On the other hand, many of the men who were openly gay in the gay community were gay only to other gays. If they lived in an apartment house that wasn't known by the management to be gay, they had problems there. They couldn't let the management know that they had AIDS. They couldn't have a hint come out that they'd been visiting a doctor, because if the manager guessed that they were gay, and they were going to a doctor, they were out on the street.

You couldn't blame the apartment house managers for wanting to get a dangerous, deadly communicable disease out of their buildings. They didn't want it to infect anybody else. For one thing, they didn't want anybody else to get sick or they'd lose a tenant; but on the other hand, they also didn't want to have some other tenant get sick and say, "Now, you let us be exposed to this disease, and it's going to cost you everything you own, plus everything you can earn the rest of your life."

So I could understand their point of view, and yet, couldn't see it. None of us could. You don't throw these people out on the street! What are you going to do with them? Conant and the KS Foundation found some way to get enough money to buy a couple of old Victorians where they could put these people who were out on the street.

The HIV Antibody Test

Dritz: Now, the other part of the confidentiality picture was that when we did have a test finally, we had a big problem getting the gay men to come in to be tested, because it was almost impossible to reassure some of them that the results would remain confidential. We finally worked out, especially in District Health Center 1--that's right in the Castro just off of Noe and Market Streets--that there would be pre-test counseling, so that they could be told what was going to be looked for, what might be found, that they would not get AIDS from being tested, that they could not get AIDS from donating blood, that they could not get AIDS from just being in the clinic there next to another gay man.

Then the blood was drawn. Their name was not taken. They were given a number. The same number was put on the blood tube. They were told, "Hang onto this number. In three or four days,"--I forget which--"call us, give us this number, and we'll tell you what the test result is. If you lose this piece of paper with the number, we won't be able to tell you what the test result is. We

do not have your name." And they could see we were not writing down the name.

They were also told, "If the test is negative, you're fine." We didn't know then that there might be a window period. Later on, we told them, "Better repeat the test in three or four months just in case you've just gotten infected and your blood doesn't show it yet. But if your blood is reported positive, we want you to come back in, and we will talk with you about the ramifications of this--what you can do, what you can't do, how you can protect yourself, how you can protect other people, what you can expect to happen, where you can go for medical and emotional help." We didn't really know what was going to happen, but we told them what we could. "As we know more, we can tell you more. Come back in if you want to, as much as you want. We'll advise you. We can't treat you." We didn't know then how to treat the disease. Later on, we could.

Hughes: Was the return rate high?

Dritz: In district 1, it was slow in starting, but they did come back for counseling. The district health officer, the late Dr. Hope Corey, felt that she could get cooperation from them in following up their course later on. And they could also be referred, if they wanted to, to Winkelstein's group, San Francisco Men's Health Study, for follow-up for the course of the disease. He was trying to do a prospective study, starting with men who were apparently healthy, but we didn't know a lot of them were infected already. The study population was checked every few months on how its condition changed.

The confidentiality issue finally worked out quite well, and we still have the anonymous testing program going on in the health department. There are two testing sites now. The important thing was not the test so much, because if they tested positive, it was too late to help them at that time. But the pre-test and post-test counseling were important to help them prevent getting AIDS if they turned out to be negative; to help them prevent giving it to somebody else, if they turned out to be positive. We were doing public health preventive medicine. The medical treatment was in the San Francisco General Hospital arm of the health department and at UC Medical Center.

Hughes: Did you feel that these efforts at counseling were successful?

Dritz: Well, it varied as people vary. A lot of the gay men responded very well, and we thought it did them some good. We didn't see the numbers of new cases going down, and we didn't know how some of them had been infected a year or two before, and there was

nothing we could do about that. Some of them you couldn't reach. Most of those who wouldn't have been helped by this program--emotionally, intellectually--didn't even come in for testing. They didn't want anything to do with the health department; they didn't believe it would be confidential. "You're trying to trap us." Or, "Oh, what the hell. I'm not going to get sick. I haven't gotten sick yet; I'm immune." So they died. Too many, too fast, too young.

The health department wasn't permitted to continue asking, like Bill Darrow and Dave Auerbach from the CDC had asked, "You've got AIDS. Who did you get it from? Who were you sleeping with in the last couple of months or so? Can you give us names?" That was how they got the name of Gaetan Dugas, our so-called patient zero.

There was such an outcry for confidentiality, especially from the New York [gay] group: "You can't tell everybody we're gay." They wouldn't tell any of the medical people whom they had been with. Later, medical people were no longer permitted to ask, "Who was your contact?"

Hughes: Did you do contact tracing?

Dritz: Well, yes. Our VD clinic now was able to send an epidemiology inspector out to talk to positive cases with positive gonorrhea and other types of VD, and ask them, "Who was your contact? We have to find out who you got it from or who you might have given it to." That's the way to control syphilis and gonorrhea, and some of the other sexually transmitted diseases. They could ask that. We were told, "You can't ask them about AIDS." I don't remember whether it was '82 or '83, but the confidentiality fight just blew up. As a result, the notebook I had, full of all my AIDS data for a couple of years, which I left in the department when I retired--it was their property--was shredded to preserve confidentiality.

Just as I was leaving, all of my data from that notebook was transformed into code for the computer. No names. There were birthdates, so that we'd have the age range of the patients. There was date of diagnosis, presumed date of infection, general zip code--where they lived--even occupation. No names. So the computer had all the data, but we couldn't go back to it to find out who it was if we had wanted to.

Fortunately, the transfusion case, Ammann's baby, had been before all of this, so that the blood bank was able to give us the names of the thirteen donors who had helped transfuse the baby. Otherwise, we wouldn't even have been able to know for sure that

the baby was infected by a known case of AIDS who had already died.

Hughes: What did you feel personally about the issue of confidentiality?

Dritz: It hampered us. We could tell them, "We're doctors. We've taken the Hippocratic Oath. We swear to you we will not do you damage by giving your name out as a gay person." If we gave the name out of an AIDS person, it was assumed that he was gay. So we could say, "We won't tell anybody, but we have to know about you, and we have to know about anybody you might have given it to, so we can prevent it. We won't tell their name either, but tell us so we can help them. Tell us where you got it so we can tell that person"--it was he most of the time--"that he has it, so he won't give it to somebody else. We can tell him how not to do it. But tell us who it is." If they wouldn't, that was it.

Hughes: But you could ask?

Dritz: Well, I asked informally. Later on, I couldn't ask. We just said, "Do you know where you got it from? You'd better go and tell him." But we couldn't ask him. And of course, he would or he wouldn't tell.

Hughes: That removed a powerful epidemiological tool, didn't it?

Dritz: Of course it did. That's one of the things that Don Francis was screaming about. But the confidentiality issue just tied our hands.

Hughes: Don Francis found the same problem at the CDC level?

Dritz: Of course. We all knew we were hampered with it. The newspapers occasionally would mention the confidentiality question.

Hughes: Now, had confidentiality been an issue with any other sexually transmitted disease?

Dritz: As I say, with syphilis and gonorrhea, by law we could go in and ask the man whom he got it from and whom he gave it to. We couldn't threaten him, but we could make it very strong that if he didn't tell us who it was, then whomever he gave it to would give it to somebody else, and he could give it back to him. But this wasn't so terrible, because with syphilis and gonorrhea at that time, one shot of penicillin and they were cured. Of course, now we have penicillin-resistant gonorrhea and syphilis. But the men knew that you went to the clinic, you got your shot, and you were all right. You could go out and play in the baths again.

With this AIDS, though, they knew that if you got it, in a couple of years you were dead. So they were much more cautious about telling us who they were with, because they didn't want to be responsible for anybody being "outed." It was just a mess.

Gay Issues

Hughes: Did the issue hang upon homophobia?

Dritz: To a very great degree, yes--homophobia and a fear of death. A woman was afraid that the man next door who gave her dog the bone from his steak might have given her dog AIDS because he was gay, she thought. Because if the dog got AIDS, [she thought] the dog could give it to her. That isn't only homophobia; that is fear of death. I'm not laughing at these people. They didn't know whether the disease was transmissible or not, or how you got it. We were pretty sure we knew how, but then we were doctors; we were trained for it. And trying to put it out into the press, into the media, over the radio as we did, it still didn't register.

We hear some politician during the election campaign, and we tell ourselves, "Oh, that's just politics. I don't believe it." And that's how some of the people in the city here, the heterosexual community, felt about the AIDS epidemic. Remember, there were so many gays in the city, they were so visible, and some of the men were so outrageously gay--the gay parade, for instance, with its transvestites and so on--that it turned off an awful lot of the heterosexual community that wouldn't have been too bothered by the presence of gays if there hadn't been so many and they hadn't been so aggressively "out."

Yet, the gays were being aggressive because they felt so threatened, by the disease and by the increased homophobia which was a result of the disease. The publicity about it just stirred everything up impossibly. City Hall was right in the center of it, and City Hall depended on votes. Of the little over 300,000 voters in the city, about 120,000--100,000 let us say--were gay voters. The other 200,000 were splintered among the different communities--the Asians, the blacks, the East Asians, the Hispanics, the Italians, all the other ethnic groups--the city is a conglomeration of villages. Now, they wouldn't all vote as a bloc, so the 200,000 votes were scattered. On anything that threatened the gay lifestyle, 100,000 would vote as a bloc, so City Hall had to be very, very careful. When some of the more vocal parts of the gay community were saying all the time, "Civil

rights, civil rights, confidentiality," City Hall had to listen. And that hampered us at the health department.

Harry Britt, the gay supervisor, was very, very cooperative with us. He tried to help. He interpreted for us what the feeling of the gay community was. Yet he himself was only one of one group. The gays were splintered in other ways. Some of them were very vocal. Some of them were very quiet. There was a whole group of closeted gays, the upper-class gays, that we didn't hear from too much. There was the Alice B. Toklas Club; there was the Stonewall Club; there was the Harvey Milk Club; there were some of the unincorporated groups; there were the S&Ms (sadomasochists); there were the Gay Bath Owners Association of Northern California; there was the Tavern Guild, which was an association of gay bar owners and managers. All of these groups had their own agendas, and some of them could get together and some couldn't.

Unfortunately for us, like the Moral Majority, there were fundamentalist-type gays in the gay community, too, who were very vocal, very reactionary, very entrenched for their own benefit. You couldn't blame them for this, but it didn't help anybody. So it was a mess.

Meeting on Kaposi's Sarcoma and Opportunistic Infections, New York City, July 13, 1982

Hughes: Let's turn to some of the meetings that you attended in the early years. The first one was the meeting on Kaposi's sarcoma and opportunistic infections in New York City on July 13, 1982, which was sponsored by Mt. Sinai and New York University schools of medicine.

Dritz: Yes. That was a real meeting. For one thing, we didn't have any money. The city wouldn't pay for us to go. Paul Volberding and Don Abrams flew the red-eye. The meeting was to start at 7:30 a.m. in New York. They got in probably about 5:00 or 6:00 a.m. on the red-eye. I flew the red-eye also, but on a different flight. I didn't know they were coming. We spent the whole day there in the auditorium. Presentations were I think fifteen minutes each, and three minutes for comments. They went through until noon. We had a working lunch, at which we learned from each other.

At 1:00 p.m. we were back in the auditorium, and the presentations continued every fifteen minutes with three minutes for comment until 5:30 without a break, no coffee breaks, nothing.

I walked out of there on a hot July afternoon. My brains were fried.

Here's some of what went on. [consults notes] Fred Siegel gave a definition of the problem. In other words, what is this epidemic we're dealing with? Because we still didn't know. Was it cell-mediated? Was it an immunodeficiency? What are the factors? Was it immunology? Was it genetics? Was it lifestyle? Was there an incubation period? How do you manage it? How do you prevent it?

Dave Sencer, who was then head of the New York City Health Department and had been head of CDC before that, was the moderator on the panel on epidemiology. William Foege, the director of the CDC, talked on surveillance and how the problem was increasing. Pauline Thomas spoke on surveillance in New York; Michael Lang on the immunological status. He was worrying, why don't we have KS or PCP or opportunistic infections in the sick group? Now, I don't know what he was talking about there; I don't know if any of us did. Is there a pre-existing cellular immunodeficiency? Do they have so many other diseases that the immune system is so knocked down by successive insults that it finally can't respond? Lang talked about his study of 103 gays who were "well." We didn't know then how many of them were already infected, but symptomless.

And then, were nitrites being used? We tested them for their T-4s and T-8s [lymphocytes], and for the cytomegalovirus titer--everything that was going on. Did this early diminution of the T-4/T-8 ratio indicate a prodrome? At that time, we didn't even know this.

Michael Marmor had an article in the *Lancet* in which he matched his twenty cases of Kaposi's sarcoma against forty control gays.[1] When I talk of controls, we didn't know when they weren't. Some of them were controls; some were already infected. He found that there was no difference between the two groups in their ethnic distribution or the risk ratio. For drugs, the question was amphetamines, coke [cocaine] and ethyl chloride. I don't know what gays used ethyl chloride for. He asked how many sex partners they had per month, and so on and so forth. After that, he discussed what things were significant and what weren't.

This was all on epidemiology; in other words, what's doing it? Jim Curran described the CDC program on the surveillance of

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[1]M. Marmor, L. Laubenstein, D. C. Williams, et al. Risk factors for Kaposi's sarcoma in homosexual men. *Lancet* 1982, 1(8281):1083-1087.

KS and PCP. Mansell of the University of Texas had similar data. [Alexander C.] Templeton, who had been in Africa, said that the KS and Burkitt's lymphoma had different distributions there. I think it was KS that's above 10,000 feet, and Burkitt's lymphoma below 10,000 feet. Since that's the differentiating line between mosquito presence and lack of mosquito presence, maybe it was transmitted by mosquitoes.[1] That was exciting. It didn't mean anything in the long run.

Templeton also said that you didn't get Burkitt's lymphoma in all the kids. It depends on the age distribution of the population at risk. We in San Francisco didn't have any cases yet, but shortly after that I had eight cases of Burkitt's lymphoma in San Francisco in gay men within nine months. So that went right back to what he said.

Then Curran asked, "What about the Haitians? What are the risk factors among them? Is their voodoo a factor, since it draws blood?" And then he talked about the similarity of distribution of hepatitis B among these people, because a lot of the gays were infected with hepatitis B. But that's because it was also being blood-transmitted through traumatized rectal tissues, and we didn't know that then. Some of them were shooting up; we didn't know that either. In the first few cases, we didn't even ask, "Do you use drugs?" The questionnaire hadn't been developed. In New York I think 12 percent of their AIDS cases admitted using drugs. Later on, our numbers went up to about that, too.

Then there was a section on the immunology. Dr. Erica Goode moderated that. Fred Siegel talking about various tests of pokeweed mitogen, the natural killer cells, the cellular production of interferon, the PHA [phytohemagglutinin] responses --all these things. You have to be a virologist really to have all of this clearly in your mind. They suspected that the cellular interferon was not being produced, and maybe that was something that was wrong, or maybe when it was not being produced, maybe that was "ominous." You see, we were almost talking Middle Ages here. It was the blind leading the blind, with a little hope there was a light at the end of the tunnel, or maybe it was an oncoming train.

Michael Gottlieb then talked about his cases with a decreased percentage of helper cells and increased percentage of suppressor cells--that's the T-4s and T-8s--what we call now CD-4s, CD-8s. He talked about immune globulin production, again the pokeweed

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[1]For more on Burkitt's lymphoma, including its distribution in Africa, see the oral history in this series with John L. Ziegler, M.D.

cells. At the time some of the cases were beginning to develop large lymph nodes, gay lymph node syndrome, which Donald Abrams here then began to follow, thinking maybe this was a milder form of AIDS; maybe it was an early form of AIDS; maybe it had nothing to do with AIDS but it was related somehow. He's got a big study going on with that now. We know now gay lymph node syndrome is an early manifestation of developing active AIDS.

Then Tom Spira. He was important. He was the virologist for CDC. He talked about the gays and the Haitians and heterosexual patients, and the fact that gays' lymphocytes and leukocytes were down. The T-helper cells were lowest in cases who were sick, and they were going down in cases which just had the enlarged lymph nodes, et cetera. He was one of the first who gave us a fair picture of what the helper-suppressor cell ratio meant.

Arye Rubenstein talked about his probable AIDS infants. He couldn't say they were children of infected mothers because we couldn't test for infection then. So perhaps it was genetic. He and Friedman-Kien also had reported something called the HLA-DR5 gene, which was the same in epidemic KS versus classic KS cases. So maybe that wasn't a clue.

Then the New York cases in blacks and Haitians versus Caucasian controls left some questions in their mind. This is genetics. Remember, this was ten years ago, and genetics has exploded since then. So this is not really medieval genetics, but it's very, very early Renaissance genetics, if you wish. Yet, that was the foundation for what we learned later.

Then the panel talks: Roger Enlow speaking for New York. He's a gay doctor or a doctor with a gay practice, I don't know which. He talked about the gay lymph syndrome. We were getting too much data, too fast to tabulate. His general findings were the same as San Francisco's, as well as CDC's. And I won't go through all of my notes.

Somebody called Fitzgerald was talking about the differences in the production of interferon. This is all to show you how little we knew and how many things we were considering--thymus production, and alpha interferon levels. Would chemotherapy do us any good in improving the T-cells before and after the treatment for the KS cancer? In other words, we knew that when cancer patients were being treated with chemotherapy, their immune system, their T-cells, went down. It was in cases like that, that we found occasional *Pneumocystis* pneumonia. The same occurred in Salvitierri's kidney transplant group at UCSF. When he had to use chemotherapy on his patients to keep them from rejecting the new kidney, they sometimes developed *Pneumocystis* pneumonia. That was

the first clue we got that maybe these patients with *Pneumocystis* were also immunosuppressed.

I would talk on the phone to three, four, five doctors a day about the AIDS epidemic, and about other things, too. I'd be talking about some other case, and they'd say, "Oh, by the way, I've got another case," and tell me a little about it.

Hughes: People all over the country?

Dritz: Well, here in San Francisco. About the other cities, I don't know. You see, we were such a tight-knit community here. We had already put together our network, because of the enteric disease transmissions that we had in this very visible gay community, with shigella and amoeba and hepatitis A and B, so we already knew each other, and we were used to talking to each other. I could just pick up the phone and say, "Tom, what are you using now for aggressive hepatitis B?" I won't use his last name; he doesn't believe ethical physicians should seek or accept publicity. And according to Hippocrates, he's right.

As a matter of fact, about a year ago when I was in the neighborhood, I walked up to Tom's office. I asked him how it was going. He said, "Well, we're using AZT, but I'm finding after about twelve months it's no longer effective, and then the patients go down. They die sixteen, seventeen, eighteen months after diagnosis."

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Dritz: I could talk to Tom and then call Bud [Louis] Boucher, a private practitioner with a large practice in the gay community, and say, "Well, Tom says thus-and-so. What are you finding?" That way, we were up-to-date on what was happening here in the city, and the best information that any of us knew was being transmitted. I was the stirring spoon. In German they use the word "Kochleffel." I was in every pot, and getting information distributed around. That was my job.

You don't really want me to go on through all this meeting. There was Friedman-Kien, there was Goedert from the National Cancer Institute, Shearer on auto-immunity, mouse experiments they talked about, then the etiology panels--all of this was still going on. Etiology, what's causing it? If you look at this, you'll see my scribbling is getting more and more illegible.

Hughes: I can see why.

Dritz: Then Al Prince was talking on hepatitis B in the gays in New York, with a 35 percent increase among them. I could have told him I had a 70 percent increase among the gays in San Francisco in the preceding years. But you see, the New York group were spread through five boroughs. The doctors were spread all over the place. I imagine that maybe a doctor in Manhattan didn't necessarily have day-by-day contact with a doctor in the Bronx. I'm not sure; I don't know New York that well. They would meet at the medical society meetings, maybe. But if they had their own borough society, then maybe the word wouldn't get around so much.

So if Prince saw a 35 percent increase in hepatitis in the gays in New York, maybe that was a delayed report at that time, whereas, when I had a 35 percent increase, I knew it as of last week. I'm not saying for me, but in our department, that's the way it could have and did work, because we were in the field. We were on the ground.

Martin Mass said that a virus was more likely to be the cause than anything else. He ruled out nitrite drugs. He said, "We do know from some reports that sperm also decreases the level of the T-cell activity." So they were saying, "Well, these guys are shooting sperm into each other back and forth. Maybe that's doing it." It didn't turn out to be.

When all of these things were finally put in on the computer grid--a regression analysis--forty reports against fifty contacts, the only thing that came up as significant was number of sexual contacts and type of contacts.

Friedman-Kien here was reporting about the Haitians. He told about his sixty patients in New York. It was a very active scene there.

Linda Laubenstein, a hematologist and oncologist, was very good. She used chemotherapy on things like leukemia and so on. She said she now had about seventy cases of KS at New York University, and she talked about Uganda treatment trials. She talked about how using vinblastine and blastomycin would give her fairly good results, but we didn't know that later this would drop down the immune system efficiency.

Hughes: Did those drugs pre-exist the AIDS epidemic?

Dritz: Yes. These were some of the newest drugs being used in cancer chemotherapy. And since we had KS as the earliest manifestation of AIDS, we began to use cancer treatment. What we didn't find early was that the cancer treatment made patients worse, because

it diminished the activity of T-4 cells; it dropped the T-4/T-8 cell ratio.

Oh, yes. Bijan Safai talked on immunological therapy. He was a cancer doctor at Sloan-Kettering. He had used interferon and thymosin, transfer factor, DCG--I don't even know what that is any more--maybe he said BCG [bacillus Calmette-Guérin], the TB vaccine--mixed bacterial vaccines. He said, "This one gave no good clinical results, and that one gave mixed results, and this other one dropped the immune response, and that one maybe caused NK [natural killer cell] activity to increase and maybe it didn't."

Hughes: Was there a conclusion?

Dritz: When I came out of there, my brains were fried. All we knew was that a lot of questions had been raised, a lot of theories had been presented, a lot of data had been presented, which didn't come to any clear presumptive theory as to the etiology, the management, the prognosis, or the prevention of the disease.

I walked home from 101st Street, down 5th Avenue to the hotel, which was on 54th Street. I stopped in at Rustermayer's, I think it was, and had an ice cream soda. I felt human again.

Now, that same night, Paul Volberding and Don Abrams flew back to San Francisco on the red-eye, because they both had clinics at 8:00 the next morning. Now, this is devotion. I stayed over that night at my own cost and took an early flight out the next day, and because of the three-hour time difference, I was still at my office at 9:00 a.m.

Hughes: That's devotion too!

Dritz: Well, we had to do that. It was so exciting; you couldn't miss it. Just couldn't.

Hughes: How did you hear about meetings?

Dritz: Oh, I would be talking with CDC, or they would call or send a notice around to all the health departments and interested people.

Hughes: So very quickly the individuals interested in the epidemic were identified?

Dritz: Yes. This was the summer of '82; it was a year since the first cases had appeared. It was two, three, four years since the first cases had been infected, but we didn't know that yet. And it wasn't until I think the next year, when Winkelstein's San

Francisco Men's Health Study developed, that we realized that with the blood test that we had and the testing that Paul O'Malley got us to do on the hepatitis B cohort blood samples, the 6,700 blood samples still in the freezer at CDC, that men had been infected with this virus as far back as 1978. Since they were already infected in 1978, it meant somebody else had to have had it to infect them. And later, we saw there was a two, three, four--now ten--year incubation period, maybe they'd been infected way back in '74 or '75, or earlier.

Hughes: Yes, the time of initial infection kept getting pushed back.

Dritz: That's right. In order for the individual to have transmitted AIDS to somebody else, he had to have been infected in '78 or earlier in order for us to find out about it in '81 or '82.

Medical Grand Rounds on AIDS, July 1983

Hughes: Well, the next meeting you attended, I believe, was at UCSF in July of 1983.

Dritz: Well, there were informal talks here and there. We were lecturing to the epidemiology class at UC Medical School and we were lecturing to the STD, sexually transmitted disease, clinic course at UCSF during that time.

This medical grand rounds in July of 1983 was at Cole Hall at UCSF. It was announced as a special medical grand rounds: [reading] "The Acquired Immune Deficiency Syndrome, a multi-disciplinary enigma. Moderator, John E. Conte, Jr., M.D." He was chief of infectious disease at UCSF. There was only an hour allotted for it, I think. There were going to be six speakers and a panel discussion, so we were allotted fourteen minutes each. Not very much time.

The first speaker was Art Ammann on the immunology; he was the chief pediatric immunologist at UCSF, and world-famous. He reviewed the immunological aspects of AIDS.

Then I presented the epidemiology. In fourteen minutes--around the world in fourteen minutes--I talked about the sociological aspects, the community needs--

[tape interruption]

Dritz: --the demography, that is, the distribution of cases, geographically and in different types of populations. I talked about the increase in the numbers of the gay population in the city as contributing toward the rapid dissemination of the disease, about their exposure to the enteric diseases first, then about the earliest cases of PCP and KS and the incidence. With all of these factors, I showed slides on how the numbers were going up, doubling every six months. And how our numbers were just one year behind New York's, and therefore we could expect a similar rise in one year.

The CDC's case-control study showed us what the risk factors were. By now, I think we already had our regression analysis showing that frequency and intensity and type of sexual contacts were the significant contributing factors to dissemination of the disease.

Hughes: That was the analysis that was so slow in coming because of the lack of federal money for a statistician?

Dritz: That's right. We did the study in late '81, early '82. No, it was late '81, because we were already in Atlanta, testing out the use of the 24-page questionnaire before the end of the year. We were using it in early '82. It wasn't until '83 I think that the word came out about the results of the case-control study.

To return to grand rounds, I talked about the etiology; what could be doing it? Here I talked about lab studies and the numbers of things we had tested against on that, using the very complex slide I showed you previously. I talked about what we were using as treatment and the results we were getting, or rather, not getting.

I also talked about the possibility of cases among health workers, because they were being intimately exposed to the patients. At that time, in my whole roster of cases, I had fourteen cases in health workers, but they were all--I didn't say they were all gay men, but I said they were all members of a risk group. There were quite a number of gay men among the nursing and the AIDS staffs in the various hospitals in the city.

Then I gave them Andrew Moss' survival curves, based on the patients we had and the dates of diagnosis and the dates of death. There was some hope, I supposed, because eventually we were going to find out how to treat AIDS, and how to make a vaccine. It might take years, but we'd have it. And what was still needed was a better definition of the cases, because Burkitt's lymphoma wasn't included as an AIDS case. Toxoplasmosis, cryptosporidiosis were being reported and CDC was not yet using them as a definition

for AIDS. Therefore, if a patient only had one or more of those manifestations, he wasn't considered an AIDS case, and so he wasn't eligible for help from AIDS programs.

The new definition that has come out now has increased the numbers of cases that are defined as AIDS, which means it's increased the cost to local governments for those who can't pay for their own care, and the cost to hospitals that have to take Medicaid patients. And as we're getting more effective treatment, we're maintaining the patients alive longer. Therefore, they're needing treatment longer, which means the cost of their maintenance is greater. AZT was costing patients $8,000 a year. Burroughs Wellcome dropped the cost of it because the market has grown bigger--supply and demand, and aggressive demands from the gay community.

The cost of the epidemic is wiping out cities' budgets. San Francisco is putting a tremendous portion of its budget into care for AIDS patients now, because patients just don't have any other resources. The churches have opened hospices for the care of AIDS patients. These are just places for them to die, but at least they're not dying on the street. The cost of care is going up and up and up.

Stuart Anderson and Vitamin C

Dritz: Did I tell you about Stuart Anderson and the vitamin C problem?

Hughes: Why don't you mention it now?

Dritz: In the gay community, there were some people--I don't think they were organized in a group--who simply felt that the medical community was so homophobic that we were just pretending to treat them but were actually letting them die because we didn't want any gays to survive. One policeman who came into my office said, "Oh, hell, they're a big problem. I think we ought to take a flame thrower and just clean out the Castro (gay center in San Francisco)." A policeman in uniform! On the other hand, there were other policemen who would give mouth-to-mouth resuscitation without thinking twice, because that was their job.

Anyhow, some of the gays felt that the doctors, the health department, the community didn't want to do anything except kill the gays. As a matter of fact, some of them claimed we had introduced AIDS in order to wipe them out. I don't know how we would have done it; we didn't know what the cause was yet.

Linus Pauling announced that 30,000 units of vitamin C every day would keep you alive--prevent you from catching colds or anything else. I don't know if he said it treats cancer, but it was just about that. He's a very, very famous, very, very marvelous mind, but I think he went off the deep end on that.

Stuart Anderson, an aggressive gay, then came in to my office and said, "We're going to use vitamin C." He was walking up and down Castro Street telling the gays, "Don't go back to those doctors. They're trying to kill you. They only want to kill you. You've got to have vitamin C." He was using 30,000 units. He got quite a number of the gays to leave their doctors and go on vitamin C. Of course, they died--a pity--and he died a year later, too.

But there was that kind of resistance, which was a corollary of the confidentiality resistance, so in several different ways, we were hampered in trying to get complete cooperation in the gay community. A lot of them believed us, did what we thought would help them, and cooperated in bringing us information. Without their cooperation, we would have been blind to developments.

But at the same time, there were aspects that hampered us and maybe helped to contribute to the spread of the disease. I know the baths did.

Lecturing on AIDS

Hughes: You mentioned off-tape giving a Friday night lecture to gays in the Castro. When was that?

Dritz: It was a very hot Friday night, so it must have been in September or October after the fog season in San Francisco. Probably 1981. They had asked me if I could come and talk. They were asking one or two other doctors to come, also. They wanted me to represent the health department. They said, "There is so much confusion and guys are saying so many different things. They're going to hold a big meeting there at the recreation hall behind the Cala supermarket off of Castro," and would I be willing to come in and talk on Friday night. They said, "I know it's a weekend, et cetera," but I had nothing else to do, and I was glad to help. If I had something else to do, I'd have gone to their meeting anyhow.

I came in there, and every seat was taken. It was a gymnasium, and they had set up well over 200 folding chairs there.

Every one filled. I had brought my slides along. I think it was Bob Bolan who introduced the talk.

I presented what I had to tell them: where it is, who's got it, what we think is causing it, how it's being transmitted, how we think it can be prevented, what we're using to treat it, the poor results we're getting, what we think is going to happen. And please stop doing these crazy sexual things! That's what's transmitting it. I said, "Whatever you're doing in the bedroom," --I wasn't going to say in the back room of the bars; I think I mentioned the baths--"I won't stand in your bedroom and shake my finger under your nose and say, 'Now, don't do that, you're going to catch something,' but I'm telling you here, now, that's how we think you're catching it. It doesn't go through the air. You can't cough it into somebody's face. You can't get it from a telephone or from shaking hands. But you can get it sexually, and if you can't stop this extreme sexual activity, at least cut it down so your Russian roulette gun will have two bullets instead of six bullets in the chamber. Because right now, the way you're going, you've got six bullets in the chamber."

Hughes: Were they listening?

Dritz: They were listening. They were listening enough to say, "Well, how do we know who's got KS? How do we know if we've got it?" I said, "Well, I didn't think there'd be enough time to show all these pictures. I've got a whole bunch of pictures of KS. Do you want to see them?" They said, "Yes!" So my talk ran a little over time. They had to get out of the center at ten o'clock. I showed them the ten pictures, twelve, whatever I had, that Jim Groundwater had given me, taken of his own KS patients. I didn't name names, but they saw Simon Guzman; they saw Bobbi Campbell; they saw some of the other early patients.

I showed them the different ways KS looks. If you've got a light skin, it looks pinkish; if you've got a dark skin or you're heavily tanned, it looks dark brown. This is what you'll find. You'll find it on you here; you'll find it there; you'll find it in your mouth. If you've got thrush (candidiasis), look for KS in your mouth.

Also, if you've got a cough and it just doesn't go away, and it's not a cold, and it's a dry cough, and you have fever, and now you're getting chills, and you're having night sweats, and you're losing ten pounds in a week and you don't even know why because you're not dieting--all of these things mean get to the doctor right now, because you've already got it. "If you haven't got any of these symptoms yet, please don't let yourself catch it, because once you've got it, you've had it."

Learning to Recognize Opportunistic Infections

Hughes: In 1981, getting to the doctor didn't really do very much good, did it?

Dritz: No, but a lot of them didn't get to the doctor, because in 1981, they thought their KS "spots" were bruises or eczema. Doctors weren't so well aware of KS in San Francisco then--well, the gay doctors were--and they would prescribe antihistamine creams to cut down the eczema. Then when it didn't turn out to be eczema, it wasn't anything else, they finally did a biopsy and they learned it was KS.

Some of them didn't know what KS was. I had to find out about it myself and do some reading. You never saw it here. If you had heard about it in medical school in dermatology class, you sat for an hour and a half asleep while they showed pictures. You walked into derm class, they shut out the lights, and they started to show pictures of what it looks like. Which right after lunch, isn't exactly electrifying. Same with x-ray class. I slept through x-ray. I had to learn it eventually, but that wasn't the way to teach it.

A lot of us who had maybe seen one slide of KS and heard about it only in old men in the Mediterranean or North Africa, didn't pay much attention. We weren't ever going to see it here. Now, when the doctors in San Francisco got a report of KS, "Huh?" was the response. Then, after a while, they learned about it with a vengeance.

Doctors were treating patients with a cough for bronchitis, because the chest x-ray showed just a bronchitis and later on a diffuse bronchopneumonia. Well, bronchopneumonia is usually a viral affair or a yeast affair. They didn't know that it was a *Pneumocystis* pneumonia, because you didn't see that except if you knew about Salvitierri's work in kidney transplants in UCSF, and that sometimes an immunosuppressed patient gets *Pneumocystis* pneumonia.

When I gave a lecture to the epidemiology class at UC on *Pneumocystis carinii* pneumonia and Kaposi's sarcoma, one of the students--this is a third-year medicine class--raised his hand and said, "How do you spell *Pneumocystis* pneumonia?" They hadn't even seen the term in their books.

So we all got a real education on some of these obscure diseases, especially cryptosporidiosis, the diarrhea disease of

sheep. "How do you treat the sheep?" we asked an expert. "We shoot them."

[tape interruption]

The Health Department's AIDS Program

Development of Program Components

Hughes: Dr. Dritz is looking at one of her outlines which is titled, "San Francisco Department of Public Health, Department AIDS Program, 1983." And it goes on for three pages.

Dritz: Three or four pages in big type. This program developed gradually, step by step here, as the AIDS cases developed and we began to see what the problem was going to be. We didn't know from the beginning what it would be. It became a model for a city's approach to an AIDS outbreak, and later was adopted--adapted, anyhow--by New York, by Houston, by Miami, by Chicago. We heard that they were using different parts of this program, or they were using it as their model.

First of all, we were concerned with active surveillance and treatment. We had an AIDS clinic for screening and outpatient treatment at San Francisco General, and we had the AIDS ward, 5B, there--it became a famous place--for patients who were too sick for an outpatient regime. We cooperated with Marc Conant at the UCSF clinic, with San Francisco General, with John Ziegler at the Veterans' Administration Hospital, and also with the California Tumor Registry, under Eva Glaser. It was that registry that gave us the indication that the numbers of Burkitt's lymphoma cases we were seeing was <u>way</u> out of line with what they would have expected to see in the whole state of California in two years.

We had a central case registry in our office, and we exchanged data with the state and with CDC also on their cases. We gave them our case names at that time, until we were forced to observe more confidentiality later. We also used a laboratory test for checking cytomegalovirus and adenovirus titers. At that time, we didn't know which virus was causing what, if it was a virus. And we kept a serum specimen bank on all of those bloods that we had drawn since 1980.

CDC also had set aside, without realizing they were going to be so useful, the 6,700 bloods that had been drawn during the

hepatitis B vaccine trials, which were still in the freezers at CDC. We used those later in our retrospective study on how far back infection had been present and unsuspected. It was Paul O'Malley of the San Francisco Department of Public Health AIDS Activities Office who remembered about the stored bloods--a major contribution.

Besides the active surveillance and treatment, our department carried on research, in-house projects. There was this hepatitis B cohort study I told you about; the case-control epidemiological study with Moss at UC; we kept track of transfusion cases with Irwin Memorial Blood Bank. We did contact tracing in-house, just as we did for syphilis and gonorrhea, until the confidentiality issue closed that down.

Hughes: Contact tracing stopped with the availability of the AIDS test?

Dritz: It goes so far back, I can't say for sure now. You may find something in the literature on that.

Then we were doing viral culture studies. Our laboratory was testing for beta microglobulins and every virus we could think of, including Epstein-Barr virus and cytomegalovirus and retroviruses, if there was any test for them, as a screening test for AIDS.

This was summer of 1983, and it was about that time that Luc Montagnier and his group at the Pasteur Institute said that they had isolated a new retrovirus in their AIDS cases. But it wasn't until 1984, a year later, that Gallo and his group at NIH said that they had "the virus," unquote. And it wasn't until March of 1985 that the federal government actually licensed a test for the AIDS antibody.[1]

Then, in addition to our active surveillance and our research, we had outpatient support. We had public health nursing home visits and counseling to AIDS patients. We had the community mental health services section of our department doing substance abuse counseling, and then we had our educational program, both for professionals and also for the lay population. Under professional education, we talked with hospital staffs, we developed guidelines for medical schools and hospital outpatient departments, and we had our education program for the political people, because politics in San Francisco was a real labyrinth of Minotaurian dimensions.

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[1]See R. Gallo, L. Montagnier. The chronology of AIDS research. *Nature* 1987, 326:435-436.

Hughes: Were these activities in addition to those of the committee that you described at the beginning of the session?

Dritz: Yes. These were the activities of the department as a whole, through my bureau office. The committee was an advisory committee to the director of the health department. What I just described was a program which probably included some of what we had learned from the advisory committee, as we developed information on the needs of the patients and their health providers.

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Dritz: I should point out, at this time--this was 1983 already--the AIDS "staff" in my office still was me, one epidemiological assistant, who had been borrowed from the city VD clinic, and two clerks. That was it.

Hughes: How many hours were you working a day?

Dritz: Eight hours a day in the office, and then there were meetings in the evening and on weekends. I didn't feel that I was killing myself physically, but I was killing myself emotionally and intellectually, because I was so excited about the challenge. I had a tape recorder on my bedside table. I used to wake in the middle of the night and think, "God, what are we going to do?" Sometimes I would tape an idea, because I might forget it by morning. In the morning I'd play it and it wasn't any good anyhow. But you know, it got you by the throat. You couldn't stop.

Well, anyhow, we had to deal with City Hall, we had to deal with the state, we had to deal with the federal government, and the feds included NIH and CDC. Now, City Hall governed our budget. City Hall got a lot of its budget from the state, which got its from the feds, and the feds didn't have any money. It was all being shot up into Star Wars and things like that. So the government took money from NIH, which ran CDC. If CDC needed more money, NIH had to take some away from the National Cancer Institute or from the NIAID [National Institute of Allergy and Infectious Disease] under protest.

The piece of financial pie for the health services--federal, state, and city--was diminishing all the time. And yet the needs were exploding. So we had these problems with the politicos. We had to educate the politicians.

Education Program

Dritz: And then we had our educational program for the lay population. One part was with the gay groups. We put posters in the baths and the bars, pamphlets everywhere--it didn't mean anything. We had the community meetings; the Eureka Valley meeting is the one I just told you about.

We had the press meeting with bath owners, in which Silverman tried to explain to them, "We've got to close the baths," and all they said was, "We are now organizing the Northern California Association of Bathhouse Owners, and you do anything to close the baths and we'll have a TRO, temporary restraining order, on you the next morning."

Silverman knew we couldn't prove it was infectious; it was presumptive. An opposing lawyer would say, "Now, doctor, show me that this bath was the source of this man's infection." You know how lawyers are. So there was no point in closing the baths until we had proof. So we handed out pamphlets, and we had meetings, and we had the press meeting with the bath owners.

Then I had an informal meeting with the Tavern Guild, which is the association of gay bar owners. All I could do with them was say, "Well, at least let me teach your bartenders how to talk to a gay man." A gay man would be having a beer at the bar, or whatever they have there. He'd say, "You know, a friend of mine, he's got this AIDS now, and I don't know if I'm going to get it." I would say to the bar owner, "At least, alert him that there is help, there is sympathetic help, in the health department. Go to the office of infectious disease, tell your story there. Or go to the AIDS clinic at San Francisco General. I've been told--I believe them--that they're not going to give your name away." We tried to get through to the bar owners.

Hughes: And did you?

Dritz: Well, we talked with them, we got to them, we told the bar owners what to do. We couldn't stand there in every bar and see if they did it. But at least we hoped that some of the information would get through. You know, when you're working with a big population, it's not like God puts his hand down and everybody changes immediately. You can't pass a miracle. But you work step by step.

With a disease, if you don't know what's happening, you treat the symptoms; at least make the patient a little more comfortable so his own body is more able to conquer it. In the case of AIDS,

his body couldn't conquer it, but maybe we could make him more comfortable. It's the same way with the population. You work where you can wherever there's an opening. You treat the symptoms. If the bartenders can be an avenue for help, you use them.

We also worked with the heterosexual, the general, population. We had an interesting problem with employers. We worked with Wells Fargo Bank, Bank of America, Levi Strauss, Pacific Telephone. The personnel manager at Wells Fargo called us and said, "We're having a problem." I remember this very clearly. "One of our men has been out with *Pneumocystis*, and the doctor says he can come back to work now. But we've got 3,000 employees here in the building, and they're threatening to strike if he comes back. Can you help us?" This was part of the AIDS hysteria.

I asked him if I could meet with him and his subordinates in the personnel department, and I would tell them what I could. I spent a whole afternoon with them in their offices, telling them everything I could about AIDS--epidemiology, etiology, everything we knew--how it was transmitted, how we were pretty sure it was not transmitted. One of them said, "Can you guarantee we won't catch it?" I said, "Nobody can guarantee you anything. Can you guarantee I won't be hit by a car when I cross Market Street? I don't know if I can tell you the odds [for getting AIDS] are the same or less. I can't guarantee it, but we haven't had any reports that AIDS can be casually transmitted, and we know of no secondary AIDS cases in close household contacts of AIDS cases unless the contacts are also of high-risk behavior."

At the end of the afternoon, all of his division heads were experts on transmission of AIDS, unquote. The next day he called me and said, "We're having a meeting with all of the employees. Would you come to the meeting?" I said, "I can't. I have to be in Atlanta this day. But I'm sure you can tell them what you need to." I would have been there if I hadn't been in Atlanta.

He called me back the next day. He said, "We had a meeting. I told them what you told us. My division heads told them what you told us. We said we believe what you said. They took a vote, and they're going to permit him to come back to work, but they'll put him in a little different division, and his desk will be near the window, a little further away." That's all right. When they said, "You can come back to work," this man said to himself, "I'm living again!" It made that much difference.

He died six weeks later, but he had been able to come back to work, and they didn't strike. If they had struck, some of the

other companies might have struck also. I was able to give other companies some counseling over the phone. We were able to head off strikes and hysteria in large organizations.

Hughes: What an accomplishment!

Dritz: You do what you can.

Hughes: You were doing a lot.

Dritz: Well, to put it crudely, that's what I was getting paid for.

Then we worked with neighborhood associations, including mine, the Crestlake-Pinelake Park Association. Also the Haight-Ashbury group. I wasn't called by the Fillmore [District]. I talked with the Castro and Noe Valley groups. As I said, this city is a group of villages, and I was able to talk with a lot of them.

There was a group down in Bayview-Hunter's Point, way off by the bay, where they used to have quonset huts. It was a colony of Hawaiians and Polynesians. They were terribly worried about AIDS, and they had a language difficulty. I was able to talk with them at their Assembly of God meeting house. The minister interpreted for me. I was able to tell them what was happening, where, and how. The minister turned to me and said, "You don't have to worry about that, because we don't have any homosexuals in our group here." I said, "Well, that's fine. I hope you don't." I don't know if he did or he didn't. On the other hand, the Japanese people had also said, "We won't have any AIDS here; we don't have any homosexuals." They do.

Hughes: Were these communities concerned as a result of media coverage of AIDS, or did they think that they had a particular risk for AIDS?

Dritz: I think they were just scared. For one thing, they saw themselves as aliens in a strange land. They were set off because they looked different. A gay man can pass. A Jew can pass. An Arab has a little darker skin. A Korean cannot pass; he looks different. These Hawaiians and Polynesians looked different; they were aliens. A lot of them had a language problem. They were fairly recent immigrants.

Hughes: Had your reputation spread so that when a group wanted a speaker, they asked for Dr. Selma Dritz?

Dritz: Well, Dave Perlman once said at one of Silverman's advisory group meetings, "When we need information, we call poor Dr. Dritz. She gets all the calls. Everybody knows Selma." The radio stations,

the newspaper people, the TV people called my office because they knew the information was accurate. Many times I think they might have called Silverman's office, and he or his secretary would have directed them to me.

Hughes: Your name was out there.

Dritz: Oh, yes. They knew me.

Hughes: I know that from going through the newspaper clippings on AIDS in San Francisco.

Dritz: Oh, there were some before that. Our Legionnaire's disease outbreak put me in the paper, and our infectious hepatitis A outbreak--that was the famous tofu salad mystery in San Francisco. I won't go into that because it has nothing to do with AIDS. But it was part of getting the health department known as interested in controlling infection without damaging people, that we were friendly. Our pictures were in the papers often.

We put out pamphlets targeted for every group in the hetero[sexual] community, in English, Chinese, Spanish, Tagalog--that's for the Philippine community--and we had translators for Korean and Thai. We put our material out in comic-book style, with big lettering so that it would be easily assimilated. We put out pamphlets in different languages--for kitchen sanitation, for food handling, for transmission of airborne diseases. We didn't put them out in Japanese. The Health Education Bureau believed that Japanese in San Francisco had mastered English. But all the others went out in multiple languages, so our AIDS literature did, too.

We put out guidelines for the workplace which had been set up by CDC. We put out "AIDS for the General Population"--you can shake hands, you can use the same telephone, things like that. Questions from the public always came in to my office. I'd answer them on the phone. Then I lectured at the state and local colleges, too.

Hughes: Was the content of the AIDS pamphlets changed according to the targeted population?

Dritz: I don't think so, no, except for the gay community.

Now, we knew that AIDS could be transmitted by blood; we knew that it could be transmitted by sexual contact. We were beginning to see heterosexual cases. So we mentioned these sources of infection, and we didn't use the word "promiscuity," but we implied it, and said that is the major risk. The more times you

expose yourself to a risk, the better the chances are that one of those times, it will hit you. We used the term Russian roulette: "The more times you play Russian roulette, the more chances you have to get that one bullet in your head."

Hughes: You avoided the term "promiscuity" because it was pejorative?

Dritz: That's right. But we said, "If you have a lot of sexual activity with a lot of people, and a lot of very traumatic--" we didn't use the word traumatic "--if you have sex in a way that damages your skin or your tissues, you transmit body fluids, semen or blood, you have to be careful." You wouldn't use a word like semen with a group that was a very orthodox or fundamentalist religious group.

Hughes: So you'd leave it at "body fluids?"

Dritz: Body fluids, yes, or just "too much sexual activity, careless, frequent, with many, many people," instead of "promiscuity." "It's not so bad to have many contacts with only one partner. Your chances of being infected depend on whether that partner is infected. But if you have one contact with each of many partners, among them you're going to find somebody that's infected, and you'll get it." That was about the way we put it.

The Department's Ties with Various San Francisco Organizations

Dritz: Our program also cooperated with allied groups. There was the KS [Kaposi's Sarcoma] Foundation, the Shanti Foundation for home finding and counseling of patients and others, the Home Health Service, and the VNA, Visiting Nurses Association. Haight-Ashbury Clinic was good, because it sent us drug-associated cases. David Smith--I think he's still in charge there--did a wonderful job. That was a drug treatment program that started in the Summer of Love, the sixties, and it continued from then.

Some of our contacts with the gay community started long before AIDS, with those drug-associated cases from the Haight-Ashbury Clinic. I had forgotten that. Many of the gays who first came to the city when the gay community began to expand lived in the Haight-Ashbury. The drug junkies--to use a pejorative term there--in the Haight-Ashbury were outsiders. The gays that came in were outsiders, too. They gravitated to the other outsiders. They were in the Haight-Ashbury first. Later, they spread into the Castro, which is not so far from there.

So our first contacts, through the drug-associated cases in the Haight-Ashbury, gave us contacts with some of the gays, too. They got to know the health department, even if they weren't on drugs.

Then we worked with Children's Hospital, a general, not a pediatrics hospital, which instituted one of the early AIDS treatment programs for gay men. We worked with the Pacific Medical Center's men's clinic. The two hospitals have since merged. The men's clinic was for sexually transmitted diseases, and of course AIDS became one of those. We worked with the Gay and Lesbian Health Services Coordinating Committee. We had weekly meetings at first and later monthly meetings with them on AIDS.

And we worked with the Irwin Memorial Blood Bank on transfusions, and we worked with BAPHR, Bay Area Physicians for Human Rights, because those were the doctors who had the largest concentration of gay patients. There was a large number of gay doctors in that group, although there were other gay health workers and non-gays there too.

Then the last was our AIDS advisory committee, with members from the health department, San Francisco General, UCSF, Irwin Memorial Blood Bank. Herb Perkins, the medical director of Irwin Memorial Blood Bank, was on the AIDS advisory committee, as well as John Ziegler from the VA Hospital, and representatives from BAPHR and the San Francisco Medical Society. That covers the high points of our city-wide AIDS program.

Hughes: Do you think any other health department came close to having that number of institutional contacts?

Dritz: I have no way of knowing, but I know that a lot of them were using San Francisco as a model, and CDC told other cities about our program, too, because I was on the phone with them all the time.

Hughes: AIDS being an infectious disease was also a reportable disease. How was compliance?

Dritz: Well, AIDS itself in the beginning wasn't reportable. Later on, the state declared it as a reportable disease, and by law, it had to be reported, and doctors reported it. AIDS patients were reported, because it was a sexually transmitted disease. AIDS-infected persons who were not actively sick with AIDS were not reported, and they still aren't reported.

Hughes: Even with the new expanded definition?

Dritz: Even with the new definition, being infected with the AIDS virus, having a positive AIDS antibody test, is not reportable. That is one thing that hampers us. For political reasons, civil rights reasons, such cases are not reportable. So all we can do is urge people that we know are AIDS-positive not to expose others and to go for medical care as soon as any symptoms develop, or medical advice before symptoms develop. That's what the AIDS post-testing counseling is designed for.

San Francisco Men's Health Study

Hughes: Do you want to comment on the San Francisco Men's Health Study?

Dritz: Well, I can to a degree. That is Warren Winkelstein's study, which started with a door-to-door survey in zip code 94114--that's the Castro and Noe Valley--to find where unmarried gay men lived who would be willing to be part of a study. That's a prospective study. The men are asked to have a confidential AIDS test. At first they weren't asked, because we didn't have the AIDS antibody test then. This was now ten years ago.[1]

They are interviewed, I think every six months, maybe it's more frequently, and they and their physicians are asked to keep in touch with the program. The program follows them statistically as the symptoms develop. We now know, based on that study, that from the time a man enrolled in the study with no symptoms at all, he then developed what looked like a severe flu and got over it; then weeks, even months later, he developed enlarged lymph glands. That lasted for a month, year; it varied.

When the lymph gland subsided, he thought he was getting better. After that, real AIDS by the old definition developed. So we now have a case history of how the disease progresses, and much faster than when Robert Koch worked perhaps ten years seeing how a case of TB developed.

I sat on Winkelstein's advisory committee until I retired. We tried to work out how to analyze one symptom versus another, how to get money for a machine that would do T-4 and T-8 counts, which we didn't have money for. CDC said maybe they could get us some money, but they would monitor and run the machine, and it would be their program. Winkelstein and the rest of the committee

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[1]Winkelstein's study began to recruit subjects in 1984. See the oral history in this series with Winkelstein.

said, "No way, this is our study. We want to keep track of our own patients here and know what's happening." So there was a lot of infighting.

About that time I retired [1984], so I don't know what happened. But I do know that the study defined the course of the disease, which is different from the retrospective study of the hepatitis B cohort. They had bloods of 6,784 persons who had taken part in the hepatitis B vaccine trials, which they now tested for the AIDS antibody after March of 1985 when they finally had an antibody test. They found that 4 percent of the bloods drawn in 1978 were already positive.

Winkelstein was able to follow every few months the 300 or 400 who hadn't yet been infected, and they found that the infection rate increased and increased and increased, so that they had about 60 percent positives by 1984 or 1985.

A prospective study tells you a lot more certainly than a retrospective study. Retrospectively, we could tell how many people had been infected back in 1978. We didn't know how they got infected, and what happened to them in the course of it. Most of those had died off by the time we got to them. But when you start prospectively with people who aren't yet symptomatic, you follow how the disease develops in them--and also, you can define the probable degree and distribution of future cases.

So a prospective study can give you clearer information on where you're going and what you can expect. On the other hand, the retrospective study tells you where you've been and how much is already bad, that you have to gear up for.

The Bathhouses

[Interview 4: July 8, 1992] ##

Hughes: We've talked tangentially about the bathhouse issue, but I thought it would be well to go through it sequentially. As I understand it, the issue began to simmer early in 1983. Is that your perception?

Dritz: Well, the battle to close the bathhouses began to simmer then, but we were aware of the problem and trying to do something at least sub rosa to diminish it long before that in fighting the STD diarrheal diseases there. In '82, we were aware of Gaetan Dugas and the connections between him and so many people that he met

here in San Francisco at the baths, and his open announcement that, "Well, I'm off to the baths tonight, and there's nothing you can do about it." He came to my office and said, "It's my right to go where I want to."[1]

We were becoming reasonably sure that this was a disease caused by a transmissible agent. It seemed to be concentrated in gay men who were very sexually active. (I'm leaving out the question of the hemophiliacs.) The place where they could be most sexually active, most traumatically active, was in the baths.

We felt that, as with any transmissible disease, you try to diminish the numbers of contacts between the infected person and uninfected people. That was why we had quarantine for smallpox and chicken pox and scarlet fever, for instance. We couldn't quarantine the men here, because we couldn't prove that this really was an infectious disease, and even if we knew it was an infectious disease, we didn't know what was the infecting agent yet.

We became very unhappy about the baths. The bars had activity rooms in the back, the bookstores had activity rooms in the back, but the baths were the ones that were the most openly irritating to any epidemiologist, any physician.

Meeting with the Bathhouse Owners, 1982

Dritz: Some time in mid-'82, late '82, Dr. Silverman finally called a meeting of all the bath owners in San Francisco. I think he even had the manager of the Water Garden, down in San Jose, which I was told concentrated on urine transmission. But that was not in my San Francisco County jurisdiction. Glory holes were another inventive variation.

The Club Baths, the back room of the Mine Shaft, which was on Market around 15th Street--that one's gone, fortunately--the Ambush and the Jaguar bookshops: these were all places for rapid transmission, effective transmission, among many people. The more contacts a man had, the more opportunities he had to be infected, the more the odds were that one of his contacts would infect him.

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[1]For a press account of Dugas' role as "Patient 0" in the transmission of HIV, see: "Patient 0 tracked as carrier of AIDS." *San Francisco Examiner*, March 3, 1984. (Archives of the Gay and Lesbian History Society of Northern California [GLHS], AIDS clipping file, folder: AIDS 1-3/84.)

Well, Silverman met with the bath owners--fifteen or twenty men. I was there. It was a hot meeting. Silverman tried to be politic, calm. He was a very, very good administrator and a good public health man. But these people came primed for battle. He tried to explain the difficulties and that if they could at least tone down the opportunities for infection, raise the level of lighting in the "orgy room" where 100 men could have indiscriminate contact without even knowing who they were being in contact with, if they could take the doors off the cubicles, cut down the privacy a little tiny bit--

They wouldn't have it. There was table-banging, there was anger, and the spokesman for the group said that they were organizing the Northern California Bath Owners Association, that would include, I think, Marin County, although there wasn't anything much there that we knew of. There were some active bars in the East Bay, dealing mostly with sailors and staff from the naval air station there. And there were all the baths here. They were really centralized here in San Francisco. The major gay population was here in San Francisco.

Relying on the Gay Community for Information

Dritz: A few days, perhaps a week, after that, I had word that Gaetan Dugas was active. I have to point out here: if we hadn't had rapport with the men of the gay community, not only their political groups but the men themselves, we would have been blind, because they brought us information. We got word that, "Gaetan Dugas is out again, and he's being extremely active." There was a little risk in this news, too, because we couldn't always be sure that the information that was coming to us was really true.

More than once, my chief would point out, "Well, yes, maybe he's fingerpointing that man, and that man is really doing things he shouldn't do. But maybe also he's not only doing them, but this guy is fingerpointing at him because they were lovers and they had a fight and he wants to get him in trouble." There were informal members of what they call the Street Ministry, one or two or perhaps three men who wore clerical garb and a cross. They were gay men who said they were trying to bring God to the men in the community. We got a call from one who said, "Father John said this man's doing something terrible. You ought to really take him in and just lock him up." We got in touch with that man and he said, "Oh, we're lovers. We had a fight."

So there were different things that we had to be aware of here, aside from the fact that we were trying to do epidemiology and trace down a serious disease. That could have skewed our ability to get a real answer to the question, just as our case-control studies were skewed--we didn't know it--because we thought we had matched gay controls who were not ill. We didn't know that maybe 10 percent of them were already infected and coming down with AIDS. So everything we were getting was Alice in Wonderland with a warped mirror. However, we did make a little progress.

Threat of a Temporary Restraining Order

Dritz: Then, a few days after I had word about Gaetan Dugas' actions in the baths, I began to talk to some of the doctors in the community. Did they know anybody that we could contact in connection with the baths that wouldn't be so aggressive, abrasive actually? One of the baths owners--of the Cauldron, I think--came up to my office. He banged on the desk and said, "You can't close us up." I said, "I'm not thinking of closing you up. I'm trying to figure out how to keep people from getting sick at your place, if they do go."

He said, "We're a business, we've got a license, and you can't close us up. If you close us up, the next morning I'll have a TRO [temporary restraining order]." I had already called the city attorney's office [November 1983] to ask about our chances to close the baths and have them stay closed, and they said, "You have to be able to prove it." I talked to them again, "He's threatening to TRO." Ed Bacigalupi, who was the attorney for the health department in the city attorney's office, said, "You'll have to be able to prove to the judge that that is a definite health hazard, but the information you have is only anecdotal. You can only tell the judge that some men go to the baths, and a lot of men are active, and a lot of people have the disease. That wouldn't be sufficient information to close up a licensed business."

Hughes: But that's what you wanted to do?

Dritz: We wanted to close them, yes. That was one place where there was the most open and the most frequent, the most voluminous, contact. And contact for an infectious disease is the sine qua non for transmission.

Well, it went on for more than a year. Silverman talked about it, and then there would be a meeting, and then of course

the meeting was postponed until next month, and then somebody couldn't come to the meeting, so it was postponed for another couple of weeks. Then they couldn't come to a conclusion, so they decided to organize a subcommittee to look into this in more detail--you know how organizations go. It dragged on and on.

Open Hearing at the Health Department, March 30, 1984

Dritz: Eventually, Silverman decided that he really had to close the baths; expecting the gays to stop patronizing them didn't work. So we put out word that he would have an open hearing when he would announce what he was going to do about the baths. That was the time when everybody met in Room 300 at the health department at 101 Grove, including three nude gay men, wrapped only in towels around their middles, carrying a sign that said, "Today the baths, tomorrow the ovens."[1] They screamed about their civil rights--which was a justifiable fear for them, but it didn't balance the risk to other members of the population. I went into the meeting too, waiting to hear this announcement.

In the meantime I had had a couple of calls from different men in the gay community. They knew that the meeting was scheduled for this particular day. They said, "Some of the guys are saying they're going to kill him"--Silverman. I had to warn him. I called his office. I said, "Now, this is what I'm hearing. It's probably not so, but I would be remiss in any kind of duty I owe to the department or to you if I didn't tell you about it."

So we waited for about an hour at that meeting in Room 300, and it got more and more restless. The press was there, members of the health community were there, members of the gay community and politicians were there. Finally, after an hour, Silverman walked in--through the back door, all the way to the front, to the podium. This was a big auditorium. He was bracketed by security men. I was glad to see that, because the meeting was very scary.

He got up on the platform, and we realized that he had been talking in his private office right next to Room 300. There were representatives of City Hall there, too. I think [Supervisor] Harry Britt was there. Apparently, an hour's talk hadn't brought

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[1]See the article and accompanying photograph: Randy Shilts. "Silverman delays on gay bathhouses," *San Francisco Chronicle*, March 31, 1984, p. A1.

any results, because when he got up on the platform, he said, "I'm sorry to tell you, but I will not make an announcement about the baths today. I'm putting this off for a week." And that was it.

Hughes: What had happened?

Dritz: Well, the big fist from City Hall had come down. They wanted the baths closed, but they wanted Silverman to make the announcement so that City Hall, the mayor's office, would not be politically responsible. On the other hand, Silverman just hadn't felt earlier that it would work that way. He had very strongly felt that to close the baths would simply disseminate the problem, that the men would find some other places to go, although the baths were the most effective place to get the most number of contacts in the shortest number of minutes. Minutes, actually.

I didn't get to ask him too much in detail. It was a very tricky question. We were all very busy with other things. So all his intimate thinking about it wasn't evident. But what he had said to us--earlier in the advisory committee, in the office--was, "The gays have got to want to stop this themselves. If we stop it, they'll just find some other place to go. We've got to convince them that it's their responsibility; they've got to stop this. If it isn't on their own initiative, on their own desire, it won't work." But they didn't stop.

Bathhouse Closure, October 9, 1984

Dritz: Larry Littlejohn was an activist there. I didn't like what he was doing; I didn't like what he said, but that's aside from the point. He was pushing hard to close the baths, probably for political reasons, because, as I told you, the gay community was splintered on the issue of bathhouse closure.[1] The responsible ones--those who I think were the responsible ones--wanted to close the baths. The very aggressive ones wanted to have nothing interfere with their utter freedom to do anything they wanted in their own way, and their own way was to reassert their freedom to be actively, openly gay, any time and any way they wanted to. And that was their right, as long as it didn't kill other people.

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[1]In March 1984, veteran gay organizer Littlejohn announced sponsorship of a city ballot initiative to close the baths. See: Randy Shilts. "Gay campaign to ban sex in bathhouses." *San Francisco Chronicle*, March 28, 1984, p. A1; Randy Shilts. "After shutdown order comes." *San Francisco Chronicle*, October 10, 1984, p. A4.

Littlejohn made an announcement to the press that if the baths weren't ordered closed by a given day, he was going to arrange for an initiative to be put on the ballot to close the baths. Then we would see exactly who wanted what. Well, that seemed to be the final blow, because if it became an initiative, and the majority of the people voted to close the baths, that would be a black eye for the health department for having delayed closure. It would be a black eye for City Hall, too, because the people would have had to say they wanted the baths closed. On the other hand, if the voters voted to keep them open, then our hands would be completely tied.

Hughes: So there was no way of winning, was there?

Dritz: That's right. It was a no-win situation. So Silverman ordered the baths closed.

Hughes: Largely because of this initiative?

Dritz: Well, that finally forced his hand. Eventually, he would have had to order them closed. He had said previously to the bathhouse owners, "You must raise the level of lighting and put up notices saying the surgeon general says that this is dangerous to your health," or something. But nobody would have paid any attention.

If a man goes in to a bathhouse and pays his ten dollars, he's going to have his ten, fifteen, twenty contacts. He isn't going to say after reading the notice, if he could even see it on a dark back corner wall, "Give me back my ten dollars," and the bath owner isn't going to give it back and take back his towel.

Closing the bathhouses didn't do a lot of good. One of them reopened the next day to challenge Silverman. A few of them went out of business. The first one was a leather club, which finally went out of business because of dropping business. The newspaper had a big picture of the different equipment that the bath owner was trying to sell--chains and slings and--oh gads, forget it. The publicity about closure helped wake up some of the more complacent gays.

Hughes: Did you make a deposition regarding bathhouse closure? I know Paul Volberding and others did.[1]

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[1]Declaration of Paul A. Volberding, M.D., in support of a temporary restraining order to close the bathhouses, October 10, 1984, Superior Court of the State of California in and for the City and County of San Francisco. (Dean Echenberg papers, San Francisco Department of Public Health, Bureau of Epidemiology and Communicable Disease Control, drawer: bathhouses,

Dritz: No. If that had been necessary, it would have been the director of the department who was asked. I was his subordinate, and so he would have spoken for the department. I wasn't asked. Now, Paul Volberding could be asked, because he was running the AIDS clinic at San Francisco General. Incidentally, he was doing a magnificent job. But I wasn't at the top levels.

Divided Opinion in the Gay Community

Hughes: How did BAPHR feel about closing the baths?

Dritz: Officially, it wanted to close them. It was a large organization of chiefly gay doctors and other health workers, but it was not all gay. They were a bit splintered, but as physicians, they had to feel responsible for protecting the lives of their patients and the population that they serve. So they officially said, yes, it's a better idea to close the baths. I can recall perhaps only one or two that openly said, "We've got to protect our civil rights." Most of them were medically responsible.

Hughes: An article on the front page of the *Chronicle* on March 30, 1984, said that Supervisor Harry Britt and fifty gay businessmen, physicians, and other political leaders had signed a statement asking Silverman to "temporarily close" all businesses "intended to facilitate anonymous, high-volume, high-risk sexual behavior."[1]

Dritz: Which is political jargon for, "Close the baths."

Hughes: Yes, exactly.

Dritz: That was part of the battle going on. That was City Hall pushing, and the mayor also was of the same mind. You see, supervisors were elected at large, but Harry Britt was considered the representative spokesman for the gay community particularly. But the gay community was splintered, too. There were those that supported him completely, and there were those that hated his guts

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folder: 10-10-84 Declarations in Support, vol. 1.
See also, "Doctors side with city in suit." *San Francisco Examiner*, October 12, 1984. (GLHS, AIDS clipping file, folder: Bathhouses-gay.)

[1]Randy Shilts. "SF planning to close gay baths." *San Francisco Chronicle*, March 30, 1984, p. A1.

and felt that he was a traitor because he was supporting City Hall to close the baths. So he had a big problem there, but he was a responsible man, and from our point of view he did a good job for the health and the welfare of the city and the gay community.

Hughes: Did Silverman lose his job as health director because of the bathhouse issue?

Dritz: That was a very, very big factor. If there were others, I'm not aware of them. No health director at that time, at that place, could have survived that. It was a can of worms. It was huge--nobody could have survived that. There was no way he could win. I think I saw him losing weight during that time. He was grey-haired anyhow, but if he hadn't been, his hair would have turned. I'm not being funny. It was a very traumatic time. I was losing weight then. We were all working like dogs, and aggravated and frustrated. Incidentally, he wasn't fired. He resigned when City Hall appointed a health department commission to set policy for health matters in San Francisco at about that time. Practicing public health and preventive medicine by committee or commission is not for San Francisco.

The Continuing Problem of AIDS Etiology

Dritz: But it was not only that. From the scientific aspect, we were going crazy. For instance, you had a question, "Is AIDS an infectious disease?" You finally assured yourself that you were pretty sure this was an infectious disease. You had clues: one, two, and three, that all pointed to an infectious agent. So we answered the question at least tentatively: it's infectious.

Now, which of these clues was the most likely to lead us to the cause of the infection? Could it be a herpes virus, such as cytomegalovirus which causes blindness and herpes encephalitis in gay men? After all, a number of gay men had developed overt AIDS who maybe six months before had had very severe herpes zoster, which is caused by the varicella zoster virus which is also a herpes virus.

On the other hand, if it was cytomegalovirus, it was rampant in the gay community--genital herpes--but it was just as rampant in the heterosexual community. Now, if it was causing AIDS in the gays, why didn't it cause AIDS in the straight population, too?

Well, we spent some time looking at that, and in the meantime, we didn't have people to look at possibility C or

possibility A. And then there were the other possibilities: is it blood transmitted, or is it just caused by repeated infections which diminish the immune response to below a critical level? And if that is so, then we'd have to go back to all these AIDS patients and find out how many other diseases they had had previously.

Hughes: What a job!

Dritz: Yes. And we couldn't spread ourselves that thin. Detective Hercule Poirot has clues one, two, and three, and he puts them all together and he has the answer. Well, this was a whodunit too, but we had the problem first to decide which clue to follow up. Which one would be the most effective, the most efficient?

Hughes: What difference would it have made if the questionnaire had been processed faster by the CDC?

Dritz: It would have helped. We spent a lot of time tracking down amyl nitrite. I sent Carlos Rendon, my epidemiology assistant, into the Jaguar Bookstore or the Ambush, and I think even the Mine Shaft, to buy amyl nitrite "poppers" that the gays were using to give themselves a sexual rush. He brought them back to us and we sent them down to CDC in Atlanta, and they analyzed them. They came up with amyl nitrite as the active ingredient.

Well, if AIDS is an infectious disease and amyl nitrite is a toxin, it wouldn't cause the infection, but could it be a cofactor, or could it be activating an infectious agent? So we spent time investigating amyl nitrite. Finally, two years later when the CDC's computer analysis report came out, it said, "Forget it, it's not amyl nitrite." But we had lost time and effort looking at that possibility.

The Effects of Insufficient Funding

Dritz: So not only that, but if we had had more money, we could have had other people looking at other things at the same time. But it wasn't coming down from the feds and the Reagan administration. It wasn't coming down from the Deukmejian administration. Even now if it had, we might be much closer to a possible effective treatment for the active cases. We might be closer to a vaccine to prevent new cases.

There was homophobia at the top levels of the government. [pounds table] There's blood on their hands. I have to say that.

Don't let me edit that out of the transcript. I feel that very strongly. By withholding the money, people were dying here sooner or in greater numbers than they need have done. The epidemic was exploding. We already knew that it was exploding in Africa, and we could expect it would happen here. And we were already seeing heterosexual cases.

Hughes: Well, it wasn't CDC--

Dritz: It wasn't their fault. It was top levels of government.

Testing Stored Hepatitis B Blood for HIV Antibody

Hughes: Knowing now about the long incubation period for AIDS, is it possible that even in 1981 there were already too many people infected to stop the epidemic?

Dritz: Well, we went back to the CDC freezers for the hepatitis B trials bloods. The first bloods had been drawn in 1978, and when they were later tested for HIV antibody, they already had a 4 percent positive antibody rate. When they tested the bloods drawn in 1980 and '81, I think they had 15, 20 percent positive. By the time they got to '85, '86, they were up to the 60, 70 percent infection rate. So the infection rate was not that high way back then in '78, and if we had been able to learn that this was a virus and there was a test for this, we might have been able to do something about it sooner. Or we could have run into the civil rights issue. We wouldn't have cured it; we wouldn't have prevented it; it's too complex a problem. But I think we'd be closer to the answer now, or we might already have solved part of it. As it is, even with all those delays, the average survival rate now from time of AIDS <u>disease</u> diagnosis to death is about eighteen months, where a few years ago it was only twelve months.

But we would have been closer to it, and maybe some would still be alive now, and alive in a year or two or three when we hope to have the cure for AIDS, or at least a maintenance regime, as for diabetes. That's why I say, people died because the money didn't come through. And it didn't come through for a variety of reasons, some political and some "moral." I feel strongly about that. I'm not a red-hot liberal. As a matter of fact, year by year as I get older, I become more conservative. But as a doctor, I have to say that there was fault, for whatever motive moved it.

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Dritz: It wasn't until I retired and I was replaced by a competent epidemiologist [Dean Echenberg] that he screamed loud enough to get a Dictaphone--"What kind of an office is this?" When I asked for a little index card case, I ended up using an old shoebox because my chief said, "We haven't got any money."

Every budget time, you asked for as much as you thought you could get, and then you were told by City Hall, "Across the board, 10 percent cut, everything." Well, you couldn't do it across the board. So we tried to figure out how we could get a 10 percent cut overall, knowing that we were cutting below what we needed. But come July, we'd go for a supplementary budget. That was how it worked. At the end of the year, if there were two or three dollars left in any one of the line item budgets, the chief would say, "What do you want to buy? If we don't use it up now, they won't give us that much next year." Which is how a lot of organizations work. But here we were screaming for money.

Hughes: Screaming at the state level as well as the federal?

Dritz: We were screaming at City Hall. It was their problem to scream to the state and the federal governments. But we were screaming to CDC, and they themselves weren't getting enough. Don Francis told one of the men in CDC who passed it on to me--this is hearsay--that he couldn't get enough money to fix the handle on his laboratory door, which he thought might be a source of cross-contamination for his staff.[1] I think he finally got it fixed himself. That would have been in character.

There just wasn't money. As I said, CDC had to share the Public Health Service's money with NIAID and the other NIH institutes. If CDC got more money, the institutes would have their budgets cut. They all needed the money, and it wasn't coming down from above because it was being shot up into the air. I think I am painting myself really red like a wild-eyed bomb-thrower. I am not. I'm a very, very nice Democrat.

The Impact of Discovering the AIDS Virus

Hughes: How closely had you been following the work in retrovirology?

Dritz: Well, our office didn't do viral research, but we were aware of what was going on, particularly through the work of Jay Levy, who

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[1]Francis mentions this episode in his oral history in this series.

is the virologist at UCSF. He kept us up to date; we met at intervals. He eventually isolated a virus which turned out to be HIV, but by that time, [Luc] Montagnier and his group at the Pasteur Institute had isolated in a handful of their patients what they called the cause of AIDS. It wasn't recognized by the American establishment in Washington.

Hughes: Why was that?

Dritz: Because [Robert] Gallo was working on it at NIH. A year later he announced that he had it from a bunch of his patients. And then the big battle really took off, because Montagnier's and Gallo's viruses seemed to be the same. The question is still unsettled, although the scientists hold very "polite" meetings to solve the dispute. Gallo is appealing a reprimand now, I think, but I don't know directly.[1]

The crux of it is the honor of having isolated the virus of the greatest medical mystery of the century. There will be a Nobel Prize, and it's worth well over a million dollars now.

Hughes: There was also the more immediate financial gain from the test for the AIDS antibody.

Dritz: Yes, there was the antibody test. The commercial people are going to be paying a royalty to the government and to some of the universities, which now are also looking to the possibility that any portion that they or their researchers may have had in promoting the discovery of the AIDS antibody test should give them a proportionate amount of the royalty.

There are unsavory ramifications to the idealism in medicine and science. Too many people think of fame and money. Of course, I'd like fame and money, too, but within the limitations of what's right and what's not acceptable.

Once we had the virus and the test, work on the problem became primarily a job for the lab researchers and the clinicians and the hospitals to find treatment and a vaccine and to test out medications, which Don Abrams and his group at the County Community Consortium in San Francisco are doing very, very effectively.

Hughes: In the early days of the epidemic, as you well know, the approach was epidemiological and multi-factorial. Some argue that after

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[1]See: Joseph Palca. "'Verdicts' are in on the Gallo probe." *Science* 1992, 256:735-738 (May 8, 1992).

the discovery of the virus, epidemiology became less important in defining the disease.[1]

Dritz: No, it didn't. We had the first step of the puzzle solved: we knew what caused it, and we had a test for the antibody. We still have the problems of what groups were more at risk for AIDS, why were we getting more cases among IV-drug users, why were we getting somewhat fewer cases among the older gays?

[tape interruption]

The problem of diminishing the opportunities for transmission hadn't gone away yet. Even with the baths closed, men were still having a lot of contacts at other places, in their sex clubs and the back rooms of the bars and so on. But we had a test now, so we could offer them the opportunity to find out if they had been infected. If two men wanted to become monogamous partners, and that became a movement for a while, then they could test themselves and see if they were both clear.

On the other hand, many of them were afraid to be tested, because they didn't want to know that they were infected. If they were found to be positive, then perhaps their whole way of life, their associations, their work, their insurance, their place of living, everything, would change. Their lovers, their friends would drop them completely. So the answer to the cause of AIDS and the test for the virus became intricately entangled with the problem of confidentiality. Before we had the AIDS antibody test, a man presumed gay was outside the pale of general society. Now, a man known to be infected was not just outside, he no longer existed. He was thrown out of the gay community and the world--his world.

So the question became, how do we get men to come in to be tested? How do we assure them that they won't suffer if they're found positive? How do we assure them that they'll be able to have access to care if they are positive and they haven't got any money for it? This again became epidemiology, because we had to search the neighborhoods--not on a one-to-one basis, but by word of mouth--get word out that we wanted to offer them a chance to prolong their lives, if they were found positive, by getting medical care. We also wanted to assure them that by anonymous

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[1]For example, see G. M. Oppenheimer. In the eye of the storm: The epidemiological construction of AIDS. In: E. Fee, D. M. Fox, eds. *AIDS: The Burdens of History*. Berkeley: University of California Press, 1988, pp. 267-300.

testing they wouldn't pay for it with the loss of insurance and their livelihood and everything else.

There again, our rapport with the community helped a lot. But we still had the resistance of the red-hot gays who screamed, "Confidentiality! Civil rights! It's our right to live the way we want to!" And it is their right to live the way they want to, unless they kill somebody doing so. Testing positive is still a sentence of death--maybe not as soon as in two or three months of diagnosis as it was at the beginning, but still eventually they will die of this unless we find a cure or a maintenance regime soon.

Broadening the Definition of AIDS

Hughes: Did the diagnostic test affect the case definition of AIDS, which heretofore had been based on the opportunistic diseases that developed as a result of the immune suppression? Was it enough to say that a person had the virus, and therefore that defined the disease?

Dritz: No, that wasn't the thing. The definition of the disease was changed several times by CDC on the basis of complications that develop in patients with AIDS. A person who is positive and has no symptoms is infected; he's a symptomless AIDS statistic. With the first definite symptoms, he becomes by CDC's definition an active AIDS case. But it didn't depend so much on whether we had a diagnosis that he was antibody-positive, and therefore infected, but that each new complication--cytomegalovirus, Burkitt's lymphoma, lymphoma of the brain, *Mycobacterium avium intracellulare*, cryptosporidiosis, cryptococcosis, even some cases of coccidioidomycosis, a whole bunch of fungal infections, herpes zoster, candidiasis--all of these slowly were added, in a different order than I've given to you, to the definition of AIDS, making more persons eligible for AIDS financial support from one government agency or another.

CDC at first defined an AIDS case as, "A person with no known predisposition for immunosuppression," from cancer therapy or something, "who is younger than sixty years, a male, with Kaposi's sarcoma or Pneumocystis pneumonia."[1] So at first it was only

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[1]Centers for Disease Control. Update on acquired immune deficiency syndrome (AIDS)--United States. Morbidity and Mortality Weekly Report 1982, 31:507-514.

sarcoma or *Pneumocystis* pneumonia."[1] So at first it was only those two conditions. And then I got them to add Burkitt's lymphoma; others got them to add cytomegalovirus, toxoplasmosis.[2] The CDC was slow in changing the definition, because every time they changed it, they had to go back and rework the computer data. Our data from San Francisco went into the computer also, without personal identifiers. For confidentiality control, the health department shredded my notebooks.

The latest definition by CDC has increased the numbers of persons recognized as cases and therefore eligible for payment for their treatment if they have no other resource.[3] The costs of management of this disease are just exploding.

A person who's positive may go two or three years without any symptoms, and so he's only antibody positive and is not reportable, because of confidentiality. But the person who is positive and has symptoms is diagnosed as a case of AIDS.

Health Care Workers and the Risk of AIDS

Hughes: Do you think physicians have an obligation to care for AIDS patients?

Dritz: There's absolutely no question about that. A physician has an obligation to care for any patient who requests his help. It's the Hippocratic Oath; you don't turn anyone down. If you don't care for him, you have to have a good reason, and you have to give him a reference to someone who can care. You just don't abandon a patient. On the other hand, a physician can hardly be severely criticized for being cautious about exposing himself to an infection or hazard which might be dangerous to his own health or make him liable to transmit something dangerous to his other

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[1]Centers for Disease Control. Update on acquired immune deficiency syndrome (AIDS)--United States. *Morbidity and Mortality Weekly Report* 1982, 31:507-514.

[2]Centers for Disease Control. Revision of the case definition of acquired immunodeficiency syndrome for national reporting--United States. *Morbidity and Mortality Weekly Report* 1985, 34:373-375.

[3]See: 1993 revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. *Morbidity and Mortality Weekly Report* 1993, 269:460.

make him liable to transmit something dangerous to his other patients. He has to take proper precautions within the limits of what knowledge is available to him.

In the case of AIDS, there were physicians who were worried if a patient coughed in their face and the droplets got to the mucous membrane of the eyes, because that would be presumably a way to transmit "body fluids." Well, with experience, we know now that probably doesn't happen. But we can never say 100 percent.

Hughes: Were you ever concerned personally?

Dritz: When I was a very young pediatrician, I took care of smallpox cases; I took care of chicken pox; I took care of tuberculosis; I took care of scarlet fever. These diseases were transmissible, and we didn't have penicillin yet. At that time, we just had the sulfa drugs, which maybe would and maybe wouldn't protect us from one thing or another. We didn't have the vaccines. For scarlet fever all we had was the Dick test to see if we were immune; we had no treatment for it, except sulfa drugs and supportive treatment. So, you took your risks.

Hughes: So dealing with an untreatable infectious disease was nothing particularly new to you.

Dritz: This was the same thing. We didn't know for sure how AIDS was transmitted. I made it a point to shake hands with patients, because some of them used to say, "My friends don't even want to shake hands with me. They put their hands behind their backs. They used to come in, they put their arm around your shoulder and hug you. Now they don't. I feel like I'm outside the world; I'm encased in something." I made it a point to have them sit at the desk and talk a long time. One or two of them would start to cry; I'd give them my Kleenex. Then they'd stick it in their pocket; they didn't want to stick it in my wastebasket. I told them, "Forget about it; it's all right." You took your chances. You were a doctor.

Hughes: Well, AIDS wasn't the same as the other infectious diseases because of its 100 percent fatality, but I guess in the very early days, you didn't realize that.

Dritz: No. But we did know scarlet fever could give you a damaged heart, which would kill you in time. We did know that diphtheria could choke you to death with membranes in your throat. There wasn't the 100 percent fatality of AIDS, and we knew at least what was causing them; we just didn't have very good treatment for them. And we knew how they were transmitted. We didn't have treatment

for AIDS, and we didn't know what was causing it, but we knew that there was a risk.

The other doctors in the health department clinics and hospitals treated AIDS patients the same as I did. When we started the anonymous AIDS testing program, the doctors there were drawing bloods on the patients. This was a needle-stick risk, and yet they did their job. In the hospital on Ward 5B [the AIDS ward at San Francisco General Hospital], the nurses and the phlebotomists were drawing bloods on the patients, with needles, and they were at risk. We learned later that some of them did become positive--a very, very small percentage, but some did. But you did your job.

Some doctors and nurses refused to take care of AIDS patients. Some aides didn't have a great deal of knowledge of transmissible disease and were afraid to walk into the patient's room with a tray of food. They'd leave it on the floor outside. We could understand why they felt that way, although we didn't feel it was the best thing for everyone concerned. But most of us took our risks.

Hughes: When was the height of the hysteria, would you say?

Dritz: Late '81, early '82. It was still simmering through '82. By '83, we were beginning to see that it was an infectious disease, but the agent had to get into your bloodstream. By November of '82 we had Ammann's baby diagnosed with AIDS as a blood-transmitted disease. So by '83 we were able to say pretty surely, "It won't go through a handshake, and it won't get to you from the telephone. But if you're punctured with a needle that's been in the skin of a patient who has AIDS, you might get it." And we didn't know then that a person who's infected with AIDS but not yet sick is already infectious and dangerous by needle stick. So the situation was really very, very complex and vague.

Once, one of the news anchors was doing a remote newscast from my house and asked me, "Do you guarantee that we'll not get AIDS through the air?" I had to say, "We can't guarantee anything." But in medicine, you don't guarantee anything.

Finding Treatment for AIDS

Hughes: Americans increasingly expect science or medicine or both to "fix" disease. We're not used to having unsolved problems. What do you

think is the impact of the fact that so far we haven't "fixed" AIDS?

Dritz: Well, I think your statement is not completely accurate. Americans did expect doctors to be able to "fix" disease, but now, what you hear from too many people is, "Doctors are incompetent," or "Doctors are crooks," or "Doctors are looking for big money," or "Doctors won't take a night call." So, with that mixed view of doctors now, it's no wonder that they are not surprised that we haven't "fixed" AIDS yet. On the other hand, the public doesn't notice the very slow, slow, step-by-step progress we're making, which we see in the medical journals, which come out maybe four, five, six months after the fact.

Americans, especially the younger generation, want instant gratification. You've got the disease today; you have to have the cure, the magic bullet, tomorrow. It doesn't work that way, not with something this complex. Jim Curran from CDC said a long time ago that the cure would be found eventually, but it was going to take a long time. There are a lot of steps to take. There are a lot of questions to ask, and a lot of other questions that rise from each answer.

Hughes: What was his basis for saying that?

Dritz: He was saying that from his knowledge of past history of conquering diseases. It was much slower in the past because we didn't have instant communication between the different medical centers and so on. Koch with tuberculosis worked a number of years before he published a paper. Pasteur worked a long, long time and wasn't even believed for a long period. We started with a disease we didn't know anything about, and in ten years we know what is causing it, we know where it is, we can pull its genetic patterns apart, we have a test for it, and we're on the road to preventing it with a vaccine.

Accelerated Approval of AIDS Drugs

Dritz: Drug approval could go faster, except you have to test carefully, because each thing you use might have a bad side effect or cross reaction with other medications, worse than the benefit. The Food and Drug Administration is right in being cautious, although many times it's been too cautious and kept us from using medications which might have done some good. We've had to twist arms and scream to get them to loosen things up.

Hughes: Which they have by speeding up the approval of drugs for AIDS and other life-threatening diseases.[1]

Dritz: Well, the establishment hasn't screamed as much as activist groups in the gay community, like the ACTUP [AIDS Coalition to Unleash Power] group have.

Hughes: What about the three drugs that are now on the market, AZT, ddI, and ddC?

Dritz: We've known about them for a year or two already.

Hughes: Their approval wasn't speeded up?

Dritz: They were approved faster than they would have been if they hadn't been pushed politically. If we had had better support from the top of the government, they would have been approved faster. We have the president; we have the cabinet; we have the secretary of health, Louis Sullivan, and he does the bidding of the president; because he's appointed by the president. I'm not blaming him for anything. I'm not blaming the president. I'm just saying, whatever their motives were, even the best, they have caused delays which result in the loss of life, which might have been avoided or at least delayed.

AIDS in Women

Hughes: From early in the epidemic, women have been known to be susceptible to AIDS, and yet AIDS in women has not been a great area of investigation or even education.

Dritz: Well, it hasn't been from the very first, but gradually we found that women were susceptible to AIDS, particularly those who were using intravenous drugs. However, it was the heterosexual transmission to women from high-risk men that caused the shift of attention to women.

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[1]See: H. Edgar and D. J. Rothman. New rules for new drugs: The challenges of AIDS to the regulatory process. In: D. Nelkin, D. P. Willis, and S. V. Parris, eds. *A Disease of Society: Cultural and Institutional Responses to AIDS*, pp. 84-115.

Dritz: Connie Wofsy has been concentrating on AIDS in women, and she's been doing a fantastic job and published a number of papers. She should speak for herself on that.[1] So I won't comment too much, except that the press coverage was spotty. Recently the women's movement has pointed out that women are at risk from many, many sources--battery, sexual assault--and that women in danger for any reason should be recognized and helped and publicized. But I don't think that the press has made a particular point of women as victims of AIDS, except as victims of the general milieu which permits women to be in hazard because of activities of men around them.

Retirement

Hughes: You retired from the health department on April 24, 1984. Is there a story?

Dritz: Not really. I had planned to retire a month or two earlier. You see, when Montagnier and then Gallo announced that they had found the virus, and later a test for the antibody was developed, more or less that answered our question, "What's causing this epidemic? Where's it coming from? How's it transmitted? Who has it? How can we keep patients from giving it to other people?" We could test for it; we could identify those who were at risk and who could put other people at risk. The basic questions from my part of it, epidemiology, the detective job, were more or less answered.

Now, a lot of epidemiological questions still remain. Moss and his group, using my data, were able to see how long patients survived with various complications of the AIDS infection.[2] Which areas now were developing AIDS more rapidly than other areas? Which populations are developing it more rapidly than others? But the basic question, "What is this, and where is it, and how do we attack it?" we had answered.

And I was already past retirement age. I don't subscribe to the term "burnout" but it had been a hectic time. Our office was a pressure cooker, with everything coming through except TB and VD. But with AIDS, there was also the radio and the TV and the newspaper people interrupting what we were trying to do. We were

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[1]See the oral history in this series with Constance B. Wofsy, M.D.

[2]See the oral history in this series with Andrew R. Moss, Ph.D.

talking to different communities, trying to assure different members of the health profession that they were not at risk, and traveling to northern California and southern California and to Atlanta and New York, all over the country, on this AIDS problem. I was tired. And there were a number of things yet that I wanted to do with my life that I never had had time to do. So it was time to quit.

My colleagues were very, very nice about it. We're still all good friends. I get back to the health department for various clinics and grand rounds and such. My medical license is in order. I could go back to practice any time I wanted to. I continue with the CME, Continuing Medical Education. But I prefer not to be earning my keep right now.

Hughes: Is there anything on this subject that you want to add?

Dritz: Only that you have been a marvelous interviewer, that without your questions and guidance I would probably have been all over the lot, which I probably was anyhow.

Hughes: Thank you.

Transcribed and Final Typed by Shannon Page

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Berkeley, California

The San Francisco AIDS Oral History Series

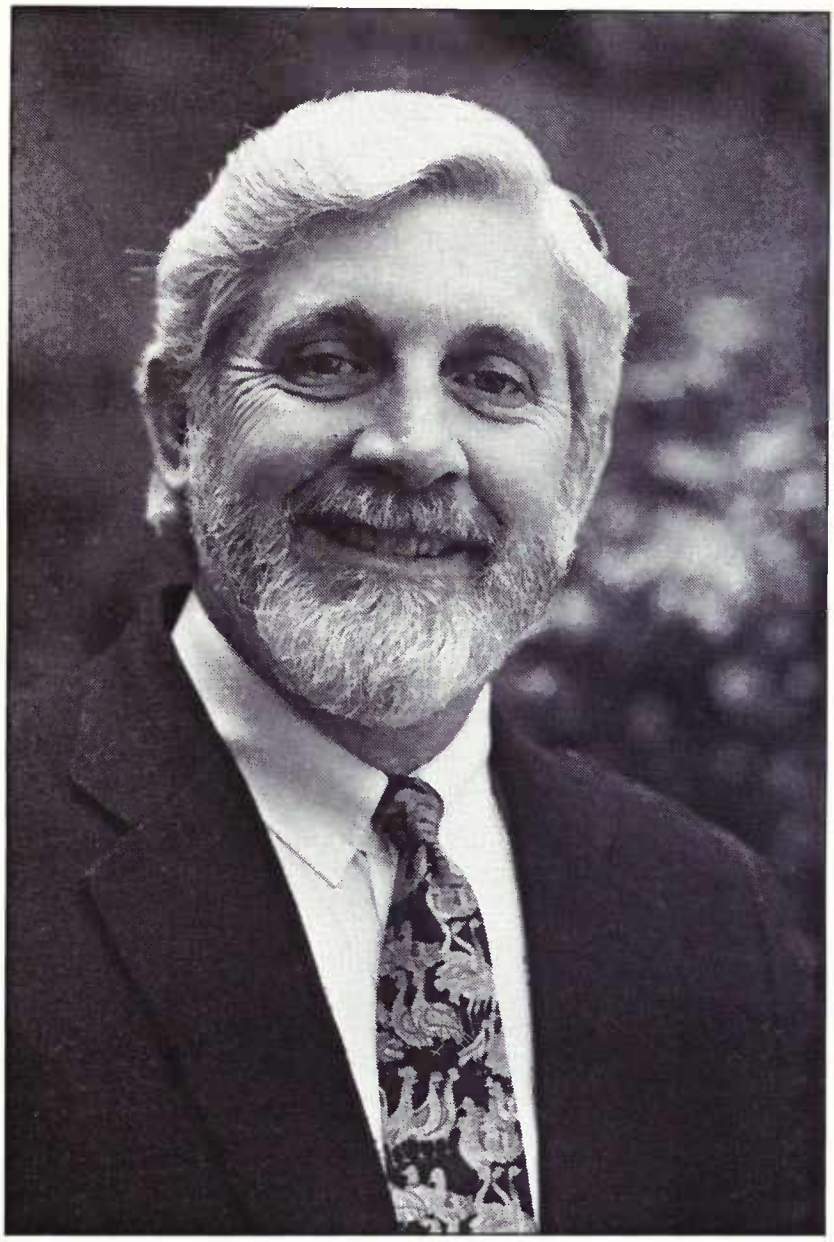
THE AIDS EPIDEMIC IN SAN FRANCISCO: THE MEDICAL RESPONSE, 1981-1984

Volume I

Mervyn F. Silverman, M.D, M.P.H.

PUBLIC HEALTH DIRECTOR: THE BATHHOUSE CRISIS, 1983-1984

Interviews Conducted by
Sally Smith Hughes
in 1993



Mervyn F. Silverman, M.D., M.P.H., 1983

INTERVIEW HISTORY--by Sally Smith Hughes

Dr. Silverman was interviewed because he was director of the San Francisco Department of Public Health from 1977 to 1985, precisely the years in which the AIDS epidemic was building and breaking. Appropriately, his oral history is bound with that of Dr. Selma K. Dritz, the only other voice representing the health department in this series.

As director, he was official coordinator of all health-related activities in the City and County of San Francisco, some of which he describes in the first interview. "There was really no aspect of health care [in San Francisco]," he stated, "that wasn't somehow touched by the health department." As a result of his myriad professional responsibilities, the AIDS epidemic was at first only one of his many concerns.

By early 1983, his other official duties began to pale in comparison to those engendered by the expanding epidemic which was devastating the city's gay community and raising complex medical and political problems in its wake. The oral history tells, among other things, of establishing AIDS education programs, the department's AIDS Activity Office, and anonymous sites for AIDS testing.

However, it is Silverman's views on the so-called "bathhouse crisis" of 1983 and 1984 which are the oral history's major focus. The question was, should he close the city baths, heavily frequented by gay men, because some saw them as locations of indiscriminate sex and hence as sites of AIDS transmission? He was battered from all sides by the political factions active in the epidemic in his determination to listen to every viewpoint. Sensitive to the political agenda of the gay community, he knew it saw the bathhouses as symbols of newly won gay liberation.[1] In fact, the community's considerable size and high degree of political organization and social cohesion largely stemmed from this achievement. Silverman was sympathetic to the view that bathhouse closure would be seen as a step backward and a dangerous affront to the gay movement. He determined that closure would be counterproductive unless he had the support of the gay community. But the community itself was fractured into opposing political groups which could not reach consensus. Without consensus, Silverman at first refused to mandate closure, hoping that educational programs would stem the rising tide of infection.

While sensitive to the views of the gay community, Silverman at the same time was accountable for the city's health and welfare. Mayor

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[1] See, for example: Press Statement of Civil Rights and Lesbian and Gay Community Organizations, October 10, 1984. (Dean Echenberg papers, San Francisco Department of Public Health, Bureau of Epidemiology and Communicable Disease Control, drawer: bathhouses, folder: sex clubs/bathhouse. Hereafter: Echenberg papers.)

Dianne Feinstein, some physician groups, and a few gay activists, including the journalist and author Randy Shilts, pressed for closure. But Silverman's medical advisory committee, composed of representatives of local medical institutions and the community, failed to reach consensus on the issue.

Silverman remembers a turning point, probably in August of 1984, after one of the meetings of his committee:

> I remember walking out of the meeting and saying, I've met with the community enough; I've met with the advisors enough; I'm just going to make the decision and I'm going to follow through. And that night I said, I'm going to close them.[1]

On October 9, invoking emergency powers, he issued an order to close the baths. As he stated for the press:

> Today I have ordered the closure of 14 commercial establishments which promote and profit from the spread of AIDS--a sexually transmitted fatal disease. These businesses have been inspected on a number of occasions, and demonstrate a blatant disregard for the health of their patrons and of the community. .... Make no mistake about it. These 14 establishments are not fostering gay liberation. They are fostering disease and death.[2]

The oral history describes further legal actions yet to come, but the public crisis was essentially over. On a personal level, Silverman's troubles were still unfolding. In December 1984, he resigned as health director, forced out by a political system looking for a victim.

Yet Silverman's involvement in the epidemic was far from ended. He spoke of his subsequent role as director of the AIDS Health Services Program of the Robert Wood Johnson Foundation (1986-1992), and his current positions as president and national spokesman (1986-present) for AmFAR, the American Foundation for AIDS Research.[3]

The Oral History Process

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[1] p. 156.

[2] Press statement of Dr. Mervyn F. Silverman, October 9, 1984. (Echenberg papers, folder: sex clubs/bathhouse.)

[3] This portion of the interview recorded on July 6, 1993 is outside the project's time frame and for this reason, as well as funding limitations, was not immediately transcribed. The tapes are on deposit at The Bancroft Library.

Three interviews were recorded with Dr. Silverman between March and July, 1993 at his attractive Victorian home in San Francisco's Upper Haight-Ashbury District. The interviews were sandwiched into visits home from AmFAR's New York and Los Angeles offices. Although Dr. Silverman appeared relaxed and friendly, the frequent telephone interruptions indicated the hectic pace of his life. (The last interview was conducted with one hour's notice.) Nonetheless, he spoke willingly of the stressful San Francisco period of his career, obviously concerned to explain his consensus approach to bathhouse closure.

The interview transcripts were edited, rearranged for better chronology, and sent to Dr. Silverman who edited them lightly, suggested further rearrangements, and then went over them a second time. The result conveys his reactions to an exceedingly complicated--and fascinating--episode in AIDS history and in the process reveals a man sensitive to the diverse and contentious factions active in the early years of the San Francisco epidemic.

Sally Smith Hughes
Interviewer/Project Director

January 1995
Regional Oral History Office
The Bancroft Library
University of California, Berkeley

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University of California
Berkeley, California 94720

BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name Mervyn F. Silverman

Date of birth 5-4-38 Birthplace Washington DC.

Father's full name Max Silverman

Occupation Dentist (Retired) Birthplace Russia

Mother's full name Faye Silverman

Occupation Housewife Birthplace Russia

Your spouse Deborah Brown Silverman

Occupation Clinical Psychologist Birthplace Washington D.C.

Your children Lauren M. S. Bolfango, Lisa Silverman, Stephanie Silverman

Where did you grow up? Washington, D.C.

Present community San Francisco, CA.

Education Primary & Secondary - Washington DC., Washington & Lee University (B.S.) Tulane University (M.D.) Harvard School of Public Health (M.P.H.)

Occupation(s) Physician - Preventive Medicine

Areas of expertise Public Health Administration, Public Policy, AIDS

Other interests or activities Restoring Antiques, collecting slot machines and canes

Organizations in which you are active American Foundation for AIDS Research, APHA

I EDUCATION AND CAREER

[Interview 1: March 23, 1993] ##[1]

Education and Early Career

Hughes: Dr. Silverman, could you give me a brief summary of your education and early career?

Silverman: Yes, I went to Washington and Lee University [1956-1960] for my undergraduate work, and then to Tulane Medical School [1960-1964] for my medical training. Then after interning at Los Angeles County General Hospital, I went with the Peace Corps in Thailand as a Peace Corps physician. Then I became regional medical director for Southeast Asia and the Pacific [1967-1968] for the Peace Corps. [tape interruption]

I then went back to school to get a master's degree in public health at Harvard [University] [1969], then went with the Food and Drug Administration as special assistant to the commissioner [1969-1970], and then director of the Office of Consumer Affairs [1970-1972]. I really wanted to get closer to the people, because from Washington it is very difficult to see any impact on people. So I became director of health in Wichita, Kansas [1972-1977], and also ultimately medical director of Planned Parenthood for Kansas [1976-1977].

Then in 1977--I guess it was it was as early as '76--I saw an ad for a job as director of health in San Francisco and applied, and ultimately was appointed, to start in May of 1977, a job which I held until January of 1985.

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[1]## This symbol indicates that a tape or tape segment has begun or ended. A guide to the tapes follows the transcript.

Interest in Public Health

Hughes: Why public health? That started with the M.P.H. [Master of Public Health] degree [1969]?

Silverman: Well, I guess it started even a little before that, although I probably didn't know it at the time. When I was in medical school, between my sophomore and junior year I worked as a research assistant in South America. I think that planted the seed--the idea of doing some public health-type work. And then Peace Corps really solidified my interest. I realized after Peace Corps, even though I was taking care of all the volunteers we had in Thailand, that I could never practice medicine the way I did there. I was with them when they were healthy, and so when they were sick, I really knew them. I used to be "Merv" when they were well and "Dr. Silverman" when they were sick, and that was a very interesting relationship.

I realized I could never have something like that in the States, and that a private practice would be too confining, and that the real way of dealing with diseases was to prevent them rather than trying to treat them after the fact. So that's when I went to Harvard and also did what was really a residency in preventive medicine, and then got my boards [1970] in the specialty of preventive medicine.

Hughes: With the idea of becoming a public health director?

Silverman: I'm not sure that I really thought about what exactly I would do. I just found out after being in Washington and the federal government, and though I was born and raised in Washington D.C., I realized that it was too far away from really having an impact on people. I thought local health was really where I should be, found that to be the thing I enjoyed most, and actually spent a total of almost thirteen years [1972-1985] in local health in Wichita and San Francisco.

When I went to medical school, I didn't even think about public health as an option. In those days, people in public health were either people from private practice who were retiring, or people in the military, or people who just couldn't make it in private practice. So public health wasn't held in the highest esteem.

But what happened with Peace Corps is a lot of young physicians, who probably had no thought of going into public health, had their heads turned around during and after the Peace Corps experience. So there was a whole cadre of young,

energetic, eager individuals going into public health, and I think that sort of rejuvenated the whole system.

Hughes: Did the experience in Kansas tie in with what you were going to be doing in San Francisco?

Silverman: In absolutely no way, shape, or form! [laughter] There were no pressure groups. I think Native Americans, the Indians, were a little bit vocal, but you could ignore them and not have to worry about it.

Director, San Francisco Department of Public Health, 1977-1986

Comparison with the Department of Public Health in Kansas

Silverman: Then coming to San Francisco, where on every corner there is another interest group based on race, religion, ethnicity, age, disability, sexual orientation, medical society, or hospital affiliation, you name it, was a real eye-opener, and so a real education for me.

Hughes: Did you realize what you were getting into?

Silverman: After I was appointed, I was sort of stunned, like the dog who's caught the car. What do you do with it now, after you've chased it? I really was very concerned that I had decided to do something that I might not have the ability to do, that maybe according to the Peter principle, I had reached my level of incompetence in Wichita, and what was I going to do here? So it was scary, but it was very exciting.

Hughes: Scary mainly from the standpoint of the factions that had to be dealt with?

Silverman: Yes. There is a classic little postcard that shows Dorothy and Toto from *The Wizard of Oz* in a leather bar in San Francisco saying, "Toto, I don't think we're in Kansas any more." It was very clear to me that I wasn't in Kansas any more.

I had in Kansas a department of around 100 people, and just classic public health problems. I didn't have mental health; I had alcohol but no substance abuse; I didn't have any of the medical services, really. We had some clinics in the health department, and a budget I think of several million dollars. I don't remember. Then here I had a budget of

several hundred million dollars, and 5,000 employees. I used to say then--I don't say now--that we were involved in everything from bathhouses to brain surgery. Of course, I didn't realize that bathhouses were going to be a major part of my experience here.

What makes the San Francisco Public Health Department so unique and I think so great compared with others around the country is that it is an umbrella agency that truly has everything, from emergency care--the emergency medical services, ambulance services, a major trauma center in northern California--to an acute care hospital, San Francisco General; Laguna Honda Hospital, for long-term care; and then mental health and drug abuse and alcohol--just everything. There was really no aspect of health care that wasn't somehow touched by the health department.

In Kansas, I would sometimes have to have my secretary or nurse stay on the phone all day going through the yellow pages, trying to find a physician who would take a public patient--a patient on Medicaid, which here is Medi-Cal. Here, if the health department took a Medi-Cal patient, the medical society was upset, or sometimes the hospitals were upset.

Relations with Other San Francisco Institutions

Silverman: I became very actively involved in the medical society from day one. In fact, on my first day here, which was the second of May [1977], that night was a medical society meeting and I went to it, and was active throughout my tenure here. I realized that we had to work with these people, because they actually saw the health department as competition.

Hughes: So there was a tension between the medical society and the health department?

Silverman: Oh, yes. And there had been, but as I became an active member of the society, we worked very cooperatively. In fact, until this year when I didn't run, I've been elected as a delegate of the San Francisco Medical Society to the California Medical Association for the last dozen years. If there was a public health issue, the medical society would call me for my advice and usually they would follow it. I was on the Political Committee, looking at the political issues in the city, and state. The medical society and the health department worked

very, very closely during those years. Which is what I think should happen.

Hughes: How was the relationship between the health department and the university?

Silverman: Well, that was actually fairly good, because we were trying to get a new contract between the university and the city for San Francisco General Hospital. So although there were some tensions, I think it was very clear to myself and many of us that this was a very symbiotic relationship. The university really needed us, and we really needed the university.

Now, there's always arguing about who got the better end of the deal, and I don't know that anyone really did. But we could not have run the hospital without the university, and I don't think the university could have had the kind of clinical experience without the hospital.

Hughes: Were you immediately involved in that negotiation?

Silverman: Yes, relatively soon after I arrived in 1977.

Hughes: Did the terms remain what they had been?

Silverman: We never arrived at a contract by the time I left in 1985. I assume one has been reached, but I haven't seen it.

Hughes: Were there any other particular issues during the years in San Francisco right before the AIDS epidemic?

Silverman: Well, there were many, many issues. I closed the emergency aid stations [1978], which was very controversial. There were emergency aid stations around the city that were giving very, very poor care, but it was something the city was used to. If you burned yourself, cut yourself, had a little problem, thought you maybe had some pressure in your chest or whatever, you'd go to these places. A lot of people went there who were on Kaiser [Permanente] but rather than going all the way across town, if they could get it done there, it would save them time and money, and mostly energy.

They were poorly run, and I just couldn't see, with the number of hospitals and the number of emergency rooms, keeping these stations open. When I closed them, there was picketing, they put pictures of me up around the neighborhood, they followed me up to Sacramento when I was appointed to the advisory committee to assist the new state director of health [Beverly Meyers], and so that was one of my early tastes of San

Francisco politics. But by the time that was over, I was celebrating with them. They gave me a T-shirt, "I sat in Alemany for 43 days," and we actually ended up having a pretty good relationship. But it was a new experience.

Threat to Remove the Health Department's Jurisdiction over San Francisco General Hospital[1]

Silverman: There was a situation at San Francisco General--it may have been in the early years of the epidemic--where it was reported several people had died because of negligence. I had heard of only one case. The other two had not been made known to me by the administrator of the hospital. Probably one of my biggest problems is that I'm not as bastardly as I should be on certain occasions. The hospital lost accreditation. If I had fired the administrator, I'd have come out smelling like a rose. I could have said, he didn't keep me informed, blah blah blah--gone.

I wasn't aware of all the details at the time, and I didn't fire him. I figured, Let's see if we can work this out. I had a press conference. I've always felt, if I'm the head of the health department, I take responsibility. That probably wasn't totally smart. My successor was smart, and he had a person to share credit and blame. When the situation was bad, he put the person up who took the gaff, and when it was good, the health director got some of the credit.

[Roger] Boas, the chief administrative officer, used me as the scapegoat. He was going to take the hospital away from me. Which was fought by a lot of people.

Hughes: You mean take it out of your jurisdiction?

Silverman: Exactly. And [Mayor Dianne] Feinstein went along with him. I was very upset. I was getting calls from mayor's staff saying, "Gee, we're really sorry about what's happening," and I was saying, "But I was so loyal to the mayor," and they laughed, to a person. "What are you talking about? Loyalty's a one-way street here."

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[1]This section was moved from Interview 3 for better continuity.

Ultimately the hospital remained under the jurisdiction of the health director, but only after several flip-flops by Boas.

Departmental Links with the Gay Community

Hughes: Well, talk now about the relationships between the health department and the gay community that pre-dated the epidemic.

Silverman: Well, I was involved I guess somewhat peripherally with the gay community. They had asked me to participate and ride in the Gay Liberation Day parade, which I did. I always felt that the department should reflect the city in its makeup and in its services. Certainly the lesbian and gay community was and is a very important segment of the community. I had a lesbian/gay coordinating committee within the department to help sensitize the department to issues, and also to serve as a liaison when different issues were raised. So we were sort of ahead of the game in that sense.

Hughes: Had you established that?

Silverman: I think there may have been a committee before I came. I strengthened it, and had a full-time staff person dealing with it. I don't remember whether I started it. But certainly, it got more involved after I got there.

Hughes: Was Pat Norman the committee head?

Silverman: Yes, she was head of it at the time. In fact, I know she was when the AIDS epidemic started. Now, whether she had been head all the way from the beginning, I'm not sure, but I think so.

Hughes: What sorts of things was she supposed to be dealing with?

Silverman: It was to make sure that our clinics were sensitive to issues that related specifically to the lesbian and gay community, that we were responsive to the needs of the community. I can't remember how often the committee met; it didn't meet every month, I don't believe. If an issue came up from the community, that would come generally through that group to me.

Hughes: Because of the committee, the department had links with key members in the gay community?

Silverman: Yes, I did by virtue of becoming more actively involved. There were people that I knew in the gay community who wanted me

involved, so I was invited to their social affairs; I was in their parades. I would usually have my wife and kids ride in an old car or what have you, in the parades. So I just happened, both in my community here where I live and also the health department, to have friends, some of whom were members of the gay community. Maybe I spoke at one of the dinners of the Bay Area Physicians for Human Rights. I just don't remember. I was active in those ways, just as I was with the black leadership forum and the Italian-American community out at Laguna Honda, and various other groups.

Hughes: So the gay community was just another faction that you had ties with.

Silverman: Yes.

II THE AIDS EPIDEMIC

Becoming Aware of the Epidemic

Hughes: Tell me when you first became aware of the epidemic?

Silverman: Well, I remember the *Morbidity and Mortality Weekly Report*, *MMWR*, in June of 1981 that spoke about this strange situation of five white gay men.[1]

Hughes: You read the *MMWR* routinely?

Silverman: Yes. This was an interesting medical oddity of some sort. It certainly didn't pique my curiosity to any great extent.

Hughes: It didn't really register.

Silverman: No, not any more so than many of the other things that were there. Then I think it probably came from Selma [Dritz] and others in the Division of Communicable Diseases [in the health department] that they were starting to see these cases in San Francisco. The numbers, though very small, obviously were increasing.

Hughes: When did it hit you that the city had a real problem on its hands?

Silverman: Oh, I think by the end of '81, we certainly had the sense that this was not something small.

Hughes: Were there other reasons?

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[1]*Pneumocystis* pneumonia--Los Angeles. *Morbidity and Mortality Weekly Report* 1981, 30:250-252 (June 5, 1981).

Silverman: I think mainly the increasing numbers. And the ignorance that we had as to the etiology. We weren't sure if it was a toxin, whether it was bacterial, what it was. We had a sense about mode of spread. Everyone was talking about poppers. Especially related to KS [Kaposi's sarcoma]. There was every kind of conspiracy theory. [tape interruption]

I certainly knew we had an epidemic on our hands when we were planning Ward 5A. We hadn't planned any real model, but we kept growing to meet the needs. As more people needed to be screened, we wanted to take that burden off the clinic. So we set up a screening clinic. Well, when you're setting up screening clinics, and you have a clinic devoted specifically to AIDS, and you have an inpatient unit being prepared, you've got an epidemic. I mean, it's real. That was going on in '82.

So if you ask me, did I ever believe we'd be where we are today, no. I don't think I envisioned a worldwide pandemic that is growing in the way in which it is. But we were very well aware at that time that we had a problem; we had an epidemic on our hands.

Turf Battles

Hughes: Were you aware of a scrambling for turf amongst some or all of the physicians?

Silverman: You're talking about the [Paul] Volberdings and [Marcus] Conants of the world?

Hughes: Yes. A jockeying for what part of this epidemic they were going to appropriate. Did that ever come across to you?

Silverman: No. Volberding moved right up, I think because of his personality, his presence. I think there were some jealousies there from some who seemed to always be in the shadow. Whether that was early, middle, late in the epidemic, I don't remember, but I know there was some tension.

I didn't get that sense with Conant. I had some concerns with Conant over the politics, not the medical side of it. We worked much better on medical issues than most groups. We weren't like the [Robert] Gallos and the [Luc] Montagniers. There was a real sharing of information. So I guess the answer would be really no.

[Donald] Abrams and [Constance] Wofsy and Volberding were doing their thing, and that seemed fine. The other medical elements of the city weren't falling all over themselves to deal with the epidemic; this was not something that looked like it was a winner, if you will. Marc was certainly doing his stuff up on the hill [Parnassus, the location of UCSF]. I think others at SFGH [San Francisco General Hospital] needed to be educated about the gay community and the unique issues surrounding HIV/AIDS, and they became educated. Infection control I remember was an issue at the hospital [SFGH] that we were really concerned about.

But again, I really got the sense of working together, because I remember that infection control committee [UCSF Task Force on AIDS] getting together and kicking it around. As I say, we're probably pretty unique. Again, it gets back to personalities, but people who like to be here [in San Francisco], people who like to be at San Francisco General Hospital, are a different kind of breed.

One of the things that has kept me rejuvenated in this fight is the people that are involved, who are some of the most outstanding individuals, human beings, I've ever dealt with. You can sometimes deal with the other aspects when you have that to work with, and we had that. And we had it especially in this community.

Conceptualizing AIDS as a Gay Disease

Hughes: How were you conceptualizing the disease?

Silverman: Well, basically as a gay disease. It was not affecting anyone else. I don't think we ever believed it would stay just a gay disease; epidemics don't stay in any neat little packaged way. And it was very interesting, because it was first called GRID, gay-related immunodeficiency disease.

I remember members of the gay community coming in and saying, "Listen, everyone's pointing their fingers at us. This is obviously not just a gay disease; it's a public health problem. Can you not use that term [GRID]?" I said, "Well, with regard to terminology, it is like legionnaire's disease--the disease named for those it struck. I'll be amazed if we can get away from that term. But I would agree with you that it is a public health problem."

The reason I bring that up is later on, the community would come back and say, "Wait a minute, this is a gay disease! We need money for the gay community. This is not everyone else's problem." So it was--schizophrenic is probably not the right word--but depending on the time and who was talking, the concern changed.

But at that time, and actually except for a really small number of cases, it has continued to be a gay, bisexual disease in this city.

Hughes: Is that how your literature was oriented?

Silverman: Oh, yes. Until December of '83. I can't remember, but I think it was '83, when we saw our first heterosexual case in the city.[1] We reported it, even before CDC started talking about it.[2] There seemed to be a real reluctance for the government to acknowledge the heterosexual possibilities, because I think the next question would be, "Okay, what are you going to do?" And I don't think they were prepared.

We acknowledged it; we informed the media. I remember doing two public service announcements [1984]. We had a gay man do one, and I did the other. The gay man did the one directed towards the gay community, and mine was directed towards the heterosexual community. With all the pressures that were coming about with bathhouses and [AIDS] education, I decided, "Why am I doing this alone? This is crazy."

AIDS Education Programs

Educational Approach

Silverman: I believe we got some money as early as December of '81 for the Kaposi's Sarcoma Research and Education Foundation to fund some education programs--probably the first monies every asked for and spent for AIDS education in the United States.

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[1]John Jacobs. New AIDS case stumps medics. *San Francisco Examiner*, March 2, 1983, B8.

[2]The CDC reported six cases of PCP and/or KS in heterosexuals on August 28, 1981, but did not comment specifically on them. (*Morbidity and Mortality Weekly Report* 1981, 30:409-410.)

Hughes: There was controversy about the educational efforts of the department.

Silverman: Well, there were several. One of them had to do with the first poster on the AIDS epidemic which we [the health department] designed. Interestingly enough, when the first iteration of it was brought to my attention, it showed some almost nude men, and I thought, "Wait a minute, this is not where we should be at this point in time." I don't know if we used the word AIDS at that time or not, but we said, "Reduce your number of sexual partners, reduce your drug use, use condoms every time," things like that.

On one side, there were some elements of the gay community which said we had no business talking about that. On another side, some people, mostly in the straight community, said, "This is ridiculous. Why don't you come out and say, 'Stop using drugs. Don't have more than one partner.'?" So we really didn't satisfy anybody significantly.

I believed in those days that just coming out and saying, "Don't, don't," is like what parents tell their kids, and that doesn't work. The whole concept from the very beginning was to try and work with the community in education about AIDS. I never felt that government was very good at dealing with sexual issues. My other thought at the time, as we started getting money and directing it out from the department, was that I had no idea this disease was going to be with us for so long, and I clearly didn't want to add more people to our staff only to have to find something else for them to do when this epidemic was over.

My way of managing is trying to bring people around the table, trying to get a consensus, ultimately realizing the decision is mine, but getting the input from people who very possibly have more expertise in that specific area, whatever it is, and then making a decision. So very early, we started bringing the community in and trying to respond to its needs and to provide funding, planning, and oversight, but letting it provide the actual services.

Attacks by Randy Shilts and Harry Britt

Silverman: I had problems because my education program [of 1983] was being hit in the press by Randy Shilts, and by Harry Britt, who at

that time was the only gay [San Francisco] supervisor.[1] I'll never forget, Harry called a meeting for me to meet with him and the mayor to talk about the education program.

We went into her office, and her first question to Harry was, "Well, what's the problem with the health department's education plan?" He said, "I haven't read it," which I thought was very interesting. Then she said, "Well, what would you like to see?" He said, "I don't know, because I am not an expert in education." I was sitting there scratching my head. What's wrong with this picture? He doesn't like the program that he hasn't read, and he has no idea of what he wants. What are we sitting here for? It was really a bizarre situation.

But for some reason, Shilts was carrying this and running it [in the *Chronicle*]. He'd come in and I'd lay out this whole educational program to him, and then he'd go and find somebody who might not like it and then write the whole article that way. I remember he talked about the [health department's] lackluster AIDS education plan. The thing was, he didn't say, "So-and-so said it was lackluster." Lackluster was his word, and that's not reporting. That's commenting. It's opinion. So I finally got tired of this really biased treatment. In fact, I got so upset--obviously, none of us like to be criticized, but it's okay if at least there's balance--that I cut him off from access to me.

He ended up writing me a note saying, "I'm sorry, you're right, I shouldn't do this, and I promise not to do it again." Not promise not to be critical, but promise not to be so biased and one-sided. I used to call his editor and say, "For God's sake, put him on the editorial page."

Hughes: The health department's AIDS Activity Office was formed in 1983. Fairly close thereafter, the department came up with a seven-page AIDS education plan. Do you remember that?

Silverman: Vaguely. I think that's the plan I'm talking about.

Randy has done some very important things for the AIDS movement, and for getting the information out. But he was not an objective, unbiased reporter. He was really stirring up diverse reactions in the gay and general community.

Hughes: There was an article in the *Chronicle* in September of '83, and I'll quote: "A growing number of city leaders believes that

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[1]*And the Band Played On*, p. 376.

San Francisco's emergency AIDS education program has produced few results for the hundreds of thousands of dollars of city money spent this year [in 1983]."[1] That was the money that the health department then turned over to Shanti and the AIDS/KS Foundation.

Silverman: Yes. I can't speak specifically to that. It would be interesting if [San Francisco Board of Supervisors President] Wendy Nelder's name is in that article.[2] After interviewing me, Shilts went over to Wendy Nelder and said, "What don't you like about what's happening?"

I realized that my mistake was not keeping the supervisors up to date. So I went over and met with her, and she apologized after I explained what we did. She said, "I never knew what you were doing." What I really wanted to say was, "If you didn't know what we were doing, why did you comment?" And from that point on, she was totally supportive. You can follow that, as you look at the press after that and at the minutes of the meetings of the board of supervisors. She became totally supportive of what we were doing. My mistake was not having kept her informed.

This doesn't mean it was the perfect educational program. I can't even tell you now what the contents of that program and plan were. The thing was, it was the only one in the world. And we were all looking to find out what should be done. You had some factions within the gay community saying, "Don't air our laundry in public. We have gay liberation now. Don't start throwing us back into the closet by discussing our sexual activities and what we shouldn't be doing." Another group was saying, "Listen, our brothers are dying. Get the information out there!" So there was no unanimity in the very group we were trying to reach.

It sounds like I'm protesting too much, and maybe I am. Randy's book maintains that I was playing to the gay community

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[1]Randy Shilts. S.F. wonders where AIDS money goes. *San Francisco Chronicle*, September 22, 1983, A1.

[2]Nelder is quoted twice: "We passed the money because it was an emergency--we wanted something urgently done. We haven't seen results. [Dr. Silverman] had better be ready to have some answers." In reference to the health department's AIDS education plan, she was quoted: "If this is all the documentation [the health department has], then they wouldn't have gotten money from agencies I've worked with before. We pay Dr. Silverman a lot of money to be professional. Where is the professionalism here?"

as if there was some political benefit. The gay community was the community I was trying to reach with the message. And if I wasn't reaching them, I wasn't doing my job. So obviously, it was very important to me to know what they were thinking, why they were thinking it, and to have them listen to what the health department, through these various agencies, was trying to accomplish. That was my goal. In fact, the closing of the bathhouses needed to be an educational message, not just closing some buildings. That doesn't change sexual behavior. It's whether closure has an impact on the community, and what is that impact.

Is the impact, government is again controlling behavior and controlling the gay community, and it's sodomy laws, and this, that, and other things? Or, is the perception that the health department is there as our partner; we're trying to work together to put an end to this epidemic? That's a much different type of thing. I don't think you get people to change behavior by force. I think you get it through compliant behavior based on behavior change that has come about as a result of education and information.

Diversity within the Gay Community

Hughes: Well, some of your problem, as you've touched on, was the fact that there really wasn't a unified community position, at least in the political sense. There was a schism in the gay community that to a certain degree lined up with the two main gay Democratic clubs.[1] Would you put it that way?

Silverman: Pretty much. It was the [Alice B.] Toklas and the Harvey Milk [gay Democratic clubs]. Oh, yes, for anyone to assume that the gay community is somehow monolithic is a mistake. I think the only thing that they probably can agree on is that people shouldn't be discriminated against because of sexual orientation. That's where it stops. You get every political color and stripe. You've got the Stonewall Club, which is Republican. The infighting amongst the [gay] groups I guess is as much as amongst any other groups.

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[1]Randy Shilts. The politics of AIDS. *San Francisco Chronicle*, June 11, 1983. John Jacobs. Gay political groups swap charges over AIDS. *San Francisco Examiner*, June 26, 1983 (Gay and Lesbian Historical Society folder: AIDS 6-7/83).

I really think people's concept of the gay community, and I'm not gay so I had probably had a similar concept, is that it's a monolithic group. And it's very clear that it just isn't. The community is made up of lesbians and gay men, and there are certainly many differences between them and within them.

Complexity of the AIDS Problem ##

Silverman: But you couldn't, nor can you today for the most part, get agreement by everyone affected on any single issue. AIDS is really somewhat unique that way. There is nothing simple about it. When you think you've got something solved and you move it aside, it will come back.

Hughes: Why?

Silverman: Well, I think there are several reasons. One, you have a devastating disease that is attacking people at an age when one's own mortality is hardly even thought about. I mean, young people, teens, early twenties, unfortunately they think nothing can happen to them, and here all of a sudden they have to face their own mortality when their friends are dropping like flies. And not just dropping, but dropping in a very tragic, tragic way. Dying from any disease is not very pleasant, but dying from AIDS is I think one of the worst.

Then you had a group in which many had finally gotten a sense of self, as far as community and individual were concerned. Here was a caring, supportive community in San Francisco. They could walk down the street holding hands and not have to worry about being beaten up like they might in some other place. So gay liberation had taken place; they were really on a roll. Then the epidemic came along.

Also, you had a disease which affected a community. Cancer cuts across all communities, and AIDS to some extent does. But in San Francisco, this was basically and still is basically a gay disease. So you had an already organized, not necessarily homogenous but organized community to then get involved in fighting the epidemic.

In those early years, we didn't know what it was that was doing it. We had an idea it was related to sex, because what is unique about gay men is their sexual orientation and

activities. And so there were so many things coming together, a confluence of things hitting all at the same time, that I think it's not surprising that there were controversies. In fact, once you get past the tragedy of the epidemic itself, the thing most tragic to me is the backbiting and infighting that still exists amongst and within AIDS organizations. I see it internationally; I've seen it all over the world.

Plus, because the epidemic was new, all these organizations, not necessarily the gay political organizations, but these other organizations were also new and growing and maturing and going through what I like to call adolescence. It seems like every organization, mine [American Foundation for AIDS Research] included, had to go through that. People are involved in many AIDS organizations, not because it's nice to be involved but because their life, they feel, depends on it. This creates an incredible sense of urgency.

So all of these things come into play. Probably no single one more important than others, but all of them come into play, making the AIDS epidemic one of the most complex things that I've ever dealt with. And because of the administrations we've had in Washington, one of the most "political" diseases I've ever dealt with or have read about.

The AIDS Activity Office

Hughes: Let's go back to the health department itself. I know what Selma Dritz was doing.[1] Who else was directly involved with the epidemic?

Silverman: Well, I'm trying to think--Pat Norman was. Also the person [Cunningham] whom I appointed to head the AIDS Activity Office, which I set up in '83. He had been in public health; he had run a health center in San Francisco.

Hughes: Why was he brought back?

Silverman: Well, quite honestly, I needed someone who could be fairly objective, and I felt he could be, more so than some of the people who were in the department. I thought he could handle it in a very professional way.

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[1]See the oral history in this series with Dr. Dritz.

There is in some people who finally [publicly] come out [as gay] an all-consuming involvement in that issue. I've said, whether it's in the foundation that I'm running now or the health department, when they're health department employees or they're foundation employees, that is the first thing, and then their gayness or their blackness or their greenness or their Jewishness or whatever can come after that.

But unfortunately, especially when people are just coming out, the issue of gayness becomes quite often--and I'm generalizing--overpowering. That first poster on AIDS was an example. Even though San Francisco is a relatively open community, this was much too strong for the first poster. But this was what was in their minds. They thought naked men would be fine.

Sometimes in the foundation that I'm with, the American Foundation of AIDS Research, some young men to whom the gay scene is very important make decisions which make sense in that arena, but not necessarily for what the foundation is trying to do.

A classic example: I remember someone once wanting the foundation to sign on to a letter decrying the immigration policies vis-a-vis homosexuals. I said, "All of us are upset about it, but that's not an AIDS issue. Give me a letter that says, 'We decry the immigration policies related to AIDS,' and you've got it [the support of the foundation]. But not the other."

It's a long way around, but in this situation [appointing a director of the AIDS Activity Office], I didn't think Pat Norman, to be quite frank, could give that kind of objective approach, and that's what I needed. She was very upset, because she thought she was the heir apparent to that position. [tape interruption]

Hughes: How did you envision the AIDS Activity Office operating?

Silverman: Well, its basic function was to do almost what the Lesbian and Gay Coordinating Committee did--well, actually much more so. Obviously, we wanted to be sensitive to the services we were providing and make sure we were providing relevant services in the area of AIDS. This would be an office that would get requests for support, would review and provide the grants, and would provide fiscal oversight and what have you, of the various [AIDS] programs that we were funding.

So the office really was the focus of the AIDS program in the department. It was a resource for me to go to, to follow up if the hospital [San Francisco General] wanted to put in an inpatient unit, or somebody wanted to set up another screening clinic, or start an education program--whatever it was. It was like having a TB [tuberculosis] unit or STD [sexually transmitted diseases] unit or what have you.

Hughes: And did it indeed function in those capacities?

Silverman: Yes, I thought so for the time that I was there. I gather it's grown tremendously, but when I was there, it was basically a small office.

Hughes: Did that mean hiring people?

Silverman: Yes. There was support staff, two to four--I just don't remember. It was a very small office. I gather now there are over ninety people in the AIDS office. But this was slim pickins then.

Selma Dritz

Hughes: How directly aware were you of what Selma Dritz was doing in the health department's Bureau of Disease Control?

Silverman: Well, we were in contact quite regularly, especially as we got involved with the bathhouse thing. She was very much involved. She was the obvious resource of the epidemiologic information. She was also the source of some other information. I will never forget, she made it clear to me that it was [pronounced] Káposi's sarcoma, not Kapósi's sarcoma, and even gave me some historical information. She was a very good, very level-headed person dealing with this epidemic. I think she was the perfect person in that role at the time. She is to be played by Lily Tomlin in the upcoming HBO movie [based on *And the Band Played On*]. It was going to be Whoopie Goldberg, which would have been a real kick.

I sought, and also without my seeking it, Selma would provide counsel to me on these issues. I don't know that we always agreed. I don't remember exactly the kinds of things we discussed, but she was a very good resource.

Hughes: She herself had had considerable experience with the gay community prior to the AIDS epidemic in following sexually-transmitted diseases.

Silverman: I believe so.

Hughes: Well, the health department in July 1981 established a reporting system and registry for AIDS cases.[1] Do you remember that? Was that something that Selma instituted?

Silverman: Oh, I'm sure it was something that Selma started, to try and get a handle on what was happening in this community.

Hughes: Then there was a registry of physicians throughout the state who were willing to care for AIDS patients.

Silverman: I wasn't involved in setting it up, because I wasn't the implementor of these things. But I remember, we were hearing from the AIDS clinic that it was getting overwhelmed, and there needed to be physicians that we could refer patients to. It was also another way of getting the other hospitals to start caring for these patients, because if they were admitted from private doctors' offices, it was easier to have them admitted. So it was a subtle--I don't know the word--sort of a way in which to get HIV-infected patients into many hospitals.

Hospital Admission of AIDS Patients

Silverman: In fact, I remember one of the hospital administrators who I had been meeting saying, "Listen, we're not going to put a sign up that say, 'AIDS, y'all come,' but if they come in and they're admitted, we obviously are going to take care of them." And in fact, most of these people with AIDS had private insurance. That was money for the hospitals.

But the hospitals couldn't come out--if you will--as favoring their admission, so we set up this registry as an attempt to both take some of the load off the AIDS clinic, Ward 85, but also to get the AIDS patients into other hospitals without any problem.

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[1]Mervyn F. Silverman. San Francisco: coordinated community response. In: *AIDS: Public Policy Dimensions*. New York: United Hospital Fund, 1987, pp. 170-181, p. 171.

Hughes: So in terms of the hospitals, admitting AIDS patients was a monetary issue; they wanted to fill their beds.

Silverman: Yes. If you talked to the administrator privately, he wanted to fill the beds because we had a lot of empty hospital beds in this town. Publicly, as I say, they couldn't come out and make it clear, because they were afraid they'd lose other potential patients who might fear coming to what they might imagine was an AIDS hospital.

Hughes: There is documentation that UCSF was not interested in having AIDS patients for a variety of reasons.[1]

Silverman: You mean up at Moffitt [Hospital].

Hughes: Yes. And that was one of the rationales for moving AIDS activities to the General [San Francisco General Hospital].

Silverman: Well, I don't think it was moved. It was begun there.

Hughes: Well, remember, the KS clinic was at UCSF.

Silverman: The KS clinic was, yes, but the inpatient and outpatient AIDS activities were at San Francisco General.

Hughes: Well, you could argue that they could just as easily have been established at UCSF, if the administration had wanted to.

Silverman: Oh, sure, if there was an interest. I think that's probably true.

Hughes: Was there ever a period when hospitals said, "This is a disease that nobody knows anything about. People are dying with no means of cure. We don't want these patients."

Silverman: Well, I never heard that voiced from UCSF.

Hughes: What about at the other hospitals?

Silverman: Other hospitals were worried about having these patients because of what it would do to the other patients. Hospital administrators feared the presence of AIDS patients would keep non-AIDS patients away out of concern that AIDS patients would spread the disease. I think there was a real fear of that.

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[1]*And the Band Played On*, pp. 480-481.

Initial Opposition to the AIDS Ward

Silverman: Interestingly enough, because we had the dedicated unit [the inpatient ward] at San Francisco General, people who could afford to go elsewhere came to General, because it was the best AIDS service, the best care you could get anywhere in the country. It was a unit that I initially, as you've probably read, was opposed to.[1] Not opposed to, but reluctant to accept, because I feared it would have the stigma of and be like a leper colony. Fortunately, I was convinced otherwise.

Hughes: By whom?

Silverman: Oh, I guess Paul Volberding and others. And ultimately, probably also Cliff Morrison, who I think did an absolutely superb job in setting up that ward and running it. As I say, I tend to run by consensus. When people who seemed to have a sense of the need for a dedicated unit made it very clear, I certainly acceded to that and said, "Well, let's try it and see what happens." It didn't take very long to see that it was not only just a good idea, but it was something that was an absolute success. In fact, too successful, because there were too many patients for the unit to serve.

And it wasn't our purpose to save money by implementing the San Francisco model of AIDS care. Our purpose was to provide the best care. The spinoff was we reduced hospital length of stay. We could probably reduce hospital stay to a greater degree in the gay population than in the drug-using population. So instead of going from sixteen to eleven hospital days, maybe we would go from twenty-two to sixteen. In other words, I'm not expecting the same absolute results in other communities, but the relative results can be there. I think if you don't have a program, there's going to be a higher cost in human and economic terms; and if you have a program, it will be a lower cost in both areas.

Hughes: Could you have stopped the creation of the ward?

Silverman: As director of health, oh, yes, of course. I just would not submit for the funding, or I could turn it down.

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[1]Mervyn F. Silverman. San Francisco: coordinated community response. In: *AIDS: Public Policy Dimensions*. New York: United Hospital Fund, 1987, pp. 170-181, p. 172.

Hughes: You would have done so on the basis of the argument that it was discriminatory?

Silverman: Well, it could appear that the unit was set up to protect other patients like leprosariums were established years ago (unnecessarily). And there was also the argument, "Don't we really want every nursing service to be able to handle AIDS patients?" In fact, when I became director of the Robert Wood Johnson AIDS Health Services Program the year after leaving the health department [1986], it was to have a demonstration project throughout the country, based on the San Francisco model, as it came to be known. I was not one that said you absolutely had to have a dedicated, inpatient unit. It would depend on the community and the numbers of AIDS cases and other factors.

My ultimate goal was always to have AIDS become mainstreamed, but not normalized. By mainstreamed I mean that no matter what ward AIDS patients went on, no matter what unit, whether it was cardiac or whatever, there would be trained staff that could handle people with AIDS. Not normalized, in that AIDS not get treated like heart disease, which gets attention every February as National Heart Month or what have you, but otherwise is not considered by many as a health crisis.

AIDS must receive proper attention, but it ought to be integrated not only into the hospital but into the entire health care system.

San Francisco's Unique Response to the Epidemic

Hughes: What was unique about San Francisco's response to the epidemic?

Silverman: Well, first of all, we had several things going for us. One, that the disease was primarily in the gay community. New York had the gay community and very quickly the drug-using community, two totally different communities--not that there isn't some overlap. You could tell even in the dedicated inpatient unit, the desire to take care of people who were using drugs as opposed to gay men was quite different. Gay men were compliant, cooperative. Working with a gay man is a lot different than working with someone who is always trying to con you, the way some people who are addicted to drugs are.

Secondly, we had a budget surplus instead of a budget deficit, which was unique.

Thirdly, we had a very supportive mayor. So the executive branch was supportive, the legislative branch was supportive, and the community in general, obviously with some exceptions, was very supportive.

Hughes: Did personalities enter in?

Silverman: Personalities? The mayor, Feinstein, and I obviously had our disagreements, but I don't think she ever turned down any funding request that I brought to her. The personalities on the board of supervisors obviously supporting it.

Hughes: You were a consensus-builder, which made a big difference.

Silverman: Yes, and I was interested in the epidemic. There are health officers in other cities who still don't want to touch it with a ten-foot pole, probably because they read about what I went through. [laughs]

Hughes: It would have been hard for you to avoid dealing with the epidemic.

Silverman: Absolutely. But if I had tried to avoid it, then I would probably have been removed, because I would not have been providing for the city's needs, and somebody else would have come in. Obviously, whether I was the person or not, somebody who understood the situation and was involved in the community in planning and implementing the government's response would be necessary here. Personalities were very, very important.

The community was very supportive. I remember walking over to City Hall one day--my office was right on the corner across from City Hall--and this woman came up to me pointing her finger at my chest saying, "As a native San Franciscan,"--and of course, once she said that, she already had me, because I wasn't born here, and even if I stayed here a thousand years, I'd never be a native San Franciscan. She was very concerned about all this money spent on and interest about AIDS. There were some people that were opposed. But for the most part, this was a very, very supportive community, a very caring community.

You can see that just in the per capita expenditure for health care in the city. Probably the only place that exceeds it is Bahrain or somewhere in the oil-rich Middle East. You figure it out: I think we're up to about $500 million now,

divided by the San Francisco population of 750,000--that's a hell of a lot of money per person in a community for public health care. So this community has always been supportive of meeting its health care needs.

New York had garbage problems and this problem and that problem. AIDS was just one of a thousand major unsolvable problems in New York City, though I still think they didn't handle it appropriately at all. But they had so much more on their plate. That's another one of the benefits that we had; though we certainly had problems, they just weren't of the character nor the quantity that a city like New York had to deal with.

Hughes: In a sense all you players were politicians; you had to be. How much do you think Feinstein and the board of supes and other politicians were motivated by the knowledge that gays were politically active, they were voters? In other words, if you were a politician and wanted to get reelected, you'd better listen to what they were saying and what they were needing.

Silverman: I think that's a factor. I don't know how much weight to put on it. I do think it's the character of the city to be more caring than most cities, but no one should ignore the political power of the gay community.

Hughes: What were Feinstein's motivations?

Silverman: Well, I would like to believe it was for humane reasons, and I really believe that for most of the time. I saw some changes when she thought she might be in the running for the vice presidency. She all of a sudden distanced herself and had me be the point person from the city side--although I was the point person from the health side--when we went to the U.S. Conference of Mayors meetings. Prior to this time she would publicly deal with AIDS issues.

But I still have to believe that she is a basically humane individual. I don't know that all her motives were based on the health issue. I think part of her interest was to clean up the city. She really had a real problem with the fact that we had sex clubs and bathhouses in this city. My feeling was, it's not the role of the health department to "clean up" the city; it's to make sure that there are not any unhealthy situations in the city. It's like inspecting restaurants: the food may taste lousy, but if it's not unsafe, it's not my role to interfere.

The Health Director's Powers

Silverman: The power of the health director is, to use a "Valley" term, awesome. It really is. I could have closed City Hall; I could close a police station. In fact, I overrode the police and fire departments when we had a transformer burst down in the financial district, putting out PCBs [polychlorinated biphenyls]. I went down there first thing in the morning. They were getting ready to open it up, and I was sliding on the PCB oil on the sidewalk. I said they couldn't open it, and I'm sure millions of dollars were lost during that time. That was my decision.

Now, if I used my power capriciously, I could be in trouble. But otherwise, the power is incredible, and I think that you use it very cautiously, very carefully. My feeling was, if you don't like sex clubs, you have a political way to deal with them. They weren't even licensed. If you were not licensed, what are you looking at the health department for? License them, and then have the health department regulate them. But there was no political will, there was no political commitment to do that. I think the mayor and probably some others would have liked to have had the health department do that for them. As I say, that wasn't our role.

Hughes: These powers that you're talking about, are they unique to San Francisco?

Silverman: No.

Hughes: They are common to any health department.

Silverman: Yes.

The Health Director's Medical Advisory Committee on AIDS

Hughes: In March of 1983, you formed an ad hoc medical advisory committee to "keep abreast of developments and present as consistent a response as possible to the public on matters relating to AIDS."[1]

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[1]Mervyn F. Silverman to Marcus Conant, March 11, 1983. (Marcus Conant's KS notebook for 1983.)

Silverman: Couldn't have said it better myself. [laughter]

Hughes: Do you remember the people who were on that committee?

Silverman: Well, Marc [Conant] was on it. Paul Volberding was on it. Who else did I have on that? I'm sure the files will show. I had several gay physicians from the community, Bob Bowen, and Rick Andrews--

Hughes: Who is he?

Silverman: He's a psychiatrist. And I had someone representing the hospitals, and someone representing the medical society. I just don't remember who. I am blanking on exactly who was there.

Hughes: Did you attend those meetings?

Silverman: Yes. I ran them.

Hughes: Can you give me a feeling of what went on?

Silverman: Well, we'd bring in a representative from BAPHR [Bay Area Physicians for Human Rights]. We'd discuss the issues of care, not only at General but at other hospitals. I think the [AIDS physician] registry probably came out of that.

If there was a new finding, we tried to bring it to the table or someone else could bring it to the table, trying to update all of us as to what was topical. Selma I know was part of that committee. Maybe Don Abrams was; I'm not sure.

It was basically to monitor what was happening in reference to the epidemic, what we were doing from the public side. Again, it's this idea of bringing together the various players, as the statement said, so as to have a united front. Not to be in lock step, no conspiracy. But if we all knew that something was wrong, we could all go out and say that. So we didn't issue misinformation which was confusing to the public. Of course, part of the reason was that we didn't know all the answers, but on issues we agreed, we could all say the same thing. The committee was intended to cut down on the confusion and unnecessary fears.

Hughes: And were you successful?

Silverman: I don't remember--we didn't seem to have people going every which way. So I think in a sense it was successful. You'd have to ask them.

The Community Advisory Committee on AIDS

Hughes: Well, in addition to the medical advisory committee, there was a general AIDS advisory committee, which I believe was established at the same time, with members from the gay community.[1] Anybody else?

Silverman: I really don't remember the exact composition. I had an ad hoc committee around the bathhouses that was separate from these two.

Hughes: Those committees presumably met separately.

Silverman: Yes.

Hughes: Did you always attend the community AIDS advisory committee meetings?

Silverman: I'm sure on occasions I attended, but I don't know that I was there all the time. I set up the medical committee directly for me, so I was always in attendance.

AIDS Screening Clinics

Hughes: Well, as the number of AIDS cases increased, screening clinics were added at two city health centers.[2]

Silverman: Yes, we had one at District Health Center number 1 on 17th Street. And then we set up another one in Health Center 2, which is over in the Western Addition. I don't remember what street it was on [1301 Pierce Street].

See, this is how the model grew: as the AIDS clinic at San Francisco General seemed to be getting overwhelmed, then we added screening clinics elsewhere. It was like, "We'd better see if we can set up screening clinics, so we take some of the burden off of

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[1]Mervyn F. Silverman. San Francisco: coordinated community response. In: *AIDS: Public Policy Dimensions*. New York: United Hospital Fund, 1987, pp. 170-181, p. 174.

[2]Mervyn F. Silverman. Addressing public health concerns of the city of San Francisco. In: *AIDS and Patient Management: Legal, Ethical and Social Issues*. National Health Publishing, 1986, pp. 27-35, p. 31.

the AIDS clinic at SFGH." So what you had was the net getting smaller and smaller. As you moved to higher degree of service, you had the screening, the clinic, the inpatient unit.

Hughes: Do you know anything about the questionnaires used in the screening process?

Silverman: Not really. Of course, when we set the screening clinic up, we didn't have the HIV antibody test, so screening was obviously very much based on the clinical findings.

Hughes: Did adding the screening clinics mean increasing staff?

Silverman: I'm sure it must have. But I just don't remember. I don't remember whether we were able to use existing staff--I'm pretty sure we had to add staff. In fact, I'm almost positive we did.

Hughes: You have implied that funding wasn't a big problem.

Silverman: That's true.

Hughes: Was this because of the budget surplus, and because the powers that be, Feinstein on down, were behind this effort?

Silverman: Yes, both.

Hughes: So you weren't struggling for money.

Silverman: No. And that's what so unique.

Hughes: And so very different from the stories I hear about what was happening at the federal level.[1]

Silverman: Oh, yes.

Hughes: What were your ties at the state and federal levels?

Silverman: Well, at the federal level, I was working with the CDC [Centers for Disease Control and Prevention]. And sometimes we were setting [AIDS] policy before they did.

Hughes: Explain what sorts of things you told them.

Silverman: Well, it was a two-way street. They were obviously getting much more epidemiologic information than we were getting. We

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[1]See, for example, the oral history in this series with Donald P. Francis, M.D.

were always looking to them for trends and how things were going. For the bathhouse issue, I had Jim Curran [head of CDC AIDS activities] on my little advisory committee, and the reason I think he participated is because he saw the bathhouses as an issue that needed to be looked at, not just in San Francisco.

I'm sure Selma on a day-to-day basis dealt much more with CDC than I ever did, but I was brought down there for meetings, consultations; they came out here.

We talked with them on some regular basis about policy issues. I believe the report the UCSF Task Force on AIDS put out preceded the CDC's report on what should be done in health care settings to reduce the spread of HIV.[1] So there was constant dialogue, plus we were involved in various regional, national, and international meetings.

Government's Role

Hughes: Well, I want to quote another Silverman statement--

Silverman: Then it's absolutely true.

Hughes: [laughs] What else! "The basic concept underlying our approach to the AIDS epidemic in San Francisco when I was Director of Public Health ... was that government cannot do everything." Do you want to expand on that statement?[2]

Silverman: Yes. When it comes to telling people about sexual behavior, government certainly hasn't done nor is it really set up to do very much in that area. Witness the kinds of things we've seen from the federal government, which have been anemic at best.

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[1]John E. Conte, W. Keith Hadley, Merle Sande and the UCSF Task Force on AIDS. Infection-control guidelines for patients with the acquired immunodeficiency syndrome (AIDS). *New England Journal of Medicine* 1983, 309, No. 12:740-744. The UCSF guidelines preceded those of CDC. For details, see the oral history in this series with Merle A. Sande, M.D.

[2]Mervyn F. Silverman. San Francisco: coordinated community response. In: *AIDS: Public Policy Dimensions*. New York: United Hospital Fund, 1987, pp. 170-181.

My feeling is that instead of we in government being the planners, the implementers, the evaluators--the everything--why not use the community, which is better able to do it, and has better rapport with the people we're trying to reach. And again, as I say, I didn't want to expand my empire. My empire was certainly big enough.

When you contract out, that allows for a lot more flexibility. You don't have to deal with the civil service system, which is an incredibly problematic system. So you have much more flexibility, you can get things started much faster, you can get the people you need much faster, get the right people.

So government, I felt, should help in the planning, help obviously provide the funding, and provide the oversight and the evaluation of what's being done, make sure the tax dollars are being appropriately utilized. I still believe that. It's proven itself. If we left it up to the federal government to educate us, we'd be in big, big trouble.

More on AIDS Education

[Interview 2: May 10, 1993] ##

Strategy

Hughes: Dr. Silverman, last time we talked about some of the educational efforts of the department; I have a few more questions on that subject. Did the department consider itself one of the main venues, if not the major one, in San Francisco for education on the subject of AIDS?

Silverman: Well, we saw ourselves as not necessarily producing the educational material, but seeing that it got out there. That's why we used local groups. I think it may have been the Kaposi's Sarcoma Research and Education Foundation when it began, and then it became the San Francisco AIDS Foundation. In the very early years, we didn't know what we were educating about; we didn't have a virus and we weren't sure AIDS was caused by one. But we were pretty sure how whatever it was that was causing it was being spread, and so the education was directed more towards behavior--sexual activities. As more information came in, obviously we became more precise in our educational activities.

Hughes: Was it common practice at health departments to not actually produce the material themselves but to farm it out?

Silverman: Probably not in the classical sense. I think in the classical sense, the health department produces the health education materials and puts them out. I think because of the sensitive nature of what we were doing, it was best to have the community group put its name on it. In that way explicit materials could be disseminated without political repercussions. It seemed to me government was never terribly good at dealing with these issues anyway.

Hughes: You mean the health department as a branch of government?

Silverman: Yes, as a branch of government.

Everything that was being produced, I reviewed. If it was sexually explicit, we just didn't put our name on it. Now, if it was being put out by, say, the AIDS Foundation, and because they were getting some money from the private sector, we could always say, "Oh, that was funded from the private sector. No government money." There were a few pamphlets that we just said, "Don't put our name on it." Now, the funds obviously came from us, most of them, anyway. But they were sort of commingled in the financial offices of the foundations.

And the reason why I think this was good preventive medicine was that the Los Angeles department of public health didn't do that, and their county commission made them stop producing two of their education pamphlets, one of which they had used our materials, and one they didn't, both of which were quite good. It's like the NEA [National Endowment for the Arts] kind of thing. Because we were using taxpayers' money, we couldn't be saying things of that sort.

Hughes: Homophobia was the problem?

Silverman: No, more the explicitness of the sex. As an example, one of them in L.A.--it was a very cute ad--was of a little woman and a big hulk of a guy, and she says, "Listen to your mother: use a condom every time" or something like that. Very cute, very nice, whimsical, it caught your attention. The L.A. county commission didn't allow that ad to go public.

If government has its name attached to something which causes controversy, it can become a problem. If the name isn't on it, the only thing the public can say is, "Why is this coming out?" And they can raise hell about the source, but it doesn't come back to the government.

Hughes: Was that your strategy?

Silverman: Yes. In fact, I vividly remember reading something and saying, "I think this is good, but boy, we just can't put our name on it." And we didn't, and it never was an issue. Now, whether it would have been a problem in San Francisco, I don't know. I just didn't want to have to face that when there was so much to do.

More Criticism

Hughes: I'd like to read a quote, dated May 4, 1984, from Randy Shilts' book: "The prevention program was not the only controversy snaring the mayor in May. The bathhouse issue was stalled, as was the city's AIDS prevention campaign. Silverman subsequently said he was disappointed with the AIDS education campaign mounted by his department and the San Francisco AIDS Foundation, although he never expressed his reservations in public. He felt he had no choice but to include all the various gay factions in his considerations, aware that any one of the groups would move to sabotage prevention efforts if they felt excluded. As he said later, it was better to have all the Indians inside the tent pissing out than to have them on the outside pissing in."[1]

Silverman: That's actually a phrase of Lyndon B. Johnson; I can't take credit. I honestly don't remember what Shilts was talking about. I would be happy to tell you if I could remember. In retrospect you can always see things that could have been done better.

City Money for AIDS Services

Hughes: Well, in 1983, there was a flap over whether money for AIDS services should come from the health department's budget for

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[1]*And the Band Played On*, p. 453.

health care for the poor. Feinstein refused to appropriate money for AIDS services from the budget surplus.[1]

Silverman: That surprises me, because, although she and I may have had our disagreements, I don't remember ever going to her with a proposal for funding for AIDS services and having been turned down.

[tape interruption]

Silverman: Sal Roselli [of the Alice B. Toklas Lesbian/Gay Democratic Club] was reacting to the fact that the mayor's office had taken $500,000 budgeted as a reserve fund to provide health care to the city's poor and given it to AIDS. Feinstein said that the $500,000 reserved for the health care of medically indigent adults had become unnecessary because the poor were supposed to go to San Francisco General Hospital. So the mayor insisted that no worthwhile programs would get thwarted because of AIDS appropriations. Some leaders were worried that AIDS might become the whipping boy, I think they used that term, for why the money was going into AIDS rather than into some of the welfare programs.

Hughes: There was an article in the *Chronicle* about this time, saying that because there was a scramble in the health department for AIDS funds, there was fear that other health department programs, particularly community clinic services, would be cut.[2]

Silverman: Yes. And to my recollection, none of that ever took place.

Hughes: Yes, largely because there was a budget surplus. You said that in the first interview.

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[1]Warren Hinkle. Flap over funds for AIDS. *San Francisco Chronicle*, October 12, 1983. (Gay and Lesbian Historical Society, folder: AIDS-8-12/83.)

[2]*San Francisco Chronicle*, October 12, 1983. (Gay and Lesbian Historical Society, folder: AIDS August-December, 1983.)

The Census Track Study, 1983

Hughes: [Andrew] Moss, in his interview with me, said that he showed you and Pat Norman his census track data.[1] Remember that early study he and Mike Gorman made in the Castro, which was later published in the *Lancet*?[2]

Silverman: Yes.

Hughes: He expected some sort of response from the health department, which he didn't feel he got. Do you remember anything about that?

Silverman: Vaguely. Let me see how to put this. The results of that study were no surprise. If you go into the Castro, which has the highest concentration of gay men in San Francisco, and you find a higher incidence of AIDS in the Castro, what does that tell you? We were focusing our messages on the gay community. We were focusing them into the Castro district. As I said, we had a screening clinic at the health center number one over on 17th [Street]. I remember people responding, and my scratching my head and saying--

Hughes: What's new?

Silverman: Yes. It's almost like saying, when you go to Miami Beach, there's a lot of problems with people who have chronic ailments. Yes! Miami Beach is full of old people! [laughter]

Hughes: Well, what might have been news was that the study showed that one in three gays was infected.[3]

Silverman: That I don't remember, but it could be. But I guess the lack of any major response from the health department had a lot to do with the fact that there wasn't a lot of news there.

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[1]See the oral history in this series with Andrew R. Moss, Ph.D.

[2]Andrew R. Moss, Peter Bacchetti, Michael Gorman, et al. AIDS in the "gay" areas of San Francisco. *The Lancet*, April 23, 1983, 923-924.

[3]See Moss oral history.

The Bathhouse Episode, 1983-1984

Regulation Rather than Closure

Silverman: Now, this of course was in the middle of the bathhouse controversy. I'm not sure what Moss' position was. I think he was for closing the bathhouses.

Hughes: Yes, he was.[1]

Silverman: Of course, the results of his study provided further ammunition to close them. By mid-'84, the bathhouses were being inspected. I don't know the exact date I sent in the inspectors. I happen to have a chronology. [pulls out paper] "Fall [1984], health department hires private detective." As I mentioned, I had this ad-hoc advisory committee on the bathhouses that I had put together. When we met the first time, we decided rather than closing the bathhouses to go with the regulatory approach, which obviously didn't work, because Feinstein didn't want the police department involved in it. I was trying to keep it out of the police department, but by law, the police chief had to make the final decision.

I even had Phil Lee, who's now the Assistant Secretary of Health, chair the session. It was going to be held in the health department, but I would have to submit a recommendation to the police chief because he had the authority over bathhouses--not me.

Hughes: Now, clarify what you mean by regulatory approach.

Silverman: The city attorney, George Agnost, thought it made much more sense, since there were already regulations in place for bathhouses. The health department inspected them for health reasons, sanitation, but regulation was under the police department, because the police department saw them as fronts for prostitution, gay or straight. So the regulations were in the police code. Sex clubs didn't come under the regulations, because they weren't licensed at all.

The city attorney said, "Why don't you just expand, add to, the regulations, that there could be no sex between people. Then the only issue is, if you can get the regulations passed, was there sex between people. And if there was, you could

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[1]See Moss oral history.

close them." In other words, you don't get into the whole civil liberties question, because you have a regulation already on the books.

So I started trying to get regulations written by the city attorney's office; they were being written. Feinstein was getting very, very antsy that we were bringing the police department in on this, and we shouldn't be doing that. And of course, she couldn't seem to comprehend the fact that involving the police department wasn't something I wanted to do; that was the law. And I even tried to get the responsibility for bathhouse inspection and regulations transferred to the health department, not because I wanted more responsibilities, but because it made more sense.

Everyone seemed to be in favor of that, including Feinstein. Then Harry Britt got worried and figured, "Right now the enemy is not the police department, it's Silverman, and if you give the health department the power, he's already indicated he wants to close them. We don't want to give the health department the power." So when I heard that, I realized politics wasn't going to let the change in authority go through.

In July [1984], about a week before the Democratic National Convention in San Francisco, I was going to have that hearing that Phil Lee was going to chair. Feinstein canceled it, which I thought was a very interesting thing, since Feinstein was saying the only interest she had was in health. But she canceled it because she figured with all these reporters around with nothing to do until the convention started, this would become big news. She was also being considered as a candidate for vice president. And she canceled it.

Hughes: It was just too controversial.

Silverman: Yes. On the other hand, she was saying to me, "You must close the bathhouses, if you can save just one life," and yet she cancels the very hearings that would have had the same effect.

When the hearing was canceled, I brought the bathhouse advisory committee together again, and people were all over the place concerning closure. I decided when I left that meeting that I was going to make the decision myself. I had talked to enough people; I had involved the community; I had involved the experts. That night I went out for drinks afterwards with my wife and Jim Curran, who was from the CDC, and said, "I'm going to close them."

Hughes: When was this?

Silverman: This would have been some time in the summer of 1984.

City Attorney's Opinion

Silverman: The city attorney said, "If you want to close them, you must have them inspected and detail unsafe behavior." This is the information he hadn't given me in the months before that non-press conference which you have a news clipping for.[1] He said to me--shows how stupid I was about law--"All right, if you want to close the bathhouses, which ones? And why? What have you seen in them?" I said, "What do you mean, what did I see in them?" He said, "You just can't close them. You have to have evidence that whatever your reason for closing them for is taking place in them."

So then we figured, and this is what took some time, we can't send in health department inspectors, because people know who they are. They've already been there inspecting. So what we did was hire private investigators, since nobody knew who those people were, and had them go in. They also know how to collect visual evidence, and they keep very tight records, so it would hold up in court.

Once we got that evidence, then we proceeded to put up signs closing the bathhouses. The theory was, instead of us being on the defensive, we should be on the offensive. So we closed them anticipating that they would probably open them, and then we could get a temporary restraining order. That, rather than us forcing them closed and then them suing us.

Hughes: This represents a change in viewpoint on your part, because I believe you didn't enter this episode, which began in early 1983, with the idea that closure was a good idea.

Silverman: Oh, well then I guess I've left some stuff out.

Hughes: Yes, there's a lot left out. Start at the beginning.

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[1]Randy Shilts. Silverman Delays on Gay Bathhouses. *San Francisco Chronicle*, March 31, 1984 (Gay and Lesbian Historical Society, folder: AIDS 1-3/84).

Deciding on Education Rather than Closure[1]

Silverman: All right. It didn't take a rocket scientist to know that the types of behavior that were taking place in bathhouses were conducive to the spread of whatever was causing this epidemic. In those early years, we didn't even know what the agent was. We didn't have it. What was clear was that the number of people regularly frequenting the bathhouses probably represented 5 percent of the gay population.

Hughes: That was one of my questions: were there statistics?

Silverman: Well, only from some of [Leon] McKusick's studies.

Hughes: Which you looked at?

Silverman: Yes, all the time. In fact, he was on my advisory committee, and his findings were very important in the ultimate decisions.

Hughes: Why?

Silverman: Because the AIDS-prevention education that was going on in the bathhouses wasn't having any effect, and I'll get to that in a minute.

All right, so you have 5, maybe at most 10, percent of the gay community regularly going to the bathhouses. And I would say 10 percent is a very liberal amount. That means 90 to 95 percent are not going to the bathhouses. I had to try and reach the whole gay community, and change behavior across the whole gay community. If the people who were practicing the highest risk behavior could be found in one type of venue, then it seemed to make sense--instead of closing the bathhouses down, because it doesn't stop unsafe behavior everywhere--why not go into those bathhouses and try through safer sex pamphlets to focus attention where you have somewhat of a captive audience, and a group that is practicing the highest risk behavior, if for no other reason than they could have many more partners in a bathhouse than they could in the park.

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[1]See Silverman's press statement, April 9, 1984, advocating education rather than bathhouse closure. (Dean Echenberg papers, Bureau of Epidemiology and Disease Control, San Francisco Department of Public Health, drawer: Bathhouses, folder: Sex clubs/bathhouse.)

Hughes: Yes. Perhaps the 5 to 10 percent that you cite should be inflated in terms of the effect that it had. I am presuming that this is a very sexually active segment of the gay community, and that their activities aren't necessarily confined to the bathhouses.

Silverman: Well, that's true, although I can't really tell you how many had sex outside or inside the bathhouses, although there was probably some of that data in McKusick's stuff. No question about it that bathhouse customers represented the higher risk group. But it was also very clear to me that closing the bathhouses wasn't going to stop the behavior. It might reduce the numbers of partners, the frequency of behavior, but if a person enjoys a certain type of sexual activity and he can't do it in the bathhouses, then he can do it where many other people are doing it, which is in their homes or public bathrooms or the parks, or wherever--out there on [Highway] 280 where that rest stop is on Junipero Serra Boulevard; that's supposed to be a big pickup point. And up near here in Buena Vista Park.

I also felt that because we were talking about a 90-10 ratio, that I wanted to make sure that we tried to change behavior across the whole community. In order to do that, I had to have the community be responsive to and supportive of what the health department and its programs were doing. My fear was that if I closed the bathhouses, then the health department would be seen as the police department, and our prevention messages would be lost. Also it appeared very likely that the courts would reopen them and then it would appear that--

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Silverman: --Silverman doesn't know what he's talking about. The courts have found that it isn't a problem. I'm being very simplistic, because the press is often very simplistic. Silverman closes down the baths for a health reason; the courts open them up saying it's not a sufficient reason. And as you know, when I did close them, they were reopened. So in fact, I was right about the legal outcome.

I was trying to get the gay community to take action, to force the bathhouses to stop allowing unsafe sex to take place in their establishments or close down. The reason why I thought this was possible was because a number of years ago, some gay bars had only one exit. They were obviously a real fire hazard. So people within the gay community tried to get these gay bar owners to put other exits in, and some wouldn't do it. So they picketed them. They actually brought a fire

door, got outside of the gay bars, and picketed. And [snaps fingers] almost overnight that was changed. So taking a similar action with the bathhouses was something they could do --if they wanted to.

My feeling was because I was trying to reach the whole community, the action had to go beyond the physical closure of the bathhouses; there had to be an educational impact. The way to get an educational impact would be to have the gay community do it, not the straight community, not the government.

I kept working with the gay community up to July of '84. The reason why that July of '84 is so important is we had the Democratic National Convention here. There was a party that was given by the Gay and Lesbian Caucus, to which I was invited, and I tried there for the final time with a certain number of leaders in the gay community to get them to take an action against the bathhouses. Especially since there were people in the gay community who made it very clear that they didn't like the bathhouses; they thought they should be closed. But if I closed them, they'd man the barricades in defiance of my actions.

And why would they man the barricades? The pervasive argument that turned around even the strongest gay backers I had for closing the bathhouses was, if government closes the bathhouses in San Francisco, which is seen as this bastion of gay liberation, what message does that send to less liberal states and communities? And then the next step is, well, obviously people get picked up in gay bars, so you close the gay bars. And then the sodomy laws would either be enforced or reinstated, depending on what the status was in any given state.

I remember having one very important person in the gay community who had been supporting me for bathhouse closure, who had been active in politics and still is, call me up and say, "Merv, I can't support you any more." I said, "Why?" And he gave me the above argument. That argument was pervasive, and was a very strong argument. The deal was, if the bathhouses closed down because they didn't have any business, or they closed down because we [the gay community] closed them down, that would be one thing. But if you, government, close them down, we just can't have that. Not after all the gains we've made in gay liberation.

Paul Lorch's Editorial

Hughes: Well, one of the illustrations of what you're talking about is the editorial by Paul Lorch that appeared in the *Bay Area Reporter*.[1] Certain gay leaders--Conant was one--were listed as traitors. There were sixteen names listed, all prominent members of the gay community.

Silverman: Well, except for Conant and maybe one or two others, all sixteen took their names off the list supporting bathhouse closure.

Hughes: The list I'm talking about was in Lorch's editorial.

Silverman: That list he had was taken from people who initially signed on urging me to close the bathhouses, and I'll get to that in a minute.

Press Conference on Regulations, April 9, 1984

Silverman: I had a press conference about the new regulations that I wanted to impose in the bathhouses. I met with people in the gay community. I remember vividly it was Sunday night down in my offices, and I said, "Let me tell you what I'm going to do. I'm going to impose regulations which I think the bathhouse owners can comply with. The bathhouses will certainly stay open if they comply with them. What I'm saying is no penetrative sex between individuals. And the reason I'm saying that is, you can't inspect for safer sex. What are you going to do? Separate people and see if they are using a condom? You can't do that. It's even a greater invasion of privacy, I think, than anything contemplated by the health department." And I thought they understood that.

I said, "If you want to have masturbation clubs, that's fine. But I'm not going to stand up as the health director and talk about masturbation." Well, I gave the press conference, and a few of the people who were standing behind me, literally standing behind me at this presentation, went after the press and said, "I'm not going to support Silverman. I'm sorry, I didn't know he meant no sex in the bathhouses." One of the first things that really upset me was the fact that you

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[1]*And the Band Played On*, pp. 445-446.

couldn't count on people to maintain their support, which is important in an issue which is so sensitive and so intimate.

Reactions from the Gay Community

Silverman: I had been saying all along to the leaders in the gay community, "If I have your support, then I can move ahead and close the baths. I prefer you all to do it, again as a major education impact, but at least if I have your support, we have that education impact." Then one day, I got a call from Marc Conant, who said, "I've got what you want. I've got the gay leadership, asking you to close the baths. I have in my hand a signed document." What he didn't tell me is why they decided to back closure. Why they decided was Larry Littlejohn had made it very clear that he was going to put an initiative on the ballot to vote on whether the baths should be closed. Obviously, Conant and his group thought they'd rather have Silverman close them than the public. On a vote like that, they definitely would have lost. No question about it. Marcus didn't tell me that Littlejohn was the reason for their action.

It was the night before I stupidly announced that I was going to have this press conference [on March 30, 1984], and the stupidity was that I hadn't touched base with the city attorney's office. I don't know the exact days, but let's say just for the hell of it Monday night I hear from Conant, "You got what you want." Tuesday I go to the mayor and say, "I've got what we've been looking for. I'm going to have a press conference tomorrow." Tuesday night members of the gay community say, "Would you please come down to the Valencia Rose and talk to people. They're really concerned about this."

And what ticked me off is I said to Marc, "Will you come with me?" He said, "Yes, I'll meet you there," and he never showed up. It reminded me of cartoons where there is a bomb with a fuse, and someone lights it and hands it to another person, [whistles] and then splits. In fact, that night at the Valencia Rose, the place was packed but only two people who had signed the document showed up, and both of them stood up and said, "We were wrong to sign that asking for bathhouse closure."

Now, obviously it was a stacked meeting, because a lot of bathhouse owners were there. When they were talking about the safer sex programs we had in bathhouses, interestingly, one of the gay men got up and said, "You know, putting a sign up in a

bathhouse about safer sex is like putting a sign up in a candy store saying sugar's bad for you. Once you're there, it's not going to have much impact." I've never forgotten that. He was a lone voice in the crowd.

But just to show you the depth of the concern about closing the bathhouses, somebody who was at that time a friend of mine had been in my office several days before in tears saying, "You've got to close the bathhouses, another friend of mine is in the hospital dying and he only had sex in the bathhouses." So when I was invited to come down to this meeting at the Valencia Rose, I said, "I want you to be there." He was there, and they were calling on people. He kept raising his hand. He was the last person called on. I was waiting for him to say, "We've got to close the bathhouses." Instead, he said, "I think we ought to put signs up in the cubicles." I said to myself, I'll be damned. This was the person crying in my office only a few days before.

Hughes: What had happened to change his mind?

Silverman: The power of the image of government closing the bathhouses, plus the peer pressure, was just too much for him.

So when I came in to work the next morning, I realized what I had been promised by Conant didn't exist. The way it writes up in Shilts' book is that I was somehow pandering to the gay community for political purposes. Politically, I needed nothing from them. The mayor wanted the bathhouses closed. Roger Boas, who was my immediate boss, was not responsive to the gay community. So my actions had nothing to do with politics but with public health.

Randy has Feinstein saying, "Why didn't Silverman have the guts to close the bathhouses?" In a sense, it took guts not to close the bathhouses. The easiest thing I could have done was to close them, the courts open them up, and I shrug my shoulders and say the mayor wanted it done. In short, I very easily could have responded to her wishes and been off the hook.

A gay man who, sadly, has died, whom I had tremendous respect for, said to somebody else who said it to me that he thought I was the single person responsible for more people being alive in the gay community because of the way in which I handled the bathhouse issue. All this back and forth in the press over the summer of 1984, which was very stressful for me, actually was very fortuitous, because it shrunk the issue down. In April, it was a major issue; I'd say my mail was probably

90-10 against closing the bathhouses. By August, it was probably 60-40 for closing them, mostly from the gay community.

Hughes: Why the change?

Silverman: I think because it went back and forth in the press, and Feinstein was dinging me from her limousine in Washington as she was going to see Mondale to become vice president. She was really taking hits on me. So there was a lot of dialogue in the press, constant dialogue. And I think the issue just came down to a manageable size as people had more time to think, and there was more dialogue and more discussion.

Canceling the March 30, 1984 Press Conference

Silverman: Anyway, I came in the next morning after the meeting at the Valencia Rose, and I went to the city attorney's office. That's when they told me, "You can't [legally] close the bathhouses." They had sent me a memo saying, "If you want to close the bathhouses, you can." But then when it got down to specifics, they said, "You can't just close them. Have you had them inspected for unsafe sex? Do you know which ones you want to close, and what the unsafe behavior was?" I said, "Hell no, of course I don't have that information." They said, "Well, you just can't close them."

So I walked down the hall, and Hadley Roff, Dianne's chief of staff, and Feinstein were there, and I said, "I'm not going to close the bathhouses. I can't." Well, I thought Feinstein was going to have a conniption. Hadley said, "You can't have this press conference." So the decision was, I was not going to have it.

Hughes: Am I right in thinking that the March 30, 1984, press conference might have been at the height of the paranoia?

Silverman: Oh, I think so.

Hughes: I'd like you to describe the atmosphere.

Silverman: Well, in Feinstein's office, it was very heated.

Hughes: Who was there?

Silverman: I know Hadley and the city attorney and Dianne, and probably her press person at that time.

Hughes: This was the morning of the press conference?

Silverman: Of what I call the non-press conference. So I walked back across the street to the health department, and in my office were the people who were going to be standing behind me at this press conference. Paul Volberding was there, Marc Conant, some physicians in the gay community, some others. I said, "I'm not going to have the press conference." The reaction was mixed, some people very upset that I wasn't, others I think very pleased that I wasn't. I said, "Just for the hell of it, how many of you now think I should close the bathhouses, and how many think I shouldn't?" The way it comes out in Shilts' book is as if that was the determining factor. I had already decided I was not going to close them at that time. I left the mayor's office knowing exactly what I was going to do. One of the problems I had with Randy was his selective listening. His version is even going to be in the television movie that's coming out this fall, based on *And the Band Played On*.

Hughes: Your mind was made up when you walked in to the press conference.

Silverman: Oh, there was no question. The city attorney said, "You can't do it, because you don't have the necessary evidence to close them down." There was not going to be a press conference announcing their closure! Randy certainly wasn't in the room but had heard I'd taken this vote, and then just assumed that that vote determined my decision against closure.[1] I don't even know why I did it now, but I think I really wanted to see where people were on this issue right then. It was very interesting. The psychiatrists were for not closing the bathhouses. The clinicians who were seeing the patients with the medical problems were.

And then somehow, and I don't know whether Randy got to me or somebody else, but Randy had heard or said, "There are death threats against you." That's when I got the bulletproof vest, so I went into that meeting with the bulletproof vest.

Hughes: Death threats from the gay community?

Silverman: I would assume. The straight community wasn't terribly concerned about this issue.

I remember walking into this meeting in a big, big, two-story room on the third floor of the health department. I was

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[1]See *And the Band Played On*, pp. 442-443.

escorted up there by two plainclothes policemen. I think it was overkill--bad choice of terms--in regard to protection. I wore the bulletproof vest mainly for my wife, not for me. I really wasn't terribly worried.

I am used to joking around with the media when I go into press conferences--"Hi, Sally, hi Joe, how are things going, what's new?" Since I knew something they didn't know, which was that I was going to walk in there and not have anything to say, it was almost like a Fellini movie. It was sort of out of focus--you know how they sort of blur the picture in a movie. I thought I saw somebody standing there with a towel wrapped around him. I remember going up to the front, and there were more microphones than had ever been placed before me, more television cameras than I had ever been before.

And then I got up and said that I was not going to close the baths. I didn't want to be explicit in what I was going to do, because I didn't want to tip my hand as to what the issues were. I said something to the effect that there were some legal and medical issues that I wanted to investigate.

Hughes: Here's the picture of the press conference.[1]

Silverman: Oh, there it is. [laughs] This was, as I say, just a blur. I walked in, I said my few things, got up and walked out. I had never done that before, because I've always been very open. I said, "I am not discussing the opening or closing of the bathhouses at this point. I am looking into facets of the issue, some of which have basically nothing to do with medicine," which was the legal thing, "and some which do." And I'm not sure what the "some" would be. I may have thrown that in just to throw people off a little bit. But the real issue was the legal aspect.

Hughes: But wasn't it also this desire of yours to work with the gay community, not just to legislate?

Silverman: And I thought I had done that. That's why I gave you that timing. I thought when Conant called me and said, "I've got what you want [a list of gay leaders supporting closure]. We were there. I have the support." Carole Migden was on the list, and a whole bunch of other people. That's why I was so exhilarated that we were finally at that point. That's why I

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[1]Randy Shilts. Silverman delays on gay bathhouses. *San Francisco Chronicle*, March 31, 1984. (Gay and Lesbian Historical Society, folder AIDS 1-3/84).

decided to close the bathhouses. My biggest mistake, of course, was calling a press conference before I really understood what the legal ramifications of closing the bathhouses were. That was the real issue.

Hughes: What was the reaction in the room when you made that announcement?

Silverman: Well, there was applause by these jokers in the towels. There were cheers and all that, which I wasn't looking for at all. Of course, what happens when you do something like that is there are a thousand questions. But, I just walked out.

I conferred with the city attorney, and we talked about regulations. Now, that's when I called in this health director's medical advisory group, and we agreed to what the regulations would be, which was basically no sex between individuals. I then called the press conference later on April 9 [1984].

Hughes: Yes, the regulations were proposed on April 9.

Silverman: Yes. I didn't realize it was actually that fast. It seemed like it was longer. But then Wendy Nelder said, "Shameful delays in proposing sex guidelines." I guess the specific guidelines came later.

Hughes: You proposed having regulations, but apparently it took a while to formulate them.

Silverman: Yes. And then some members of the board of supervisors proposed transferring the bathhouse authority from the police department to the health department. Then they delayed and ultimately failed to give me the authority, and that was Britt's doing.

Hughes: So the issue does go on a while.

Silverman: Yes. And while that's going on there is a lot of debate.

So then I called together that advisory group. Probably it was in late August, when I realized I had lost on the regulatory front, and I got a mixed response to the question of closing the baths. It wasn't unanimous at all from this committee.

Deciding to Close the Bathhouses ##[1]

Silverman: I remember walking out of the meeting and saying, "I've met with the community enough; I've met with advisors enough; I'm just going to make the decision and I'm going to follow through." And that night I said, "I'm going to close them." I knew what I had to do. I set about sending the inspectors in to the bathhouses. We sent them in; they came back; we looked at the reports; we spent a lot of time over at the city attorney's office seeing how we would proceed. And then I had that press conference which I guess was on October 9, closing all the bathhouses where unsafe sex occurred. We had inspected gay and straight bathhouses, so there wouldn't be discrimination. Then we did it [closed them].

Hughes: By the time you closed them, the virus had been isolated. Did that make your case easier?

Silverman: At this point in time, I think I would have done it without that. But it certainly helped. Initially, with all this Feinstein pressure, we didn't even have the virus.

The Mayor's Reaction

Hughes: Why were the bathhouses such an issue for Feinstein?

Silverman: Well, I can tell you what the surface issue was, and then I can tell you what I think the real issue was.

Hughes: I want to hear both.

Silverman: The surface issue was, you had a place where people went who practiced unsafe behavior. If you closed them down, you then saved lives. Simple, A equals B, B equals C, then A equals C.

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[1]See Silverman's declaration in support of a Temporary Restraining Order to close the bathhouses, Superior Court of the State of California, City and County of San Francisco, October 10, 1984. (Dean Echenberg papers, Bureau of Epidemiology and Communicable Disease Control, San Francisco Department of Public Health, drawer: Bathhouses, folder: 10-10-84 Declarations in Support, vol. 1.) See also: Press statement of Mervyn F. Silverman, October 9, 1984. (Same reference, folder: Sex clubs/bathhouse.)

Feinstein had even said it: "If you can save just one life--." Well, my feeling was, if we pushed people out of those baths--as they said, out of the baths and into the bushes--then we had absolutely no ability to reach them. Or, if we closed the bathhouses and they were reopened by the courts, then the impact that the health department could have would be minimized and more people would die. A little more abstract than, go to a bathhouse, get sick, and all that.

If the mayor felt so strongly about saving lives, why would she have canceled this hearing we were going to have to set the necessary action into place? What I think is, she wanted me to clean up the city. It was abhorrent to her that these things [bathhouses] existed. Now, interestingly enough, not abhorrent enough to do something politically about it, because bathhouses were regulated already for sanitation; there was absolutely no regulation on sex clubs. None. We charged $300 to license a pretzel vendor, and yet sex clubs, which were making tons of money, were unlicensed. There was never a political move, and I think what she wanted me to do is to do it for her--clean up the city.

The mayor, unbeknownst to me, sent police inspectors into the bathhouses.

Hughes: Unbeknownst to you?

Silverman: Oh, yes. I had no knowledge of it.

Hughes: Why?

Silverman: She wanted to find out what was going on in the bathhouses. Then she showed me the report.

Hughes: But why would she have done that without consulting you?

Silverman: Because I guess she felt frustrated. I don't know.

Hughes: And she thought you might--

Silverman: I don't know what she thought I might do, but she sent them in, and sent me the report, and I looked at it. There were a number of things that obviously indicated high risk behavior. There were a lot of things in there which had nothing to do with high risk behavior, but that were abhorrent to her. The interactions that took place in these locations were basically abhorrent to the mayor. I think sex is an issue for her. And especially this kind of blatant, raw sex.

Hughes: In her city.

Silverman: In her city. You could see how upset she was about some of the things in the report. I'm sitting there thinking to myself, Yeah, there are some things that don't appeal to me, but they don't relate to AIDS necessarily. They related to this sort of crass sexual activity.

Hughes: Well, it's an illustration of how personality enters into history.

Silverman: Absolutely. She had a special feeling for the police department and ignored the existing regulations placing authority for the bathhouses under the police. So she was upset at any action she thought might involve them and when the time for action came near to the Democratic Convention, she didn't want any action at all. This doesn't sound like an overriding concern for health to me.

Then the other problem is that Harry Britt was there [on the board of supervisors], and I think Harry was the most ineffectual supervisor we've had, and certainly ineffectual for the gay community. Oh, he was dancing from one side to the other, and he was against closing, and he was for closing--whatever way the winds were blowing. [tape interruption]

Leon McKusick's Studies[1]

Silverman: Then I found out through [Leon] McKusick's studies that the education activities were ineffectual.[2] When people were

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[1]For a summary of McKusick's reasons for supporting bathhouse closure, see: Memo--Bathhouses and Public Policy, Leon McKusick to Mervyn Silverman, April 3, 1984. (Dean Echenberg papers, Bureau of Epidemiology and Communicable Disease Control, San Francisco Department of Public Health, drawer: Bathhouses, folder: Sex clubs/bathhouse.)

[2]Leon McKusick, William Horstman, and Arthur Carfagni. Reactions to the AIDS epidemic in four groups of San Francisco gay men. Study conducted November 1983. A report prepared for the Department of Public Health, City and County of San Francisco, 1984. (Dean Echenberg papers, Bureau of Epidemiology and Communicable Disease Control, San Francisco Department of Public Health, drawer: Bathhouses, folder: 10-10-84 Declarations in Support, vol. 1.)

asked, "What do you know about AIDS?" there was a fairly good knowledge base. When they were asked, "Where did you learn about it?" it wasn't from the bathhouses. And also, people were reporting back that when they went into bathhouses and there might be a bowl of condoms, or there might be a poster. But when they went into the back room, there were the orgy rooms and the glory holes. I realized I was being lied to pretty much by the bathhouse owners. Some of the places they swore to me that they had closed up the glory holes, they obviously hadn't.

So I wasn't getting the cooperation of the bathhouse owners. I had been informed that the parking lots reflected a real decrease in clientele but it started to increase again. See, business was bad and bathhouses were closing, so there wasn't as much of a push to close them. I mean, if they closed on their own, we would have accomplished what we wanted while maintaining the cooperation of the gay community. But when I got the sense that business was starting to increase, along with the fact that I had tried everything else and had failed, that I had worked with the community long enough, that the community was educated now... I mean, they really knew the issues, as opposed to '83, when people were debating whether educational materials could even talk about safer sex. Then I thought, All right, I think we're at that point where we're just going to close the bathhouses. And we did it. And then they were reopened.

Hughes: Did you look upon the Larry Littlejohn initiative as another thing pushing you to make a decision?

Silverman: Oh, no. That was the reason Conant got his group to sign on to back bathhouse closure by me. They were afraid that Littlejohn's initiative would get on the ballot, and it would be voted in. Conant didn't tell me that in the phone call. The Littlejohn initiative didn't push me. The Littlejohn initiative pushed the leadership of the gay community to say, Silverman, not Littlejohn, should close the baths. Littlejohn really wasn't my issue.

The Baths Reopen

Silverman: After I closed the bathhouses, [San Francisco Superior Court Judge Roy L.] Wonder came out saying, "The bathhouses can open,

but--" and then he put into effect all of the regulations concerning safer sex that I had tried to get in before.[1]

When Feinstein was questioned, she was just about ballistic that he had reopened the bathhouses. And when they asked me, I wasn't. Because, I said, "If there is no unsafe sex taking place, I don't care if they reopen." And I think that showed vividly what I knew all along, that the issue was the bathhouses and not AIDS. It was clear to me, if you don't spread the disease in there, then the bathhouses are not a health issue.

Hughes: Had Wonder literally picked up your regulations?

Silverman: I think almost word for word.

Hughes: So you got what you wanted.

Silverman: Yes. I think in fact there is a statement in one of the press articles that Silverman was vindicated. It demonstrated that, in fact, the bathhouses would have been reopened by the courts no matter when I closed them, but I don't think they would have been reopened, if I had closed them in '83, with that kind of regulation. If I had my 'druthers,' would I have done it that way again? Knowing what I know now, I'm not sure, but knowing what the situation then was, I think it was the proper way to go.

Civil Liberties versus Public Health

Hughes: You couched your arguments for keeping the baths open in terms of AIDS education and cooperation with the gay community. I'm wondering to what degree you also saw the issue as one involving civil liberties as opposed to public health issues?

Silverman: Well, I have been criticized, along with a number of other public health people, of being more concerned about civil liberties than public health. My feeling has always been that when public health and civil liberties come into conflict,

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[1]See Modified Preliminary Injunction, signed by Judge Wonder, December 21, 1984. (Dean Echenberg papers, Bureau of Epidemiology and Communicable Disease Control, San Francisco Department of Public Health, drawer: Bathhouses, folder: Sex clubs/bathhouse.)

public health wins. During a smallpox epidemic, you don't worry about confining people; you do it.

However, with AIDS, civil liberties and public health are consonant. I did not see the bathhouses as a civil liberties issue. There are certain places where things are allowed, and certain places where they're not. You can't have sex at McDonald's. You generally cannot have sex in the pews of a church or in a synagogue. People don't feel their civil liberties or civil rights are being in any way abrogated because of that. So I don't think the reasoning was really civil liberties.

I think where the civil liberties issue came in, and where I'm sure it had some effect, if people saw government closing the bathhouses, the issue would become civil liberties, civil rights, homophobia, whatever, and not AIDS. And what I was trying to do was keep it AIDS.

Now, as I said, until I closed them down, I was trying to work with the community to have a behavior change that spanned the whole community, not just the bathhouses. When I closed them down, I made it very clear that this did not in any way take away from civil liberties; all it did was say, "In certain situations, certain behaviors are not allowed," and we do that throughout our daily lives. You can not drive fifty miles an hour down the street. You can not stand out in the street and yell at three o'clock in the morning. What we were saying is that commercial establishments like the bathhouses can't allow penetrative sex.

Hughes: And yet, elements of the gay community were putting the bathhouse issue forward as a civil liberties issue.[1]

Silverman: Oh, most certainly, throughout the entire episode, and afterwards. And what I said is, "In your bedroom, you have the right to do whatever it is you want. When you have commercial establishments that foster the spread of a disease that is lethal, especially at the same time that the city is being asked and even demanded by the very same constituency who might frequent such places to do something with regard to education and care, there seems to be a real paradox." To have these

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[1]See, for example: Press statement of civil rights and lesbian and gay community organizations. October 10, 1984. (Dean Echenberg papers, Bureau of Epidemiology and Communicable Disease Control, San Francisco Department of Public Health, drawer: Bathhouses, folder: Sex clubs/bathhouse.)

clubs operating--some of them with no inspection and no regulations--to me didn't make a lot of sense.

Hughes: Did the actions you took in the bathhouse episode extend the powers of health department?

Silverman: The powers of the health officer in most cities and counties in the United States are incredibly extensive. They are far-reaching. Now, you can't be capricious; if you are, you could be held personally liable. I kept a part of the financial district [of San Francisco] closed for several days, even though the fire department and police department thought they could open it up, because PCBs had been spilled as a result of a transformer explosion. I could close City Hall. I could close any police station, any restaurant. I could close your house down; I could evict you from your house. I really in a sense had almost more power than the police have. So I always dealt with that power very judiciously.

In answer to your question, in one sense, yes, it did extend the power, because I don't think there had been a situation where a place was closed for public health reasons solely because of activities that were taking place rather than because of raw sewage, contaminated air circulating--what have you. So this was a legal departure, but certainly I don't think it was any departure at all from the powers invested in the health officer.

Hughes: Did you enforce public health policy differently in the AIDS epidemic than in other epidemics?

Silverman: In a sense yes. People have said, "Why are you treating AIDS differently than other diseases?" With other diseases we have testing and reporting, and we don't place such emphasis on maintaining absolute confidentiality and protecting people's civil rights. Why is AIDS different? I think because of discrimination, we have to do things differently with AIDS than we might do with, say, polio. It created, and still creates today as we speak, incredible barriers and reactions by others to people with HIV, people who have AIDS, people who care for them, and people who are family members.

So we do things differently, because it is a different epidemic. It is not like others. The virus behaves like many other organisms, in a sense. But the way in which society behaves is totally different, and therefore the epidemic has to be dealt with differently.

Assessing the Decision Regarding Closure

Silverman: I look at public health like a physician should look at the human body. The community is the organism, if you will, the human being. If you have a heart problem, I wouldn't want to give you heart medicine that destroyed your liver. So even though this drug works for your heart, it's almost like "the surgery was a success but the patient died." In your zeal to cure one problem you don't want to create an even bigger one.

If bathhouses were the only place that people were being infected, closing them wouldn't have been an issue. It was very clear that 90 percent of the gay community was having the same kind of sex, maybe with fewer people, maybe a little variation on the theme, but from everything I heard, it was risky behavior. Anal intercourse is risky behavior. That was the predominant mode of sexual activity. We weren't sure at that time where oral sex placed on a risk scale. I didn't want to politically solve this problem while a bigger cancer was growing, and that bigger cancer was the unsafe sexual behavior throughout the community.

Dean Echenberg, who was my communicable disease person, took over after Dritz as head of the health department's Bureau of Communicable Disease Control. He is convinced that the rate of rectal gonorrhea dropped about 85 percent--not down to 85 percent; dropped 85 percent from about late 1981, early '82, until the time I left [December 1984], and then it even dropped further. We used as a surrogate marker the rate of rectal gonorrhea, which obviously is a very good marker for homosexual activity. He is convinced that it was because of the messages I was putting out there, along with seeing the impact of this disease. I mean, you can't get away from that.

Our city clinic, which was basically a STD clinic for gay men, was packed solid when I went to visit it as the new director of health. When I went back there in '83 or so, you could hear a pin drop. The place was literally empty. Not because people were going somewhere else. The rectal gonorrhea rate had dropped dramatically.

Hughes: So the message was getting through.

Silverman: The message was getting through. My biggest fear was that if people didn't see the health department as a partner in their health care, but rather saw it as the policeman, which is what would have happened if I closed the bathhouses and they

reopened in the early eighties, we wouldn't have been the force that I think we were able to be.

That point does come out in *Cities on a Hill*.[1] I think the author captures that, and that's really where I was at. Now, I can't say that I was clear of mind all the time. This [the bathhouse issue] was one of the most difficult things that I've ever dealt with, and the problem was compounded because there was nobody there to help me. Feinstein was saying, "It's very obvious." I said, "If it's so damn obvious, why am I the only health director considering bathhouse closure? None of my colleagues are considering it anywhere in the country."

Hughes: You were talking with them?

Silverman: Oh, yes. I became president of the U.S. Conference of Local Health Officers in 1984. So I looked on the surveillance list for AIDS, and took the top ten cities, called their health officers and said, "Let's have a meeting. I want to meet with all of you guys and gals. Let's get together." I said, "And bring your educational materials."

We got together. I walked in the room, and what do I see but our education materials with their name on it, and everyone looking at me. [laughter] And so if it was such an obvious public health answer, then why was I the only one being asked the question? To this day, there are public health officers that don't want to see bathhouses closed in their communities.

Now, my position today is that unless there is only masturbation going on, mutual or single, whatever, in a bathhouse, that I can't condone their opening. Now someone would say, "Gee, that doesn't sound the way you sounded before." Well, we're at a different point. Everyone knows the issues. Bathhouses no longer are the symbol of gay liberation.

And that's why I purposely used in my statement, "Bathhouses aren't a symbol of liberation, they're a symbol of death." I chose my terms carefully. This was the place where you could go quietly from your "straight" public existence, have sex, protected--no cop was going to hassle you, and nobody was going to bash you--and then walk back out and you were in the straight community again. Yes, initially the bathhouses were a symbol.

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[1]Frances FitzGerald. *Cities on a Hill: A Journey through Contemporary American Cultures*. New York: Simon and Schuster, 1986.

Hughes: Well, it's an important point. I think one of the reasons why the epidemic was handled differently in this city as opposed to, say, New York, was the cohesion of the gay community. It was an organized political force. It had created a place where gays could be themselves, and then the epidemic hit. The information I've gotten is that the gay community in New York was not as cohesive.

Silverman: Yes, and New York just being New York.

Hughes: Exactly, there were so many other issues.

Silverman: And there was a lot of fighting within the gay community, and there still is, because the gay community is not monolithic. There is every color and stripe.

But we had many things going for us that other communities didn't. We had a caring community, gay and straight. We had a supportive executive and legislative branch, we happened to have a budget surplus, and we were talking about a disease of gay men primarily, not of drug users. That's a much different community to deal with, whether you're talking about services in clinics or services on the wards. When the wards at San Francisco General started getting some drug addicts, some staff started leaving who had stayed longer than anyone would have believed under the emotional pressure. The gay man was very appreciative of what was being done, supportive, and followed what was being asked of him.

Resigning as Health Director

Hughes: Let me ask a final question on the bathhouse issue: you resigned in December, 1984.

Silverman: Effective January 15. That's the date that the commission began.

Hughes: Well, explain that, please.

Silverman: There was a move, an initiative, to separate the health department from the CAO and put it under a health commission--

Hughes: What's the CAO?

Silverman: The chief administrative officer--Roger Boas, at that time. I worked for Roger Boas; I knew that whether or not this passed,

I'd be out of a job. (Boas would try to get rid of me for supporting the health department's removal from his office and, for reasons I will explain, Dianne would want me to leave.) But I went out and supported it. The reason I did is because the health department is much bigger than I am. You see, the way the system was, if you had a problem with the health department or health situations in the city, you had only one person to go to after the health director and that was the CAO, and if he or she didn't want to listen to you, that was it! And I thought the health department was too much of a community organization not to have real community input. I thought a health commission was important.

Now, the minute it became a health commission, the health department would be under the mayor. That would put me under the mayor. And I was aware, because of Dianne's and my differences on this bathhouse issue, plus her lack of support for me when I had some other problems at the hospital early on, that that was probably going to mean I'd be out of a job.

So when it passed, as I say which I supported, I went to meet with the mayor, and it was very clear she wanted her own health director. It was a mutual 'splitting of the blanket.' She kept me on as a full-time consultant for three months, and then it was going to be as a half-time consultant for the next three months. I think I brought in over a million dollars to the city. I was the reason why we have anonymous testing sites around the country. Another interesting story which may not be of any import here.

They were actually asking me to stay on full-time, and I wouldn't do it. On a half-time basis I was still getting dinged by [San Francisco Supervisor] Quentin Kopp over things, and I figured, What do I need this for? So I actually could have stayed on, but at the end of the six months, I just left totally.

If the situation were different, I probably would have stayed on as health director, but when you don't have the mayor's support behind you, that's a very vulnerable position. I've said often that I was happy and challenged--I loved my job, and people thought I was crazy, with all the controversy here. But I didn't mind trying to slay the dragons out there as long as I had somebody behind me. Well, when you lose that backing, and I realized that I had lost it with Feinstein, then you're in a very untenable situation. You have to constantly cover your flanks.

Hughes: That period must not have been fun.

Silverman: It really wasn't. It was very, very difficult. A lot of the difficulty was wondering if I was doing the right thing. There were a lot of sleepless nights.

Hughes: I heard that you lost weight during this period. Is that indeed true?

Silverman: I could have used the weight loss, but I don't think I did. I think I probably showed the strain in my face.

Hughes: It took a physical toll.

Silverman: Yes. People see me as fairly ebullient, and I don't think I probably was very ebullient during that time. I certainly didn't want to do things that were going to result in more death and dying, whether it was from not making a decision or making a decision. It wasn't terribly clear all the time that the way I was going was necessarily the best, even in my own mind. But I didn't want the unsafe behavior continuing in bathhouses. It was very clear that they needed to be closed. It was how to do it in a way that didn't cause more problem rather than less, and that was where the dilemma was, not whether they should be closed.

There are still some people out there upset that I closed them, but I don't think very many. However, I don't think there's anyone out there who thought I was homophobic, that I was doing it for that reason. I think all of them, even if they were on the other side of the issue, realized that it was something that I was grappling with. I can live with myself.

As I say, I've thought long and hard, would I do it exactly the same way? In general, yes. Knowing what I know now, I probably would do some things differently, but I wouldn't close the bathhouses immediately. I certainly wouldn't hold that press conference, either. And I might deal with the gay community in different ways, to try to further encourage them, maybe give them an ultimatum: "Well, listen, guys, I'll give you to this day, and if I don't get support from you, then I'm going to take action," statements like that.

Hughes: So no regrets in terms of this episode?

Silverman: No. I'm glad I went through it. As I may have mentioned to you before, I would do it <u>all over</u> again, but I wouldn't do it again.

Hughes: [laughs] Yes, you did say that.

Silverman: It was an incredible period; it was an exciting period; it was challenging. There are a lot of health officers who haven't experienced it and won't, and I don't think they're better for it even though it saved themselves the aggravation. Not me. I think it was a very, very challenging time.

When it became a problem is when I no longer had any political support. Then that was untenable.

Hughes: Did you feel betrayed at that juncture?

Silverman: Oh, yes, I think to some extent. But you see, I had expected it.

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Silverman: The mayor was somebody that I would have obviously gone to bat for--I mean, I may in the back room have said, "What the hell is going on?" but I was going to bat for her, and she didn't have the courtesy to pick up the phone and say, "Merv, what's your side on this issue?"

She took potshots at me when she was in Washington in a limousine with a political reporter, which is in Randy's book, saying, "Why didn't Silverman have the guts to close the bathhouses; if it related to heterosexuals, he would have closed them." Which was true: heterosexuals didn't have the bathhouse issue as a symbol.

Feinstein got wind of the fact that I was upset about her position on the hospital problem I mentioned before, and I remember after one of our general meetings of department heads she called me into her little private room and said, "I hear you're upset with me." I said, "Absolutely." She said, "Why?" I said, "Because you didn't even pick up the phone to call me. We've worked together all this time, I was with you in this city and that city, we traveled together, I've always supported you." A lot of people thought I was crazy, especially the gay community. Many didn't like her. And I was arguing in her favor.

She said, "Well, you work for Roger Boas." And I said, "What are you talking about? You and I are on the phone every day. I don't talk to him for weeks. You and I sat up all night working on the strike at San Francisco General; he was at home sleeping. We've had a relationship." She sort of danced around. So she was really doing a number on me.

Hughes: Was it in an attempt to distance herself from the whole issue?

Silverman: Well, no. It was to be on the "right side" of the issue.

Silverman's Recent Positions

Hughes: You went straight to AmFAR [American Foundation for AIDS Research] after resigning as health director?

Silverman: No. Interestingly enough, I went with AMI [American Medical International], which was a for-profit hospital corporation. I was going to become their spokesperson, a very lucrative thing for me. We were going to have our own TV studio, and I was going to be their point person. Then their profits started going down, and they decided to eliminate the whole concept. I worked with them for about seven months, and I was also doing some consulting in Africa, family planning.

January of '86, I came on with AmFAR half-time, and about the same time went on half-time with the Robert Wood Johnson Foundation as director of the AIDS Health Services Program. I've been doing nothing but AIDS since then, except one consultation, which has ended, in Santa Clara County dealing with the reorganization of their health system.

Hughes: Is that all right that you're focused fully on AIDS?

Silverman: Probably not all right for an ultimate career kind of thing, because you get typecast. But certainly all right because it's so challenging, and it's something that I think I can contribute to. I have absolutely no regrets about any of this, including leaving the health department. I was planning to do it when I turned fifty.

Hughes: To leave the directorship of the health department?

Silverman: To get into some corporate situation in order to make some money so I'd have something for retirement. I'd been in federal and city government; I hadn't really developed any retirement fund. I was getting a little antsy about that. Also, people had told me when I first came to San Francisco, "Don't stay in the health department longer than five years. You really ought to get out."

Hughes: Because that's typecasting too?

Silverman: No, just that it starts turning against you. If you look at most positions, it doesn't matter what department you're in,

that happens. Whether you're the mayor or whatever the position is, there's a time frame. Now, I'm glad I didn't listen to them, because the AIDS epidemic occurred in the last part of my term, two and a half years beyond the five.

[Interview 3: July 6, 1993] ##

Hughes: You were quoted in the book *AIDS and Patient Management*, in which you had a chapter called "Addressing Public Health Concerns in the City of San Francisco," as saying, "The screening test is a good screening test for blood. It is not a good test for people." Would you like to amplify on that?

Silverman: Well, at that time [1986], we couldn't do too much with the test. The results of the test didn't change your treatment schedule, because there was none at that time. Obviously, if you were donating blood, the blood should be tested. But testing people did not make any sense at that time. I initially was a little reluctant to encourage testing, because the message would be the same. In other words, if you're negative, stay negative, and here's how to do it. If you're positive, don't get reinfected and don't infect others. Here's how to do it. The message was basically the same.

An individual from Australia heard me say that, and he said, "I think you're selling the community short. I think there's much more that can be done. Certainly there is the impact of the testing on the message that you give. If a test is positive, it can be a powerful factor in motivating behavior change." And I reevaluated what I was thinking about, and really within months encouraged people to take the test.

I guess what I was saying here is, they're testing people in the military. They're testing people for insurance. It's not part of a diagnostic workup; it's not part of a treatment plan.

Hughes: It's the social implications.

Silverman: It's the social implications. I was encouraging people to get tested through anonymous testing sites. I reevaluated my position probably over thirty days from the time the test was available. I realized that when someone is a smoker, you can take their chest x-ray and put it up on the light box and say, "Look at your chest. If you keep smoking, I don't know what I'm going to do." Now, the chest x-ray may be negative, but to the untrained it always looks strange. The point is that the x-ray film serves as a further reinforcement for the message you're trying to give.

Testing Advocate

Silverman: As I reviewed my position, it seemed that taking the antibody test was not a bad idea. Again, I wanted it done in a way that would not come back to haunt anybody from the social side. I became a real advocate of testing, I'd say, from April or May of '85.

Hughes: One other use of the test, before early drug intervention was possible, was to inform people that they were HIV-positive, and discourage further transmission.

Silverman: Well, that's what I said. You should be counseling somebody who's engaged in high-risk behavior that, regardless of what the test result is, you should not be having unprotected sex. If you're positive, I don't want you to be reinfected; I don't want you to infect others, so properly use condoms. If you're negative, I don't want you to get infected, so use condoms properly. Therefore, the message really was the same regardless of the test result.

Incredibly, early studies showed that people who learned they were HIV-negative ended up having more unsafe acts than people who were HIV-positive.

Hughes: Yes, that was one of the arguments.

Silverman: Believe me, I don't want to try to get into the psyche of the gay mind, but there was the idea, "If I'm positive, I don't want to hurt you. If I'm negative, if I get it, I get it." Self hate. There are a lot of issues that people go through who come to grips with their homosexuality. So it was almost a sense of altruism on the part of the positive, and a sense of who knows what on the part of the negative.

Hughes: Well, that sort of argument was used by some of the blood bankers when the HIV antibody test was developed. Their argument was that if a member of a high-risk group did indeed test negative, and the validity of the test was not at all ascertained, that this might encourage promiscuity and unsafe sex practices.

Silverman: Well, I don't know if it would encourage promiscuity, but it might encourage you to continue your behavior, whatever it is. The questions asked before donating blood should eliminate you: "Have you engaged in A, B, C, D, E? If you have, we'll chuck your blood." However, one could argue that the markers could

be there for someone who didn't believe they were at risk, and so it might help.

Blood Screening

Silverman: I think there was probably a sense of fear of losing a lot of the donated blood supply because a lot of donors were gay men.

Hughes: Oh, there was that fear.

Silverman: I was upset at some meetings, international meetings and such, where blood bank people were more concerned about maintaining the volume of the blood supply--and obviously they should be concerned about the supply of blood--than they were about the risks to people who might be getting that blood.

Hughes: I have read that the blood bankers felt very strongly that they had the prime responsibility of preserving the volume of blood donation, that it was much more harmful to society to not have a unit available when somebody really needed it than to run what they considered to be a rather slight risk of transfusion AIDS.

Silverman: And I think that's true if physicians use blood only in life-threatening situations. If there's anything good that has come of this horrible epidemic, it is a rethinking of when blood should be transfused. It used to be if you came out of surgery and you looked a little weak, they might give you a unit of blood to perk you up. Now that's changed for the good.

Setting Up Anonymous Testing Sites

Silverman: As president of the U.S. Conference of Local Health Officers [1984], I had written a letter to [Secretary of Health and Human Services Margaret] Heckler, because the HIV antibody test looked like it would be approved soon. There was no interest, it seemed, in setting up anonymous testing sites, and from the few surveys that we made here, it was very clear that many gay men would be going to the blood bank--this was before the fear

of discrimination resulting from taking the test--to find out whether they were infected or not.

I wrote a letter to Heckler basically saying, "We've got to set up outside testing centers, anonymous testing sites, so that we don't actually further contaminate the blood supply by encouraging gay men to donate blood in order to be tested. If I don't get some response in a couple of weeks, I'm going to have to go public with this thing."

I didn't get any response in two weeks, so we put out a press release, which I didn't realize was going to be seen by HHS before the press conference. The Public Health Association, APHA, was going to be co-sponsor of this thing. I didn't know that my press statement was issued on Wednesday night--this was going to be a Thursday press conference release.

All of a sudden I get this call from Frank Young, the commissioner of FDA [Food and Drug Administration], and Heckler's special assistant, who I think was sent to jail for something he was doing in the department. My press statement was a warning to the nation that its blood supply could be contaminated if alternative testing sites were not set up. Young and Heckler's special assistant said, "How can you say this?" I said, "Because I believe it." At that time, we didn't know how accurate the antibody test was, because it was information kept secret by the company [Abbott]. We didn't know how many false negatives, false positives the test produced. Well, to make a long story short, by the end of the call, I had $12 million, and they set up anonymous testing sites around the country.

The Epidemic's Impact on Medicine

The Doctor-Patient Relationship

Hughes: Do you have ideas about what effect the epidemic has had on medical practice?

Silverman: Yes, there are several. One, the issue of blood supply. Two, changing some of the very sloppy techniques that we had in clinics and hospitals and emergency rooms, dealing with body fluids and needles and sharps of all kinds. Three, it's certainly changed the doctor-patient relationship in a very

positive sense. Merle Sande from San Francisco, who is chair of an NIH advisory panel, said in the paper over the last week, "If you're going to use AZT, that should be discussed with the patient and the decision jointly arrived at."[1] Historically, medicine has been top down. The decision is arrived at by the physician, and he or she tells you what it is.

Hughes: Isn't that a result of the ambiguity of science at the moment, the fact that it isn't clear that early drug intervention in AIDS is beneficial?

Silverman: Yes, but it wasn't clear several years ago.

I have always believed that there ought to be a partnership in medicine, and I was preaching that long before AIDS. I think it would reduce malpractice suits, because you don't generally sue your partner. But if a stand-offish physician tells you what you should do, and it doesn't work, then [the patient] may be upset and sue. So that's a non-altruistic reason for physicians to form a partnership with their patients.

I also believe that patients do better when they're part of their therapy. It became a reality with AIDS, at least with physicians in this community and some of the other communities. It's also allowed physicians to break out of their very stiff mold and think of alternative therapies, which before the epidemic they would have totally discarded out of hand. Physicians, many of whom were gay men themselves, were frustrated and realized that they didn't have much to offer to patients, decided, why not, let's do it [alternative therapy]. But maybe you should let me supervise your health care while you're doing whatever it is you're doing. I think that's also a potential plus.

The whole program of the Robert Wood Johnson Foundation, utilizing the San Francisco model, is a plus because it certainly can be used in any chronic situation, whether it's cancer or Alzheimer's or whatever--the idea of case managing or care coordinating with the patient, generally trying to emphasize out-of-hospital care when it's appropriate. So it doesn't have to be utilized only with AIDS. What we did in a number of cities throughout the country was bring people to the table who hadn't been there before. Eventually you get some coordination and collaboration which also hadn't happened

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[1]Lawrence K. Altman. Government panel on HIV finds the prospect for treatment bleak. *New York Times*, June 29, 1993, C3.

before. So the process is another positive impact of the epidemic.

Hughes: It seems to me another voice in this movement has been the patient himself, herself. I'm thinking particularly of the gay community, which is, speaking in generalities, an informed, intelligent group, which when this epidemic struck set about to become informed about AIDS. In some cases, patients perhaps went with more knowledge to a physician than the physician himself had.

Silverman: Not perhaps; in most cases. That's definitely true.

Women with breast cancer and other cancer patients are looking at AIDS activism and saying, "Why aren't we doing the same thing?" Of course the difference is just what you said, gays had a community before they were affected, whereas the cancer community is--

Hughes: Too dispersed.

Silverman: Very. That kind of activism has mixed blessings, and I have some real problems with some of it, but some of it has had very positive effects. All the things that I've mentioned are a plus to medicine and a plus to the patient. There may be more, but none others come to mind.

Accelerated Drug Approval

Hughes: Well, I can think of one which is related to AmFAR, and that's the transformation of the drug approval process.

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Silverman: The positive aspects of it are the streamlining of activities at FDA and the appointment of community people to what previously were very much pure scientific review or advisory boards at NIH. Activists said, "If you're going to be studying me, I want to have a say. I may not be able to tell you the microbiology, but I can certainly tell you what it means to me, what the impact of doing this or doing that may be."

It's like Los Angeles County General Hospital, where I did my internship, showing us the formulary. And then they showed us what the cost of each of those drugs in the formulary was and also the costs of the tests that you were doing on

patients--I guess it was the tests even more than the formulary--so that you would have an understanding when you ordered that test what the financial impact was going to be. At that time, there wasn't a lot of health insurance. So when you told the patient, "You need this test," he had to reach in his pocket for $100 or $200. Physicians ought to know those costs and factor that aspect into the decision making.

That's the reverse of having consumers on these boards to tell them what the impact of medical decisions is. Well, for example, if it means I have to be hooked up to a machine in the hospital; that means I can't go to work. Which might change the system so that we have in-home infusions. That's another impact of the AIDS epidemic--more emphasis on care in the home. There are a lot of things that people are doing on an outpatient basis that before were inpatient, and a lot of things done in the home that probably would not have been allowed in the past.

Hughes: There also has been a change in the standards by which the FDA had previously judged a drug. The fact that you are dealing with a lethal disease for which there is as yet no really effective treatment gives a different dimension to how you think about safety and efficacy.

Silverman: Well, it doesn't change safety too much. It does change efficacy. Generally drugs are not released until phase II efficacy trials. I was asked to testify before a committee advising the Food and Drug Administration, and one of the people on the panel had been the counsel to the FDA when I was there, Peter Barton Hutt.[1] He asked me, "Are you really saying that once a drug has been shown to be relatively safe, that people should have access to it?" And I said, "Yes. When you and I were both with FDA, I probably wouldn't have said that. But now, knowing what I know and what I've seen, I would have to support some type of distribution--it certainly wouldn't be putting the drug in the pharmacies--that allows people who have no therapeutic alternative to have a chance at it."

When people say, "I should be able to take any drug no matter what," I don't know that government can sanction that. Those people say, "I don't have an alternative. I'm going to die." Yet, they do have an alternative, and that is <u>when</u> they're going to die. So I think it's important that we still

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[1]Dr. Silverman was special assistant to the FDA commissioner, 1969-1970, and director of the FDA Office of Consumer Affairs, 1970-1972.

have certain safeguards. There obviously were people who died of PCP the day before a drug that could treat PCP became available. And they may have died the day before because they took something that was counterproductive. So I think we have to be sure we don't do more harm than good by accelerating drug approval.

San Francisco Model of AIDS Care

Definition

Hughes: What does the San Francisco model entail?

Silverman: Well, first, let me make it clear: we never set out to establish a model. Most of it was reactive; some was proactive. The model was a care system, basically a case-managed continuum of care with emphasis on outpatient services. And this is how it grew: we had the AIDS clinic. As it became crowded we set up testing sites in the community, and then we needed to take care of people who required inpatient care so we created the dedicated inpatient unit. Then we had to address the question of what do you do with the patient who no longer needs acute care but has nowhere to go? We then looked into emergency housing, long-term housing, hospice care, support care, buddy systems, all these things. What was becoming very, very clear here and everywhere else was that what was making the length of hospital stay so long wasn't the actual condition of the patient, the acuity. It was the fact that there was no place for this person to go. He didn't need acute care, but he needed care, and there was no one in the home to provide it, and a number of other situations.

Because San Francisco is unique and because the health department provides an umbrella of health services, there was a much greater ability to look outside to the community, to bring people together, to say, "Okay, let's get the Visiting Nurses Association to help; let's see about hospice; let's get the mental health people involved and some support groups; let's get the gay community to contribute." Most of the pieces exist in most communities. They just don't seem to talk to each other very often.

And this should not be unique to AIDS. Any chronic health care condition can benefit from this kind of "model." Unfortunately, case management has a different definition

everywhere you go. Sadly, some insurance companies are using case management primarily to manage the case in order to keep the cost down. We were managing the case, or better put, coordinating the care so that the individual got the best care, the most appropriate care. That ended up being an economic benefit to the community. But our purpose wasn't to save dollars, it was to provide the most appropriate care that was needed.

Transfer of the Concept

Hughes: I'm wondering in your experience how transferrable the San Francisco model indeed has proven to be.

Silverman: The concept is transferrable, although it need not necessarily be a Xerox copy of San Francisco's program. The concept is based on getting people who can provide some service around the table, and getting them to reach a consensus on what needs to be done. That service could be through the media, through education or information, through private doctors, private hospitals, public hospitals, public health, visiting nurses, hospice. I cannot believe this model is not transferrable almost everywhere.

Now, you may not have a visiting nurses association in Houston, and in Dallas you may not have a hospice, and in Detroit or Chicago you may not have housing or 'what have you' already available. But the concept is transferrable. The exact image might vary, and it did. In the eleven cities in which the Johnson Foundation developed health care delivery demonstration projects for people with AIDS, there were no two alike. [tape interruption]

It's obvious: New York City is totally different from San Francisco. To say, "You ought to do what we did in San Francisco, and if you do, you'll have the same results," is nonsense. In San Francisco, we had a supportive board of supervisors, a supportive mayor, a budget surplus; the cases were almost all in gay men, not drug users. So the way in which all the aspects of the model apply change totally when you go to where there's drug use, political differences, and financial distress almost all the time. So it makes New York look entirely different. The consensus that you get in New York may be by neighborhood rather than city-wide. But the concept of trying to bring people together to solve problems

that ultimately affect them, either in the delivery of services or what have you, makes sense.

Robert Wood Johnson AIDS Health Services Program

Hughes: Were just eleven cities interested in the San Francisco model?

Silverman: No. There were I think about 100 eligible cities. The criteria for selection had to do with the number of AIDS cases. The Robert Wood Johnson Foundation did site visits on twenty-five. The amount of money available was limited to nine programs, but two of them were double sites. In other words, there were Miami and Ft. Lauderdale, or Dade and Broward Counties, and in New Jersey, Jersey City and Newark. So we funded nine programs, but that meant eleven sites, and the only magic was the availability of funds. It was a $19 million program, going to nine programs serving eleven cities for three years.

Hughes: How was the program implemented?

Silverman: Well, Paul Jelinek of Robert Wood Johnson, who's now one of the vice presidents, and Drew Altman, who's now head of the Kaiser Family Foundation, were impressed with what they saw here. They came out and talked with Phil Lee and myself, and then invited me to come back and interview and see if I would be willing to help them do the final planning and then implement it, which I did. The program actually was housed at UC at the Institute for Health Policy Studies that was directed by Phil Lee. He's now Assistant Secretary for Health, as you know.

The decision was that numbers of cases would be the determining factor. So we put out an RFP, request for proposal, to the 100 cities. I think almost all of them applied. We did a review to eliminate those that just really didn't look like they could do it, for whatever reason, and then settled on twenty-five cities, realizing that we would probably only be able to fund ten to fifteen, depending on how much funding would be needed in each community. New York required more funding because of the complexity, and so we ended up funding nine programs. They were New York City, Long Island, Miami and Ft. Lauderdale--Dade and Broward Counties--, New Orleans, Atlanta, Seattle, Palm Beach County, which was where there was a big brouhaha over the mosquito theory of transmission of AIDS, Newark and Jersey City, New Jersey, and Dallas. So that was the nine programs affecting eleven cities.

What also made them not carbon copies was that only one of the programs was out of the local health department. One was part of the Catholic charities in New Orleans. One in Palm Beach County started with a hospice for other conditions. Jackson Memorial Hospital in Miami received the funds for Miami and Ft. Lauderdale. In Atlanta, it was a community-based organization, Aid Atlanta. In Dallas, it was a community consortium already formed for other purposes. In Seattle, it was the health department. On Long Island, it was the county-based group. In New York it was a joint arrangement between the AIDS Institute and New York City. In New Jersey it was the state health department.

Hughes: Why these particular institutions?

Silverman: That's who applied. I was upset initially that more health departments hadn't applied, but afterwards was glad more didn't, because they were much more resistant to community involvement, and that really bothered me. San Francisco and Los Angeles applied, and did not get it.

Hughes: Why not San Francisco?

Silverman: Well, basically, it was a very poor proposal. I think it was also due to a sense on their part that they were a shoo-in. In fact, Dave Werdegar wouldn't talk to me for six months after that. I remember saying to him, "I'm sorry you all didn't get it, but of course you understand that Phil and I had to absent ourselves from the process." And instead of saying, "Oh, yes, of course," there was no answer. And I think he was angry that Phil and I didn't do something to assure San Francisco would be chosen. In fact, San Francisco had a second crack at it at a site visit, and still didn't get chosen. And Los Angeles I figured would be a shoo-in also, and it was not.

Hughes: Again, because of a poor proposal?

Silverman: I think basically yes. I don't remember the exact reason, because I didn't do the site visit in L.A., and I of course didn't do it in San Francisco, but was very interested. I remember going to Chicago, where I knew the politics, and when we were doing our site visit anyone could come from wherever to talk. The Howard Brown Memorial Clinic, which was the main gay clinic there, came in to talk down the group that had applied. Which was upsetting to me, but it indicated that we weren't going to get that cooperative, collaborative kind of process, so we turned that proposal down. So it varied in communities. Houston just couldn't get it together; Dallas did.

Kathy Whitmire was the mayor in Houston. When we went into her office, she introduced herself. She didn't introduce herself to me, because she knew me through my work with Dianne Feinstein at the mayoral association meetings. But she introduced herself to everyone else there, including her AIDS coordinator! I realized that we had a real problem if she had to introduce herself to her own AIDS coordinator. So that didn't help their proposal--they obviously couldn't get it together.

The Media

Hughes: Would you care to comment on the media's role in the epidemic in San Francisco?

Silverman: They basically did an excellent job. I did have some problems with Randy Shilts, which I think I may have mentioned dealt with his biased reporting. However, I believe this community's journalism, electronic and print, outstripped all others. In fact, in a meeting in New York in I guess it was '85 or '86 on the media's role in the AIDS epidemic, Randy made the point that the *San Francisco Chronicle* had carried twice as many column inches on AIDS as the *New York Times*, *L.A. Times*, and *Washington Post* combined.

Hughes: Amazing.

Silverman: KPIX [TV] was doing a lot. In fact, I was a consultant for KPIX on AIDS when I left the health department in 1985. They had an AIDS reporter. Very few other communities did.

After the media, nationwide, started getting on the bandwagon--probably a bad choice of words--I really felt they were doing more than the government was doing. We needed the media because the government just wasn't doing what needed to be done in the area of public information.

Hughes: As director of the health department, did you use the media to get your message out?

Silverman: Definitely. In fact, I remember doing public service announcements, which they were very cooperative in running on TV. I remember doing one in December of '84 when we had just recently found the first heterosexual case. We had a gay man with AIDS to talk about gay men doing things to protect themselves, and I did one for the heterosexuals.

Hughes: Did your exposure to the media increase with the AIDS epidemic?

Silverman: Well, I always had a very open door to the press. So I was on a first-name basis with probably at least one reporter from every news outlet. I've always felt that they should have access, since we were working for the public.

Now, it increased during the AIDS epidemic, but I don't know if it increased more proactively or reactively. I tend to think it increased more reactively, because AIDS raised so many different issues that pushed so many buttons.

The Federal Government's Response to the Epidemic

Hughes: Would you like to comment on how you view the government's response?

Silverman: With regard to the Reagan and Bush administrations--in a word, abysmal. It wasn't for lack of care and initiative and creativity on the part of many working in the federal government; it was the inability to get anything past the administration that wasn't of the pablum variety.

Hughes: What were the reasons for that?

Silverman: A conservative agenda in the administration. They weren't going to talk about sex; they weren't going to talk about condoms; they weren't going to talk about homosexuality. It took them years to get that first mailing on AIDS to every household.[1] Switzerland I think had already sent a second mailing, and they had fewer cases nationwide than we had in San Francisco. I usually ask every audience I speak to, "How many of you have heard of 'America Responds to AIDS?'" (It is the federal government's information program which until recently provided only the most insipid messages.) Whether I'm talking to fifty or five thousand, I generally get only a few hands.

The public service ads were so unmeaningful. One that just came out several years ago showed a beach ball bouncing across the screen, and the voice-over or the print-over was, "You can't get AIDS from a beach ball." [laughter] To me,

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[1]"Understanding AIDS," a plain-language AIDS-information pamphlet, was sent by Surgeon General C. Everett Koop's office to every American household in 1988. (*Surgeon Koop*, Gregg Easterbrook, Whittle Direct Books, 1991, pp. 54-56.)

that means that if you play with a beach ball, you don't have to wear a condom. This was the kind of drivel that came out, not because there was lack of creativity and initiative, but because the administration just wouldn't allow it.

Hughes: Do you remember when "America Responds to AIDS" started?

Silverman: I would say '87, '88. Some very good people were so frustrated over it that they told the CDC they just couldn't continue to work there.

Hughes: Does this relate to your work in 1987 with some of Reagan's speechwriters?

Silverman: No. That was an interesting thing. Reagan was going to speak for the first time on AIDS at AmFAR's awards ceremony. I was going to be the host for the evening. I suggested that if the speechwriters were going to write his speech, I would like to meet with them, which I did. I spent several hours over lunch going over what I thought the president should say.

I had heard that Gary Bauer had gotten to him too. Gary Bauer was one of William Bennett's domestic advisors, somebody just to the right of Ghengis Khan. He's head of one of these family-values organizations now. After I introduced the president, I was standing off to the side, and my wife was sitting in the first or second row.

As he started giving the speech, we acknowledged to each other those comments that resulted from my input. I was really feeling good, because he was talking about compassion and caring, and the need to fight the virus, not the person--nothing terribly esoteric, but appropriate. And then he went into the second half of the speech, which was obviously Gary Bauer's: "We have to have a test, and the tests have to be mandatory." Then there were hoots and hollers and boos from the audience, and of course, that's all the media picked up.

I remember complaining to one of the media people that the first part was not covered, not because I had written it, but because it was so important for the nation to hear the president say it. And he said to me, "Why is that important? Any president should say it." I said, "Yes, but he hasn't." This was six, seven years into the epidemic, and he hadn't said it. For a middle American to hear the president saying, "We can't discriminate--" was important. But the media only covered the controversy.

Hughes: Because that made news.

Silverman: So that was my lone speechwriting effort for the president. He lifted phrases right out from what I gave him. So I felt good about it, but it was wasted, except for the people in the audience, whom I'm sure will not remember any of those remarks.

Transcribed and Final Typed by Shannon Page

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Interviews with Selma K. Dritz, M.D., M.P.H.

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AIDS CHRONOLOGY, 1981-1984[1]

Appendix A

1968-1970 David Baltimore and Howard Temin independently discover reverse transcriptase, a marker for retroviruses.

1974 Charles Garfield founds Shanti Project to provide free volunteer counseling to people with life-threatening illnesses.

1976 Robert Gallo isolates T-cell growth factor (interleukin-2), allowing T-cells to be cultured in vitro.

1978 San Francisco Mayor George Moscone assassinated; Dianne Feinstein becomes mayor.

1980 Gallo demonstrates that retroviruses (HTLV-I and HTLV-II) can infect humans.

1981

Feb. Drew et al. document prevalence of cytomegalovirus [CMV] in homosexuals.

Feb. Michael Gottlieb, UCLA, diagnoses *Pneumocystis carinii* pneumonia [PCP] in two homosexuals.

Mar. Gottlieb diagnoses another case of PCP in a homosexual.

Mar. Sandra Ford, drug technician for Centers for Disease Control [CDC], officially notes increase in requests for pentamidine, for treatment of PCP.

Apr. Gottlieb diagnoses two more cases of PCP in homosexuals.

By June CDC establishes Kaposi's Sarcoma/Opportunistic Infection Task Force; James Curran head.

June 6 CDC's *Morbidity and Mortality Weekly Report* [*MMWR*] publishes Gottlieb and Wayne Sandera's report on PCP in 5 gay men.

July 3 First press report of syndrome appears in *New York Times*.

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[1] This chronology is an ongoing working draft created to assist the oral history project; its focus is San Francisco and its accuracy is contingent upon the many sources from which it was derived.

July 7 *MMWR* reports Kaposi's sarcoma [KS] and PCP in 26 gay men.

July 13 First article on AIDS in *New York Native*.

July City of San Francisco establishes reporting and case registry system for AIDS.

Aug. 28 *MMWR* reports first heterosexuals with AIDS.

Aug. CDC requires health departments to notify CDC of all AIDS cases.

Sept 15 CDC and National Cancer Institute sponsor workshop on KS and opportunistic infections [OI]. CMV leading candidate for cause.

Sept 21 First KS Clinic held at UCSF.

Oct. CDC launches case-control study of factors in homosexual environment possibly causing KSOI.

Oct. Friedman-Kien et al. begin study of clinical course of KS in gay men.

Nov. Shanti begins to focus on psychosocial problems of people with AIDS [PWA].

Dec. 9 Marcus Conant passes out flyers on KS at American Academy of Dermatology meeting in San Francisco.

Dec. 10 Durack at Duke suggests amyl nitrites might cause immune dysfunction.

Dec. 10 *New England Journal of Medicine* article links immune deficiency to T4 helper cell/T8 suppressor cell ratio.

Dec. First clinical descriptions of immunosuppression in IV drug users.

Dec. John Ziegler, Conant and Paul Volberding receive $50,000 from American Cancer Society to support KS Clinic at UCSF; first grant awarded for AIDS.

CDC investigators suspect that causal agent of AIDS is infectious but cannot provide irrefutable evidence.

Reagan proposes massive cuts in CDC budget.

1982

Early 1982 Syndrome is named gay-related immunodeficiency disease--GRID.

Jan. First case of immune deficiency linked to blood products is reported in a hemophiliac.

Jan. Helen Schietinger becomes nurse-coordinator of KS Clinic at UCSF.

Jan. San Francisco health department makes first request for tax funds to support AIDS prevention and community services; Board of Supervisors appropriates $180,000 for AIDS programs.

Mar. *MMWR* lists four risk groups for AIDS--homosexuals, hemophiliacs, Haitians, and IV drug users [IVDUs].

Apr. Congressional subcommittee hearing in Los Angeles on AIDS, Henry Waxman (D-CA), chairman.

May 15 Friedman-Kien et al. publish study showing promiscuity greatest risk factor for KS. Authors support immune overload theory of AIDS causation.

June 18 CDC reports cluster of PCP and KS cases in LA and Orange County, suggesting infectious agent is cause of AIDS.

June KS Research and Education Foundation established in San Francisco.

July 9 CDC publishes first report of 31 cases of opportunistic infections in Haitians.

July 13 First international symposium on AIDS, at Mt.Sinai Medical Center, New York, sponsored by Mt. Sinai and New York University [NYU] schools of medicine.

July 16 *MMWR* reports first three cases of PCP in hemophiliacs, representing first cases of AIDS caused by blood or blood products.

July 27 CDC adopts "acquired immune deficiency syndrome--AIDS" as the official name of the new disease.

Aug. CDC asks blood banks not to accept high-risk donors; CDC recommends hepatitis B core antigen testing.

Sept.24 CDC defines AIDS as disease due to defect in cell-mediated immunity occurring in people with no known cause for immune deficiency.

Sept. 24 CDC first uses term "AIDS", in *MMWR*. Rapid adoption of term.

Oct. KS Research and Education Foundation contracts with San Francisco Department of Public Health [SFDPH] to provide AIDS education services in San Francisco.

Nov. *MMWR* suggests that hospital staffs caring for AIDS patients use hepatitis B precautionary measures.

Dec 1 House of Representatives votes $2.6 million to CDC for AIDS research.

Dec. 4 CDC presents Blood Products Advisory Committee with evidence that AIDS being spread through blood supply; no official action taken.

Dec. 10 Ammann, Cowan, Wara et al. report first case of possible transfusion AIDS, in *MMWR*.

Dec. 17 *MMWR* reports four cases of unexplained immune deficiency in infants.

Dec. Shanti makes first in series of contracts with SFDPH to provide counseling services and a housing program for PWA.

Late 1982 Most investigators convinced that AIDS is caused by an infectious agent.

UCSF symposium on AIDS is attended by nearly 200 MDs and researchers.

Nation's first and largest AIDS specimen bank established at UCSF, coordinated by KS Clinic.

1983

Early in year: Beginning of bathhouse crisis. Formal AIDS infection control guidelines instituted at San Francisco General Hospital.

Jan.1 First outpatient clinic dedicated to AIDS (Ward 86) opens, at San Francisco General Hospital.

Jan. 4 CDC national conference to determine blood bank policy re testing blood for HIV but fails to reach consensus.

Jan. 7 San Francisco's Irwin Memorial Blood Bank [IMBB] adds medical history questions designed to screen out donors from high-risk groups.

Jan 14 National Hemophilia Foundation asks blood and plasma collectors to screen out high-risk donors.

Jan. 19 Irwin Memorial Blood Bank adds more medical history questions.

Jan. Luc Montagnier, Barre-Sinoussi, and Chermann at Pasteur Institute, seeking to isolate an AIDS virus, begin to grow cells from lymphadenopathy patient.

Jan. 7 CDC adds heterosexual partners of AIDS patients as fifth risk group for AIDS.

Jan. 25 Montagnier et al. find traces of reverse transcriptase in lymphadenopathy cell cultures.

Jan. President of New York Blood Center denies evidence of transfusion AIDS.

Jan. Orphan Drug Act becomes law, giving exclusive marketing rights, tax breaks, and other lucrative incentives to companies developing drugs for rare diseases.

Feb. 3 Physicians from UCSF KS Study Group urge IMBB to use hepatitis B core antibody test to screen out blood donors with AIDS.

Feb. 7 IMBB launches confidential questionnaire designed to detect potential blood donors with AIDS. Bay Area Physicians for Human Rights urges potential donors to refrain from donating if they have AIDS symptoms.

Feb. At Cold Spring Harbor Workshop on AIDS, Robert Gallo suggests that a retrovirus probably causes AIDS, presumably a variant of HTLV-I or HTLV-II.

Mar. CDC establishes clinical definition of AIDS in attempt to standardize epidemiological surveillance.

Mar. UCSF Task Force on AIDS created, mainly to establish infection control policy.

Mar. 4 *MMWR* advises members of four AIDS risk groups to defer blood donation: gays with multiple sex partners, IVDUs, Haitians, and hemophiliacs.

Mar. 4 CDC states that "available data suggests that AIDS is caused by a transmissible agent."

Mar. 24 Federal Drug Administration [FDA] issues donor screening guidelines.

Mar. California requires reporting of AIDS cases, but not AIDS-Related Complex [ARC].

Mar. Public Health Service [PHS] recommends members of high risk groups reduce number of sex partners.

Mar. Mervyn Silverman, SFDH director, forms Medical Advisory Committee on AIDS.

Apr. 11 Date NCI officials later cite as when NCI became committed to finding AIDS etiology.

Apr. 14 Irwin Memorial Blood Bank adds donor sheet designed to screen out donors at high risk for AIDS.

Apr. 26 Recall of Feinstein, supported by White Panthers and some gay groups, fails.

Apr. Congressman Phillip Burton dies; Sala Burton eventually is elected to his seat.

Apr. City of San Francisco and Shanti open hospice-type care center for neediest AIDS patients.

Apr. Conant, Volberding, John Greenspan, Frank Jacobson, and others persuade Willie Brown to ask for $2.9 million in state funding for AIDS research.

May 6 *Journal of the American Medical Association* [*JAMA*] press release: "Evidence suggests household contact may transmit AIDS."

May NIH announces $2.5 million for AIDS research.

May Heat treatment, developed at UCSF, to reduce infectious agents in transfused blood approved by FDA.

May SF health department issues first brochure on AIDS.

May Feinstein declares first week in May AIDS Awareness Week.

May 2 "Fighting for our Lives" march in San Francisco; similar march in NYC.

May 20 Montagnier publishes discovery of "T-cell lymphotrophic retrovirus", later called lymphadenopathy-associated virus (LAV). Gallo and Essex publish three papers indicating HTLV-I as cause of AIDS. All four papers published in same issue of *Science*. Evidence inconclusive.

May 23 San Francisco Board of Supervisors votes $2.1 million for AIDS programs, $1 million of which is for out- and inpatient wards at SFGH.

May 24 Edward Brandt, Assistant Secretary of Health, declares AIDS research #1 priority.

May 31 Mervyn Silverman, backed by Feinstein and Board of Supervisors, requires city bathhouses to post public health warnings about contracting AIDS.

June $1.2 million grant awarded to Volberding and Conant for AIDS research at SFGH and UCSF--largest NIH grant for AIDS research to date.

June UC issues guidelines to protect AIDS patients and health workers.

June San Francisco Men's Health Study begins to recruit participants.

June Feinstein chairs first U.S. Conference of Mayors Task Force on AIDS.

Jul. 26 Twelve-bed inpatient Special Care Unit (Ward 5B) opens at SFGH--first dedicated AIDS hospital unit in U.S.

July California legislature approves $2.9 million for UC AIDS research.

July Adult Immunodeficiencies Clinic established at UCSF; first patients seen August 1.

Aug. Willie Brown, Rudi Schmid, Conant and other AIDS researchers criticize UC for delays in releasing state funds for AIDS research.

Summer Universitywide Task Force on AIDS created to advise UC president on guidelines for state-supported AIDS research at UC and to coordinate UC AIDS research.

Set. 13 Montagnier sends Gallo sample of LAV.

Sept. 21 UCSF Task Force on AIDS first to create infection control guidelines for health care workers caring for AIDS patients.

Sept. At Cold Spring Harbor NCI meeting on human T-cell leukemia retroviruses, Montagnier et al. report LAV-like viruses in five lymphadenopathy patients and three AIDS patients, selective affinity of LAV for CD4 helper lymphocytes, and evidence of similarities between LAV and lentivirus causing equine infectious anemia. Gallo presents findings of HTLV-I in 10 percent of AIDS patients; doubts LAV is retrovirus.

Sept. UC states that there is no scientific reason for healthy medical personnel to be excused from caring for AIDS patients.

Nov. KS Research and Education Foundation contracts with State of California Department of Health Services to provide information and referral services on AIDS to other counties.

Nov. Mika Popovic in Gallo's lab discovers method for growing HIV in T-cells.

Nov. SF Department of Public Health asks for legal option to make baths off-limits to PWA. Lawyers decide that medical uncertainties about AIDS prevent such action.

Nov. Jay Levy obtains six viral isolates from AIDS patients but decides not to publish until further proof.

Dec. Pasteur Institute applies for U.S. patent on diagnostic kit based on ELISA test for LAV antibodies.

Dec. Feinstein votes against live-in lover legislation, angering gay community.

Department of Health and Human Services declares AIDS top health priority in U.S.

AIDS Clinical Research Centers established at UCSF and UCLA to collect clinical and laboratory data.

National Association of People with AIDS formed.

Entry "AIDS" added to *Cumulated Index Medicus*.

Hospice of San Francisco contracts with SFDPH to include AIDS patients in its care of terminally ill.

1984

Jan. 12 *NEJM* publishes CDC documentation of first eighteen transfusion-associated AIDS cases.

Jan. *Annals of Internal Medicine* reports case of heterosexual transmission of AIDS before overt manifestation of disease (hemophiliac to wife).

Jan. American Red Cross, American Association of Blood Banks, and Council of Community Blood Centers oppose proposal to screen out high-risk groups from blood donor pool.

Feb. Chermann in talks in U.S. states that French have discovered LAV.

Mar. 2-4 19th Annual SF Cancer Symposium, "Cancer and AIDS". Conant, Abrams, Wofsy, Ziegler, Volberding speak.

Mar. 6 Blood industry task force meets on surrogate testing; blood bankers oppose it.

Mar. 26 Government allots $1.1 million to develop AIDS antibody test to seven institutions, including Irwin Memorial and Stanford blood banks.

Mar. President of New York Blood Center continues to deny HIV transmission by blood.

Mar. Larry Littlejohn, gay activist, sponsors San Francisco ballot initiative to close baths.

Apr. 9 Silverman and state and SF health officials outlaw sex in bathhouses, rather than close them.

Apr. 24 Margaret Heckler, Secretary of Health and Human Services, announces discovery by Gallo et al. of AIDS virus, that an AIDS test will be available soon, and that a vaccine will be available in 18-24 months. Gallo had not yet published his results.

Apr. Feinstein issues first formal statement that Silverman should close baths. Silverman says that he will formulate guidelines banning sex activity that spreads AIDS in baths.

Apr. NIH applies for patents on Gallo's AIDS antibody test, a diagnostic kit based on Western blot technique.

May 1 IMBB and other Bay Area blood banks begin testing blood for hepatitis B core antigen.

May Gallo publishes four reports and Montagnier one, in *Science*, linking AIDS with a new retrovirus which Gallo calls HTLV-III and Montagnier calls LAV.

May Board of Supervisor's president Wendy Nelder chides Silverstein for "shameful" delays in proposing sex guidelines for baths. Silverman replies that he is waiting for board to transfer authority to regulate baths from police to health department.

May Rock Hudson diagnosed with AIDS.

FDA gives Syntex permission to distribute ganciclovir for CMV retinitis on compassionate use basis.

Summer Silverman orders bathhouse surveillance for unsafe sex.

June Board of Supervisors committee delays action on giving health department authority to regulate baths until after Democratic National Convention in SF.

June IMBB adopts directed blood donation program.

July Democratic National Convention in San Francisco.

Aug. After gay lobbying, Board of Supervisors tables move to give Silverman regulatory power over baths, killing his idea to promulgate sex guidelines for baths.

Aug. Levy et al. isolate virus which they claim to cause AIDS.

Sept. Chiron Corp. announces cloning and sequencing of ARV genome.

Sept. Giovanni Battista Rossi in Italy isolates HIV.

Sept. 60 physicians at Pacific Medical Center sign petition asking baths to be closed.

Oct. 9 Silverman closes baths and private sex clubs as "menace" to public health. Baths reopen hours later.

Oct. Feinstein forms Mayors Advisory Committee on AIDS.

Oct. FDA approves Lyphomed's injectable pentamidine for PCP and gives it orphan drug status.

Nov. 28 SF Superior Court Judge Roy Wonder rules baths can remain open if monitored for safe sex practices every 10 minutes.

Nov. Gallo et al. clone HTLV-III.

Dec. Montagnier et al. report cloning of LAV-1; they also report CD4 molecule as HIV receptor.

Dec. 26 Simon Wain-Hobson, Pierre Sonigo, Olivier Danos, Stewart Cole, and Marc Alizon at Pasteur Institute publish LAV nucleic acid sequence in *Cell*.

Dec. Silverman resigns as director of SFDPH.

Dec. 90 reported cases of transfusion AIDS; 49 reported cases of Factor VIII hemophilia cases.

CDC recommends use of heat-treated blood products for hemophiliacs; other specialists differ. Heat-treated blood products become commercially available.

National Kaposi's Sarcoma Foundation renamed SF AIDS Foundation.

1985

Jan. 14 Irwin Memorial Blood Bank prohibits males having more than one sex partner to donate blood.

Jan. Gallo et al. publish full nucleic acid sequence of HTLV-III.

Jan. Jay Levy announces virus which he call AIDS-Related Virus (ARV).

Feb. 1 Paul Luciw, Jay Levy, Ray Sanchez-Pescador et al. publish ARV nucleic acid sequence.

Feb 7 Dan Capon, M.A. Muesing et al. at Genentech publish ARV nucleic acid sequence.

Feb. FDA approves Gallo's AIDS diagnostic kit based on Western blot technique.

Mar. 2 FDA approves Abbott Laboratory's commercial test for AIDS. Red Cross contracts with Abbott, one of five companies supplying test, and in days phases in test. Britain and France delay testing six months to introduce their own antibody tests.

Mar. 3 IMBB introduces genetically engineered hepatitis B antibody core test.

Mar. 6 IMBB institutes anti-HIV antibody test, the first blood bank in U.S. to do so.

Mar. 14 *San Francisco Chronicle* reports army study showing AIDS transmission through heterosexual contact.

Mar. County Community Consortium founded for community-based AIDS drug testing.

Spring California legislature and Gov. Deukmejian approve bill banning HIV antibody testing without subject's written informed consent, except at alternate test sites where testing is anonymous. Bill also bars employer and insurance company discrimination on basis of HIV status. $5 million appropriated to establish HIV community test sites. Disclosure of test results to third party must be improved in writing by test taker.

May U.S. Patent Office awards patent on Gallo's antibody test.

Summer AIDS diagnostic kits using ELISA become commercially available. California law mandates every county to offer AIDS test at public health centers; guidelines for preserving confidentiality.

June 24 IMBB adds bar codes for confidential exclusion of blood units.

June American Association of Blood Banks, American Red Cross, Council of Community Blood Centers agree not to begin "look back" program to identify people who have received HIV-infected blood.

June National Institute of Allergy and Infectious Diseases [NIAID] creates first AIDS Treatment Evaluation Units, predecessor to AIDS Clinical Trial Groups (ACTGs).

June California public health clinics begin testing for AIDS.

Sept. Mathilde Krim and Michael Gottlieb found American Foundation for AIDS Research, merging AIDS Medical Foundation of New York and National AIDS Research Foundation of Los Angeles.

Sept. Martin Delaney and others found Project Inform.

Oct. Public's awareness of AIDS rises with Rock Hudson's death. Congress allots $70 million to AIDS research day after Hudson's death.

Dec. Pasteur Institute goes to court to win share of royalties on HIV antibody test.

Dec. CDC first considers vertical transmission of HIV; advises infected women to "consider" delaying pregnancy until more known about perinatal transmission of HIV.

CDC contracts with SF AIDS Foundation to develop materials for anonymous AIDS testing sites.

First International Conference on AIDS, Atlanta.

Late in year Department of Defense announces that new recruits will be screened for AIDS and rejected if positive.

Third UC AIDS Clinical Research Center founded at UC San Diego. Goals of three centers broaden to include rapid evaluation of new therapeutic agents.

13-year-old Ryan White, a hemophiliac with AIDS, is barred from school in Indiana.

KEY PARTICIPANTS
in San Francisco AIDS History, 1981-1984

Appendix B

*[1]Donald A. Abrams, M.D., AIDS clinician and member of original AIDS physician team at San Francisco General Hospital (SFGH); early research on AIDS-associated lymphadenopathy (swollen lymph glands); organizer of County Community Consortium.

*Arthur J. Ammann, M.D., pediatric immunologist at University of California, San Francisco (UCSF); conducted early studies of AIDS-associated immune deficiency in adults and children; reported first case of transfusion AIDS; currently head of a pediatric AIDS foundation.

Francoise Barré-Sinoussi, retrovirologist at Pasteur Institute and member of team which isolated AIDS virus.

Edward N. Brandt, Jr., M.D., Ph.D., Assistant Secretary for Health, U.S. Department of Health and Human Services, 1981-1984.

Conrad Casavant, immunologist in Department of Laboratory Medicine and associate director of Clinical Immunology Laboratory at UCSF; died of AIDS in 1987.

Jean-Claude Chermann, retrovirologist at Pasteur Institute and member of team which isolated AIDS virus.

*Marcus A. Conant, M.D., clinical professor at UCSF, and dermatologist with private AIDS practice; diagnosed first case of Kaposi's sarcoma in San Francisco; founder of first AIDS clinic (at UCSF); medical activist at local, state, and federal levels.

James W. Curran, M.D., M.P.H., epidemiologist and director of AIDS research at Centers for Disease Control (CDC), Atlanta, Georgia.

William Darrow, CDC sociologist.

Larry Drew, virologist at Mt. Zion Hospital, San Francisco.

*Selma K. Dritz, M.D., M.P.H., epidemiologist at San Francisco Department of Public Health (SFDPH); tracked early AIDS cases in San Francisco; addressed medical and community groups on AIDS recognition and prevention.

Gaetan Dugas, French-Canadian airline steward who was among first to be diagnosed with AIDS; sometimes mistakenly referred to as "Patient Zero" and held responsible for early dissemination of AIDS.

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[1] The asterisk indicates that the individual has been interviewed for the AIDS oral history series.

Edgar Engleman, M.D., medical director of Stanford University Hospital blood bank.

Anthony S. Fauci, M.D., director of AIDS activities at National Institute of Allergy and Infectious Diseases, later director of Office of AIDS Research, currently director of NIAID, National Institutes of Health (NIH).

*Donald P. Francis, M.D., D.Sc., epidemiologist and virologist at CDC in Phoenix and Atlanta; conducted early epidemiological and virological studies of AIDS; later became CDC advisor on AIDS to California Department of Health Services; current director of research on AIDS vaccines at a biotechnology company.

Robert Gallo, M.D., retrovirologist at National Cancer Institute, NIH, involved in controversy with Pasteur Institute over isolation of AIDS virus and patent rights to HIV test.

*Deborah Greenspan, D.D.S., D.Sc., clinical professor of oral medicine at UCSF; identified AIDS-associated hairy leukoplakia; instrumental in establishing infection control procedures in dentistry.

*John S. Greenspan, D.D.S., Ph.D., professor of oral biology and oral pathology at UCSF; organized and directs UCSF AIDS specimen bank; current director of UCSF AIDS Clinical Research Center.

Margaret Heckler, Secretary of U.S. Department of Health and Human Services, 1983-1985.

Harold Jaffe, epidemiologist with the AIDS program at CDC.

*Jay A. Levy, M.D., virologist and professor of medicine at UCSF; second to isolate AIDS virus; devised early AIDS diagnostic test and heat treatment to rid blood of HIV.

Luc Montagnier, virologist and member of Pasteur Institute team which isolated AIDS virus.

*Andrew R. Moss, Ph.D., M.P.H., epidemiologist at SFGH; conducted early epidemiological studies of AIDS in San Francisco showing high incidence in gay community; later work focused on AIDS incidence in drug users and homeless.

Herbert A. Perkins, M.D., scientific director (later president) of San Francisco's Irwin Memorial Blood Bank; involved in formulating national blood bank policy regarding blood screening for HIV; currently represents blood bank in legal cases associated with transfusion AIDS.

*Merle A. Sande, M.D., professor of medicine and chief of medical services, SFGH; chairman of AIDS advisory committees at university, health department, and state levels.

Randy Shilts, journalist who covered AIDS for *San Francisco Chronicle*; author of *And the Band Played On: Politics, People, and the AIDS Epidemic*; died of AIDS in 1994.

*Mervyn F. Silverman, M.D., M.P.H., director, San Francisco Department of Public Health; center of controversy over closure of San Francisco bathhouses; current director of American Foundation for AIDS Research.

*Paul A. Volberding, M.D., oncologist and chief of AIDS Services, SFGH; member of original AIDS physician team at SFGH; prominent AIDS clinician.

Girish Vyas, Ph.D., professor of laboratory medicine, UCSF.

*Warren Winkelstein, M.D., M.P.H., epidemiologist at University of California School of Public Health; director of early on-going epidemiological study of AIDS (San Francisco Men's Health Study); member of panel deciding in June 1994 to disprove expanded clinical trial of two AIDS vaccines.

*Constance B. Wofsy, M.D., infectious disease specialist at SFGH; member of original AIDS physician team at SFGH; authority on *Pneumocystis carinii* pneumonia and women with AIDS.

*John L. Ziegler, M.D., oncologist at Veterans Administration Medical Center, San Francisco; authority on AIDS-associated lymphoma and Kaposi's sarcoma.

NAME _____ DOB _____ CC# _____
LAST FIRST Date
ADDRESS _____ Phone _____ of exam _____

SYMPTOMS
- ☐ Persistent fever
- ☐ Night sweats
- ☐ Dry cough
- ☐ Shortness of breath
- ☐ Loss of weight
- ☐ Persistent fatigue
- ☐ Recurring headaches
- ☐ Rec. herpes-simpl/zoster
- ☐ Persistent cramps, diarrhea, upset stomach or bloody stools

SIGNS
- ☐ Swollen lymph glands
- ☐ White patches tongue/throat
- ☐ Chronic skin infections
- ☐ Bluish/purplish spots

HISTORY
- ☐ Syphilis
- ☐ Herpes
- ☐ Hepatitis B
- ☐ Sex with known AIDS Patient
- ☐ Gonorrhea
- ☐ Intestinal parasites
- ☐ IV drug use

TESTING RESULTS

VDRL
GC
OTHER:

Skin Test:
Candida
Mumps

Hematology Evaluation:

HEM	MCV	WBC	M
HGB	MCH	N	E
RBC	MCHC	L	B
			P

Comment

DISPOSITION - Refer AIDS Clinic SFGH Date Time

Other:

LIST THOSE PRESENT AND DESCRIBE on reverse (Duration, frequency, measure of severity, exacerbating and ameliorating factors, previous medical evaluations, treatment and other significant details)

Screener

I authorize the City Clinic to send a copy of this record to
if it appears I need further evaluation.

GUIDELINES

SYMPTOMS	
Persistent fever	- low grade but over 101°F, unexplained cause, especially in late afternoon and evening, for three or more weeks.
Drenching night sweats	- for three or more weeks
Dry cough	- persistent daily for more than one week & of recent origin
Short of breath	- present without or minimal exertion (climbing one flight of stairs).
Loss of weight	- more than ten pounds in past year without known cause
Persistent fatigue	- for two or more months without cause
Recurring headaches	- no obvious cause, such as sinusitis, vision problem, etc.
Herpes infections	- zoster in any male under 60 years and of recent origin - recurring "cold sores" or genital herpes with episodes every four - six weeks
Persistent cramps, etc	- for one or more months without explanation
SIGNS	
Swollen lymph glands	- in two or more sites for more than three months, excluding inguinal. Bilateral cervical would be considered two sites; or excessively large nodes in any one site for any duration without explanation of its existance, i.e. infection,
White patches	- identify presence of candidiasis with microscopic examination of suspect lesions with scraping and wet mount preparation
Chronic skin infection	- particularly a folliculitis present more than three months without other explanation
Bluish-purple spots	- on skin and/or mucus membranes, such as in mouth or anus; does not pale on pressure.

Final Draft

City Clinic-May 83

MARY WOLF

We will be screening for AIDS in a more organized manner starting May 2, 1983. A 5 x 8 card is being photocopied to be used as the patient record for this specific service with plans for its printing sometime in the future. It will be in addition to the regular Access card used in documenting all patient visits.

1. A patient who is interested in an AIDS evaluation will be asked by the Screener(or by the Clinician if that is when the interest is first expressed) what symptoms or signs are present which makes the patient think he has AIDS. In the absence of significant symptoms or signs the patient can be reassured and given appropriate informational pamphlet. The patient can be offered a routine VD examination by the Screeners and an Access patient record can be initiated.

2. Only a patient having significant symptoms or signs listed on the card and to the extent described in the Guidelines will have a special AIDS examination card initiated. The presence or absence of particular symptoms, signs and history items will be noted by + or - placed in the respective boxes by the Screener(or Clinician). The Screener (or Clinician) doing this should place his or her identifying number or letter in the Screener box on the face of the record. This AIDS record will accompany a completed Access card to the Clinician.

3. Clinician evaluation and services

A. Perform an appropriate VD examination properly documented on the Access card as currently practiced. In addition, the patient's Access record will be stamped with "AIDS Evaluation" on the dateline of the examination. Each examination room will be supplied with the stamp.

B. Describe on the reverse side of the AIDS clinic record the "duration, frequency, etc...." of the symptoms, signs and historic factors noted as being present. The clinician should identify his or her notes written on back of record.

C. Perform a brief physical examination focusing on:

1) Lymph nodes - cervical, axillary, popliteal and inguinal
2) Mouth and throat - for candida and Kaposi-like lesions
3) Skin - including peri-anal and soles for chronic folliculitis and Kaposi-like lesions

D. Use the regular treatment form to order skin tests for candida and mumps to be applied by a nurse who will also supply the patient with an information sheet regarding the test reading and interpretation.

E. Place X to the left of the test ordered. Consider hematology one test for this purpose. Write in name of other tests that might be ordered, ie CSP.

F. Offer ova and parasite collection kits to AIDS evaluation patients with cramps and other bowel problems. The kits contain directions for collecting specmens,where and when to return them, etc. NOTE: Start of ova and parasite testing may be delayed to after 5/2/83.

G. Secure a hematology evaluation. We anticipate funding will be secured which will allow patients a referral for the CBC, differential and platelet count starting in the Summer of 1983.

In the interim the patient can pay here the fee of $11.00 ($12.00 starting 6/1) and we will complete the Smith Kline Clinical Laboratories "Client Bill" slip, keeping the Client Copy. The patient will take the remaining parts of the lab slip and to to one of the five Smith Kline Labs in the City. If the patient prefers to pay at the Lab, he will pay $19.00. In this latter case, we complete the "Patient Bill" lab slip, again keeping the Client Copy, giving the patient the remaining copies to the laboratory.

The Supervisor of Registration and Patient Services, or designee, will complete the appropriate lab slip and collect payment when indicated. If the patient wishesto pay the $11.00(or $12.00) by check, the check should be made out to

Smith Kline Clinical Laboratories.

H. Depending on the Clinician's evaluation, a patient can be referred for a definitive evaluation at the completion of our screening if the indications are strong enough. This referral will then be made before test results are available or even the tests ordered.

Appointments can be made at SFGH AIDS Clinic at 995 Potrero Avenue, corner of 22nd Street, Ward 86, 861-8830 for Thursdays from 8:45 to 11:15 A.M.. Call while patient is in our Clinic and arrange for a photocopy of our AIDS record sent to SFGH with note as to date and time of appointment.

4. When the disposition is being deferred until after testing results are back, the STS review physician will make the determination and form letter will will be sent to the patient which will have various options, such as referral, return for repeat screening, etc.. If referred, a copy of the record should be sent to the designated evaluating agency with note indicating patient was advised to make an appointment.

5. The AIDS Coordinator will be responsible to see that test results are posted, referred to review physician and to send out disposition letter to the patient. As indicated by a review physician follow-up phone call by AIDS Coordinator to selected patients to confirm compliance with recommendations can be arranged.

6. Screeners and Clinicians should keep themselves informed as to the latest developments in this program area.

7. The AIDS record will be filed numerically in a designated file drawer.

INFORMATION TO PATIENT REGARDING SKIN TESTS

You have had skin tests placed on your arms-mumps on the right arm and candida (fungus) on your left. These are common infections which most people have, although they may not always be aware of the illness at the time.

For our purposes they are "read" by observing the amount of redness that develops around the injection site. This reading is done 48 hours after the injection. You can come to the City Clinic for this reading in 2 days. If this is not convenient or possible (weekends or holidays) call the Clinic the day it is to be read, or in the case of weekends or holidays, the following work day to give the 48 hour reading (864-8100 ext 40 or 41).

If there is a lot of redness on an arm, it probably means you have had the particular infection applied to that arm some time in the past; less than the prescribed amount of redness on an arm suggests you have not had the infection tested on that arm but have some non-specific sensitivity to the material injected into the skin; while no redness in an arm can be interpretted as your having no sensitivity to the injected material.

A lack of sensitivity in both arms could mean you haven't had either of the infections and no sensitivity to either of the injected materials, or less likely but significant for this screening, you are different in your immune response mechanism. If you have no redness in either arm tested, its proper interpretation must await an evaluation of your complete history and other tests done here or later as part of a more complete work-up.

City Clinic 4/83

AIDS EVALUATION REPORT

PATIENT NAME_____ DATE OF EVALUATION_____

CC#_____ DOB:_____

After reviewing the findings of your recent AIDS Evaluation at this Clinic, we recommend:

1. ☐ Your history, physical examination and lab tests do not show any significant increased risk of an AIDS disease at this time. If there is a continuation of your symptoms suggestive of possible AIDS, we would recommend a repeat evaluation in 6 months, or sooner if the intensity or number of such symptoms increase.

2. ☐ Our findings suggest you may have a possible increased risk of having an AIDS associated disease. At the time you were seen here, you designated

who would perform the more thorough medical work-up you might need. Photocopies of both this letter and your record is being sent there. Please arrange to make an appointment, telephone #

3. ☐ It does not appear you have AIDS at this time. However, our reviewing physician finds that your history and our findings, particularly

suggest you should seek general medical care.

4. ☐ We are unable to complete your evaluation

a) ☐ No report of skin tests

b) ☐ No report of blood tests

5. ☐ Stool Examination

a) ☐ The stool specimen examination was negative for parasites and enteric organisms. If you still have a problem, you should see a doctor for a more complete work-up.

b) ☐ The stool specimen examination showed

you should take this letter to a doctor for further evaluation and possible treatment for this bowel problem.

6. ☐ Other: Specify -

If you have any questions you can call me at 864-8100 ext. 40 or 41.

Attachment 1 : ACCESS MEDICAL RECORD USED IN THE CITY CLINIC - FRONT SIDE

S.F. Dept. of Public Health-City Clinic | Corresp. In File | Epidem. referral

Name (last) (first) | DOB-M/D/Y

Signature | W O M / B X F

GC- U R P E O

Last syph. Dx- I II III LL C E L

Rx Date

DxSTS date result DF

Last STS date result

Last MHA date result

DATE M D Y	TREATMENT Drug Sensitivity?

DATE M D Y	GC Cult	Result	Sm DF	Result	STS	Result	MHA	Result	Other	Result	Diag.

CS-1163-06D

- Back Side -

Attachment 2 (A)
CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

San Francisco City Clinic
356 Seventh Street
San Francisco, California 94103

In cooperation with the:
Centers for Disease Control
Atlanta, Georgia 30333

Participant Consent Form for Project 24: A. Person diagnosed with AIDS.

I freely agree to participate in the City Clinic cooperative study of risk factors for acquired immunodeficiency syndrome (AIDS). I understand that AIDS is a growing problem in San Francisco and that certain sexual practices may be important in its spread. By comparing information collected from people with AIDS with information collected from others who do not have AIDS, benefits to the community may include the possibility of finding the cause of this serious outbreak.

I also understand that if I do not choose to participate in this study the medical care offered me by the City Clinic will in no way be affected. Furthermore, even though I consent now, I am free to withdraw at any time with a written or verbal statement to this effect. I understand that the only risk incurred by participation is that associated with having blood taken from a vein in my arm — fainting, possible bruising and, rarely, infection.

I understand that participation involves: 1) answering questions concerning my medical history and sexual habits after I was first tested for hepatitis infection, and 2) having samples of blood and urine taken. Both the interview and having samples taken should be completed in less than one hour.

I understand that should I have any additional questions I may call the City Clinic (Telephone No. 864-8100, ext. 41 or 42: Paul O'Malley) and that any important medical information uncovered during the study will be made known to me and, at my request, my doctor. This is the extent of responsibility of the City Clinic.

I understand that special care will be taken to protect the confidentiality of everyone who participates. Identifying information will be kept separate from the questionnaire as soon as the interview is completed and stored in a secure locked file at San Francisco City Clinic. I understand that the questionnaire will be identified only by my Hepatitis B Study Number and the link between name and number will only be available to the cohort study coordinator and his immediate staff. I have been assured that I will not be identified by name in reporting of any study results. I understand that all study data will be kept in locked cabinets and will remain as confidential as possible under the law.

I have read this consent form and have been given the opportunity to ask any questions relevant to my participation.

Date:_____ Signed:_____(Participant)

Interviewer:_____

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

San Francisco City Clinic
356 Seventh Street
San Francisco, California 94103

In cooperation with the:
Centers for Disease Control
Atlanta, Georgia 30333

Participant Consent Form for Project 24: B. Person not diagnosed with AIDS.

I freely agree to participate in the City Clinic cooperative study of risk factors for acquired immunodeficiency syndrome (AIDS). I understand that AIDS is a growing problem in San Francisco and that certain sexual practices may be important in its spread. I understand that personal benefits of participation may include knowledge of my current health status and proper referral should I be found to have evidence of AIDS. By comparing information collected from people with AIDS with information collected from others who do not have AIDS, benefits to the community may include the possibility of finding the cause of this serious outbreak.

I also understand that if I do not choose to participate in this study the medical care offered me by the City Clinic will in no way be affected. Furthermore, even though I consent now, I am free to withdraw at any time with a written or verbal statement to this effect. I understand that the only risk incurred by participation is that associated with having blood taken from a vein in my arm — fainting, possible bruising and, rarely, infection.

I will incur no added risks for AIDS by participating in this study. Whatever the risk of acquiring AIDS may be, it will be the same whether I participate or not.

I understand that participation involves: 1) answering questions concerning my medical history and sexual habits after I was first tested for hepatitis infection, 2) having samples of blood and urine taken, and 3) having a physical examination for signs of AIDS. The interview should be completed in less than one hour and the physical examination should be completed in less than 15 minutes.

I understand that should I have any additional questions I may call the City Clinic (Telephone No. 864-8100, ext. 41 or 42: Paul O'Malley) and that any important medical information uncovered during the study will be made known to me and, at my request, my doctor. This is the extent of responsibility of the City Clinic.

I understand that special care will be taken to protect the confidentiality of everyone who participates. Identifying information will be kept separate from the questionnaire as soon as the interview is completed and stored in a secure locked file at San Francisco City Clinic. I understand that the questionnaire will be identified only by my Hepatitis B Study Number and the link between name and number will only be available to the cohort study coordinator and his immediate staff. I have been assured that I will not be identified by name in reporting of any study results. I understand that all study data will be kept in locked cabinets and will remain as confidential as possible under the law.

I have read this consent form and have been given the opportunity to ask any questions relevant to my participation.

Date: _____ Signed: _____ (Participant)

Interviewer: _____

AIDS IN A COHORT OF MALE CLINIC PATIENTS: OBSERVATIONAL STUDY 1983-1984

San Francisco City-County Health Department Centers for Disease Control AIDS Project

PATIENT: GO 1 |__|__|__|__| (01 02 03 04) AIDS CASE NO. |__|__|__|__| (05 06 07)

DATE OF ENTRY INTO COHORT: Month |__|__| (09 10) Day |__|__| (11 12) Year |__|__| (13 14)

HBV TEST STATUS (CIRCLE ONE) 0.Neg 1.Ag 2.An 3.Oth 9.Unk

TEL: AC |__|__|__|-|__|__|__| (16 17 18 19 20)

LAST KNOWN ADDRESS:

City _____ |__|__|__|__| (22 23 24 25) State _____ |__|__| (26 27) ZIP |__|__|__|__|__| (28 29 30 31)

DATE OF BIRTH Month |__|__| (33 34) Day |__|__| (35 36) Year |__|__| (37 38)

RACE (Circle One): 1. White 2. Black 3. Hisp. 4. Asian 5. Amerin 6. Other |__| (39)

Assigned to: _____ |__| (40)

ATTEMPTS TO CONTACT PATIENT:

Month	Day	Year	Hour	Minutes	Attempt to Contact	No Ans.	Ct. Pt.	Unknown	Other	Comment
(42 43)	(44 45)	(46 47)	(48 49)	(50 51)	First Telephone Call _____ (52)	0	1	2	3	
(53 54)	(55 56)	(57 58)	(59 60)	(61 62)	Second Telephone Call _____ (63)	0	1	2	3	
(64 65)	(66 67)	(68 69)	(70 71)	(72 73)	Third Telephone Call _____ (74)	0	1	2	3	
(75 76)	(77 78)	(79 80)			First Letter _____ (81)	0	1	2	3	
(82 83)	(84 85)	(86 87)			Follow-up Letter _____ (88)	0	1	2	3	
(89 90)	(91 92)	(93 94)			Site Visit _____ (95)	0	1	2	3	
(96 97)	(98 99)	(100 101)	(102 103)	(104 105)	Appt. for Interview _____ (106)	0	1	2	3	

Codes: 0=Returned 1=Not Ret.

Codes: 0=Pt. Moved 1=Not Moved

Disposition (Circle One): |__| (107)
0. Alive, Refused interview
1. Alive, Int. scheduled
2. Unable to Participate
3. Unable to Locate
4. Deceased, Previously intervie
5. Deceased, Not interviewed
6. Other: _____
9. Unknown

DATE OF DEATH: Month |__|__| (108 109) Day |__|__| (110 111) Year |__|__| (112 113) CAUSE: _____ |__|__|__|__| (114 115 116 117) AIDS Related? 1.Yes 2.No 9.

LAST KNOWN ADDRESS:

City _____ |__|__|__|__| (119 120 121 122) State _____ |__|__| (123 124) ZIP |__|__|__|__|__| (125 126 127 1

'O CITY CLINIC HISTORY: From Date of Entry into Cohort to Date of Last Clinic Visit.

Month	Day	Year	Disease	Codes: 0	1	2	3	3	5	Code	Comment:
|__|__|	|__|__|	|__|__|	Gonorrhea	Never	U	R	P	E	Multiple	|__|	_____
|__|__|	|__|__|	|__|__|	Syphilis	Never	1	2	3	E	Other	|__|	_____

Month	Day	Year	Visit	No DX	Diagnosis: GC	Syph	Both	Oth	Unk	Code	Comment:
|__|__|	|__|__|	|__|__|	First	0	1	2	3	4	5	|__|	_____
|__|__|	|__|__|	|__|__|	Second	0	1	2	3	4	5	|__|	_____
|__|__|	|__|__|	|__|__|	Third	0	1	2	3	4	5	|__|	_____
|__|__|	|__|__|	|__|__|	Fourth	0	1	2	3	4	5	|__|	_____
|__|__|	|__|__|	|__|__|	Fifth	0	1	2	3	4	5	|__|	_____
|__|__|	|__|__|	|__|__|	Sixth	0	1	2	3	4	5	|__|	_____
|__|__|	|__|__|	|__|__|	Seventh	0	1	2	3	4	5	|__|	_____
|__|__|	|__|__|	|__|__|	Eight	0	1	2	3	4	5	|__|	_____

otal Visits: \|__\|__\| Total Cases of Gonorrhea: \|__\|__\| Total Cases of Syphilis: \|__\|

ERSONAL INTERVIEW: Written, Informed Consent Obtained? 1. Yes 2. No \|__\|

ATE OF INTERVIEW: Month \|__\|__\| Day \|__\|__\| Year \|__\|__\|

NTERVIEWER: _____ \|__\|__\|

ITY OF INTERVIEW _____ \|__\|__\|__\|__\| STATE: _____ \|__\|__\|

PLACE OF INTERVIEW:
1. Hospital
2. STD Clinic
3. Home
4. PMD Office
5. Hotel
6. Hlth Dpt.
7. KSOI Fnd.
8. Pts Office
9. Other: _____

\|__\|

omments: _____

SOCIODEMOGRAPHIC INFORMATION: Let's begin by talking about your place of birth, your age, your current residence and the type of work you do.

PLACE OF BIRTH:
City_____|__|__|__|__| State_____ |__|__| AGE:|__|__| years.

CURRENT RESIDENCE
City_____|__|__|__|__| State_____ |__|__| Comment:_____

How many months (total) have you lived in the San Franciaco Bay Area? |__|__|__| months

In the past 5 years, how many months have you lived with a lover(s)? |__|__|__| months

USUAL OCCUPATION: What type of work do you usually do?_____Code:|__|__|__|

Other jobs in past 5 years?_____Code: |__|__|__|

EDUCATION: How many years of school have you completed? |__|__| years.

PERSONAL INCOME: In the past year (1982?), about how much income did you earn?
Income categories: 1. less than $10,000 3. $20,000 to $30,000
2. $10,000 to $19,999 4. more than $30,000 |__|

MARITAL STATUS: Have you ever been married (to a woman)? ___. No. |__| times.

If ever married, are you married now (Circle one)? 1. Yes 2. No Code: |__|

MEDICAL HISTORY: The next set of questions concerns your medical history since you were first tested for hepatitis in the City Clinic. According to the information I have, you were first tested for hepatitis on _____. Today is _____, so let's focus on all the medical problems you have had in the past (difference between HBV test month and today) |__|__| months.

In the past __ __ months (above), have you experienced any of the following symptoms:

Circle as many as apply (Code the number of symptoms circled; if none, code 0).

SYMPTOMS
Code:
|__|

1. Fever lasting more than 7 days
2. Night sweats (more than 7 days)
3. Swelling of lymph nodes at 3 or more body sites
4. Aches and pains (arthralgias or myalgias) for more than 7 days
5. Painful blisters on your skin Describe_____
6. Unexpected weight loss of 15 lbs. or more
7. Persistent diarrhea (more than 7 days
8. Shortness of breath (more than 7 days)
9. Skin abnormalities, lesions Describe _____

SYMPTOM ONSET: If respondent has experienced any of the symptoms suggesting possible AIDS, ask for the month and year that he first experienced the symptom(s). (If no symptoms are reported, code 00 00).

Month Year
|__|__| |__|__|

In the past __ __ months, have you been told by a medical doctor that you have had any of the following medical conditions. If you have, please tell me when you were diagnosed.

MEDICAL CONDITIONS	Circle response		Code	Month	Year
Lymphadenopathy, or enlarged lymph nodes	1.Yes	2.No	|__|	|__|__|	|__|__|
Leukopenia, or a lack of sufficient white cells	1.Yes	2.No	|__|	|__|__|	|__|__|
Lymphopenia, or a lack of sufficient lymphocytes	1.Yes	2.No	|__|	|__|__|	|__|__|
Acquired Immunodeficiency Syndrome, or AIDS	1.Yes	2.No	|__|	|__|__|	|__|__|

In the past __ __ months, have you ever been diagnosed with any of the following diseases:

Circle as many as apply (Code the disease: if none, code 00; if more than one, code 12)

DISEASES

Code |__\|__\|

01. Kaposi's sarcoma
02. Pneumocystis carinii pneumonia
03. Toxoplasmosis (encephalitis/brain)
04. Atypical mycobacterial infection
05. Candida esophagitis
06. Disseminated cytomegalovirus infection
07. Cryptococcal infection
08. Chronic herpes simplex
09. Progressive multifocal leukoencephalopathy
10. Cryptosporidiosis
11. Other Cancers: Specify _____

ONSET DATE FOR AIDS: _____ If the respondent has been diagnosed with AIDS, indicate the earliest date for symptoms of AIDS Month |__\|__\| Year |__\|__\|

Before __ __ __ __ (ONSET DATE FOR AIDS) or in the past __ __ months (approximately 60), have you received any of the following therapies:

Circle as many as apply (Code the therapy: if none, code 00; if more than one, code 11)

THERAPIES

Code |__\|__\|

01. Systemic corticosteroid therapy
02. Cytotoxic chemotherapy, or other immunosuppressive therapy
03. Hepatitis B Vaccine
04. Hepatitis B Immune Globulin
05. Other immune globulins
06. Hemodialysis
07. Factor VIII or IX concent
08. Cryoprecipitate
09. Blood or packed red cell transfusion
10. Other blood components

Before __ __ __ __ (ONSET DATE FOR AIDS) or in the past __ __ months, how many times did yo

Donate Blood or Plasma |__\|__\| times.

Obtain Dental Care |__\|__\| times. Reasons: _____

Visit a Physician |__\|__\| times. Reasons: _____

Receive Hospitalization |__\|__\| times. Reasons: _____

Have Surgery |__\|__\| times. Reasons: _____

Before__ __ __ __ (ONSET DATE FOR AIDS) or in the past ____ months, how many times were you treated for the following conditions. If you were treated, please tell me how many times you were treated in the City Clinic, at a hospital, by a private physician or by someone else:

OTHER CONDITIONS	Times	City Clin	Hosp	PMD	Other	Comment (Name of hospital, physician or other place)
Amebiasis	|__|	|__|	|__|	|__|	|__|	
Giardiasis	|__|	—	—	—	—	
Shigellosis	|__|	—	—	—	—	
Syphilis	|__|	|__|	|__|	|__|	|__|	
Gonorrhea	|__||__|	|__||__|	|__|	|__|	|__|	
Herpes Simplex	|__|	—	—	—	—	
Herpes Zoster	|__|	—	—	—	—	
Candida Infection	|__|	—	—	—	—	
Idiopathic/Autoimmune thrombocytopenic purpura	|__|	—	—	—	—	

In your lifetime, have you ever had any of the following diseases or medical conditions? Circle as many as apply (Code the condition: if none, code 00; if more than one, code 15).

LIFETIME CONDITIONS

Code \|__\|__\|

01. Tuberculosis
02. Nocardiosis
03. Coccidioidomycosis
04. Lymphoma or reticulum cell sarcoma (brain only)
05. Burkitt's lymphoma
06. Non-Hodgkin's lymphoma
07. Hodgkin's disease
08. Lymphocytic leukemia
09. Multiple myeloma
10. Diabetes mellitis
11. Chronic renal failure
12. Chronic hepatitis
13. Congenital immune deficiency syndrome
14. Bleeding or clotting disorder

HEALTH BEHAVIOR: The next few questions concern some things related to your health that you might have done. For these questions, let's focus on a 4-month period after you were first tested for hepatitis and during which you felt normal and healthy. If you have had any of the symptoms we talked about earlier (see page 3), then let's talk about the 4-month period before you experienced the first symptom. If you have not experienced any of these symptoms in the past 5 years or so, let's use today's date. Now, which date shall we use?_____

FOUR-MONTH CRITICAL PERIOD

Month Year
\|__\|__\|__\|__\|

In the 4-month period before _____, did you:	Circle One:	Code	Comment
Smoke more than 4 packs of cigarettes?	1.Yes 2.No	|__|	
Drink alcohol more than 3 days per week	1.Yes 2.No	|__|	
Share a toothbrush with someone?	1.Yes 2.No	|__|	
Share a razor with someone?	1.Yes 2.No	|__|	
Share a needle with someone?	1.Yes 2.No	|__|	
Share douching equipment with someone?	1.Yes 2.No	|__|	

DRUGS AND SUBSTANCES: The next part of this study concerns the use of certain drugs. The first few questions are about drugs you might have smoked, sniffed or swallowed. Later I'll ask you a few questions about drugs and substances that can be injected. Before __ __ __ __ (ONSET DATE FOR AIDS) or in the past __ __ months, about how many days in an average month would you use ...

(Note: If never code 00, but if less than once a month, code 01)

Recreational drug or substance:	Days/Month	Comment
Marijuana (including THC, "hash")	|__|__|	_____
Nitrite Inhalants: Unlabeled bottles	|__|__|	_____
Nitrite Inhalants: Labeled bottles	|__|__|	_____
Ethyl Chloride	|__|__|	_____
LSD ("acid")	|__|__|	_____
PCP ("angel dust")	|__|__|	_____
Amphetamines ("speed"), including MDA	|__|__|	_____
Barbituates ("downers"), excluding 'ludes	|__|__|	_____
Quaaludes	|__|__|	_____
Cocaine	|__|__|	_____
roin (and other narcotics)	|__|__|	_____

In the past __ __ months, about how many times have you injected drugs or substances under your skin or into your veins? \|__\|__\|__\| times.

If respondent has injected a drug or substance, please specify: _____ \|__\|__\|

How many times have you used needles that were also used by someone else? \|__\|__\|

IF RESPONDENT HAS BEEN DIAGNOSED WITH AIDS, ASK: Since you first noticed a skin lesion or were diagnosed (whichever happened first), how many days per month have you used :

Nitrite Inhalants: Labeled bottles \|__\|__\| Nitrite Inhalants: Unlabeled bottles \|__\|__\|

SEXUAL BEHAVIOR: Now I'd like to ask you some questions about your sexual activities from t day you were first tested for hepatitis until the day you first became ill (ONSET DATE FOR AIDS: _____) or, if you haven't been sick, until today. Some of these questions may n apply to you. For those that do, I'll ask about two time periods: The entire period from your hepatitis test until you became sick (or today) and the period of 4-months before you became sick (or today).

ENTIRE PERIOD: The entire period before ONSET DATE FOR AIDS (or today) is \|__\|__\| month

Number of Sexual Partners:	Entire period	4-Month Perio
How many different male sexual partners?	|__|__|__|__|	|__|__|__|
How many different female sexual partners?	|__|__|__|__|	|__|__|__|
Total sexual partners?	|__|__|__|__|	|__|__|__|

MALE PARTNERS ONLY: Of your male sexual partners for these two periods, the entire period and the 4-month period, about what percent did you meet or have sexual contact with in each of the following places?

Places of Exposure:	Entire Period	4-Month Period	Specific Places:	Code
Bathhouses	___%	___%	_____	__
Gay Bars and Discos	___%	___%	_____	__
Bookstores and Movie Theatres	___%	___%	_____	__
Public Parks and Restrooms	___%	___%	_____	__
Other: _____	___%	___%	_____	__

Steady and Nonsteady Partners: Of your _____ male sexual partners during the entire period, and your _____ male sexual partners during the 4-month period, how many did you have sexual contact with once or twice (that is, one night or a weekend and not again) and how many did you have sexual contact with more than twice during these respective periods?

	Entire Period	4-Month Period
NONSTEADY SEXUAL PARTNERS (Once or Twice)	____	___
STEADY SEXUAL PARTNERS (Three or more nights)	____	___

Types of Exposures: Now I would like to ask you about your sexual activities with male partners during the entire period, and also during the 4-month period. First we should talk about your nonsteady partners and then talk about your steady partners. For these questions, let's talk in terms of percentages. The totals for all activities can exceed 100% if you have different kinds of contacts with your sexual partners.

Sexual Activity	Entire Period Nonsteady	Entire Period Steady	4-Month Period Nonsteady	4-Month Period Steady
Orogenital: Your penis in his mouth, with or without ejaculation on your part.	___%	___%	___%	___%
Orogenital: His penis in your mouth, with or without ejaculation on his part.	___%	___%	___%	___%
Anogenital Contact: Your penis in his anus, with or without ejaculation on your part.	___%	___%	___%	___%
Anogenital Contact: His penis in your anus, and he ejaculates in your rectum.	___%	___%	___%	___%
Anogenital Contact: His penis in your anus, but he does not ejaculate in your rectum.	___%	___%	___%	___%
Oroanal Contact: Your tongue in his anus.	___%	___%	___%	___%
Oroanal Contact: His tongue in your anus.	___%	___%	___%	___%
Fisting: Your hand or fist in his rectum.	___%	___%	___%	___%
Fisting: His hand or fist in your rectum.	___%	___%	___%	___%

FEMALE PARTNERS: If no female partners during the entire period, check here ___ and go to ALL SEXUAL PARTNERS. If any female partners, say "Now let's talk about female sexual partners during the entire period since you were first tested for hepatitis. Of your ___ female sexual partners during the entire period, how many did you have sexual contact once or twice (but not again), and how many did you have contact with more often?"

Nonsteady female sexual partners during the entire period: |__|__|__|

Steady female sexual partners during the entire period: |__|__|

Types of Exposures: For your nonsteady female partners, then your steady female partners, how often did you engage in each of the following kinds of contact:

Sexual Activity	ENTIRE PERIOD ONLY Nonsteady	Steady
Vaginal Intercourse: Your penis in her vagina, with or without ejaculation into her vagina.	|__|__|__|%	|__|__|__|%
Penogenital Contact: Your penis in her anus, with or without ejaculation into her rectum.	|__|__|__|%	|__|__|__|%
Oroanal Contact: Your tongue in her anus.	|__|__|__|%	|__|__|__|%
Oroanal Contact: Her tongue in your anus.	|__|__|__|%	|__|__|__|%
Fisting: Your hand or fist in her rectum.	|__|__|__|%	|__|__|__|%
Fisting: Her hand or fist in your rectum.	|__|__|__|%	|__|__|__|%

ALL SEXUAL PARTNERS IN THE ENTIRE PERIOD: Just a few more questions about your sexual activities with all of your sexual partners during the entire period (before ONSET OF AIDS, if) after you were first tested for hepatitis.

How many sexual partners paid you money or did you pay money? |__|__|__| partners.

How many of your sexual partners used drugs intravenously? |__|__|__| partners.

How many of your sexual partners were from Haiti or Africa? |__|__|__| partners.

How many times during or following sexual contact did you notice penile or anal bleeding, including blood in your stool? |__|__|__| partners.

How many of your sexual partners had similar bleeding during or immediately following sexual contact with you? |__|__|__| partners.

COMMENTS: Before we move on to talk about your travel outside of the Bay area, are there any other aspects of your sexual activities for us to talk about?

TRAVEL: For the entire period since you were first tested for hepatitis, how many days have you spent in each of the following places. If you have spent any time in in any of the places I name, please tell me how many different sexual partners you had while there (or from there, if you know that your partner lived there).

Place	Days	Partners
New York City (including Fire Island)	|__|__|__|	|__|__|__|
Los Angeles (including Laguna Beach)	|__|__|__|	|__|__|__|
Miami (including Key West and general area)	|__|__|__|	|__|__|__|
Haiti and/or Dominican Republic	|__|__|__|	|__|__|__|
Other Carribean Country:_____	|__|__|__|	|__|__|__|
Mexico, Other Central or South American _____	|__|__|__|	|__|__|__|
Japan, Other Asian Country:_____	|__|__|__|	|__|__|__|
African Countries:_____	|__|__|__|	|__|__|__|
European Countries:_____	|__|__|__|	|__|__|__|

NEW YORK CITY: If respondent had visited New York City, how many times did he visit:

Place	Times
The Mineshaft	|__|__|__|
St. Mark's Bathhouse	|__|__|__|
Everhard Bathhouse	|__|__|__|
The Loft (on 22nd St or in Triangle Bldg.)	|__|__|__|
Backroom of any Bar:_____	|__|__|__|

KNOWN CASES: How many people do you know (or have you known) who have been diagnosed with Kaposi's sarcoma, Pneumocystis carinii pneumonia or other opportunistic infections associated with AIDS? If you know any, how many have been your sexual partners since you were first tested for hepatitis, and how many have shared needles with you?

Number of cases that respondent knows by name: |__| |__|

Number of cases who have been sexual partners: |__| |__|

Number of cases who have shared needles with you: |__| |__|

SEXUAL PARTNERS: At this time, we believe that AIDS may be caused by an infectious agent. Th agent may be spread from one person to another by sexual contact. Therefore I'd like to ask you about your sexual partners since you were first tested f hepatitis. To distinguish one from another, it would help if we could ident each by name. However, neither you nor your sexual partners will be identif by name in our statistical studies or research reports. Can we now talk abo your sexual partners, beginning with those who you think have (or might have AIDS?

Partner	AIDS Case No.	Residence (Circle One)	Code	First Exposure Month Year	Last Exposure Month Year	Total Exposure
1. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
2. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
3. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
4. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
5. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
6. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
7. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
8. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐
9. _____	☐☐☐☐	1.SFO 2.NYC 3.Other	☐	☐☐☐☐	☐☐☐☐	☐☐

SUMMARY: Number of Sexual Partners Identified by Name: ☐☐☐

Future Research: In the future, we might be interested in having you and other patients loo list of names to see how many names you know and how many of the named persons were sexual partners. The list would include some persons with AIDS, some without AIDS, and some fictit names made out of names found in a telephone book. If we created such a list and showed the to you and other patients, would you consent to having your name included on the list?

Circle One: 1. Yes, include my name. 2. No, do not include my name. ☐

CONCLUSION:

Just a few more questions about your family and friends.
Are your parents or grandparents from Italy (Circle One): 1.Yes 2.No Code ☐

Did your parents or grandparents, or any of your brothers or sisters, ever have cancer (Circle One): 1.Yes 2.No Code ☐

Other than those with Kaposi's, do any of your friends have cancer?
Type of cancer: _____ 1.Yes 2.No Code ☐

Attachment 4: Patient Information Sheet
CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

San Francisco City Clinic
356 Seventh Street
San Francisco, California 94103

In cooperation with the:
Centers for Disease Control
Atlanta, Georgia 30333

Risk Factors for AIDS

Why this study?

Acquired immunodeficiency syndrome (AIDS) is a very serious and growing problem in San Francisco. Like hepatitis, AIDS may be caused by a virus. Like hepatitis, AIDS may be transmitted from person to person by sexual contact or exposure to blood. The cause of AIDS is unknown and there is no medical cure, but there is potential for prevention.

What can I do?

We are seeking men who participated in earlier studies of hepatitis at the San Francisco City Clinic. Participants in earlier studies of hepatitis greatly contributed to our understanding of hepatitis. Now we can offer susceptible persons a safe and efficacious vaccine to prevent hepatitis B. Once we better understand the cause of AIDS and how it is spread, we will be better able to stop its course. If you are interested in participating in this study of AIDS, please contact Paul O'Malley (Telephone 415 864-8100, ext. 41 or 42)

Why should I participate?

You will learn about AIDS, be tested, and be examined for signs of AIDS. You may benefit the Community. At present the sexual practices which are most likely to transmit AIDS are not clearly defined, therefore no reasonable counseling can be offered those at risk of acquiring or transmitting AIDS.

What is involved?

Participation requires signing an informed consent form, answering a confidential medical and sexual practices history, getting blood and urine tests to determine your current status, being examined by a doctor and, possibly, an appointment for follow-up testing at another time in the future.

What about my test results?

You will be informed if you have evidence of AIDS.

What if I am found to have evidence of AIDS?

You will be given a physical examination by one of City Clinic's physicians, have additional tests and given medical referral if indicated.

What if I change my mind?

Participation is voluntary. If you refuse to participate in this study of risk factors for AIDS, the medical care offered you by City Clinic will in no way be affected.

What about confidentiality?

Any information you voluntarily offer will be held in confidence. Study materials and results will be identified by numbers only, not by names.

Whatever your risk of acquiring AIDS may be, it will be the same whether you choose to participate or not.

Still have questions?

We will be happy to talk to you. Just call Paul O'Malley: 415 864-8100, ext. 41 or 42.

Attachment 5: Initial Letter
CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

San Francisco City Clinic
356 Seventh Street
San Francisco, California 94103
415 864-8100

In cooperation with the:
Centers for Disease Control
Atlanta, Georgia 30333

Date: _____

Addressee: _____

Dear _____,

The San Francisco Department of Public Health, in cooperation with the Centers for Disease Control, is conducting a study of risk factors for acquired immunodeficiency syndrome (AIDS). We are seeking people who were tested for hepatitis at City Clinic. Our new study is described in the enclosed patient information sheet. We hope that you will be interested in participating in this important study.

Whether you choose to participate or not, please complete the bottom half of this letter and then return the entire letter in the preaddressed envelope I have enclosed. If you decide to participate, I'll be back in touch with you shortly after I receive your response.

Thank you for your interest in our previous research project and your response to this request.

Sincerely youra,

Paul O'Malley
Cohort Study Coordinator

Please check your response and state your preferences.

Dear Paul,

|___| I am interested in participating. Please call me at _____ or write to me at _____ for an appointment. It would be best for me if you could arrange to see me on (day): _____, at (hour) _____. Other conditions: _____

|___| I am not interested in participating in this particular study.

Don't forget to return the entire letter in the preaddressed envelope I have enclosed.

ACQUIRED IMMUNE DEFICENCY SYNDROME

Screening Protocol

And

Resource and Referral Lists

The San Francisco Department of Public Health acknowledges the following AIDS Services Coordinating Committee members for their contribution to this manual: Robert Bolan, M.D., B.A.P.H.R., Steven Menalko, M.D., Franklin Hospital, Pat Norman D.P.H., Helen Scheitinger R.N., U.C.S.F., Paul Volberding, M.D., S.F.G.H.

INTRODUCTION

In recent years, the incidence of rare and often fatal diseases such as Kaposi Sarcoma, Pneumocystis Carinii and other opportunistic infections has risen in the United States in 24 states and world-wide in seven countries. These diseases are a sub-group manifestation of the disease called Acquired Immune Deficiency Syndrome (AIDS), which is an impairment of the body's immune defense system. The people most effected by these diseases, until quite recently, have been the gay male population. Seventy-five per cent of the AIDS patients are from the gay male population and twenty-five per cent of the AIDS patients are from the heterosexual and bisexual male and female population(this group includes, i.e. drug users, Haitian refugees and hemophiliacs) are affected. At this time, well over six hundred (612) diagnosed cases have been reported nationally through the Communicable Disease Center in Atlanta, Georgia, of that number, approximately one hundred (112) cases have been reported in the San Francisco Bay Area. The rise in these diseases has created questions still unanswered by the medical profession or researchers. Due to the rarity of the disease, the sudden rise in incidence, the high mortality rate and the lack of information on the etiology of the disease or the treatment method of choice, there is great concern that health service recipients have access to services that are knowledgeable, as well as, sensitively given to those who have questions about and/or symptoms of these diseases. The opportunistic infections associated with AIDS are: Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, Burkett's and non-Hodgkins lymphoma; meningitis or encephalitis due to one or more of the following: Aspergillosis, Candidiasis, cryptococcosis, cytomeglovirus, Nocardiosis, strongyloidosis, toxoplasmosis, zygomycosis, or atypical mycobacteriosis; esophogitis due to Candidiasis, cytomegloviruc, herpes simplex virus; progressive multifocal leukoencephalopathy; unusual extensive mucocutaneous herpes simplex of more than 5 weeks: 1) recurrent staphlococcus infections in axillary or groin areas (bullous impetigo); 2) cryptosporidiosis-diarrhea; 3) ITP (idiopathic thrombocytopenic purpura). Lymphadenapathy is listed here as a disease for concern and treatment need. This disease is identified by lymph node enlargement of at least six months duration. It is sometimes considered a warning sign for possible AIDS contraction.

The information contained in this directory is for use by health care providers in deciding the proper referral process and protocol for people with symptoms of AIDS or associated infections. Health care providers listed herein are experienced in treating these diseases and are either the sources of, or in contact with, the sources most familiar with the latest treatment theories and methodologies used for these complaints. If you have need for information not listed in this directory, please call the Kaposi Sarcoma Foundation at 864-4376 or the Gay and Lesbian Health Services Coordinator, Department of Public Health at 558-2541.

Fact Sheet for Teaching Classes on AIDS

This information is based upon a distillate of the knowledge accumulated by SFGH, UCSF, UCLA, Stanford, several hospitals in New York and the combined efforts of the AIDS Task Force at the Center for Disease Control in Atlanta, Georgia. There are no other authorities to turn to for more or better information. Continuing communication between all these Centers provides the best available knowledge for all.

I. What is A.I.D.S?

Acquired Immuno Deficiency Syndrome is a disease of previously healthy people who for some reason develop diseases seen only in the immunodeficient. The deficiency appears to be permanent and is not explained by other known immune defect diseases. While there are several theories as to what it is, the one felt to be the most likely is that it is a new virus, not previously seen.

II. Who is at risk?

A. 4 high risk groups

homosexual and bisexual men (75% of cases)
heterosexual men, women, and children (25% of cases)
- hemophiliacs
- IV drug abusers
- Haitians
- 5% unknown risk factors

B. Hospital workers have not acquired AIDS unless also a member of a high risk group (after more than three years experience in New York City in which no precautions were taken in the hospital for about the 1st 2 years)

C. >1100 cases in the US since late 1979
>1/2 States in US have 1 or more cases
>13 foreign countries
affects all races and all ages (none identified over the age of 60) and both sexes

III. How is it transmitted?

A. From a long list of epidemiological questions given to AIDS patients, it appears that the route of transmission is most like Hepatitis B

*1. Blood and other secretions
*2. Sexual contact
3. Food does not appear to be a source - otherwise it would have spread beyond the high risk groups
4. Air does not appear to be a source - otherwise it would have spread beyond the high risk groups.
5. Large doses or repeated exposures may be necessary as with many other diseases since there are people who have been exposed who have not come down with it.

(3)

B. Incubation period seems to average 1 1/2 - 2 years

C. Like Hepatitis it seems to be communicable during incubation and before symptoms occur.

IV. Immune System Defect

A. Characteristic of most AIDS cases are elevation in some immunoglobulins and abnormal T lymphocyte levels. Specifically, the Helper:Suppressor ratios are affected.

Normal ratios are 1.5-2 Helper cells for every 1 Suppressor cell.

AIDS patients average 0.5 helper cell per 1 Suppressor cell.

This test is not a test for AIDS. Some AIDS patients do not have abnormal levels, especially early on. Many people have abnormal ratios and do not have AIDS. Many diseases including most viruses and other infectious diseases cause temporary abnormalities. The difference with AIDS is the seeming permanence of the defect. THIS TEST IS NOT DIAGNOSTIC NOR WILL IT PREDICT WHO IS SUSCEPTIBLE.

V. How is Diagnosis Made?

The patient must have symptoms and be diagnosed with an opportunistic infection that does not normally affect healthy people. Or they must have biopsy proven Kaposis Sarcoma(biopsy is necessary to be sure this is not some other dermatologic problem).

T Lymphocyte studies are not diagnostic.

If no other explanation for the immunosuppression can be found, a tentative diagnosis of AIDS can be made.

VI. How is it Treated?

Kaposis (KS) is treated with an experimental protocol using Interferon. There has been success in gaining remission in some cases but in none have the immune defect corrected itself.

Pneumocystis carinii pneumonia is treated with high dose Septra or Pentamidine with success in some cases but without regaining normal immune system function.

These are examples of treatment of clinical illnesses which some patients have but are not actual treatment of AIDS (a transmittable agent that causes immunosuppression). There is no known treatment for AIDS itself.

Other clinical illnesses are treated according to the specific illness, frequently fungal infections.

VII. Diseases seen in these patients:

The diseases seen are old diseases seen before but which do not normally occur in healthy people

- Pneumocystis
- Aspergillus
- Cryptococcus
- Toxoplasmosis
- Mycobacterium avium

or are extreme manifestations of diseases which can affect otherwise healthy people

- massive Herpes simplex which does not go away
- Candida pharyngitis and esophagitis
- Herpes zoster
- widely disseminated Cytomegalovirus (CMV)

Most of the above are ubiquitous organisms found everywhere in nature and may be in all of our bodies right now. They become a threat when the immune system does not function. Acquiring one of these organisms does not give you AIDS. One must be immunosuppressed in order to be susceptible to one of these opportunistic infections.

VIII. CMV(Cytomegalovirus)

CMV is a ubiquitous organism which is passed from one person to another by contact with body secretions. The two most common ways of acquiring it is through sexual contact and intimate contact with children under the age of 5. In healthy people this does not often cause symptoms. Occassionally it causes a form of mononucleosis. When acquired from transfusions it may cause a form of hepatitis.

50% of the general population have already had CMV as evidenced by antibody. However, only about 1-2% are excreting it in the urine or semen. In certain populations the excretion rate is higher (children under the age of 5 up to 51% in some studies, renal transplants, Dialysis patients, Oncology patients, the Gay population, pregnant women). Having antibody to CMV does not convey immunity.

The AIDS patients, in our experience, have a high rate of excretion of CMV late in the course of their illness. This is frequently found in the lungs. Since it is rare to have anyone with CMV pneumonia, there aren't good studies to show the transmissibility of CMV by this route. Therefore, we have no way of knowing at this time if this is an important route of spread from patients.

X. Infection Precautions for OutPatients

1. AIDS Clinic - Gloves are used for any contact with blood or other secretions. Masks are worn by patients who are coughing or health worker if patient must be unmasked for procedures or examination.

2. AIDS patients in other clinics may be seen as above.

3. Emergency Room patients presenting with symptoms compatible with AIDS may be seen as above. Care should be taken to screen these patients with sensitivity. Do not forget that 25% of AIDS cases are not gay and that the focus should be on careful handling of blood and secretions from all patients rather than selecting out one high risk group.

XI. Ways of Approaching Fear of the Unknown

Although the transmissible agent of AIDS is not known, we have quite a bit of epidemiologic information about how it is spread. The more people are able to focus on what we know and use basic proven Infection Control practices not only in the care of AIDS patients but in all patients, the more feeling of control people are likely to feel. There are only a certain number of ways disease can be spread and only a certain number of technics which have been shown to be effective. Anything beyond what we are doing now is probably window dressing.

When teaching classes it is important for the instructor to be aware of his/her own anxieties so that one can make the conscious choice to give useful information rather than make statements that are expressions of free-floating anxiety. With useful information you can have control of the fear. With free-floating anxiety, the fear controls you.

XII. Employees Who Fear They May be More Susceptable

The two most common expressions of this are Gays who feel they may be more susceptible because they have heard that many Gays have abnormal Helper:Suppressor ratios and people who have special health problems.

1. An abnormal H:S ratio does not prove greater susceptibility because the cause of that abnormal ratio is not known. It may be an expression of a recent viral illness, for example. Recent CMV infection (very common in gay population) causes up to 6 months of some degree of immunosuppression but is not permanent.

The importance of CMV transmission in the hospital setting relates to acquisition by pregnant women since this is a cause of birth defect in the children of 40% of women who acquire it during pregnancy.

IX. Infection Precautions for In Patients

Precautions	Rationale
1. Private Room	This is for the protection of the patient who is more susceptible than most, to other infections.
2. Blood (and other secretions) precautions: Wear gloves for all blood and other secretion contact Wear gloves for starting IVs or drawing bloods Baker Box or other puncture proof box in room for needles, which should not be broken or recapped Handwashing	Blood and secretions appear to be the major source
3. Gowns need only be worn where heavy contamination is expected. This may mean ICUs, care of terminally ill, procedures, patients with massive lesions.	Viral diseases without excretions do not get transmitted by way of clothing.
4. Masks to be worn by health workers if patient has lung involvement and is coughing or intubated. Mask to be worn by patient outside room when coughing.	THERE IS NO EVIDENCE THAT A.I.D.S. IS TRANSMITTED BY THE AIR. Masks are to prevent spread of CMV primarily.
5. Pregnant women should not have direct contact with excreters of CMV. For practical purposes we assume AIDS patients to be excreting. Based on Virus Lab findings, we expect excretion to occur in later illness rather than at early diagnosis.	It is common practice in hospitals to not assign pregnant women to known excreters. However, should a nurse later find that she is pregnant, having taken the prescribed precautions will give her more protection than she will have from her sexual partner or preschool children.

CURRICULUM VITAE

Appendix D

Selma K. Dritz, M.D., M.P.H.

Office:
101 Grove Street
San Francisco, CA 94102
(415) 558-4046

Birthdate: 29 June 1917

Place of birth: Chicago, Illinois

Citizenship: United States

Education and degrees:

University of Illinois 1939 - B.Sc. in Medicine
University of Illinois 1941 - M.D.
University of California, Berkeley 1967 - M.P.H.

Honors achieved: Alpha Omega Alpha, Illinois 1941

Post graduate training:

Cook County Hospital, Chicago - Internship 1941-42
Cook County Children's Hospital, Chicago - Residency 1942-44
Cook County Contagious Disease Hospital, Chicago - Chief Resident 1944
University of California School of Public Health, Berkeley, CA 1966-67

Professional experience:

Illinois State Health Department, Springfield - Pediatrics Consultant 1946-47
Private practice, pediatrics, Chicago - 1945-46
San Francisco Department of Public Health - 1967-1984
Assistant Director, Bureau of Disease Control, and Chief, Division of Occupational Health, concurrent

Appointments:

University of California Medical School, San Francisco, 1972 to present, Consultant, Department of Ambulatory and Community Medicine

Governor's Industrial Safety Conference, California, 1970-73
San Francisco Medical Society, 1970 to present:
Technical Advisory Committee, Air Quality Maintenance Program
California State Task Force on AIDS, 1982-84

Professional memberships:

San Francisco Medical Society
California Medical Association
American Medical Association
Northern California Public Health Association
American Public Health Association
California Academy of Preventive Medicine (Pres. 1981)
American College of Preventive Medicine
Western Industrial Medical Association
American Occupational Medical Association
American Society of Tropical Medicine and Hygiene

Publications:

Cappucci, DT; Emmons, RW; Mullen, DA; Dritz, SK; Garcia, JP. "Unusual Laboratory Exposure to a Rabid Skunk." J. Amer. Veter. Med. Assn. Vol. 161, No. 6. 1972.

Morbidity and Mortality Weekly Report. Shigellosis - California. Dritz, SK. Vol. 21, No. 11. 1972

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Dritz, SK, & Braff, EH. "Sexually Transmitted Typhoid Fever." New England J. Med. Vol. 296, No. 23. 1977. (letter)

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Calin, A; Kaslow, R; Simon, D; Ryder, R; Kaye, R; Dritz, S. Reiter's Syndrome (RS) and the Sero-epidemiology of Shigella. The Heberden Society. September 1978.

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Spinelli, JS, Ascher, MS, Brooks, DL, Dritz, SK, Lewis, HA, Morrison, RH, Rose, L, and Rupanner, R. Q fever crisis in San Francisco: controlling a sheep zoonosis in a lab animal facility. Lab Animal: pp. 24-27, May 1981.

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Conwill, DE, Werner, SB, Dritz, SK, et al. Legionellosis. The 1980 San Francisco Outbreak. Am Rev Respir Dis 1982; 126:666-669.

Ammann, A, Wara, DW, Dritz, SK, et al. Acquired Immune Deficiency Syndrome in an Infant: Possible Transmission by Means of Blood Products. Lancet, 30 April 1983.

Jaffee HW, Choi K, Thomas PA, et al. National Case-Control Study of Kaposi's Sarcoma and Pneumocystis carinii Pneumonia in Homosexual Men: Part 1, Epidemiological Results. Annals of Internal Medicine, 1983: 99:145-151.

Ammann AJ, Dritz SK, Volberding P, et al: The Acquired Immune Deficiency Syndrome (AIDS) - A Multidisciplinary Enigma-Medical Staff Conference, University of California, San Francisco. West J Med 1984 January; 140:66-81.

Abstracts:

Sexually Transmitted Enteric Diseases in San Francisco. American Public Health Association Annual Meeting. Washington DC, November, 1977.

Sexually Transmitted Enteric Diseases. California Medical Association Annual Meeting. San Francisco, March, 1978.

Infectious Disease Incidence in San Francisco, 1977. American Academy of Family Physicians Annual Meeting. San Francisco, April 1978.

Illness and Injury Prevention in Day Care Centers. Maternal and Child Health Section Pre-APHA Conference. University of California School of Public Health. American Public Health Association Annual Meeting. October 1978.

Sexually Transmitted Diseases Study Group. National Institute of Allergy and Infectious Diseases, National Institutes of Health, Washington, DC, January 14-15, 1980.

Sexually Transmitted Diseases-Treatment Guidelines 1982, CDC: Morbidity and Mortality Weekly Review, Supplement. Volume 31 Number 25, August 20, 1982.

DECLARATION OF MERVYN F. SILVERMAN, M.D.

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

1. I am now, and have been since May 2, 1977, the duly appointed and acting Director of the Department of Public Health of the City and County of San Francisco.

2. In 1960, I received a Bachelor of Science Degree with honors from Washington and Lee University in Virginia. I received my M.D. from Tulane University in 1964 and a Masters Degree in Public Health from Harvard University in 1969. From 1969 to 1970, I served as Assistant to the Commissioner at the Federal Food and Drug Administration and was Director of Consumer Affairs for the Food and Drug Administration from 1970 to 1972. From 1972 to 1977, I served as the Director of Health for the Department of Community Health of Witchita Sedgwick County, Kansas, where I supervised a public health staff. A copy of my curriculum vitae is attached as Exhibit 1 hereto and incorporated herein by reference as though fully set forth.

3. As San Francisco's Director of Public Health, I have been responsible for directing the City's response to the epidemic of Acquired Immune Deficiency Syndrome ("AIDS"). Early in 1981, I first became aware of a strange disease almost exclusively striking homosexual males in several large urban centers. Since I believed that San Francisco, with its large

homosexual population, was certain to be particularly hard hit, I directed my staff to study all cases of AIDS In San Francisco in order to gather information on risk factors and behavioral patterns of the affected population. I initiated this study well before the State of California required the reporting of this disease.

4. The study performed by my staff was designed to assist me in formulating public health policies to prevent the spread of AIDS in San Francisco. From the information I obtained, I quickly concluded that AIDS is a uniquely virulent disease. The incidence of this disease in the homosexual male population is alarmingly high. In my opinion, the unprecedented rate of increase in new cases and the parallel growth in the number of people dying each day (now almost one per day and expected to be two per day within the next twelve months), combined with the fact that there is no cure for the disease and virtually all who contract AIDS are dead within four years, makes this disease a tragedy of unparalleled dimensions. San Francisco is the focal point of this tragedy. We have in San Francisco the highest per capita incidence of AIDS of any urban center in the world.

5. AIDS is a horrible, protracted, painful disease that debilitates its victims well before they die. Treatment is costly and ultimately ineffective. There is no known cure. The disease has a long incubation period, presently estimated to be from six months to five years. This long incubation period means

that those who have contracted the disease may experience no clinical symptoms for months or even years while they may be carriers capable of spreading the disease. The epidemiological and etiological studies I have seen indicate that AIDS is caused by a virus. All the available evidence compels the conclusion that the disease is primarily sexually transmitted. The evidence further shows that there is a direct correlation between the number of male homosexual sex partners someone has and the likelihood he will contract the disease.

6. As a public health officer, I have regularly studied epidemics and their effects on the population. As the AIDS epidemic has unfolded in several locations in the United States, I have come to realize that this disease has reached epidemic proportions in the affected population of homosexual males. An informed medical opinion leads me to conclude that we can have no reason to believe that the disease could not spread outside this population group.

7. Based upon all of the facts before me, I concluded that official public health action was required. In view of the sensitive nature of public intrusion into matters of personal privacy and the need to maintain rapport and credibility with the affected population, I initially directed a concentrated and comprehensive educational program designed to inform the affected population and businesses catering to high-risk behavior. Through this program, I sought to educate the community regarding the nature of AIDS, the dangers of the disease, and the role of

sexual transmission in the spread of the disease. In particular, the educational program urged homosexual males to avoid engaging in sexual activities that involve the exchange of body fluids. It further stressed the importance of avoiding multiple sexual contacts because of the enhanced risk of contracting the disease associated with such activity.

8. Our educational efforts proved successful in part. For example, we have always considered gonorrhea in the homosexual community a reliable measure of the degree of sexual activity amongst homosexual males. By that measure, our educational efforts have succeeded in that the incidence of gonorrhea has declined. However, the rate of new AIDS cases and the number of deaths a month have sky-rocketed. Even if eventually there is a decline in the rate of the spread of AIDS such that it declines to the present levels of gonorrhea cases, that level would still be unacceptably high. In establishing public health priorities, we can deal with the incidence of gonnorhea in the affected population because gonorrhea is a non-fatal and easily-cured illness with a short incubation period and relatively few severe complications in most cases. However, the same policy is unacceptable when we are confronted with a fatal, incurable disease, especially one with such a long incubation period.

9. In addition to the study done by my staff, the Department of Public Health contracted with Leon McKussick to do a study on the behavior of homosexual males following our

educational program. We learned that many members of the community, when informed of the risks, changed their practices to avoid unsafe sex. However, a significant number of those surveyed have disclosed that although fully informed of the dangers involved they have chosen to continue engaging in high-risk sexual activities.

10. Further, our studies have shown that in addition to multiple sexual activity being a high-risk behavior, certain commercial enterprises commonly known as bathhouses and sex clubs, but which also include book shops and certain other types of facilitities, foster, promote, encourage and facilitate these multiple sexual contacts. An individual so inclined who may be able to have one or two sexual contacts in public surroundings may be able to have eight or ten, or even fifteen to twenty, contacts in a bathhouse setting. Hence, bathhouses and similar commercial facilities have been shown to be uniquely adapted to one of the highest risk behaviors to wit: multiple sexual contacts.

11. As a public health officer, I consider it my duty to fashion and implement public policies designed to discourage and bring to an end commercial enterprises that involve exploitation for profit of an individuals' willingness to engage in potentially fatal forms of recreation. AIDS is killing young people in the prime of their lives, many of whom are hard working and valuable members of our community. The tragedy of their deaths deprives the community of their industry and creativity

and burdens the public fisc with the enormous charges of treating the plethora of AIDS-related ailments. In my opinion, although sexual activity is a matter of individual privacy, when that activity takes place in a commercial setting the government has the prerogative and the duty to intercede and halt the operation of businesses that foster, promote, encourage, and profit from individual activities that threaten to spread virulent disease.

12. In addition to our educational activites, I and members of my staff have urged owners and operators of bathhouses, sex clubs, book stores and other establishments where high-risk multiple sex has been prevalent to change their operations and assume responsibility for the health and safety of their customers by preventing them from engaging in dangerous sexual activities. Recent inspections have led me to conclude that some businesses indeed have changed their practices, and in those facilities there is a conscious effort on the part of the management to discourage unsafe sexual practices amongst their customers. However, some businesses have refused to make any significant changes in their operations. They continue to encourage and facilitate multiple sexual contacts.

13. I have determined that the AIDS epidemic has reached such proportions that strong public health measures must be taken. The continued operation of businesses that encourage, facilitate, and profit from multiple sexual contacts, directly linked by all scholars with the transmission of AIDS, constitutes a hazard to the public health. As San Francisco's public health

officer, I am duty bound to take those steps I deem necessary to prevent the tragic waste of human life, the diversion of public resources for the treatment of this insidious disease, and the continued infection of innocent people in places of business operating primarily for the purpose of profiting from this commerce in death. Therefore, I have determined that these businesses must be closed and I have ordered the same.

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

Executed on October 10, 1984, at San Francisco, California.

MERVYN F. SILVERMAN, M.D.

4206D

"Sex clubs/bathhouse" Edenberg
See archive list [illegible]
12/31/84

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ENDORSED
FILED
San Francisco County Superior Court
DEC 24 1984
DONALD W. DICKINSON, Clerk
BY: Bernie Fabro
Deputy Clerk

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE CITY AND COUNTY OF SAN FRANCISCO

DEPARTMENT EIGHT

PEOPLE OF THE STATE OF CALIFORNIA ex rel. GEORGE AGNOST, City Attorney, et al.,

Plaintiffs,

vs.

IMA JEAN OWEN, et al.,

Defendants.

No. 830-321

MODIFIED PRELIMINARY INJUNCTION

IT IS HEREBY ORDERED that Defendants, and each of them, their agents, employees, tenants, lessees, successors and assigns be enjoined and restrained from renting or operating any and all private rooms within their premises other than those which are licensed to be operated as hotel rooms pursuant to Section 160 of Part III of the San Francisco Municipal Code; provided, however, that those Defendant establishments which are licensed as massage parlors pursuant to Article 27 of the San Francisco Police Code may allow the occupation of one and only one room per establishment by a licensed masseur or masseusse for the purpose of giving massages.

E AGNOST
ATTORNEY
06 CITY HALL
NCISCO 94102
6-3315

IT IS FURTHER ORDERED that each operator-Defendant shall provide employees (hereinafter, "monitors") for the exclusive and sole purpose of observation of activity on their premises. Such monitors shall survey the entire premises every ten minutes. The number of such monitors shall be determined according to the following formula: (a) For the Defendant bookstores, one monitor for each floor or portion of a floor primarily devoted to video/movie booth arcades, and one monitor for any other floor or portion of a floor open to patrons, other than areas primarily devoted to the sale of periodicals; (b) For the Defendant movie theatres, one monitor for any floor or portion of a floor open to patrons; and, (c) For all other Defendants, two monitors for any floor or portion of a floor open to patrons.

In the event any operator-Defendant can submit, together with a declaration under penalty of perjury, competent evidence establishing the average hourly patronage based upon records of that operator-Defendant's business during the hours from seven p.m. to closing for the three month period commencing on June 1, 1984 and ending on August 31, 1984, that operator-Defendant may provide one monitor for each twenty patrons according to the average hourly patronage of the particular establishment between the hours and dates specified above. An operator-Defendant may provide monitors according to this formula ten days after submitting the declaration and supporting documentation to the City Attorney; provided, however, that if the City Attorney objects to the declaration and moves the Court for correction,

the Court shall determine the appropriate formula for monitors.

Plaintiffs and individual operator-Defendants may by stipulated order modify the number of required monitors for any Defendant establishment.

Each operator-Defendant shall prepare a report indicating the total number of patrons admitted per day and the number of patrons on the premises on the odd-numbered hours from the hour of opening until the close of business. Copies of these reports shall be served upon the City Attorney once per week during the pendency of this preliminary injunction accompanied by a declaration under penalty of perjury attesting to their accuracy. Said declarations shall be served each Tuesday no later that four p.m. and shall cover the seven day period ending at the close of business on the immediately preceeding Sunday; provided, however, that these patronage reports shall not be required of any Defendant establishment that elects to base its number of monitors upon the fixed number formula, rather than upon the average hourly patronage formula.

This duty on the part of the operator-Defendants to monitor the activity of their patrons upon the premises in no way limits or supersedes the authority of the Department of Public Health or any other authorized agency or individual to conduct any and all inspections deemed necessary.

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ORGE AGNOST
ITY ATTORNEY
M 206 CITY HALL
FRANCISCO 94102
558-3315

The Director of Public Health having defined high risk sexual activity as set forth in Exhibit A hereto, IT IS FURTHER ORDERED that Defendants shall immediately expel from the premises any and all patrons observed engaging in such high risk sexual activity.

In the event that the Director of Public Health, in conjunction with the San Francisco AIDS Foundation, determines that a definition different than that set forth in Exhibit A of this order would be appropriate, he may offer such alternative to the Court for its consideration as a basis for modification of the preliminary injunction. Should the San Francisco AIDS Foundation and the Director of Public Health fail to agree on a definition, the determination of the Director of Public Health shall control.

Each operator-Defendant shall prepare a report of incidents where patrons are expelled pursuant to this order. The report shall describe generally the circumstances leading to the expulsion. Defendants are not required to obtain or report the names of individuals expelled. Copies of these reports shall be served upon the City Attorney once per week during the pendency of this preliminary injunction accompanied by a declaration under penalty of perjury attesting to their accuracy. Said declarations shall be served each Tuesday no later that four p.m. and shall cover the seven day period ending at the close of business on the immediately preceeding Sunday.

IT IS FURTHER ORDERED that the doors to individual

AGNOST
TORNEY
CITY HALL
ISCO 94102
3315

video/movie cubicles, video/movie booths or video/movie rooms be modified as follows: for individual video/movie cubicles where at least 4 feet of clear space exists in front of a booth, removal of the bottom 24 inches of the door shall satisfy the terms of this order; where less than 4 feet of clear space exists, removal of the bottom 39 inches of the door shall satisfy the terms of this order. Defendants shall ensure that no more than one person at a time enters an individual video/movie cubicle.

Should there be a violation of this preliminary injunction, Defendants, upon written notice from the Plaintiffs, shall be given a five day opportunity to cure such violation. Thereafter, Plaintiffs, upon written notice to the Defendants, may prceed with all remedies allowed by law. This five day opportunity to cure shall apply only to the first violation of any kind at any Defendant establishment.

IT IS FURTHER ORDERED that each operator-Defendant shall participate in the education of its patrons toward the prevention of high risk sexual activity including but not limited to that suggested by the San Francisco AIDS Foundation.

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ORGE AGNOST
ITY ATTORNEY
M 208 CITY HALL
FRANCISCO 94102
558-3319

This preliminary injunction shall be dissolved forthwith or upon notice by either party should the Director of Public Health declare the AIDS epidemic to be terminated.

A copy of this order, including the attached Exhibit A, shall be posted in each room and hallway of the Defendants' establishments to which patrons are admitted.

DATED: December 21, 1984

Roy L Wonder

HON. ROY L. WONDER
Judge of the Superior Court

5448D

Exhibit A

HIGH RISK SEXUAL ACTIVITY

INTERIM DEFINITION

For the purposes of this preliminary injunction, "high ris sexual activity" shall mean:

(a) The placing of the penis of one male on or into the anus or mouth of another male;

(b) The placing of the mouth of one male on the anus or penis of another male;

(c) The contact of the feces or urine of one male with any part of the body of another male; or,

(d) The entry of any part of the body of one male into the anus of another.

ORGE AGNOST
ITY ATTORNEY
M 206 CITY HALL
FRANCISCO 94102
558 3315

Owen

December 21, 1984

Hon. Roy L. Wonder
Judge, Superior Court
Department 8
481 City Hall
San Francisco, CA 94102

Subject: People v. Owen, et al.
(Superior Court No. 830-321)

Dear Judge Wonder:

I have reviewed the language of the Plaintiffs' proposed Modified Preliminary Injunction, and in particular the definition of "high risk sexual activity" contained in the Plaintiffs' Exhibit A. I have adopted and do endorse the language of that interim definition until such time as I have had an opportunity to confer with the San Francisco AIDS Foundation next month regarding this determination. I respectfully urge this Court to do the same.

Very truly yours,

MERVYN F. SILVERMAN
Director of Public Health

cc: All Counsel

City and County of San Francisco

Department of Public Health

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PRESS STATEMENT

OF

DR. MERVYN F. SILVERMAN

October 9, 1984

Today I have ordered the closure of 14 commercial establishments which promote and profit from the spread of AIDS - a sexually transmitted fatal disease. These businesses have been inspected on a number of occasions, and demonstrate a blatant disregard for the health of their patrons and of the community.

We now have solid evidence that AIDS is a sexually-transmitted viral disease - often spread by people who are unaware that they are carrying the virus. Antibodies to this virus have been found in at least 40 - 50% of the gay male population studied in San Francisco. We know that the more sexual activity involving exchange of body fluids, the greater the risk of contracting AIDS.

From the beginning of this epidemic, we established a prevention program which placed major emphasis on education designed to inform the gay community about the nature of this disease and how it can be prevented. This became part of an overall approach by San Francisco that is serving as the model AIDS program for the rest of the country. Today's action is one part of this comprehensive program.

Central Office 101 Grove Street San Francisco, CA 94102

The places that I have ordered closed today have continued in the face of this epidemic to provide an environment that encourages and facilitates the multiple unsafe sexual contacts, which are an important factor in the spread of this deadly disease.

When activities are proven to be dangerous to the public and continue to take place in commercial settings, the Health Department has a duty to intercede and halt the operation of such businesses.

Make no mistake about it. These 14 establishments are not fostering gay liberation. They are fostering disease and death.

ORDER OF DIRECTOR OF PUBLIC HEALTH
TO ABATE A PUBLIC NUISANCE

TO:

SUBJECT:

ASSESSORS BLOCK: LOT:

WHEREAS the Director of Public Health has determined that the incidence of Acquired Immune Deficiency Syndrome (AIDS) in San Francisco has reached epidemic proportions with the highest per capita incidence anywhere in the United States; and

WHEREAS AIDS is a fatal disease with no known cure; and

WHEREAS the Director of Public Health has determined that the operation of the above designated business contributed to the spread of the virus that causes AIDS;

ACCORDINGLY, the Director of Public Health has determined that the continued operation of the above designated business constitutes a hazard and menace to the public health;

THEN by virtue of the power yeilded in him by the law of the State of California, the Charter of the City and County of San Francisco, and the Ordinance of the City and County of San Francisco,

THE DIRECTOR OF PUBLIC HEALTH FOR THE CITY AND COUNTY OF SAN FRANCISCO HEREBY ORDERS THE ABOVE DESIGNATED BUSINESS TO CLOSE NO LATER THAN 12:00 O'CLOCK NOON, OCTOBER 9, 1984.

_____
DATE

_____
MERVYN F. SILVERMAN, M.D., M.P.H.
Director of Health
City and County of San Francisco

ACADEMY
2166 Market Street
San Francisco, CA., 94114

ANIMALS
161 6th Street
San Francisco, CA. 94103

BOOT CAMP
1010 Bryant Street
San Francisco, CA

CLUB BATHS OF SAN FRANCISCO
201 8th Street
San Francisco, CA.

CLUB SAN FRANCISCO
330 Ritch Street
San Francisco, CA. 94107

DISCOUNT BOOKS
114 Eddy Street
San Francisco, CA.

FOLSOM GULCH BOOKS
947 Folsom Street
San Francisco, CA. 94107

JACK'S TURKISH BATH
1143 Post Street
San Francisco, CA.

JAGUAR ADULT BOOK STORE
4056 18th Street
San Francisco, CA

SAN FRANCISCO HEALTH CLUB
229 Ellis Street
San Francisco, CA

SAVAGE THEATRE
220 Jones Street
San Francisco, CA.

THE SLOT
979 Folsom
San Francisco, CA

TEA ROOM THEATRE
145 Eddy Street
San Francisco, CA.

21st STREET BATHS
3244 21st Street
San Francisco, CA. 94110

BRIEFING PAPER

San Francisco's Action Against the Bathhouses
and Sex Establishments

Current Status: __ of the __ establishments remain open.

Health Department inspectors monitor the remaining establishments for compliance with the court order that defines permissible activities.

Within the next few months, the San Francisco City Attorney will go to court to request closure of approximately __ establishments that have been found to be operating in violation of the court order.

History of San Francisco's Action

Before Action (April to September 1984

- Community Concern: The issue is debated among members of the gay community and health professionals. In general, gay leaders are not willing to state publicly that they favor closure of the bathhouses despite what they say in private. Many health professionals favor closure of the bathhouses.
- Legal Preparation: The San Francisco City Attorney studies the issue in order to recommend what actions are available to the Director of Health, under State and local Health Codes. The City Attorney informs the Director that he can take the following actions:
  - *Close or quarantine the public bathhouses that are licensed and regulated under the City's Bathhouse Ordinance. This measure excludes private sex clubs that are not regulated under the ordinance and are often less sanitary than the public bathhouses.*
  - *Regulate the bathhouses and sex establishments -- both public and private -- to eliminate behavior that may lead to the spread of AIDS.*
  - *Take no legal action but continue to regulate informally and provide educational materials.*

  The attorneys also consider:

  - *Transfer of responsibility for regulating bathhouses (but not private sex establishments) from the Police Department to the Health Department in order to facilitate Health Department regulation of these establishments. This proposal was rejected by the Board of Supervisors, San Francisco's legislative body.*
  - *In preparation, data are compiled to justify Health Department action. Health Department professionals begin to amass medical and scientific documentation to support the contention that the bathhouses and sex establishments are conducive to the spread of AIDS. Undercover inspectors visit the establishments to verify that activity likely to spread AIDS is taking place in each specific establishment.*

- Possibility of ballot issue furthers concern for action: During the summer, a gay activist (Larry Littlejohn) began to circulate an initiative petition for the November 1984 ballot that would call for closure of the gay bathhouses and sex establishments. This caused great concern among gay people and others concerns with the implications of holding a "gay referendum". After the City began to take action, Littlejohn withdrew the petition.

- Closure of some establishments: Throughout this period, several establishments

Action Against Bathhouses and Sex Establishments

- City takes action: On October 9, 1984, the San Francisco Health Director announces his intention to take action against 14 bathhouses and sex establishments. The establishments immediately asked for a preliminary injunction against the Health Department's action.
- Court amends action: On November 28, 1984 Judge Roy Wonder of the Superior Court issues his decision regarding the request for a preliminary injunction. Facilities can remain open only under these conditions:
  (1) no private rooms can be rented unless they are licensed to be operated as hotel rooms;
  (2) employees of the establishment shall be assigned to observe the activity on the premises -- the number of monitors needed is specified in the court order. They shall survey the entire premises every ten minutes and expel all patrons observed in high risk sexual activity as defined by the Health Department. Owners must report to the Health Department on the number of people expelled.
  (3) all doors to individual cubicles or booths must be removed.
  (4) owners shall educate patrons on what constitutes high risk sexual activity.
  (5) if violations of the court order are found by the Health Department, the owner shall be given 5 days from written notice to cure the violation. After that, the Health Department can close the facility.

Results of Court Order to date:

- Need for continual monitoring: the Court order requires continual monitoring by Health Department officials. This is difficult (inspectors should be undercover to be most effective).
- Need to continue to gather evidence: Since the Court order, the City began to compile evidence against those establishments violating the order; several more establishments closed due to lack of business.

Summary

San Francisco brought the action against several types of establishments where unsafe sexual activities take place: licensed bathhouses, backs of certain bookstores, certain movie theaters, private clubs.

In court, the City demonstrated the following:

- Scientific/medical evidence links certain sexual practices to AIDS;
- There is evidence that these sexual practices are taking place in each of the sex gay bathhouses and sex establishments. On a continued and repeated basis that constitutes a grave danger to the public health.

Health experts considered:

- what action is most likely to affect people who might contract AIDS?
- what action is most likely to minimize public hysteria about AIDS?

Elements of Case Against the Bathhouses and Sex Establishments

- Required evidence that certain sexual practices are conducive to the spread of AIDS.
- Required evidence that these practices occur and are encouraged in these facilities.
- Required demonstration that the facilities were inspected on several occasions.
- Involved argument that government cannot condone such activities in commercial establishments that it licenses or which do business in the City.
- Required evidence that owners of the facilities knowingly allowed these unsafe and dangerous activities to take place.

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Sex clubs/bathhouses Education

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

AIDS Behavioral Research Project
HOSPITALS AND CLINICS - A 405

SAN FRANCISCO, CALIFORNIA 94143
731-7468

TO: Mervyn Silverman, M.D.

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

DATE: April 3, 1984

SUBJECT: Bathhouses and Public Policy

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

Medical Issues

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

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

Behavioral Issues

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

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

Behavioral Issues (continued)

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

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

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

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

Have Educational Efforts Been Successful?

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

Would Closing or Altering the Baths Make a Difference?

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

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

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

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

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

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

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

Conclusion

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

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

Sex Clubs/Bathhouse - Ltr. 2

258

OFFICE OF THE MAYOR
SAN FRANCISCO

DIANNE FEINSTEIN

August 9, 1984

Honorable Willie Kennedy, Chair and Members
Public Protection Committee
Board of Supervisors
City Hall
San Francisco, California 94102

Dear Chair and Members:

If ever a piece of legislation cried out for adoption, it is the measure before you today regarding regulation of bathhouses (your calendar item #4). This measure would simply transfer the bathhouse ordinance from the Police Code to the Health Code. This would recognize the current enforcement situation, and give the Health Department jurisdiction over what is essentially a public health matter.

- The bathhouse ordinance is directed towards health, rather than police concerns. The bathhouses are licensed in order to protect public health concerns.

- Current enforcement efforts are carried out by health inspectors, rather than police officers. Even though the ordinance is now in the Police Code, enforcement is carried out by Health inspectors. The inspectors visit the bathhouses in order to ensure that they are complying with the sanitation and public health aspects of the ordinance.

- The bathhouses are centrally involved in the major health issue facing our City: AIDS. As you know, the AIDS crisis is an extremely serious one:
  - To date there have been 642 cases of AIDS in San Francisco, with 261 deaths; an almost 41% death rate.
  - In the month of July, there were 54 new cases and 21 deaths -- nearly 2 new cases a day.
  - In the first three days of August, there were 8 new cases and 4 deaths -- nearly three new cases each day.
  - A recent study in the City Clinic showed that over 50% -- and perhaps as much as 70% -- of gay males have been exposed to the AIDS virus.
  - The incubation period for the AIDS virus may be as much as five years.

The regulation of bathhouses should be decided by doctors and health professionals on the basis of current epidemiological evidence and not by police untrained in health care. To leave the matter of disease control to police merely politicizes the issue by making police the scapegoats for those who want to obfuscate and procrastinate about the bathhouses. I urge your approval of this crucial legislation.

Sincerely,

Dianne Feinstein
Mayor

DF/mk
5215R

ITY AND COUNTY OF SAN FRANCISCO
06 City Hall
00 Van Ness Avenue
an Francisco, California 94102
415) 558-4123

OFFICE OF THE CITY ATTORNEY
GEORGE AGNOST CITY ATTORNEY
Philip S. Ward
Chief Trial Deputy

MEMORANDUM

September 27, 1984

PRIVILEGED AND CONFIDENTIAL

TO: Mervyn Silverman, M.D., M.P.H.

FROM: Philip S. Ward, Chief Trial Deputy
Daniel E. Collins, Deputy City Attorney

SUBJECT: Closure of Bath Houses and Sex Clubs

This is in response to your recent letter requesting advice as to what steps you may take in order to close any bath houses and sex clubs which are contributing to the spread of Acquired Immune Deficiency Syndrome (AIDS).

In order that you are fully advised, we will cover the following topics in this memorandum: (1) the medical problem confronting you; (2) bath houses, sex clubs and AIDS; and (3) your authority as Director of Health under Section 3110 of the Health and Safety Code to protect the public health by closing establishments promoting or facilitating the spread of disease.

In sum, we will briefly describe the public health problem confronting you, suggest a means for determining which establishments are promoting or facilitating the spread of disease and outline a procedure for effecting closure of these establishments in the appropriate case.

I

THE MEDICAL PROBLEM

San Francisco has the highest per capita rate, and the second largest number of cases of AIDS, of any city in the nation. The best available medical evidence clearly indicates that AIDS is a highly communicable sexually transmitted disease occurring primarily in homosexual men. There have been 6122 cases reported nationally with 2800 deaths to date. In San Francisco we have had approximately 700 AIDS cases diagnosed and 300 deaths. Last month alone there were 50 cases diagnosed and 28 deaths. Reliable

scientific sources indicate that antibodies to the AIDS virus have been found in the blood of 60-70% of sexually active gay males. AIDS is fatal. Although there is great hope that a vaccine and cure will be forthcoming over the next two to five years, the single most important goal at this time is to reduce the spread of AIDS by inducing behavioral changes in the highest risk group.

Your panel of experts has recommended that multiple sexual contacts of an anonymous character between homosexual males be curtailed because the transmission of AIDS is likely to occur. The panel has advised you that the specific sexual activities that should be proscribed include multiple, anonymous sexual activities which involve the following: (a) the placing of the copulatory organ of one male on or into the anus or mouth of another male, (b) the placing of the mouth of one male on the anus or copulatory organ of another male, (c) the contact of the excrement of one male with any part of the body of another male, (d) the entry of any part of the body of one male into the anus of another. In the interest of brevity, this kind of specific sexual activity will be referred to herein as "high risk behavior".

Homosexual males who frequent bath houses and sex clubs are the most likely persons to be engaged in the kind of behavior that can lead to AIDS. Studies show that the high risk behavior referred to above typically occurs at bath houses and sex clubs. In fact, these establishments frequently serve no other purpose but to afford the opportunity for gay males to engage in such high risk behavior.

II
BATH HOUSES, SEX CLUBS AND AIDS

Though it may be obvious to you that many bath houses and sex clubs are locations where such high risk behavior in San Francisco takes place, it will be necessary to establish this as a matter of proof. Therefore, you should utilize city health inspectors, volunteer medical professionals and, conceivably, private investigators to irregularly surveil the suspect establishments on five to ten separate occasions for purposes of determining if high risk behavior is taking place. If frequent and blatant high risk behavior is discovered, it will be easy to charge the owner and/or manager with actual or constructive knowledge of their patrons' conduct. Naturally the surveillances should cover a reasonable period of time to establish that the observed conduct is not just transitory and isolated.

When you have gathered your evidence present it to this office and we will review it as to its legal sufficiency. We will advise you as to any additional evidence that may be needed.

III
YOUR AUTHORITY AS DIRECTOR OF HEALTH UNDER HEALTH AND SAFETY CODE SECTION 3110

As Director of Health you are empowered to "take such measures as may be necessary to prevent the spread of [communicable] disease or occurrence of additional cases." (Health and Safety Code Section 3110). Section 3110 empowers you to take reasonable steps to protect the public health including the promulgation of guidelines setting forth prohibited conduct, issuance of an "order to show cause" re closure and conducting hearings to determine whether specific practices are encouraging the spread of a disease like AIDS.

A. Notice Re High Risk Behavior

You should send copies of the attached notice to all bath houses, sex clubs, and other establishments that you believe facilitate the proscribed multiple, anonymous sexual activity. Send the notice registered mail, return receipt requested. Enclose a cover letter advising the establishment that you have reason to believe that its operation promotes or facilitates indiscriminate, anonymous multiple sexual contacts that can lead to the spread of AIDS. Since your ultimate sanction of a closure order could also affect the property owner, you should send the notice to the business owner, the business operator, and the property owner of the building in which the business is located. A proposed form of notice is attached. You may order a lot book guarantee through Founders Title, 551 Polk Street, (ph. no. 864-3322) to ascertain the names of property owners.

B. The Hearing Process

After your investigators have gathered sufficient evidence for you to conclude that some establishments are being operated in a particularly egregious fashion in view of the notice, you should issue an order to show cause re closure pursuant to Health and Safety Code Section 3110. That document would advise the business owner, the business operator and the owner of the building that you have reason to believe that the establishment is being operated in violation of the notice. The document would also advise that the particular business is promoting the spread of or the occurrence of additional cases of AIDS. Finally, the order to show cause would state that the respondents must be

prepared on a specific date and time to show cause in a Director's hearing why their business should not be closed. You will advise the business what sanction you are considering imposing and require the owners/operators to come forward and show cause why you should not impose that sanction. This office will of course assist you in the preparation of the order to show cause and any other ancillary forms.

You, as Director of Health, would conduct the hearing on the show cause order. Evidence would be received as to: (1) the medical issues (i.e. clinical course of the disease, epidemiology, risk factors, aetiology and transmission, control, etc.), (2) the specific testimony concerning the high risk behavior at the establishment(s), (3) the connection between that specific conduct and the spread of AIDS, and (4) the evidence proving that the business failed to comply with the notice. A court reporter would be present to transcribe the proceedings, swear in witnesses and mark documentary evidence.

If the evidence is sufficient and warrants it, you would order the bath house or sex club closed on a temporary or permanent basis. If the order is not obeyed, the City Attorney will go to court to enforce your order in the appropriate fashion.

C. Red Light Abatement

As an alternative to the order to show cause and hearing procedure set forth above, or as a supplement thereto, you may consider requesting the District Attorney to proceed under the Red Light Abatement Law, California Penal Code Sections 11225, et seq.

Section 11225 provides in pertinent part that every building or place used for the purpose of lewdness, assignation or prostitution is a nuisance which shall be enjoined, abated and prevented. Section 11226 provides that whenever there is reason to believe that a nuisance is kept, maintained or is in existence in any county, the District Attorney must maintain an action in equity to abate and prevent the nuisance and to perpetually enjoin the person conducting or maintaining it, and the owner, lessee or agent of the building in or upon which the nuisance exists, from directly or indirectly maintaining or permitting it. Lewdness is given a broad definition extending "to all immoral or degenerate sexual conduct, including public masturbation." The court may issue a temporary writ of injunction to prevent the continuance of the nuisance upon a showing of prescribed conduct made by affidavit or by verified complaint.

A red light abatement case must show that the nuisance complained of existed at the time the action was filed. No showing of specific intent is required and the action may be sustained even where the owner has no actual knowledge of the activities taking place on the premises. Circumstantial evidence may be relied upon to prove that a building is maintained for unlawful purposes and evidence of the general reputation of a place is admissible to prove the existence of the nuisance. The testimony of a competent investigator who has observed any such illegal acts may also be received.

The Red Light Abatement Act provides that an order of abatement must direct the removal from the premises and sale of all furnishings and fixtures. The building itself may also be closed for all uses for a period not to exceed one year or, in the alternative, the court may impose money sanctions in an amount equal to the fair market rental value of the property for one year. Additionally, the court has the traditional equitable authority to fashion any other appropriate remedy. Violation of an injunction issued under the Red Light Abatement Act is punishable as a contempt of court. The taking of an appeal does not stay the enforcement of an order of abatement under this Act.

We remain available to you for further advice and assistance as you deem necessary.

cc: Mayor Dianne Feinstein

PSW:DEC:jr

4002D

N O T I C E

(To be sent registered mail, return receipt requested, to business owners, business managers and property owners.)

Be advised that if the following conduct is observed on your premises so as to give rise to the assumption that such conduct is permitted, allowed, or encouraged by you or by persons under your supervision and control, or is otherwise constituting a danger to the public health by promoting the spread of or occurrence of additional cases of Acquired Immune Deficiency Syndrome (AIDS), this Department will take immediate action to suspend or terminate the operation of your business:

(a) The placing of the copulatory organ of one male on or into the anus or mouth of another male;

(b) The placing of the mouth of one male on the anus or copulatory organ of another male;

(c) The contact of the excrement of one male with any part of the body of another male;

(d) The entry of any part of the body of one male into the anus of another.

MERVYN F. SILVERMAN, M.D., M.P.H.
Director of Health

4014D

Bathhouses

PRESS STATEMENT

OF

CIVIL RIGHTS AND LESBIAN AND

GAY COMMUNITY ORGANIZATIONS

10/10/84

In this medical crisis, our primary goal is to stop the transmission of AIDS and to save lives in San Francisco. The closure of certain gay businesses and other actions by the health director are certain to have a contrary result and also to adversely affect civil rights here and elsewhere.

Closing the baths is wrong and dangerous. Medical decisions regarding public health issues must be based on solid scientific evidence. The scientific data, including the most recent data from the Centers for Disease Control in Atlanta (CDC), show that there is no correlation between the risk of acquiring the disease and bathhouses. These data were confirmed as late as yesterday with researchers at CDC. The San Francisco AIDS Foundation research confirms, it is what one does which creates risk. The correlation to a particular site is non-existent.

We deplore the politicization of the medical issues and view the focus on one small scapegoated group as unjustified and wrong. The present action sends out the wrong message that government has finally done something effective and conclusive. It has not. The government must focus on finding continued funding for research and education.

The accurate information shows that education of the entire community is the most effective means of ensuring the public health of the lesbian and gay community. The bathhouses have served as one of the major conduits of that information, and the subsequent historically unparalleled reduction in VD rates attests to the success of this approach. The health director has had all of this information, including the CDC study, for almost two months.

The actions of Dr. Silverman also sends the wrong message to the gay and lesbian community. Staying away from bathhouses does not lower the risk of encountering the disease; the efforts to educate the whole community as to what does effect the risk factor must continue.

The action sends a dangerous message to the public at large that gay males and lesbians -- a group that has historically been the object of society's fears and hatred -- is worthy of censure by government. The rationale for discrimination or violence that can be drawn from this action is especially troubling.

Use of the power of the health director without supporting data, under

great political pressure, in contradiction to existing medical information, and without circumspect consideration of all consequences, creates a dangerous precedent.

We remain committed to a joint effort of working for the saving of lives and for the integrity of government which has been compromised here.

Jay M. Kohorn,
American Association for Personal Privacy

Dennis McShane,
Bay Area Physicians for Human Rights

Roberta Achtenberg,
Bay Area Lawyers for Individual Freedom

Doug Warner,
American Civil Liberties Association of Northern California

Fred Rosenberg,
Golden Gate Business Association

Tom Steel,
Northern California Bathhouse Association

Paul Castro,
People With AIDS

MERVYN FRANK SILVERMAN, M.D., M.P.H.

Appendix F

Professional:

San Francisco Health Department
101 Grove Street
San Francisco, CA. 94102
(415) 558-2466

Residence:

119 Frederick Street
San Francisco, CA. 94117
(415) 861-5540

BACKGROUND SUMMARY:

Over 17 years of experience in Health Care Administration with particular emphasis in Community Health Services and Organizational Management on local, state, national, and international levels.

Directorships have included two local Public Health Departments, a state-wide Planned Parenthood Program, the F.D.A. Office of Consumer Affairs, and a Peace Corps Regional Medical Program.

EDUCATION:

	B.S.	Washington and Lee University, 1960
	M.D.	Tulane University, 1964
	M.P.H.	Harvard University, 1969
		Stanford University, 1981 (Executive Program in Organizational Management)

SPECIALTY CERTIFICATION: Diplomate, American Board of Preventive Medicine (General Preventive Medicine)

PROFESSIONAL EXPERIENCE:

DEPARTMENT OF HEALTH, San Francisco, California — May, 1977 - present

Chief Executive Officer for public health agency of 5,000 employees serving 650,000 residents through a $270,000,000 program providing the full spectrum of health care services.

WICHITA-SEDGWICK COUNTY DEPARTMENT OF COMMUNITY HEALTH, Wichita, Kansas
Director of Health — Sept., 1972 - May, 1977

Directed Department serving 385,000 residents through programs of environmental health and community health services, and provided clinical supervision and direct patient care in tuberculosis, venereal disease, family planning and child health programs.

PLANNED PARENTHOOD OF KANSAS — May, 1976 - May, 1977
Medical Director

Provided medical direction, clinical supervision and direct patient care for family planning services.

Exhibit 1

FOOD AND DRUG ADMINISTRATION, Washington, D.C.
Special Assistant to the Commissioner June, 1969 - Sept., 1970
Director of the Office of Consumer Affairs Sept., 1970 - Sept., 1972

Provided assistance to the Commissioner on legislative and organizational matters and directed a nationwide program of consumer services.

MODERN MEDICINE PUBLICATIONS, Minneapolis, Minnesota
Contributing and Consulting Editor 1970 - 1975

PEACE CORPS
Regional Medical Director for Southeast Asia and the Pacific (Washington, D.C.) 1967 - 1968
Peace Corps Physician (Thailand) 1965 - 1967

Directed 25 Peace Corps physicians throughout the South Pacific and Southeast Asia. Provided direct health care for Peace Corps volunteers in Thailand.

OTHER SIGNIFICANT POSITIONS

KPIX TV 1979 - present
"Resident Physician" for CBS-TV affiliate in San Francisco with regular TV appearances discussing health issues.

Contributing Editor for Healthline 1983 - present

Retirement Seminars 1979 - present
Provide lectures on Health and Retirement to the U.S. government, Wells Fargo, Bechtel, and other corporations.

KMPX Radio 1979 - 1981
Director, Producer and Host of Health Program airing weekly with interviews of health professionals.

ACADEMIC AND OTHER APPOINTMENTS:

Present:
University of California School of Medicine - Associate Clinical Professor
University of Hawaii - Associate Clinical Professor
Tulane University School of Public Health & Tropical Medicine - Adjunct Associate Professor

PAST
Advisory Health Council, State of California - Vice Chairperson
National Center for Health Services Research (HHS) - Consultant
University of California School of Public Health, Berkeley, California - Instructor
St. Mary's College, Moraga, California - Instructor
Wesley Medical Center, Wichita, Kansas - Teaching Staff
Wichita State University Branch of the University School of Medicine - Clinical Associate
Consumer Product Safety Commission -Member, Product Safety Advisory Council
National Health Council, Member, Committee for Consumer Concerns

PROFESSIONAL AND COMMUNITY SERVICE EXPERIENCE:

Active Member, Board of Directors
United States Conference of Local Health Officers - President Elect
National Association of County Health Officials
American Association of Public Health Physicians
Health Officers Association of California
California Conference of Local Health Officers
American Heart Association, San Francisco Chapter, Board of Governors
Medical Advisor to Board of Directors, Golden Gate Chapter, San Francisco Region, American Red Cross
Bay Area Chapter of March of Dimes Birth Defects Foundation
Tenderloin Senior Outreach Program, Inc.
San Francisco Regional Cancer Foundation, Board of Trustees
United States - China Educational Institute
Tulane Medical Alumni Association

OTHER AFFILIATIONS:

Present
San Francisco Medical Society Delegate to California Medical Association (CMA)
Chairman - Advisory Panel on Preventive Medicine & Public Health (CMA)

Past
Coordinating Committee for Geriatrics Curriculum and Program, UCSF
Delinquency Prevention Coordination Committee, San Francisco
Advisory Board, Collaborative Health Program, San Francisco
Professional Advisory Committee, Mental Health Association of San Francisco
Advisory Committee, Bay Area Planned Parenthood
Representative-at-large, California Public Health Association
Member, Special Committee on the Future of Publicly Funded Health Services in California, State Department of Health Services
Member, Drug Abuse Council, Wichita, Kansas
Member, Advisory Board, Mid-American All Indian Center
Member, Board of Directors, Child Abuse Foundation in Wichita, Inc.
Member, Advisory Board, Black Nurses Association, Wichita, Kansas

PAPERS AND PUBLICATIONS:

Mervyn F. Silverman and Deborah B. Silverman, "Medical Ethics and Psychotropic Drugs," Maurice B. Visscher, M.D. (ed.), Humanistic Perspectives in Medical Ethics , Prometheus Books, Buffalo, N.Y., 1972, pp. 223-247.

Quarterly Articles for Healthline

Monthly Article for San Francisco Medicine (Journal of the San Francisco Medical Society). 1979 - 1981.

Guest Editorial for Urban Health (The Journal of Health Care in the Cities), "The Self-Defeating Philosophy of Human Service Retrenchment," Sept., 1980.

PROFESSIONAL ORGANIZATIONS:

American College of Preventive Medicine
San Francisco Medical Society
California Medical Association (Chairman, Advisory Panel on Preventive Medicine); (Commission on Community Health Services).
American Public Health Association
American Medical Association
California Academy of Preventive Medicine

HONORS:

Delta Omega Honorary Public Health Society
Adjunct Scholar, Kansas Newman College
Who's Who in American Universities and Colleges
Who's Who in Government
Who's Who in the Midwest
Who's Who in the West
Who's Who in California
The Jacob C. Geiger Medal for the Best Thesis on a Public Health Problem, Tulane University
B.S. Degree cum laude (Dean's List, Honor Roll)

MEDICAL LICENSURE: California

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