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Volume I

Richard Lee Andrews, M.D.  
PSYCHIATRIST AND ADVOCATE FOR GAY MEDICAL CAUSES IN THE EARLY AIDS EPIDEMIC

James M. Campbell, M.D.  
AIDS CLINICIAN AND MEDICAL EDUCATOR

James R. Groundwater, M.D.  
DERMATOLOGIST TREATING THE FIRST KAPOSI'S SARCOMA PATIENT DIAGNOSED IN SAN FRANCISCO

With an Introduction by  
Donald I. Abrams, M.D.

Interviews Conducted by  
Sally Smith Hughes, Ph.D.
  in 1996

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Copy no. 1
Richard Lee Andrews, M.D., (b. 1947) psychiatrist: "coming out" and gay activism in San Francisco before AIDS; Harvey Milk; formation of BAPHR [Bay Area Physicians for Human Rights]; BAPHR response to early AIDS crisis, Kaposi's sarcoma brochure, advice regarding antibody testing, early safe sex guidelines, attempts to change gay sexual behavior; BAPHR and the bathhouse crisis; Mervyn Silverman, Will Warner and the Larry Littlejohn Initiative; BAPHR links to other AIDS and gay organizations; creation of the red ribbon as the AIDS symbol. James M. Campbell, M.D., (b. 1936) internist: medical education and move to San Francisco; involvement with BAPHR; gay-related sexually transmitted diseases before AIDS; first recognition of AIDS as a new syndrome; early theories about the new disease; caring for early AIDS patients and advising the gay community about risk; the bathhouse crisis; BAPHR's safe sex and blood donation guidelines; opportunistic infections associated with AIDS and typical disease progression of AIDS; BAPHR's activist role and links to other AIDS organizations; early drug therapies for AIDS; discord within BAPHR regarding bathhouse closure and antibody testing. James R. Groundwater, M.D. (b. 1937) dermatologist: medical education and move to San Francisco; first Kaposi's sarcoma case and diagnosis; Marcus Conant; diagnosing early opportunistic infections, Kaposi's sarcoma and pneumocystis pneumonia; early KS pamphlet and AIDS treatment guidelines; current involvement with AIDS medicine.

Introduction by Donald I. Abrams, M.D.


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First, transport yourself back in time to the late 1970s, early 1980s, when solo medical practitioners were the norm in the San Francisco Bay Area. Community physicians, practicing alone in their private practices, were the first to encounter patients with the unusual purple lesion or the rapidly progressive pneumonia. Many of these providers had much in common with their patients—their age, their socioeconomic status, and their sexuality. Even before the establishment of the AIDS clinics at the university facilities, the community physicians were on the front lines as the epidemic erupted. They were truly community providers not only in the contrast to the academicians, but also often as members of the community that was about to become decimated by the ravages of the terrifying new disease. Has such a situation ever before been encountered in the history of medicine?

Recall as well the history of the "Gay Liberation" movement in the United States. In the late seventies, homosexual men and women were just becoming comfortable with emergence from their closets, enjoying an openness and sense of empowerment that accompanied the newfound freedom and acceptance. Nascent organizations of lesbian, gay, and bisexual physicians were being established, initially with the founding of the Bay Area Physicians for Human Rights [BAPHR] in 1977, followed by the national American Association of Physicians for Human Rights [AAPHR (now the Gay and Lesbian Medical Association--GLMA)] in 1981. In fact, it was at a BAPHR meeting of gay physicians from around the country being held in San Francisco in June 1981 that it became evident that these unusual cases of Kaposi's sarcoma and Pneumocystis carinii pneumonia were more than freak isolated occurrences. These organizations served as early foci for information dissemination and educational efforts to alert colleagues and government health officials about the new disease. BAPHR and AAPHR meetings became informal support groups in a way, providing community physicians with a safe haven to share the sense of fear, frustration, and loss that accompanied caring for their earliest AIDS patients, even before the disease was named or the cause was discovered.

Despite an attempt to centralize care of AIDS patients at a center of excellence at San Francisco General Hospital [SFGH], community physicians maintained a desire to care for their patients in their own practices. After all, it was a brand new disease. It is not as if there were a fountain of information on how to treat it that only flowed at SFGH. Although most of the earliest clinical trials evaluating immune modulators and later antiretrovirals were occurring at the General, providers chose to maintain their primary caregiver role. They were undaunted by the novelty of the disease. They were unhampered by the lack of specialty training since there was no such thing as an AIDS
fellowship and we were all pioneers, out on the edge of medical history. Plus these men and women were bound to their patients in a unique way. Many of the community doctors had established gay medical practices, focusing their attention on the health needs of gay men. Prior to AIDS, in a young, sexually active population, sexually transmitted disease was the worst of the worries. They expected to establish their general practices and follow their patients through their maturity until old age and death. None of these young practitioners could anticipate the enormous premature loss that they would experience over the ensuing decade, presiding helplessly over the wholesale eradication of their community. Loss of a whole generation of young, intelligent, capable, productive men—like a war without guns. Has such a situation ever before been encountered in the history of medicine?

Read now the stories of some of the generals on the front line in this war. Although not himself a member of the gay community, Jim Groundwater was a favorite dermatologist in private practice for BAPHR physicians to consult. He likely saw the city's first case of Kaposi's sarcoma. Bob Bolan, Jim Campbell, Bill Owen, and Ric Andrews were providers on the front lines, tending to both the medical and psychiatric needs of the community under siege. Stephen Follansbee, completing his infectious disease fellowship just as the initial cases of Pneumocystis carinii pneumonia were diagnosed, became one of the first of the new breed of AIDSologists, his entire early career devoted essentially to the treatment and investigation of the new disease. Another investigator involved in attempting to crack the code from the perspective of the epidemiologist was Paul O'Malley, searching for clues in stored serum specimens and serial follow-up of a cohort of gay men who had been enrolled in a local hepatitis B vaccine trial in the late 1970s. All of these individuals made significant, too often unsung, contributions in the very early days of the epidemic and have for the most part continued on the same course to the present day.

In 1985, Mayor Dianne Feinstein asked Paul Volberding, the director of the AIDS program at San Francisco General Hospital, to establish a line of communication with the community providers caring for patients with AIDS in the Bay Area. The first meeting of the dozen or so providers was held in March at the San Francisco Medical Society. Seeing that many of those in attendance were from the gay community, Paul came to me and suggested that perhaps I should continue the dialogue with these physicians, many of whom he knew to be my friends from BAPHR. Links to my BAPHR colleagues had previously proven very valuable during my oncology fellowship when I established in 1981 a cohort of men with persistent generalized lymphadenopathy to follow prospectively in a natural history cohort. Many of the subjects referred for evaluation were sent by the doctors whose stories follow.

It was my pleasure to preside at the next meeting of the community physicians' group, which was initially formed for a number of reasons.
Information exchange was essential in these early days of emerging therapies. As well, we at the SFGH facility saw this meeting as a way to inform the community providers about ongoing research protocols to which they could refer their patients. As the group was a coming together of community physicians and those from the county hospital, County Community Consortium seemed an appropriate moniker. (In time the acronym CCC could never be correctly decoded by those who tried to use the organization's full name, so it was shortened to Community Consortium.)

Within the first year of meeting, it became clear that County Community Consortium providers were interested in taking a more active role in learning how best to care for their patients with the new disease. If memory serves me right, I believe it was Jim Campbell who raised his hand at a meeting and said, "You know, instead of sending all of our patients to SFGH to participate in clinical trials, there are questions we can answer in our own offices." That observation led to the development of a consensus protocol on how to prevent a second episode of Pneumocystis carinii pneumonia [PCP] in patients who had already experienced a first episode. Each provider had their own favorite regimen. Some offered no prophylaxis. Rather than depend on anecdote, we worked to develop a randomized clinical trial that was launched in July 1986 as perhaps the first community-based clinical trial in HIV disease. Soon after its inauguration, the trial was thwarted by the release of the first antiretroviral agent--AZT--because the first patients to receive the product were cautioned not to take any other non-essential medications by mouth. Since patients with a prior episode of PCP now had access to a potentially life-extending antiviral agent, interest in oral prophylaxis against a treatable pneumonia waned.

Undaunted, Consortium physician/investigators next designed a study to investigate PCP prophylaxis using the inhaled pentamidine therapy which had been developed by a UCSF/SFGH pulmonologist. Working together on the inhaled pentamidine protocol, town and gown investigators collaborated in a manner that would become a model for future productivity and success in conducting clinical trials in the sites where patients received their primary care. Ultimately the Consortium's aerosolized pentamidine trial would lead to FDA approval of the modality as the first prophylaxis for an HIV-related opportunistic infection as well as a lead article in the New England Journal of Medicine. It was clear that significant research could be done outside of the hallowed hallways of academic teaching hospitals. This Consortium achievement became a model for community-based clinical trials programs later established by both the American Foundation for AIDS Research and the National Institute of Allergy and Infectious Diseases.

Much of the success of the Community Consortium and even the larger San Francisco Model of HIV care can be traced to the efforts of
the physicians whose stories follow. No such collaborative coming together of the community was seen in other areas hard hit by the epidemic. New York and Los Angeles did not pull together the way the community did in the Bay Area. It can be attributed as well to the collaborative congeniality fostered by BAPHR, allowing its member physicians to strike out united against the common enemy—the disease—and not against each other.

I myself owe much of my professional as well as personal growth to my colleagues you are about to meet. Serving as brave, openly gay role models for a young junior faculty academic, initially fearful of coming-out to avoid derailing my career, the examples of these noble, proud and successful professionals inspired my ensuing openness. I write this today with pride as the current president of the Gay and Lesbian Medical Association. Through two decades of battle, these brave warriors on the front line of the fight have unique stories to tell of a struggle to save their community from a plague that often brought as much political as medical despair. Although the battle is neither won nor over, the contributions of the community physicians have done much to enrich the lives of their patients, the medical profession and society-at-large. Has such a situation ever before been encountered in the history of medicine?

Donald I. Abrams, M.D.
Chair, Community Consortium
Assistant Director, Positive Health Program
San Francisco General Hospital
Professor of Clinical Medicine
University of California, San Francisco
President, Gay and Lesbian Medical Association, 1999-2000

January 2000
San Francisco, California
Project Origin and Organization

This series with community physicians is the third phase of an oral history project documenting the medical response of the medical and nursing professions in the early years of the AIDS epidemic in San Francisco. Please see the earlier volumes for descriptions of the particulars of these two previous interview phases.

Phase one and two with university physicians and nurses has effectively, albeit selectively, documented the role of academics in the epidemic, the "gown" component of the traditional town and gown division of medicine worldwide. What was obviously missing were accounts by representatives of the "town," that is, physicians with private practices in a variety of medical specialties relating to AIDS. In 1995, UCSF Library, represented by Karen Butter, now Acting Director, came to the rescue with a grant to the Regional Oral History Office to conduct interviews with community physicians whose practices included substantial numbers of AIDS patients early in the San Francisco epidemic. The grant was sufficient to cover two- to six-hour interviews with seven individuals--six physicians and one professional in the San Francisco Health Department--selected because of their substantial participation in the early medical response to the epidemic. In 1996, interviews were recorded in the San Francisco offices of the participants. The only exception were the interviews with Dr. Robert Bolan, which took place in Glendale in southern California, his new home after a recent career move.

Primary and Secondary Sources

The interviews were largely based on the reading I had done to prepare for the first two phases of the project, and even more substantially by the information I had acquired in the course of these interviews. The most significant new source for phase three was documentation concerning Bay Area Physicians for Human Rights [BAPHR], a gay physicians' organization founded in San Francisco in the late 1970s. An extensive series of "The BAPHRON," BAPHR's informative monthly newsletter, and documents in BAPHR's office in the Castro District of San Francisco were rich sources of information on the response of gay physicians and the gay community to the epidemic.

Selected Themes

BAPHR has a large voice in the present series. Five of the seven interviewees were at one time or another members of BAPHR and spoke at length of the organization's contributions. Only James Groundwater, who
is not gay, and Paul O'Malley, who is not a physician, were never members. Furthermore, BAPHR was one of the focal points of the early medical response to the new disease after it was recognized in San Francisco. Its members came to the crisis with the very intersection of experiences that the epidemic seemed to demand: medical skill in diagnosing and treating diseases prevalent in gay men, and sympathy for preserving the personal and sexual freedoms that the gay community had recently won. The vast difference for physicians confronted with previously healthy young men who were suffering and dying from AIDS was that neither cause nor treatment of the mystifying new disease was known and available. These histories recount over and over, but from diverse perspectives, the ways in which physicians responded professionally and personally to the increasing stream of very ill patients with puzzling symptoms and psychological as well as physical problems. They also trace physicians' gradual awareness of the severity, extent, and complexity of the new epidemic, focused initially so frighteningly on gay men. Some of the interviewees also tell of learning to manage the "worried well" who came to their physicians with fears of acquiring or transmitting the new syndrome.

Aside from providing a portrait of AIDS medicine as practiced in private medical offices in the years before AZT and protease inhibitors were available, these interviews describe from a variety of perspectives, the interviewees' responses to major events and crises of the epidemic in the early 1980s. A pervasive theme is the formulation of safer sex guidelines. Bob Bolan particularly, but others as well, were preoccupied with the formulation of guidelines which would simultaneously reduce disease transmission and honor the community's arduous battle for freedom of sexual expression. The accounts are sometimes explicit about sexual practices and attitudes, showing how those active in the epidemic brought taboo issues out of the closet and onto the public stage. In fact, these oral histories suggest that one lasting effect of the AIDS epidemic may be to have made safer sex practices and healthy sexual expression an open topic of discussion in many sectors of American society. The histories offer an intriguing range of viewpoints on this issue in gay politics.

The interviewees also provide accounts of important events in the years closely preceding and following the recognition of AIDS in San Francisco--the deaths of San Francisco Mayor George Moscone and Supervisor Harvey Milk (the latter the first openly gay elected official in the country), the hepatitis B vaccine trials, the crisis over bathhouse closure in San Francisco, controversy over blood donation policy, fears regarding the AIDS antibody test, and so on. Most of these events highlight the intersection of medicine, sexual and gay politics, and human rights, as well as the strengths and fallibilities of individual human actors. The oral histories in this series are rife with colorful examples in all these regards. Readers may be interested
to compare these accounts with those of the university physicians and nurses interviewed for this project.

These comments only begin to tap the range of topics and insights embedded in all three phases of this project. My hope is that these interviews, over thirty in all, will provide a basis for ongoing documentation of the epidemic. Victoria Harden and colleagues at the National Institute of Health Historical Office have recorded the contributions of researchers at NIH and Ronald Bayer and Gerald Oppenheimer at Brooklyn College have interviewed physicians in various cities across the United States. But there is a great need to expand documentation in time and geography. To my knowledge, there is no systematic and sustained work on the history of AIDS in developing countries in which it is expanding at a terrifying rate. Neither are there in-depth historical projects on specific topics, such as efforts to develop AIDS vaccines and the associated ethical and social issues. Perhaps this collection of oral histories will serve as an impetus and inspiration for others to pursue the history which remains to be recorded worldwide.

Locations of the Oral Histories

The audiotapes and bound volumes of all oral histories in the AIDS series are available for research at UCSF Library's AIDS History Project Archives. The oral histories are also available at the National Library of Medicine, the Bancroft Library, UCLA, and other research libraries. Some are available on the Internet at: http://www.lib.berkeley.edu/BANC/ROHO/ohonline. The remainder are in the process of being placed online.

Acknowledgements

We are grateful to Karen Butter, Acting Director of UCSF Library, for arranging project funding. I also wish to thank Dr. Robert Bolan for giving me access to three cartons of his personal records which he then donated to the AIDS History Project at UCSF. I also wish to thank Dr. Ric Andrews for arranging access to documents in the office of Bay Area Physicians for Human Rights.

I thank editorial assistants Grace Robinson, Julia Rechter, and Celeste Newbrough, and production manager Shannon Page for their efforts in finalizing the oral histories. I am grateful as always to Willa Baum, ROHO director, for her oversight and helpful comments.

Sally Smith Hughes, Ph.D.
Research Historian and Project Director

January 2000
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PHASE 1: THE MEDICAL RESPONSE, 1981-1984

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VOLUME IV
Donald P. Francis, M.D., D.Sc., "Epidemiologist, Centers for Disease Control: Defining AIDS and Isolating the Human Immunodeficiency Virus (HIV)"
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John L. Ziegler, M.D., Ph.D., "Oncologist: Kaposi's Sarcoma and AIDS Research in San Francisco and Globally"

VOLUME V
Herbert C. Perkins, M.D., "Director, Irwin Memorial Blood Bank: Transfusion AIDS and the Safety of the Nation's Blood Supply"

VOLUME VI
John S. Greenspan, D.D.S., Ph.D., "AIDS Specimen Bank, UCSF"

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Warren Winkelstein, Jr., M.D., M.P.H., "AIDS Epidemiology at the School of Public Health, University of California, Berkeley"

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

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Helen K. Schietinger, R.N., M.F.C.C., "Nurse Coordinator of UCSF's First AIDS Clinic"

VOLUME II
Gary Stephen Carr, R.N., Ph.D., F.N.P.-C., "Nurse Practitioner at the AIDS Clinic, San Francisco General Hospital"
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VOLUME III
Diane Jones, R.N., "First Wave of the Nursing Staff on the AIDS Ward, San Francisco General Hospital"
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Ric Andrews, M.D., Psychiatrist, "Psychiatrist and Advocate for Gay Medical Causes in the Early AIDS Epidemic"
James Campbell, M.D., Internal Medicine, "AIDS Clinician and Medical Educator"
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IN PROCESS:

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Paul O'Malley, M.D., Communicable Diseases
William Owen, Jr., M.D., Primary Care
THE AIDS EPIDEMIC IN SAN FRANCISCO: THE RESPONSE OF COMMUNITY PHYSICIANS,
1981-1984

VOLUME I

Richard L. Andrews, M.D.

PSYCHIATRIST AND ADVOCATE FOR GAY MEDICAL CAUSES IN THE EARLY AIDS EPIDEMIC

An Interview Conducted by
Sally Smith Hughes, Ph.D
in 1996

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Richard L. Andrews is a psychiatrist who until his retirement had a private psychiatric practice consisting largely of gay men. He also served as consultant in psychiatry for the Children's Home Society of California and the Social Security Administration in San Francisco. However, Dr. Andrews was not interviewed for this oral history series because of these professional positions but rather because of his significant role as a physician and member of Bay Area Physicians for Human Rights, a gay physicians organization, in several seminal events of the early AIDS epidemic.

Andrews sets the scene for the recognition in 1981 of the new disease by recalling in the oral history the increasing activism of San Francisco's gay community in the 1970s, fueled among other factors by the assassinations of Mayor George Moscone and Supervisor Harvey Milk. Bay Area Physicians for Human Rights figures prominently in this story, as it does in most of the interviews in this series with physicians with private medical practices serving gay men. Particularly in the early years of the epidemic, before many other AIDS organizations in the community were up and running, BAPHR represented the medical voice of the gay community in San Francisco. Andrews as thrice president and concerned physician was thrown into the major controversies that swirled around the city in the early years of the epidemic.

Also a master of interpersonal relations, Andrews acted as the human and humane element, the facilitator, in several tough interactions. Most searing to him personally was his experience in the inflamed debate over closure of the San Francisco bathhouses. The debate rent the gay community, some, including Andrews, seeing the baths as locations tempting men to engage in unsafe sexual practices and thereby increasing chances of AIDS transmission. Others, including some of Andrews' physician colleagues in BAPHR, regarded the baths as symbolic of the gay community's hard-won civil liberties and opposed their closure on that basis. As a member of health department Mervyn Silverman's AIDS advisory committee, Andrews was in the thick of it, feeling pilloried by both sides:

The ones that wanted closure thought we [on the advisory committee] were cowards. The ones that didn't want closure thought we were traitors because we even suggested [closure] in the first place, even though we backed down from it.

As he recounts in the interviews, Andrews to this day regrets what he feels to have been his personal failure to achieve the middle ground: allowing the baths to remain open but using them as sites for a concerted effort of safer sex education.
Andrews also provides an insider's insight into other issues troubling the gay community—safer sex guidelines, blood donation, antibody testing—all of which caused him and his medical colleagues immense personal and professional turmoil. But he also tells of a few triumphs. One is the thrilling occasion when straight physicians attending the Sixth International AIDS Conference in San Francisco spontaneously joined the simultaneously occurring Gay Pride Day Parade and marched behind the BAPHR banner.

**The Oral History Process**

Two interviews were conducted, on April 12 and 19, 1996, in the attractive basement office of Dr. Andrews' home in San Francisco. As a result of an initial telephone conversation, he had directed me to a collection of The BAPHRON, BAPHR'S newsletter, housed in the UCSF Library. He also arranged for me to review documents in the BAPHR office in the Castro District. A good number of my questions for him stemmed from this research. Dr. Andrews was an affable and informative subject, his comments often revealing his interest, not surprising for a psychiatrist, in interpersonal relationships. He edited the interview transcripts assiduously, omitting some sections and in several cases writing material afresh. These additions, seven in all, were inserted in the transcripts at points which he specified.

These interviews reveal the accomplishments of and personal toll on a warm and humane individual who chose, despite sometimes hostile audiences, to take a public and controversial stand on key issues of the early AIDS epidemic.

The Regional Oral History Office was established in 1954 to augment through tape-recorded memoirs the Library's materials on the history of California and the West. Copies of all interviews are available for research use in The Bancroft Library and in the UCLA Department of Special Collections. The office is under the direction of Willa K. Baum, Division Head, and the administrative direction of Charles B. Faulhaber, James D. Hart Director of The Bancroft Library, University of California, Berkeley.

Sally Smith Hughes, Ph.D
Research Historian and Principal Editor

October 1999
Regional Oral History Office
The Bancroft Library
University of California, Berkeley
BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name: Richard Lee Andrews, M.D.

Date of birth: 7-20-47

Birthplace: Union, Mississippi

Father's full name: John Sterling Andrews

Occupation: Retired Accountant

Birthplace: Mississippi

Mother's full name: Angelene Darlene Vance

Occupation: Deceased, housewife

Birthplace: Oklahoma

Your spouse: 

Occupation: 

Birthplace: 

Your children: Kathryn Reilly Robertson, 14 yrs.
Jonathan Andrew Robertson, 9 yrs.

Where did you grow up?: Oklahoma City

Present community: San Francisco


Occupation(s): Psychiatrist

Areas of expertise: Children & Adolescents; Gay & AIDS Issues

Other interests or activities: Since on disability 4/95: mostly friends, family, gardening, etc.

Organizations in which you are active: None now; previously: see CV, many organizations
INTERVIEW WITH RICHARD L. ANDREWS, M.D.

I BACKGROUND, EDUCATION, AND THE SAN FRANCISCO GAY COMMUNITY

[Interview 1: April 12, 1996] ##1
[San Francisco, California]

Upbringing, Education and Early Career

Hughes: Dr. Andrews, please give me a thumbnail sketch of where you were born and educated.

Andrews: I was born in Union, Mississippi, July 20, 1947, and at age three I moved to El Reno, Oklahoma with my family. At age seven we moved to Oklahoma City, where my parents remained. I went to Trinity University in San Antonio, Texas, got my B.A. there in 1969. I went back to Oklahoma City, to the University of Oklahoma, School of Medicine, for medical school, where I graduated in 1973. Then I began my psychiatric residency at McAuley Neuropsychiatric Institute at St. Mary's Hospital here in the city, where I remained from 1973-1977.

Hughes: Why did you choose St. Mary's?

Andrews: When I came out to do my West Coast interviews, I wasn't "out" as a gay man at the time, and I really had no idea that San Francisco was the "gay mecca." But I was immediately struck with the beauty and the magic of the city. During my interview at McAuley's I was offered a residency position, and when I returned to Oklahoma I cancelled all my East Coast interviews. One of my best friends from college was also coming here, so I just sort of settled on San Francisco, and have been grateful ever since.

Hughes: And then what happened?

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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.
Andrews: I finished my residency in 1977 and began a private practice, which included working with children who were hospitalized or in group homes, and outpatient adults. I also became a medical consultant for the Social Security Administration Disability Program. I worked in the regional office, which involved training physicians and medical examiners in California and three other states, and reviewing disability claims for quality insurance.

Hughes: In the area of psychiatry.

Andrews: Yes. It's a multispecialty review, and I was reviewing in the specialty of psychiatry for Social Security.

Hughes: I see. And had you pretty much always intended to focus on child psychiatry in your private work?

Andrews: Not exclusively, but my residency was a combined adult-child psychiatric residency, and I enjoyed working with the kids a great deal. I had some connections with several psychiatric group homes and I just pursued them. Until I retired last April, I continued to do a combination of the private practice, mostly with adults, group homes with kids from eight to eighteen, and this administrative work with Social Security.

Becoming Active in the Gay Community


Andrews: Things were relatively undramatic for me until probably about 1975, when I began to explore the gay culture in the city. Actually, once I had my first sexual experience here, I felt "liberated." All the guilt I'd had all my life about these feelings completely disappeared, and from that point on, I was 100 percent totally and comfortably gay, as far as my sexual orientation.
Joining Bay Area Physicians for Human Rights [BAPHR]

Andrews: In the fall of 1977, seventeen gay doctors got together and formed the Bay Area Physicians for Human Rights, or BAPHR, the first gay doctors' group in the country, actually the world. I had just finished my residency that summer and although I wasn't at the first meeting, word spread quickly and I joined within the next few months.

In my opinion it was no coincidence that BAPHR was formed at the same time that San Francisco had its first district elections for supervisors. Harvey Milk, the owner of Castro Camera, had run for office three times and lost, but this time he won and made history as the highest openly gay elected official in the country.

Harvey's election served as a catalyst to activate the growing gay community here. The Gay Freedom Parade in June 1978 was historic, not only because Harvey was the Grand Marshall, but because, for the first time in this country, there were marching contingents of openly gay doctors (BAPHR), businesspeople, church groups, and even a gay marching band and twirling corps.

Nationally, we were also experiencing a backlash against gay civil liberties as one state after another repealed ordinances that had prohibited discrimination against gay men and women. And right here in California State Senator John Briggs had succeeded in getting Proposition 6 on the state ballot. The 'Briggs Initiative' would have prohibited homosexuals or lesbians from teaching in public schools; furthermore, any heterosexual who even supported the idea of gay teachers was to be excluded. Harvey quickly became the primary spokesperson in the state to address and debate Briggs and his supporters. He came to a BAPHR meeting, and met with BAPHR officers on several occasions to get medical and psychiatric support for his arguments against this legislation. It was a very tense time because it looked like we might lose even up to the day before the election. And when we won, Harvey joined a thunderous crowd of supporters at the "No on 6" headquarters on Market Street. Listening to Harvey speak, asking everyone to "come out of the closet," was probably my most intense personal experience with Harvey.

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1 Dr. Andrews, in the editing process, substantially rewrote the sections, joining BAPHR and the Assassination of Milk and Moscone.
The Assassination of Milk and Moscone

Andrews: When Harvey and Mayor George Moscone were assassinated I was just three blocks from City Hall, working at Social Security. I walked over to the Polk Street side of City Hall and just stood there, silently, with several hundred others who were in a state of shock. That evening the candlelight march, from Castro to City Hall, was a tremendously moving event. As the thousands and thousands of us gathered at City Hall, Joan Baez sang "Amazing Grace", and the newly formed Gay Men's Chorus sang for the first time. I still cry every time I see the film, "The Life and Times of Harvey Milk." But nothing was more powerful for me than the memorial service at the Opera House a few days later. The building was packed to overflowing and hundreds who couldn't get in listened to speakers outside. My friends and I were crammed high in the balcony, but we could still see Governor Jerry Brown, the State Supreme Court justices, and all the VIPs in the front rows. Dave Kessler, the president of BAPHR, was one of five speakers. I don't remember the specific words spoken but I will never, never forget jumping to my feet, again and again, clapping, with tears streaming, as different people talked about Harvey, what he stood for, about "coming out," et cetera. It was as intense an experience, whether religious or spiritual, as I have ever had and I imagine it being similar to what Pentecostal groups would call "being filled with the spirit"; and for me it was the spirit of the gay movement.

From that point on, I became much more of an activist and became much more involved in BAPHR, and was the treasurer [1980] and then the vice president [1981, 1988, 1989] and then the president [1982, 1990, 1991]. I became involved with BAPHR at a time when there was no office, no staff, and there was only an answering machine at someone's home. When I was president, I established the first office and the first staff person. So we really began to have some stability for the organization.

BAPHR's Medical Symposia

Andrews: Someone at one of our symposia, I think it was Dr. Bob Bolan\(^1\), mentioned some cases of immune deficiency, something going on with some gay men. That was the first little inkling that something was happening.

\(^1\) See the oral history in this series with Robert Bolan.
Hughes: Do you remember when that was exactly?

Andrews: You know, I really don't. If I could trace back to when that symposium was--because one of the things that BAPHR also did was we began to have medical symposia. Every year, we sponsored a symposium, and I was one of the coordinators. We had gay doctors coming from all over the United States to talk about gay health care.

Hughes: Are you talking about the symposium where Alvin Friedman-Kien spoke?

Andrews: Yes.

Hughes: That was June of 1981.

Andrews: Okay, yes, that must have been it. It was June of '81--yes, that would be right. That's when we got the first reports.

Hughes: So there had been nothing official yet on KS [Kaposi's sarcoma]. Now, there had been the article on PCP [Pneumocystis carinii pneumonia], which [Michael] Gottlieb wrote.¹

Andrews: That's right, that's right. Now I remember.

Hughes: Do you know what people were seeing? Were they seeing PCP at that early date up here, or was it all KS?

Andrews: I think it was mostly KS. Now, Bill Owen² or Bob Bolan or one of the other internists would have more specifics about that, I think. Everyone was just becoming aware there was something going on, and no one knew what exactly.

Hughes: Did you think much about it?

Andrews: At first, we were all bewildered. I just remember everyone thinking, What is this? Even early on I think many of us had this fear that whatever was happening might be related to sexual practices.

Hughes: Was your practice largely gay men?

Andrews: Yes, it was predominantly gay men.


² See the oral history in this series with William Owen.
Hughes: And did you notice that there was a lot of sexually transmitted disease?

Andrews: Oh, yes; it was fairly common for many gay men. We had been doing STD [sexually transmitted disease] screenings at our health fairs.

Hughes: The first health fair was in 1978.¹

Andrews: Gosh, was it that early?

Hughes: Yes.

Andrews: Golly. Okay, yes, so we were doing routine STD screening, vision and blood pressure screening, health awareness, et cetera. I think that by '81 we had moved away from the health fair situation, so we weren't dealing with that when the epidemic began.

Hughes: Oh, really? Why did BAPHR move away?

Andrews: I think it was mostly an issue of lack of organizers. There weren't people available to organize it; that's my guess.

Hughes: Why did BAPHR choose to organize that segment of the health fair?

Andrews: Well, at that time KRON TV and several different organizations were having these community health fairs, and for the first one, we as an organization were asked to participate. I met the director of Health Center Number 1, Dr. Hope Corey, and we explored the possibility. They were a bit apprehensive initially about having so many gay people in their facility, but Dr. Corey and I became good friends.

Out of the health fair experience came this liaison of gay and lesbian health care workers, not only physicians but other people that began to come and help us do all sorts of screening -- blood pressure and vision and GC screening, et cetera. Sexually transmitted disease screening was one of our biggest focuses.

Hughes: And was it a good thing for BAPHR in terms of community visibility?

¹ BAPHR began to coordinate a health fair at Health Center #1 on 17th Street in 1978. (The BAPHRON, March 1, 1982, p. 136.)
Andrews: Oh, it was wonderful, yes. Those first couple of years, we really got great exposure and a lot of appreciation. I think we were looked at in the community as the equivalent of the Golden Gate Business Association, the gay business organization, the San Francisco Band Foundation with the gay band, et cetera. Now we had a gay doctors' group, we had a referral service, we had people calling us all the time trying to find gay-sensitive docs. And the health fair increased our visibility in the community.

American Association of Physicians for Human Rights

Hughes: What was the state of gay and lesbian health care, beginning, say, with the late 1970s and moving to the time of the epidemic?

Andrews: Well, as I recall, as BAPHR became more visible, we would get calls from all over the country from people just desperate to talk to a gay or a gay-sensitive physician about whatever was going on where they lived. It could have been something that was psych-related, e.g., that a man had a therapist who told him that he needed to "recover" from homosexuality, or a lesbian being uncomfortable talking about the fact that she didn't need birth control and being fearful of her health care provider. Initially, we were just swamped by this.

Hughes: Then in 1981, the national organization [American Association of Physicians for Human Rights] was formed.

Andrews: That's right.

Hughes: Were you involved?

Andrews: I was one of the founding members of AAPHR, and I was the first treasurer of the AAPHR [July 1981-June 1982]. AAPHR came about as a result of these medical symposia that we were having every year. Because we had people coming from all over the country, we finally decided that it would be good to have a national organization. Sibling organizations--we called them PHR, Physicians for Human Rights--had already sprung up in San Diego and L.A. and Chicago and New York, so we decided to have a national organization.

Initially, everything was fairly centralized in San Francisco. And now, many years later, AAPHR, now renamed GLMA [Gay and Lesbian Medical Associates], has almost 2000 members, in all fifty states and twelve countries, with a staff of fifteen.
It has become the premier gay physicians' medical organization, having a national impact.

Hughes: It didn't in the beginning, affect BAPHR? It didn't take some of the activities--

Andrews: I don't know that it did. We were the "father" of all these sibling organizations. We were the only one that had a staff, the only one that had an office, the only one that had a newsletter--we were the only one organized, really.

Hughes: Now, why did it happen in San Francisco, do you think? Why BAPHR?

Andrews: San Francisco has long been known as a tolerant place to live; during World War II many gay men and women in the military passed through and decided to return. By the early seventies there was a mass gay migration to this city from all over the country. The Castro became a neighborhood of more than just bars; people lived, shopped, and worked there. Harvey Milk's election sent out another strong message: San Francisco is a place where you can "come out", where you can be yourself, where you don't always have to be looking over your shoulder to see if someone is going to attack or harass you. As I've mentioned, there was a burst of activity in the late seventies that gave us not only BAPHR, but gay churches, gay business organizations, gay recreational organizations, et cetera. It just seemed to happen here more than any other place.¹

Hughes: For one thing, if you compare the gay community here to New York's, geographically San Francisco's is more condensed, which facilitates communication and organization and everything else.

Andrews: Yes, absolutely. We really adopted Harvey's message of "come out". Harvey's message was, "Every gay man, every gay woman, should come out." It was a very proud period for us, a very heady time.

Hughes: Was there any pressure within BAPHR to come out?

Andrews: There was. Not initially, but somewhere in the first five years, people were beginning to say we should change our name to contain the word gay. But because we already had a name that was recognized no one wanted to change it. That was our initial reason why. And I think there were also, even in this

¹ This paragraph was substantially rewritten for clarity.
Hughes: progressive city, still a large number of doctors that were nervous about the word "gay". They could hide under the banner of human rights, conceal it a little bit, although everyone knew what that meant. We would get calls requesting help for human rights problems in Central America and we would say, "Well, frankly, we're really handling gay health issues here." But I think that it was just our own reticence about being open about who we really were initially.

Hughes: Also there was at least an ambiguity, too, for somebody in Des Moines looking at a CV and seeing a membership in BAPHR. They might not know what that meant, and there might have been some deliberateness there.

Andrews: That's right, there was. To make it more comfortable for everyone to join, that they weren't joining a "gay" organization that might "out" them, our membership list was completely confidential.

Hughes: In late '77 or early '78 when you joined, was anybody nervous about being at the meetings?

Andrews: Certainly. The way we started our meetings in those early days was to introduce anyone that hadn't been there before. They would tell us where they were from and what their specialty was and so on. And generally, the people that would stand up would give some little emotional speech about, "You know, I'm really nervous and excited and happy and afraid and proud"—a mixture of both apprehension and pride.

Hughes: And a mixture also of gay concerns and medical concerns? What takes predominance?

Andrews: Definitely gay concerns. Most physicians have numerous opportunities to join professional groups. If you want to get intellectually stimulated about health care, there are plenty of places to go. But there was no place to even say, "I'm gay and a doctor."

Hughes: You became president of BAPHR in 1982. Besides AIDS—because AIDS is going to so dominate the story—what else was going on in 1982?

Andrews: One effort that involved providing referrals for people in the community, to get them health care professionals that were gay-sensitive or gay. We wanted to gain some credibility in the established medical organizations. San Francisco Medical Society was a good example of that. There was a wonderful liaison between BAPHR and the medical society, because we had our
symposia there. People that came from Hawaii, New York, Minnesota, were astounded when they would come to San Francisco and we'd go into the San Francisco Medical Society auditorium for our medical meeting. It was like, "Oh, my god, I couldn't even bear to tell somebody in my city that I'm gay, much less walk into the medical society and have the president of the society greet us." It was unheard of, and very liberating.

Another focus was the mushrooming of sexually transmitted diseases. Homophobia was a major concern. We saw it in ourselves and in so many of our patients and friends. So BAPHR was involved in many things.

**Psychiatrists in BAPHR**

Hughes: There were several lists of the medical specialties represented in BAPHR, and at least as far as through 1983, psychiatry very much dominated by an overwhelming percent. Why is that?

Andrews: Well, I think people that came from a psychiatric background are used to talking about social consciousness and conflict and all that, so it was perhaps easier for psychiatrists as physicians to come out, to be identified as gay. Also the American Psychiatric Association had to deal with the whole issue of whether homosexuality was even a mental disorder, and in 1973 the APA, after much debate, did remove homosexuality from the list of mental disorders. That debate made the issue of being gay much more visible for psychiatrists.

Hughes: What impact if any did that have on BAPHR, the fact that it was heavily weighted towards psychiatry?

Andrews: I don't know. There were so many community issues that were psych issues. They were really human relations issues, but they became psych issues. Maybe we were better able to handle some of the issues that came along.

But you know, really, some of the nonpsychiatrist folks handled it just as well. It really wasn't like the shrinks took over the philosophy of BAPHR by any means. But there were so many of us and we came out sort of en masse. Even before BAPHR was formed I was asked to come to a group of gay psychiatrists, so the ball had gotten started there a bit earlier.
Hughes: I wonder if that isn't related to the fact that the American Association of Psychiatry had a subcommittee or a subgroup of gay psychiatrists? Did it precede BAPHR?

Andrews: I don't think it preceded BAPHR; I think it was after it.

Hughes: In 1979, there was already a subcommittee on psychiatric—when it was actually founded, I don't know. As of June 1979, out of a total membership of 279, sixty-five were psychiatrists.¹ You were really heavily represented.

Andrews: We were, that's right.

¹ The BAPHRON, June 1976, p. 37.
II THE AIDS EPIDEMIC

Bay Area Physicians for Human Rights

Kaposi's Sarcoma Brochure

Hughes: Was the June '81 symposium the first time that BAPHR had gotten the word about AIDS?

Andrews: I think it was.

Hughes: BAPHR later agreed to distribute a brochure on KS. Do you remember that?

Andrews: Vaguely, yes.

Hughes: Marcus Conant saw one of the early cases of KS in San Francisco.

##

Andrews: All of us were mystified: why is Kaposi's sarcoma, which normally happens in older Mediterranean men, appearing in young gay men? That's why Marc's foundation was first called the KS [Research and Education] Foundation, and only later became the San Francisco AIDS Foundation.

The KS brochure was the first AIDS-related thing we did, even thought it was a still unnamed disease at that point. We met with Marc, and produced this brochure with photos of KS lesions that went out to doctors' offices, it was all over the city--all over the country, really, because we started distributing it at the symposium.

Hughes: BAPHR and the KS Foundation were both funded by gay men and both concerned about AIDS. Was there any interaction, any idea,
"We're confronting a common problem here; we should coordinate," or were these two ships passing in the night?

Andrews: There was a lot of communication back and forth. Marc Conant was a BAPHR member and came to some of our meetings, and many of our members would go to his early discussions about what they were finding. There was a lot of interchange.

Hughes: Was the main way you got your information by talking?

Andrews: I think so. Someone would hear something from someone in L.A. or New York, and then it would get in the news or it would go through the medical grapevine. There were a lot of personal calls.

BAPHR Focus on AIDS

Hughes: You've said that BAPHR had other concerns. I'm wondering when AIDS began to dominate.

Andrews: I think it began to take over the whole focus of the organization when it became clear, not only to the physicians in the country and in the Bay Area but to the population, including politicians and homophobic people, that something--GRID [gay-related immune deficiency]--was going on that was very, very serious. And because of that, there were two things happening. The gay community was in an enormous state of anger and denial. The nongay community was in an enormous state of unrest and fear.

Hughes: Was it also something that you as a gay physician felt particularly responsible for addressing? You had two reasons to be concerned: you were not only physicians but you were gay men.

Andrews: That's right.

Hughes: And it was your community that was being hit.

Andrews: That's right. We had done the health fair and had been trying to reduce the incidence of sexually transmitted diseases, and suddenly most people were saying, "There's something infectious here. We don't know what the hell it is." It began to greatly alarm us. So it was very, very relevant to each one of us, personally and professionally.
Handling a Health Crisis in the Gay Community

Hughes: Which BAPHR committees dealt with AIDS?

Andrews: We had several standing committees, including Scientific Affairs and Social Concerns. Scientific Affairs took on the safe sex guidelines. They quickly became the committee that tried to put together the information that we were going to distribute. I don't think we ever called it the AIDS Task Force. There was an AIDS Task Force at the San Francisco Medical Society, and we participated in that.

Hughes: What did BAPHR set out to do?

Andrews: First it was information collection and trying to get the best information about what was going on to try to understand it. And then there was this challenge of how to respond as a gay medical organization. Suddenly there was a health crisis that seemed to be affecting mostly gay men. We wanted to respond to the community about what to do.

And the gay community was, as I said, suspicious. It is important to understand what had been happening in the gay male community leading up to the AIDS epidemic. I don't think it's an understatement to say that there has been little or no acceptance of homosexuality throughout history, or at least in Western civilization. Certainly in America, there has never been a period when homosexuality was acceptable; quite the contrary. Some of the most severe punishments have always been reserved for those who were found guilty of this "crime." With that in mind, imagine what it was like in San Francisco, and a few other cities that had large urban gay populations, for gay men, for the first time, to feel free to be who they were: to seek out other men without significant fear of being physically harmed. Finally there was a freedom to explore and express yourself, socially and sexually.

So what happened? Male sexuality, not gay sexuality, began to flourish with few inhibitions. I think it is important to realize that lesbians generally have fewer sexual partners than straight women. Why? Because female sexuality, in most species of the animal kingdom, is expressed differently than male sexuality. Take the bathhouses: they should not really be called gay bathhouses, but male bathhouses. It is a rare female, straight or gay, who seeks out multiple anonymous sexual

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1 The October 1, 1982, issue of The BAPHRON refers to "BAPHRs AIDS subcommittee (formerly the KS Task Force)..." (p. 167)
partners. If straight women were interested in this kind of activity, there would be plenty of straight men prostituting on city corners, and straight bathhouses would be very busy indeed. So what we've got are two men, both highly sexual, as most men are, left to "go at it" with abandon.

Okay, so this man-man thing starts getting into high gear. Bathhouses and sex clubs flourish. The rate of STDs skyrockets as "bugs" get passed around between more and more men. So everyone just goes to the city clinic and gets a shot of penicillin and is back in action in a week or less. Even hepatitis, a much more serious illness, is looked at as only a minor inconvenience that can put someone "out of action" for a few weeks or months. And then something changes: people start getting much sicker and dropping like flies from some mysterious cause that no one knows about.

So very early in the epidemic, when little is known, and nothing is proven, we still have a good hunch this is a new sexually transmitted disease of some kind. But when I, as president of BAPHR, meet with members of the community and bathhouse owners, and tell them that it does look like a sexually transmitted disease, it is not really surprising that people are upset and angry to hear this possibility. People suggested this was a plot by the CIA to eradicate homosexuals and they were putting something poisonous in air vents at the bathhouses. The local gay papers would also repost this as a possibility. It was wild!

Hughes: Can you say something about your general approach when you were confronted with a person who was close to hysterical? Or was it that far along?

Andrews: It was that far along pretty early. The hardest thing initially was to try to keep my composure, because it was upsetting to hear some people that I even knew and had considered friends addressing their anger as if I were responsible for the problem. I mean, I'm the messenger and the messenger has a bad message, like, "We need to think about the fact that it might be something sexually transmitted, you guys." The response would be, "Boo! Go away! You're a liar, you're a turncoat, you're an Uncle Tom, you're working for the government."

All that kind of stuff leaves you a little baffled. You feel like you've been working for several years, to be an advocate for gay health, coming out, et cetera, and then to be looked at as a traitor and as an enemy was very disconcerting. It was very--well, it was very difficult, is what it was. Frankly, a lot of our [BAPHR] members didn't want to go to these meetings. They knew what was going to happen when you went into
this roomful of people. You're not getting friendly people in there; you're getting very angry, upset, fearful people. They didn't want to hear what we had to tell them.

Hughes: Did denial play a role? "This can't happen to me, and it particularly can't happen to me if it means that I'm going to have to change my sexual practices."

Andrews: Absolutely, absolutely.

Hughes: Also, the epidemic came on the heels of the gay liberation movement, and here were these people trying to regulate or even close the bathhouses.

Andrews: Yes, that's right.

Hughes: Which were symbolic of--

Andrews: Freedom, absolutely. I think that is the main thing. We had come from a time in the late seventies where sexual expression and freedom were tested to the limit, and there were people who would boast of their casual sexual experiences anywhere--in a department store, in the park--just about anywhere.

As I said, I was never in that group, partly because I just felt uncomfortable going to bathhouses. I always wanted to know who I was having sex with, and I wanted to have sex with someone that I was attracted to. I didn't like anonymous sex, so the bathhouses just didn't appeal to me, or I would have been there myself.

To hear, "Wait a minute, things may be worse than hepatitis. They may be worse than gonorrhea. They may be going to kill us," was the worst thing you could say to someone. It was like saying, "You're bad." It was like the Bible saying, "You shall reap the vengeance of the Lord." There was just enormous anger and anxiety and fear when there began to be the awareness that there was some deadly disease that was affecting large numbers of gay men in our town and L.A. and New York and causing quick deterioration.

Hughes: How was the BAPHR membership reacting? Was there a consensus of, We're physicians, we should take such-and-such a stand, or was there a lot of division within BAPHR itself?

Andrews: I must say that there were very few physicians that I heard from who would come to the conclusion that this was a plot by the CIA. Most medical folks were saying, "Damn it, there's got to be something transmissible." There were a few people who would say,
"I think it's a plot; someone's introduced something," but that was very rare.

But as for what to do about it, there was enormous controversy. Should we take a stance on limiting sexual activity? There was a major, major resistance to imposing restrictions on civil rights that had been fought for for so long. So that was divisive in the organization.

**Antibody Testing**

Andrews: And a little bit later when antibody testing came along, that almost ripped our organization apart. I was strongly in favor of the organization recommending confidential, anonymous testing, and our organization would not take a stand on that. They said, "You shouldn't be antibody tested. There's no reason to be antibody tested, because there's nothing to do about it anyway. It upsets people too much; don't tell them." Which frankly just bewildered me.

Hughes: What was your argument for testing?

Andrews: That if people knew that they were positive, two things: they at least could be more aware of possible medical problems that might arise and treat them, whether it was just thrush or something else; and two, people might be more willing to take responsibility for not transmitting it further. If you just don't know and no one wants to know, you just keep having unprotected sex and the disease keeps spreading. It gets worse and worse.

Hughes: And you were in the minority with that opinion in BAPHR?

Andrews: Yes. I was in the minority, and I was the strongest voice on that side. The organization did not want to come out with recommendations for antibody testing. In fact, they initially recommended that people should not be tested. That's what we recommended.

Hughes: Yes, the minutes of a July '85 board meeting record a recommendation against antibody testing except for "special circumstances."

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1 Sam Thal, M.D., Secretary, Minutes of the [BAPHR] Executive Board Meeting, July 7, 1985 (BAPHR office documents, folder: Executive board minutes).
Andrews: Yes, and I'm not quite clear what that could mean.

Hughes: It didn't explain.

Andrews: That was when we started getting really divided about the issue of testing. Oh, people were very upset about the whole idea of that.

Hughes: The arguments against testing were: one, what good is it going to do, we don't have a treatment, and two, this is an infringement on civil rights?

Andrews: And if this information ever does get out, you could lose your job, health care. It was all of those things. My argument was always, "Well, but if you do it anonymously, you won't have those problems." We went through long arguments about, "You can't promise that it's anonymous." I went over to Health Center 1 where they were doing testing and I learned the whole procedure. I knew it was impossible for it not to be anonymous when you had to make up any two letters and numbers and that was the only code they had for you. People were worried that they might be taking your picture or something and I would say, "Really, you guys. Now, come on. Look who's doing the testing: it's another gay man." You had to sort of beg for some faith in some system, but it was very hard to get that idea through.

Hughes: Was there ever a time when BAPHR changed that policy?

Andrews: I don't know exactly when, but I know we changed it, and it was a slow process. I don't remember all the gradients we went through. It wasn't, "Everyone should be tested." That's where we are now, I would say. But way back then, it was, "If you're thinking maybe about donating sperm"--I'm just pulling this out of the air, "if you're ready to have a baby with someone, it might be good to get tested." The blood donation issue we'd already sort of dealt with by then, just encouraging people not to donate if they were sexually active. But I can't really recall. Maybe if I looked through the BAPHRONs I could see the progression.

Speculation on the Cause of AIDS

Hughes: Well, before it became obvious that this causal agent must be a virus, did you have any idea or speculation about what it was?

Andrews: There was a strong hunch that this was a sexually transmitted disease. We didn't know how, didn't know exactly what, but
people were looking at hepatitis as sort of a model. This was worse, but seemed to act like hepatitis. We didn't know if it was more or less infectious than hepatitis, but that was the model that people used. We knew about hepatitis B, and this disease [AIDS] seemed to be somehow inescapably sexually transmitted. We didn't know how casual the transmission was, but we really felt it was blood-to-blood transmission or sexual transmission that was very likely.

Hughes: Yes, because that was in essence what you were seeing, wasn't it? Physicians were taking sexual histories, were they not?

Andrews: Yes, and they were having fifteen cases of GC and two cases of hepatitis and chlamydia--I mean, they were just having everything. And if you took a history, the ones that had the huge number of sexual partners seemed to be the primary ones coming down with it at first. So it was like, Come on, who are we fooling here? Something's going on sexually here.

Hughes: Except that early on, the CDC and others looked at poppers as a possibility.

Andrews: Poppers, I knew you were going to ask me that. Yes, that's right.

Hughes: Bob Bolan waged a campaign against poppers.

Andrews: Well, he wasn't the only one, but there was concern, and it was because so many of the people who were so sexually active used poppers to enhance having all this sex, that it seemed like that was a common ingredient. So it seemed reasonable to wonder if that was a contributing thing. But I think even Bob never really thought it was just the poppers. It just seemed too unlikely. I don't remember what it was like before the spread of poppers, but I do remember that every dance I went to everyone was always doing poppers—to dance, to have sex. Poppers were ubiquitous for quite a while.

Hughes: As soon as you came to the city?

Andrews: Well, see, I didn't really get out and become more active until 1975, and even then, going to the discos in 1976, people were frequently sniffing poppers.

Hughes: So, long preceding AIDS.

Andrews: Yes.
Duration of the Epidemic

Hughes: Do you remember thinking about the duration of the epidemic in the early days? Did you imagine that it would be something like toxic shock syndrome, something where science rushed in and solved the problem, and it would be gone?

Andrews: Like Legionnaire's disease. Yes. I think there was a hope that this was some weird, idiosyncratic, bizarre, remote disease. Legionnaire's and toxic shock both preceded this. We hoped we could contain this, and it would go away. I don't think anyone had a clue it was going to be as enormous as it is. How could anyone know that?

Hughes: Right. And there was a long latency period, which you couldn't have known of in those early days.

Andrews: Yes.

Hughes: Another turning point was the 1983-1984 period when the virus was isolated. Did that prompt the idea, Well, here we've got the virus. Just around the corner will be drugs and vaccines?

Andrews: That's right. There was a real sense that, we know what it is, and we'll push for the government to do this research and get this thing nipped in the bud. I think there was a real hope initially that things weren't going to get out of hand, like they certainly have.

Hughes: Do you remember when it hit home that this problem was a long, overwhelming problem?

Andrews: Well, as the time went by, and as the BAR, the Bay Area Reporter, the gay newspaper, would report the number of cases, as did the CDC, you'd see this huge increase. It almost seemed like a geometric increase. It wasn't any longer just in three or four major urban cities; it was beginning to show up more and more and more. The hope that it was going to be something we'd snuff out quickly evaporated.

Personal Impact of the Epidemic

Hughes: What about the impact on your personal life? What about friends and associates who were getting sick, and then eventually dying?
Andrews: Well, that was tough. I remember one of my best friends--let's see, when did he die? I think 1988. But he had been sick for a number of years before that, really sick. I remember having long conversations with him about whether he should get tested or not. He was a very, very intelligent guy, and he just felt like that there was no point in doing that, because we didn't have all the treatments then; we didn't know exactly what to do. After he got some symptoms, he got tested, and he was positive. He said, "God, I wish I would have been tested much earlier, because I would have been more careful about what I did in this last year and a half when I probably have been infectious." And he died, like a number of physician friends did too.

The early deaths were so quick, too. That was what was sort of astounding, because someone would come in with advanced stages of PCP and they'd die three days later or a week later. A conversation might be: "My god, did you hear he--" "Yes, he's in the hospital." "No, he died yesterday." It seemed like the disease initially just ate people up.

Hughes: Was that because people did not recognize symptoms of AIDS and didn't come in until the later stages?

Andrews: I think so.

Hughes: There wasn't much you could do for Pneumocystis, was there?

Andrews: I don't think there was initially. I'm sure they gave them all sorts of antibiotics, but I just remember, you got Pneumocystis and you just expected you would have six months to live. You were not going to have more than a year to live at the most if you came down with Pneumocystis, if you even survived the initial bout, which most people didn't.

Hughes: Were you getting a lot of sick people in your practice?

Andrews: I had some. I've never had more than ten to fifteen men that I've seen here as outpatients, because I was so busy with the kids and with the administrative things that I didn't have a huge practice. In the eighteen years I was in practice, I probably had twenty or twenty-five men that have been positive or have died and so on. So I certainly had that in my practice.

Hughes: Did your training stand you in good stead? Because most psychiatrists don't really expect to be dealing with death and dying, at least on an ongoing basis, do they?

Andrews: No, this was a culture shock for everyone. All of us were dealing with young people, our contemporaries, being gay and dying right in front of our eyes. It was like the Vietnam War.
It was amazing to have so many people that you knew and that were so gifted suddenly dying, and at twenty-seven, at twenty-five, at thirty-one—really young.

Hughes: What personal resources did you use? I would think you'd have to protect yourself from the emotion in order to function.

Andrews: Well, most physicians are used to dealing with crises. Even though this was one that hit us in an unexpected way, and hit us personally, that's what we are trained for. Psychiatrists are used to people crying and being psychotic or trying to kill themselves, and they are used to being calm when that is happening. And certainly, surgeons are used to people dying on the table. We're used to death and dying in medicine, because it just comes with human territory.

The difference was changing gear when you felt personally so attached to the people that were dying. But the training still worked, and because we had such a good support group, there were so many of us here to talk about it. Most of my best friends were primarily gay doctors. So talking about this and sharing the angst and the concern and the anger and all that really helped a lot of us work with it.

Hughes: You mentioned a support group, and I think you probably meant that in an informal way, but wasn't there also a formal physicians' support group at BAPHR?

Andrews: Yes, there was. Originally, there were several that started out to help people that were either personally involved or were just affected by the epidemic, the mushrooming epidemic. I never was involved in any of those because interestingly enough, at Social Security where I worked, at one point the president, vice president, secretary, and treasurer of BAPHR all worked there, all of us. There were twenty-five physicians who worked in this regional office, and about twelve of us were gay, and of that twelve, about six of us were intimately involved in BAPHR and the politics. So unlike a doc who's in isolation, there were a couple of days a week where I'd be spending a few hours going over charts, and we'd sit down and talk about this stuff. We weren't in as much isolation as other practitioners.

The other thing was, BAPHR was still very much functioning at the time, so we still had social functions and many scientific meetings and cocktail parties, and there was a great deal of contact among ourselves.
Hughes: Did you have any particular connection with what was going on at the university, either UCSF (University of California, San Francisco) or San Francisco General?

Andrews: My primary connection was through Merv Silverman's meetings, which were around the bathhouse issue. At those meetings were people from all over the city: from S.F. General, from UCSF, from Marc Conant's office, the Veteran's Hospital system, the blood bank, the president of the medical society, me as president of BAPHR, researchers--that sort of colloquium was where I had a connection. The medical society also had an AIDS task force that many of us went to. So there was considerable cross-pollination.

Hughes: Was there any territoriality in terms of orientation towards the problem? By that I mean, did you as a community physician tend to take a different stance than, say, Paul Volberding and Donald Abrams and the people associated with the university?

Andrews: Well, in the context of Silverman's meetings, there was a different stance, and that was, although there were several other gay physicians in that group, I was the representative of BAPHR, and I was, I think, the only psychiatrist in the group. Everyone else was either an epidemiologist or a surgeon or oncologist; they were more academically inclined, perhaps.

I think there must have been a different orientation between the academic-affiliated physicians and the rest of us, but I really experienced a wonderful team effort of people struggling so hard to try to come up with some answers. Whether it was about safe sex guidelines, or whether it was about the bathhouse issue, people were so committed to trying to figure out what to do with this complicated medical-social-civil rights issue. One of the surgeons from S.F. General, Merle Sande, I believe, might be worried about contamination if a gay doctor was performing surgery that might infect the patient, and that would get us off into, "Well, we've got to do universal precautions for everyone anyway, so it doesn't really matter." Those kind of issues.

But I was probably the most focused on the [gay] community response--not to say that Dr. Silverman wasn't; he certainly was very, very concerned. But being the gay medical representative from the community, I think it fell on me maybe a bit more.

Hughes: And you were reflecting that opinion as you saw it expressed through BAPHR?

Andrews: Right.
Hughes: And through your life, as a member of the gay community.

Andrews: Yes, that's right.

**BAPHR's Safe Sex Guidelines**

**Formulation**

Hughes: Let's talk about the safe sex guidelines. I've read an article by Daniel C. William, "The changing lifestyles of homosexual men in the last fifteen years," which appeared in a book edited by Alvin Friedman-Kien and Linda Laubenstein called *AIDS: The Epidemic of KS and Opportunistic Infections*. William said that physicians caring for gay patients--and this is before the epidemic--reinforced the concept that "judicious promiscuity held acceptable health risks." I guess he's saying, "If you're reasonably careful, medicine can take care of any consequences." Which I suppose is what you were saying before.

Andrews: That's right: you'd go to the City Clinic, get your shot of penicillin, and then that takes care of it. So go out, and don't put a light bulb up your rectum or something like that, but otherwise, it was just like carte blanche, do what you want.

Hughes: So that was the backdrop against which you were having to formulate these guidelines. How was the process organized?

Andrews: I can't remember exactly. It seems that we decided early on that one of the contributions we [BAPHR] could make is to come up with some kind of response to the community that we could publish to say, "These are the things that, based on what we know, we're going to say as an organization you should watch out about." So how do you make that list, and how do you categorize certain things?

We had endless meetings which evolved into our first safe sex guidelines, which involved issues like closed-mouth kissing, and fondling, and body frottage or body rubbing. All those kind of things were definitely safe. Originally, I think we had three categories: things that were safe, things that were unsafe, and things that were questionably safe.

Hughes: And where were you getting that information?
Andrews: We were using the basic guidelines for sexually transmitted disease and what we knew about hepatitis B; that semen carried hepatitis B and a lot of other things, so that you want to avoid semen. So blood contamination, you probably want to avoid that. But when you think of sex guidelines, it was mainly avoid semen. Then it was maybe urine too, maybe feces, sweat and tears and all those things were major things we discussed. It just didn't quite make sense to say they are high-risk. Then you'd get everyone totally hysterical.

So part of this was coming up with guidelines that you could recommend to the gay community, but that also didn't throw people into absolute panic.

Hughes: And also were do-able.

Andrews: Yes. Guidelines that would not only not throw the gay community into panic, but throw the larger community into panic, where they would want to isolate all gay people. There was this quarantine thing going on too, that all people that were positive should be quarantined away. That was a real discussion topic, not by us but by other people saying that's what we should do. So there was a real worry that if we came out saying anything that's too constricted as far as you'd better not do anything, that people would use that to round us up. So that was scary.

Hughes: When did you come out with the first set of guidelines?

Andrews: I believe that I was president and Bob Bolan was chair of the scientific affairs committee which wrote them, because I remember so many meetings where we discussed the wording of "might" and "should" and "could" and all those kind of things. I don't remember when exactly that was, but it would be there somewhere. I know we could recover that.¹

Andrews: We put together a brochure at the request, I believe, of a group called the Sisters for Perpetual Indulgence, the nun drag group that got together to be politically active. They were very pro-sex but they wanted to protect the gay community. They came to us, as I recall, asking for some guidelines, and we came up with something that they then put together in a brochure that was very interesting. We also came up with the same thing for the AIDS Foundation. It may have still been the KS Foundation then. I'll bet you in the BAPHR office somewhere we've got these earliest brochures that we came up with.

¹ See the oral history with Robert Bolan for BAPHR's role in formulating guidelines for sexual activity.
We spent so much time just working on the wording so that it would be as amenable as possible to someone reading it, that it would be believable and nonoffensive and pro-gay. It was amazing, is what it was. It was an amazing effort to try to be taking care of all the different sides, so whatever you came up with could work and would be honest, too.

Hughes: Do you think the brochures were published as early as 1982?

Andrews: Yes, I know that we came up with the first group of safe sex guidelines when I was president. So that must have been before the end of '82.

Hughes: Were those the first safe sex guidelines for AIDS in the city?

Andrews: I think they were. In fact--and this could be wrong--it seems like they were the first ones anywhere. I remember we sent them out to New York and all over the place. I remember someone, and I forget who it was, who had some connections with the Public Health Department, and the Public Health Department adopted almost in toto what our safe sex guidelines were, to go through public health clinics.

Hughes: Were you in touch with the Gay Men's Health Crisis?

Andrews: Yes. I went to some meetings in New York in that period where those kind of things were discussed, but my recollection is that they may have discussed and maybe fine-tuned ours. But the first [set of guidelines] came from us, I think.

Distribution

Hughes: What was the community response?

Andrews: Well, mixed. Some people were just scared to death and just didn't want to have sex, didn't want to touch anyone. Other people just thought it was all a bunch of baloney and that we didn't know what we were talking about. This was before the virus was even identified, so you couldn't really stand on scientific proof. It was just based on what we knew, which people would just dismiss as a flimsy argument if we couldn't prove it. So some people took it seriously, some people took it too seriously, some people completely dismissed it. A real mixture.
Hughes: How well do you think the brochures were distributed in the gay community? Would it have been difficult not to have come across the guidelines?

Andrews: Yes. I don't know when the health fairs stopped, but at the Gay Pride day, we had a booth. Gay Pride day: 200,000, 300,000 people. During those times when we would staff the booth there, we were always handing out every kind of brochure. We had two or three brochures we were handing out, not only from us [BAPHR], but also from other organizations, and people were just flooding there. The Castro Street Fair, the Folsom Street Fair--at all the street fairs, we had booths. And we would mail the brochures out in batches of 100 to different places all over the country. It was printed up in the gay newspapers. It was widely distributed.

Now, someone that wasn't in the gay community at all, someone who didn't have any connection to this community, then they might not have gotten it. But anyone that was "out" in the community, and I mean "out" as far as going to community events, would have run across it. It was in the bars; all the bars passed them out at the door. It was just everywhere for a while.

Hughes: Was it a problem that you had a mixed audience? You talked about classifying sexual activities, but you also had at least three different categories of audience. You had the people who were well, you had the people who were sick, and you had some sort of intermediate group. These guidelines had to apply to everybody, even though the circumstances were different.

Andrews: Well, we quickly came to the conclusion that the only workable solution was universal precautions for everyone, that everyone had to assume that anyone might be positive. The message was to try to get everyone to look at the possibility they might be positive, and if they were, we thought they could transmit this. So here's what you need to do. And that was a very difficult message to give to a community that had been as liberated as it had just been.

Hughes: Right, and still a large percentage of them feeling fine.

Andrews: Yes, that's right. "This isn't going to happen to me." People could carry it for ten years and feel perfectly fine. It was really weird.
Struggle for Acceptance

Hughes: Did you do some research on how to get people to change behavior?

Andrews: I don't remember any. Well, we did try to spend a lot of time on how to get people to change behavior. The principles were, don't condemn people; we had to be sex-positive. We knew that if we said sex was bad, who would listen to us? So the message had to be that something "bad" is going on that we don't know much about, and that "bad" thing that's going on we've just got to be careful about. We wanted to try to dissociate that from us being bad.

The other thing that was very important in the discussions that I had was to explain to people why this was so upsetting to them. I don't think a lot of people thought this through. I remember many, many times saying, "You know, we have been so persecuted, and we finally came to a time where positive things were happening like Harvey's election, community organizations, etcetera--where finally we can be okay with who we are sexually. And then something comes along that makes us much sicker than GC or hepatitis. But this "thing", this organism, isn't "evil", and gay sex and loving aren't "evil." It's just that these organisms can jump back and forth between our bodies when we have unprotected sex. So the more bodies you have sex with, the more chance this organism can be spread. This isn't God's wrath; it's just basic biology."

And who wants to hear this? So my sense was, you had to explain to everyone why it is that this is so upsetting to them so they could begin to listen to what you were trying to say. Otherwise, they were so upset hearing the news that they just wanted to throw eggs at you.

Hughes: So you felt that was your job to get people to a place where they could hear?

Andrews: I felt that was one of my most important jobs, to get people to understand what's going on here instead of just reacting, and being angry or afraid.

Hughes: And did you have pretty good luck?

The Bathhouse Issue

Background

Andrews: Even around the issue of the bathhouses, the struggle had been contentious, and in BAPHR there were a lot of people that were very upset with me when Merv Silverman closed the bathhouses. In that front page picture¹ I'm standing right beside him, and several others of us on that committee [Director's Medical Advisory Board on AIDS, San Francisco Department of Health] were standing right behind him.² I remember a very good friend of mine, a previous president of BAPHR, said, "You betrayed us." It just killed me to hear that, like I'd betrayed the gay cause; that in supporting Silverman's decision to close the bathhouses, I was being a traitor. That was very hard to hear from people that I respected and admired so much. Goodness. It was very bad.

But I had been the main voice, I believe, at Merv Silverman's meetings, saying, "We've got to help people understand this, and then get the gay community to stop going to the baths, get the community upset about the bathhouse owners who are making money on us, and by the way, we're getting sick from this, and somehow we should be the ones addressing the issue." And I just couldn't get people mobilized around doing that. There were times I thought, Let's get a group of us together and go down and picket in front of the gay bathhouse. But it just never happened.

I will always remember a week or two before we had the final discussion about what was going to happen with the bathhouses. It was very much on the front pages of the newspaper, and we had a big meeting at the Pride Foundation, which was over on Hayes Street at the time--ultimately Shanti had their headquarters there--and I don't think there's ever been a time in my life that I've been more intensely striving to try to figure out a solution, that I can recall.

I remember talking to the owner of the BAR [Bay Area Report], Bob Ross, and the editor, Paul Lorch. Because previous to that, I had been listed in the BAR along with ten other people as the enemies of the community. I remember going to them and

¹ San Francisco Examiner, 4/9/84.
² Andrews was a member of the committee from May 1983 to October 1984.
sitting down and saying, "Just listen to me for a few minutes. Why can't we encourage and expect and demand that the bathhouses be the center for how we get to safe sex? Why can't we say, 'These are great places for people to come and meet where we can say this is where you're going to learn [how to protect yourself from AIDS]. We're going to help each other not get sick'?" I talked to Bob Ross and Paul Lorch, and after about twenty or thirty minutes, they really listened to me.

And at that Pride meeting, which was all about civil rights and spreading disease and all this polarity, I remember talking about, "Why can't we be promoting bathhouses as the way out?" A strange thing: to turn this bad thing that's ours into something that can help us get out of this, by expecting, demanding—we do this for our own selves, not because of government; because we're the fucking ones dying! Many people came up to me afterwards and said, "You know, that makes sense."

But Silverman was under pressure from the mayor, Dianne Feinstein.1 This [bathhouse issue] was making national headlines, and she finally got so upset, and Silverman finally said, "I can't go on anymore, we're just going to have to do it [close the baths]."

Actually, it's very interesting to realize that the decision of Merv's medical advisory group, and his ultimate decision as reported in the press, was not to close the bathhouses, but to prohibit any sexual activity that would promote the spread of AIDS. This was actually what I had been recommending. In that seven-hour meeting of his medical advisory group, which included a special trip by Jim Curran of the CDC, the majority opinion was that the baths should just be closed. But I argued strongly for the same idea I had expressed at the Pride Center community meeting, i.e., let the baths stay open, and give them a chance to become educational, safe-sex facilities, so long as they were not conducive to spreading AIDS, which primarily meant no anal intercourse.

We finally reached consensus on this idea and on Sunday, the day before the decision was to be made public, Merv convened a large group of gay community and political leaders to discuss his decision and seek support. I was the main proponent of this plan, and the vast majority of the people attending were in

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agreement. Now what ultimately happened was that some time after this decision was made public on Monday, city attorneys made some legal decisions—'I'm not exactly sure of the details—that indicated the only way Merv's decision could be practically implemented was to actually close the baths. So historically people only remember that Merv closed the bathhouses, but actually it didn't come about that simply or directly. I remember being very vocal with Merv that we give this [idea of mine] a chance to work, but the politics and legal interpretations finally resulted in closure. Ultimately, they got closed. I think time ran out. What I had hoped would happen didn't happen. They got closed.

Hughes: Your idea was, in a nutshell, that the bathhouses themselves could be places of instruction.

Andrews: That's right. That was the only way I could see out of the polarity between civil rights and [the attitude of], "We can fuck and no one's going to tell us what to do; we don't care," and "All you people should be quarantined because there's this serious disease going on, and this place is obviously promoting it." So that didn't work.

Hughes: In the report by psychologists Leon McKusick, Tom Coates, and William Horstman which came out in late 1983, one of the points made was that, "men who frequented bathhouses were the most likely of the groups surveyed to be engaged in high-risk behavior and to have contracted other STDs." Well, you've said that time and again. Later, not until 1984, there's evidence from the CDC showing that bathhouse association and AIDS don't go together. And there was big campaign stressing risky behavior rather than location. And BAPHR did not as an organization support bathhouse closure.

Andrews: That's right. And so your question is, how could we come to that?

Hughes: Yes.

Andrews: The assumption is true: if you went to a bathhouse and you only kissed someone, and you masturbated, you were not going to get anything. You might get a sore throat from a cold or something. But the premise is: it's not where you do it but what you do. That was one of our little mottoes. It can happen in the park. There were all the arguments about the bathhouses; the counterarguments were, "Now, you can't tell me that someone going

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home from a bar isn't going to transmit it [AIDS] just like in
the bathhouses."

And the answer was always, "No one ever said you can't do it
other places. We're simply saying that places that are designed
solely for as much anonymous sex as people can have, and with the
amyl nitrate, the drugs that go on there, and the orgy rooms, it
just makes it 100 times easier for this [disease] to get
transmitted than it does in a public place. People don't have
100 people over to their houses."

Hughes: There was a dissociation: it's what you do; it's not where you do
it. But on the other hand, when you go into a bathhouse--

Andrews: That's what you're there for!

Hughes: Exactly.

Andrews: It's promoted! You see, that is where politics and civil rights
and all that entered into this medical-physical epidemic. The
gay establishment had grown more powerful and become more visible
in the United States, particularly in metropolitan cities, and we
had made, as I said, liaisons with medical societies and with the
CDC, the blood bank, the Public Health Service, et cetera.

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Andrews: All those people were out here, and I was in groups that met with
them probably ten times. The meetings were here and L.A. and
Washington and New York, but mainly they came out here, and New
York, because the community was so huge here, and because the gay
community itself was more organized here than anyplace else in
the world, at that time--still is.

So there was this awareness of how to get the community
involved in solving the problem, and the community was so
sensitive around civil rights violations after these struggles of
so many decades or centuries that the message would be, Well, any
idiot can see it's not where you do it but what you do, but if
you go to the bathhouses that's what you go there to do. But
then when you go out to talk to people, you say just what we were
saying: "So it's not the place you do it, it's what you do; but
guess what: what do you do at a bathhouse? You all have been
there. Are you all playing cards, or are you having multiple
sexual encounters? Now, come on!" Those were the discussions I
was having with people.

"So we're going to say this so that they won't come down and
boycott all the gay people in the country, but you all use your
heads now. We're saying stuff in two ways so that we don't get
creamed, but if you look at this as your own personal behavior and your own risk, draw your own conclusions from it." It was weird politics.

Hughes: There were really two messages that you were trying to give.

Andrews: There really were: a political message and a medical message.

BAPHR's Involvement

Hughes: Now, do you think that in the eyes of the gay community, BAPHR, because it was gay and because it was medical, had more force, so that if a statement came out from BAPHR, the community would tend to pay more attention to it than even from Silverman or the health department?

Andrews: Yes, exactly. Because of the early work we had done, coming out, hosting these health fairs, Harvey mentioning during the Briggs Initiative that he'd gotten information from BAPHR about how to address the issue of homosexuality—we were a known and relatively trusted force, especially early on. We were gay docs, we were part of "us," we were looking out for ourselves, so that many gay people thought we could be trusted. And we were the most powerful gay physicians' group in the country. We were the best organized.

People had to work with us, because they knew that we had the inside route to where most of the infection was happening. They couldn't just say, "Screw them." They knew that if we got angry, whoever it was, it was going to turn the whole community off. That was a time when we were looked to as the good guys.

Hughes: Was the CDC involved in actually observing bathhouse behavior?

Andrews: I don't know if the CDC was. Either Silverman or the mayor definitely sent people into bathhouses to observe sexual behavior, anonymous, multiple sexual behavior. It was described in some detail, because we discussed the results of this report in one of Silverman's meetings. Again, I don't know if it was through Silverman's health department or the mayor through her own operatives—that word sounds sort of like spies—but spies, yes. I think they were health department people, actually, that had gone out and observed.
Silverman's Struggle

Hughes: Well, flipping back to the year before bathhouse closure, in December of 1983, you reported to the executive board of BAPHR that, "Dr. Silverman said that he would never agree to bathhouse closings unless a large number of gay/lesbian physicians and other health care providers gave complete support to do so." He didn't do that, did he?

Andrews: As I've said, before Silverman made his formal announcement, he had a meeting with probably forty or fifty gay community leaders, and all of the gay people that had been part of his task force were there: me, Don Abrams, and some other people too. In that meeting, Silverman tried his best to say that he wasn't really going to close them; he was going to prohibit anything besides masturbation. He was going to say, "You can go there, but you can't do more than masturbate." My sense is that the general consensus of the people at that meeting was, We can stomach this; we can handle this.

And then the next day, he made this statement that, "They'll be closed if they don't stop other than masturbatory activity." Some of the gay community leaders that had been at that Sunday meeting felt like they'd been used. But he needed to have support from the gay community to say this was a combined consensus to go to the full community.

Hughes: Did you have second thoughts about being in that newspaper photograph?

Andrews: Yes, sure. I had still such strong, agonizing, ambivalence, I wished it didn't have to be this way. Because my sense was, If we get people built up into being resistant and radically opposing this, we're going to have even more problems. We're going to lose our credibility, and the epidemic is going to keep going on unabated. But how do you get through to people? And there was just no clear way to get through to people at that time.

Bathhouse Owners

Hughes: In July of 1984, W. L. Warner of BAPHR--

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1 Minutes, Executive Committee Meeting, December 4, 1983 (BAPHR Office Records, folder: Board Minutes).
Andrews: He was a later president. That's when I left the organization, pretty much.

Hughes: Writing confidentially to Silverman he said, "BAPHR stands ready to assist the health department in transferring the main issue of safe sex and role of the bathhouses back to the gay community if that is indeed possible. We can reactivate our dormant program that was being developed several months ago for working with bathhouse owners. We also have some ideas for setting up a monitoring system for the assistance of other nonmedical gay organizations." What is the dormant program that he was talking about?

Andrews: Well, we did have meetings with bathhouse owners. We had had ongoing meetings with members of BAPHR, and I was at many of them, because we knew that the more communication we had, maybe we could make some inroads into something that would be useful. And what I think Will was saying is, "You don't do it; let us [BAPHR] do it." The problem is, we weren't able to do it.

Hughes: What were those meetings with the bathhouse owners like?

Andrews: Well, from what I recall, they were an evolution of education from initially the idea of the CIA putting something into the vents to some of them coming to the conclusion that, okay, this [disease] sounds like it is transmissible in some way. There was still that group that remained rabidly, "You can't prove anything; you're full of shit; we're not going to listen to you; and these are my civil rights." Just furious.

Hughes: Also, "This is my livelihood that's going down the drain."

Andrews: That's right--their business. There were other bathhouse owners that weren't in as much denial and they were willing to put up signs around the bathhouse, "Wash your hands; use a condom," that kind of stuff. But none of them wanted to close the bathhouses. A few of them did have safe sex information sessions at the bathhouses. So there was a movement to try to do something. Maybe if we hadn't had the political pressure, which is hard to imagine in the climate of AIDS, and more people weren't dying, we might have been able to do something. But it had gone on so long--

Hughes: What was your take on Silverman himself?

Andrews: I have the greatest respect for him. I thought he struggled valiantly to ensure the health of the people of San Francisco, and that was his charge as the health director. I felt he was not homophobic. He was at many BAPHR meetings before all this happened. He was honored. I knew his wife. I felt that he was
candid in these meetings. I felt that in the discussions with some of the more conservative docs that he said things better than I could have about being open, about how we do change, how you can't just legislate behavior, all that kind of thing. I thought he was a master at many of the things he did. I still think he's a terrific guy. Only lives a few blocks away, too.

The Bathhouses Close and Reopen, October 1984

Hughes: The baths were closed in October of 1984, and they immediately reopened. There was a press statement which included Dennis McShane--

Andrews: Oh, Denny McShane. He was the president [of BAPHR] then, I guess.

Hughes: Yes, he was. Anyway, the day after the baths were closed, a group which was not exclusively gay--there were some civil rights groups in it as well--issued a statement saying that bathhouse closure sent the wrong message. It was not location but risky sexual behavior that was the problem. Well, I guess that's the same--

Andrews: It's the same old song.

Hughes: The Committee to Preserve Our Sexual and Civil Liberties arose. Do you remember that group?

Andrews: Vaguely. I don't remember a lot about it.

Hughes: Which probably answers my question, because I was wondering if that group worked closely with BAPHR, and if they did, you probably would have known it.

Andrews: A lot of BAPHR people were very unhappy with the fact that I had even been a part of this. It was like I was a traitor, blah blah blah. So they were saying things like, "We're going to look at it in a different way." It really was the same way. In my opinion, it was just trying to get back on the good side of the community by saying, "We're going to oppose this now," and that was a politically popular thing to do. The people that were saying this hadn't sat through the hours and hours of meetings that we had sat through, earnestly trying to come up with some resolution. It's easy when you're on one side just to say the other side did it wrong. That was my opinion of it.
Hughes: In November of '84, you wrote what I assume was a personal letter, because it was on your stationary rather than on BAPHR's, addressed to "Colleagues and Friends."

Andrews: Ah, it was printed in the BAPHRON, I bet.¹ What did I say?

[tape interruption to view the letter]

Hughes: You said that you'd been through a tough time. You also said that you had "difficulty supporting the 'radical rhetoric' in recent statements by BAPHR's leaders," although you did share many of their concerns. I'm assuming this is all in the context of bathhouse closure.

Andrews: Yes.

Hughes: Your letter supports your statement at the beginning of the interview that there was a period in which you philosophically were not in tune with BAPHR leaders.

Andrews: Right, it was this time. By the time bathhouse [closure] had happened, I was the past president; I wasn't the formal BAPHR representative. BAPHR was swinging into a reaction against civil rights stuff. They were making fun of the mayor and Silverman, making them all out to be the enemy. It just seemed [that they were saying], "You're the problem," instead of saying, "Wait, this [issue] is much more complicated than that." [My letter] was an attempt to say, "Come on, you all, look at the whole picture."

Hughes: You were the voice of reason.

More on Bathhouse Owners

[Interview 2: April 19, 1996] ##

Hughes: How did the bathhouse owners feel about the threat of closure?

Andrews: Well, threatened, angry, resentful, suspicious. I think that describes what their mood was. They were very upset about it.

Hughes: How did they feel about BAPHR's role in the episode?

¹ Ric Andrews to Colleagues and Friends, November 15, 1984 (BAPHR office documents; also published in November 1984 issue of The BAPHRON).
Andrews: I think they were very ambivalent, because as I said, [BAPHR] had had this health fair; we had gotten exposure; we had a name in the community, along with the other budding gay organizations. Then for us to be the messenger of what sounded like possibly catastrophic news made us very unpopular.

Hughes: With the owners as well?

Andrews: Right, yes. There were a few owners that would talk to me and say, "I know that you're not an enemy and I know you're trying to help, and this is just so confusing." But the rhetoric of the mass of them was very suspicious and angry, as if we were betraying them by giving them the message that there was this disease that was going on that was probably sexually transmitted. That sounded like a betrayal, just hearing that.

Hughes: Can you sort out how much of their emotion was due to the fact that their business was threatened, and how much was for other causes, namely, that they too were gay men, and this disease obviously had a personal impact on them?

Andrews: Exactly. I would hesitate to proportion out what percentage for what, but I think that you can't underestimate the importance of their livelihood. For some of these people, this was their main source of income. I understand one of the bathhouse owners may have even been a doctor. I don't know if he was a straight or a gay doctor. But they were businessmen that dabbled in lots of things, and the bathhouses were making a lot of money. So to cut off that revenue faucet was alarming.

We heard that some of the baths were run by Mafia. I don't know. I didn't go to enough of them, and I didn't see any characters that looked like Mafia people to me, whatever they're supposed to look like. [laughter] But I think that it was that double whammy of money and economics, and, free expression is what the liberation movement had been all about, and now we're saying it's dangerous.

Hughes: In some of the really bitter encounters, there were some very damning things said. One of them, repeated by Paul Volberding, was something to the effect, "We bathhouse owners and you physicians are both profiting by this epidemic." Did you as BAPHR physicians also get that line from them?

Andrews: Not early on, because it was so early in the epidemic that there wasn't any profit to be had. That was before all the drug companies were into this, at least that we knew about. In the early years the outrage didn't seem to be, "You're going to profit from this." It was, "You're not telling the truth. You
have betrayed us. We can't trust you now, because you're telling us something that's so upsetting."

At the same time that organized groups were so vehement, there were plenty of my friends that were saying, "Well, this [closing the baths] makes total sense." Even lay people were saying, "This makes sense." Looking at gonorrhea and hepatitis and all the other things we talked about, this doesn't sound surprising, and what did we expect? A lot of people were very supportive. The organized civil rights groups had a hard time being supportive of any kind of news like this.

Hughes: There were essentially two arguments for closure--I got this from one of the BAPHRONS. First, obviously, closure as a means of reducing the rate of infection. But closure also as a symbolic gesture.

Andrews: As a message to the nation.

Hughes: Yes, exactly. Is that the way that BAPHR saw it?

Andrews: Well it wasn't really the message that we wanted to give: "You should close the bathhouses." As I said, it really was, "We need to make a drastic change in the way we're behaving sexually with each other, and possibly the bathhouses could be the conduit for that. But certainly right now they're the conduit for disease instead of for health."

I don't think BAPHR as an organization liked the idea that we were sending a message, because it looked like here in San Francisco, the pinnacle of gay progress, we were the ones folding to worries about health and giving up our civil liberties. That was what the majority of people looked at, I think. The vocal ones, at least.

Bathhouses Outside San Francisco

Hughes: When the bathhouses were indeed closed, did it have a symbolic, ripple effect in other communities?

Andrews: I don't think it did, because the bathhouses never closed in L.A.

Hughes: Or in New York.

Andrews: Not in New York, not in Berkeley, not in San Jose. The one in Berkeley is certainly operating now and has been for at least
five or ten years. I think it just never closed. It was outside the San Francisco jurisdiction.

It must have had some impact on both straight and gay perception of what's going on with this disease to have this controversy going on in the "gay mecca" of San Francisco.

Larry Littlejohn's Initiative

Andrews: There was a guy named Larry Littlejohn who was about to file a suit against the city, I believe, to close the bathhouses.

Hughes: It was actually an initiative measure.

Andrews: An initiative, that's exactly it. He was going to get an initiative on the ballot. This was way before the bathhouses closed. I wasn't president [of BAPHR] then; Dave Kessler was the president. He asked for a group of about fifteen leaders to come very secretly to his house and talk about this. And they included Carole Migden, who was the head of the Harvey Milk Gay and Lesbian Democratic Club; Sal Rosselli, the head of the Alice B. Toklas Gay Democratic Club; Bill Kraus, who was Congressman [Philip] Burton's aide. I think he might have been Supervisor Harry Britt's aide at the time. Gay doctors, gay lawyers. We were asked to come and very quietly talk about this initiative, and what would happen if, even in this liberal town, there was an initiative on the ballot. Everyone was concerned. Clearly it would pass; the voters were going to say, "We shouldn't have bathhouses open." We didn't want all this stuff in the paper. It was our dirty laundry.

In that meeting the politicians were pushing very, very hard that we had, as a group of gay leaders, to preempt this initiative thing. They wanted us to say the bathhouses should close, so that it didn't become a public policy issue. But specifically, all the politicians wanted to put it on the doctors to say, "The reason is medical, not political; it's strictly medical." And of course, that was long before the virus was identified. Everything was in a state of supposition.

That was an incredibly intense meeting that night. The politicians actually had convinced me and most of the BAPHR members that we did need to sign some kind of petition, and that's where my name and all these other people's names came from and got on the enemy list of the community in the BAR.
I forget all the details, but we came up with the text of the petition that night. We all signed our names to it. By the time it got to the paper the next day, somehow it had been written a little more strongly than we felt we could absolutely medically support. So then there was a massive retreat, because the gay community was furious with us.

I clearly remember that there was a community meeting shortly after that petition and after the BAR named us enemies of the community.

Hughes: Was that the Valencia Rose meeting?

Andrews: Yes, that was at the Valencia Rose. I was there; Bob Scott was there, another BAPHR member; Carole Migden was there; but no one spoke but me. Not one person that was at that meeting addressed the crowd but me, because no one wanted to. Because the people were extremely angry that we were traitors.

I remember in that meeting saying that we had jumped the gun. I backed down. No one else was up there. It was like we made a mistake; this was premature. We still thought there was clear evidence that there was something dangerous going on, but we backed down. We pulled back from that. The crowd [reaction] was mixed. Some people applauded because I said, "Hey, I made a mistake. I made an error in judgment. It's not conclusive, but we still think there's something going on." I wish I knew when Merv Silverman started his task force.

Merv Silverman's Press Conference, March 30, 1984

Hughes: I think that meeting came very close to a press conference that was scheduled by Silverman--

Andrews: To close the bathhouses, yes.

Hughes: --when he was expected to close the bathhouses.¹ And then he found that he didn't have community support.

Andrews: You're right. He called a press conference. At that press conference, there were gay men in nothing but towels. The room was full of reporters and angry gay people. Merv at the health department pulled many of the same leaders that had been at that meeting into an office. We delayed the press conference for at

¹ See the oral history in the AIDS physicians series with Merv Silverman.
least an hour, and we had this intense debate about whether we should or shouldn't close the bathhouses, and whether we had absolute medical evidence to close the bathhouses.

In that debate, I was the most vocal person saying that we didn't have clear evidence to close the bathhouses. I remember debating mainly with Bill Kraus, who ended up being a major political person back in Washington as Philip Burton's aide. He was saying, "You know that we [politicians] can't do this, but we should come down on the side of closure." Everyone else was being quiet, and I just kept debating about, "We have to try to work with the community to see if we can help them come to the same conclusion, instead of trying to impose something on them."

From that [stance], Merv could not feel comfortable closing the baths. So he went out and said, "The whole thing's canceled," and just shocked everyone. It was because we'd had this debate in the inner office that he didn't [close them].

Hughes: Had he called that press conference on the basis of that first meeting?

Andrews: I believe so.

Hughes: When he thought he had consensus of gay leaders?

Andrews: Because he had heard from the political leaders. We [BAPHR] weren't the ones contacting him, but Migden and the political people were the ones that said, "Look, we've got a way to bypass this initiative. We've got gay leaders calling for closure." And then overwhelming condemnation came out in the gay press, no one was there to back up the decision; I was the only one that spoke at that meeting.

So then there was a reversal. We were intimidated. I mean, I was tremendously intimidated being the sole person up there to talk to this angry crowd. And all of us had been invited, and no one came except me. I saw Carole Migden in the corner; she left before I got up there to speak. I knew she was there and then she was gone. No one wanted to get up in front of that group of people.

Hughes: It shows the tenor of the times, the intensity of it.

Andrews: It really does. People were just being ripped apart.

Hughes: What happened to you after that? Were you still the bad guy?

Andrews: I was still sort of wimp guy, I think. I was looked at as indecisive. The ones that wanted closure felt we were cowards.
The ones that didn't want closure thought we were traitors because we even suggested closure in the first place, even though we backed down from it. It was really a no-win situation. No one applauded what we did, and it was because it backfired. It was a dud.

And I don't remember the details of the initiative, to tell you the truth, because after all this happened that initiative never happened. Littlejohn withdrew the initiative, I believe. He was at Dave Kessler's house. He was in one of the discussions that we had with this group of people. I believe because we said we were working so strongly on trying to educate the community, I think that's why he withdrew it. He was a gay person too, and he didn't want to cause all this down stuff. He just wanted to stop people from getting sick.

Hughes: Was the initiative solely his idea?

Andrews: From the best I knew, he had come up with this thing and just sort of surprised everybody. It was like out of the blue. Now, he probably talked about it with people, but I certainly didn't know who had planned that.

An important piece that we didn't mention last week was this big "go ahead" and then a "pull back." Then there were these ongoing meetings that Merv had with all these different people, medical people primarily, to try to grapple with [the bathhouse issue], and then finally there was the formal closure.

The Final Months Before Closure

Hughes: Silverman's press conference occurred in the spring of 1984, and the baths were finally closed in October. What shifted Silverman to a position in which he felt he could close the baths?

Andrews: I think it was partly the political pressure. Gay politicians like Bill Kraus were saying, "You've got to close these bathhouses." Bill ultimately died of AIDS. He had been there. He knew what was going on. He knew the rampant unprotected sex that was happening at the baths. Certainly Mayor Feinstein was putting a lot of pressure on Silverman. The picture was just becoming clearer and clearer: This is a sexually transmitted disease, even if we don't have the virus identified. So there was ongoing political and health pressure to educate the gay community and get them to change voluntarily, which wasn't successful, until finally Silverman just said, "I've got to do it."
Hughes: We talked about the evidence coming out of the CDC showing that bathhouse attendance and the disease don't necessarily go hand in hand. There was an article in the BAPHRON accusing Silverman of having repressed that information, which implies that he himself was moving towards closure, right? Otherwise, why would he suppress it?

Andrews: I don't know that he really suppressed it. My sense of Merv from the beginning was, he knew--I think every one of us in that room knew it was in the best interest of the health of the people of San Francisco to curtail these businesses where it was so easy to facilitate the spread of the disease. He wanted closure, but he was very conscious of trying not to divide the gay community. He did not want to make it be a "strong arm" confrontation with police and then riot squads--and that could have happened. Even when he closed the bathhouses it was this convoluted thing where Merv was trying to reach a compromise by saying, "We'll just say that there can't be any rooms where the doors are shut, and so we will prevent disease transmission."

Without saying it, he was saying off the record, "There can be as much masturbation as people want. I'm not going to say that in this ordinance; I'm just going to say that we can't have closed rooms." So it was this ambivalent sort of thing of not wanting to close the baths entirely, but to say that if they had closed rooms, we were going to close them.

Hughes: And there were agents that were sent in to observe.

Andrews: Right.

Hughes: Did people as a result stay away from the baths?

Andrews: I don't think so. I believe the agents were probably gay. They put their towels on and walked around, and they didn't have badges, and they went through and just observed.

Hughes: Oh, so that wouldn't be disruptive.

Andrews: Yes, there was no disruption, that's right. The music was still going strong, the porno movies were going, and I think a lot of people actually got into this thing of, "They can't do this to us; I'm gonna go to the bathhouses." Just sort of a normal human reaction to a restriction: "Okay, I'm going to push the limit. You can't prove this to me. I'm going to go to the baths even more." I think some people had that reaction.
Will Warner

Hughes: There was an article in the BAPHRON by Will Warner, who seems to have been very active in the bathhouse episode.

Andrews: He was on the other side. He was a leather person, and he was apparently into the S&M [sadism & masochism] scene. He was strongly opposed early on to the antibody testing. He was just totally focused on civil rights. His position was, "We can't prove anything, and we've got to protect our hard-won freedoms."

Hughes: Yes, that's the gist of the articles that I saw in BAPHRON.

Hughes: Warner's article appeared in the November '84 BAPHRON, so just the month after Silverman had finally closed the baths. Warner wrote, "Open war has now been declared between BAPHR and Dr. Silverman, our presumed 'friend' for many months." Is that his perception, or indeed was there now a war between BAPHR and Silverman? How general was that feeling in BAPHR?

Andrews: I don't think that Warner had even the majority. The majority of BAPHR didn't like the whole issue. How could you like anything that disruptive and antagonistic. It was unpopular. But Will clearly represented the polar opposite of where I was. So I wrote that letter we talked about last week.

Hughes: It appeared in that same issue.

Andrews: It was because I knew Will's letter would be published, and I wanted to counter with something that wasn't so radical.

Hughes: Ah, that's interesting. So that was a deliberate move on your part to counter his argument?

Andrews: Yes.

Hughes: What kind of reaction did you get?

Andrews: Well, I think some people thought Will was a total idiot, and some people thought I was a total idiot. So I got mixed reactions. I think a lot of people thought he was too extreme, and probably people thought I was too extreme.
Dichotomy in the Gay Community

Hughes: What about perceptions within the gay community? To put it very extremely, was there a segment of the gay community that said, "If we just didn't have these bathhouse gays, we wouldn't have this AIDS problem"? In other words, was there a social hierarchy that existed before the epidemic that maybe was intensified by the tensions of the epidemic?

Andrews: Yes, I think there was. I think there was a group of people, primarily the people who didn't go to the baths, people that might be in monogamous relationships, or people that either felt intimidated or scared about going [to the bathhouses], or just didn't care for anonymous sex. They formed a little core group of people that said, "It's those idiots that are causing all this. We should close the baths, and we shouldn't be having sex in the parks, and it's disgusting." There was a revulsion with all this preoccupation with sex. There was that segment, and I know that these events polarized that group more.

But they didn't speak up very strongly, because if you got to a big gathering of people, the vocal ones were against bathhouse closure, and so it was more "traditional," what we would probably call establishment gays, not the radical ones.

Hughes: The more radical viewpoint is probably more easily heard than the establishment one.

Andrews: Definitely I think so. It's like ACT UP [AIDS Coalition to Unleash Power]. The most vocal, dramatic segment gets the most attention, and in some ways comes to represent what the whole community feels, which is often not really the case.

Hughes: Well, I err, too. I realize when I say "the gay community," it really should be "the gay communities." There isn't--


Hughes: There wasn't then and isn't now.

Andrews: During those couple of years when people were expressing fairly radical views, fairly polar views, I wasn't very active in what went on in BAPHR. I went to some meetings and events, but I just felt like there wasn't a place for me. Maybe I just didn't want to make a place. Maybe I was just worn out having gone through these ordeals.
Hughes: In February, 1985, BAPHR held a forum which was called "Community in Crisis: What is BAPHR's Role?" And that was it: Are we a medical organization, are we a political organization--what are we? And either way, what stance should we take? What prompted the forum? You were on the panel.

Andrews: Yes, along with Denny McShane, or it might have been Will Warner, or it might have been Bill Kemp, I can't remember. I believe the forum was a clear response to the stuff that had gone on, two things primarily: the bathhouse closure issue, and that meeting at Dave Kessler's house around the petition. All of BAPHR's officers were there, and we were trying to do something that we did not consult the membership about. We knew this initiative was not public yet, and we were really trying to do some--undercover is the wrong word--damage control. We knew that if we brought this up, it would get misinterpreted. We were trying not to publicize this and see if we could short-circuit it, i.e., stop the initiative before it got started.

So when we signed this petition, and it had some BAPHR members on there, including some officers, the membership felt like BAPHR had represented itself. We said, "Our signing this petition does not represent our organization." But when you have the president of the gay Democratic clubs and other community leaders, it looks like it's involving the membership of those groups. So there was a lot of anger and concern [within BAPHR] over that, that we were even involved. And it was understandable.

I have no apology about it--our intentions were noble and appropriate. We were trying to handle a community crisis. But the membership that wasn't involved in those meetings looked at it like, "You're taking the name of our organization and representing us," even though we really weren't. You get the movers and shakers together, and if they represent organizations, the organizations feel like they should be acknowledged. So that's the reason there was that forum.

Hughes: There were four people on the panel. Jim Campbell, you, Jim Krameski, and Bill Lipil. Why those latter two?

Andrews: Jim Krameski is a psychiatrist, and he had major connections with the American Psychiatric Association and was involved in forming

1 The BAPHRON, March/April 1985, p.302.

2 See the oral history with James Campbell in this series.
the Lesbian/Gay Caucus of the American Psych Association. My guess is, because I can't really recall, that he represented a philosophical approach. I think people thought he was a stable person that wasn't going to be overly reactive.

Bill Lipil was an internist. I can't remember why he was chosen. Jim Campbell was, of course, an internist who had been on the [BAPHR] Scientific Affairs Committee and had helped with safe sex guidelines and eventually became the chair of the Scientific Affairs Committee. The reason that I was on there was because I had been involved in all this stuff and I was targeted as the radical. [laughter]

Hughes: Antibody testing was another thing that was in the offing. The forum was in February '85 and the commercial tests were to become available the next month. So you were looking forward--

Andrews: You're right. "What are we going to do about that?" I was for trying to get people to take the test if it was confidential, and the organization didn't agree and clearly said people should not take the test. That was the official stance of the organization.

Hughes: Did you work out that stance at this particular forum?

Andrews: No, I don't think it was worked out. I think there was some discussion, and then the executive board continued to mull it over and came up with their recommendation. That was when I was out of the leadership and there were people that disagreed with me.

Hughes: Do you remember coming to some sort of conclusion about whether BAPHR should look upon itself as a medical organization or a political organization?

Andrews: I think there was general consensus, we're definitely a medical organization. There's no way around it. But it's impossible to be just a medical organization with something as political as AIDS, disease, homophobia, and all that. So you can't have one without the other. Yet we were a 501(c)(3) organization, which meant we couldn't use more than, I think, 20 percent of our funds toward any kind of political action. So under the restrictions of the nonprofit setup of our organization, we couldn't be primarily political. And we always knew that. At the same time, we wrote lots of letters, and always had, about medical issues that had major political implications.

Hughes: That was one of BAPHR's purposes, was it not?

Andrews: That's right.
BAPHR's Connections with Other Agencies

Hughes: Did you have a set of contacts at various levels of government?

Andrews: Yes. As I said, we knew Harold Jaffe, Jim Curran, Dr. [Herbert] Perkins, who was the head of the blood bank here, of course Silverman, Conant, Volberding. All those people were major speakers as far as representing what was going on with KS [Kaposi's sarcoma] or with the blood donation issue. I knew them all personally, they all knew me personally, and they knew other people in BAPHR. So we had strong connections to a lot of the people that were nationally involved in policy guidelines.

Hughes: You could have gone as members of BAPHR directly to the federal government, but I'm gathering it was a little bit more indirect: BAPHR used these San Francisco spokespeople to represent its viewpoint.

Andrews: Right. Our input to the federal government was often through the CDC, with Jaffe or Curran or someone like that, with us saying, "Here's what we think and here's what we know." They listened to us, because there was this huge population of infected people [in the gay community]; the numbers were going up. The same thing locally with the medical society and their stance. At least half of the composition of the San Francisco Medical Society AIDS Task Force was BAPHR members. So yes, we had a lot of input that was fairly direct to these different groups and individuals.

Hughes: But BAPHR has never had its own lobbyist or anything like that?

Andrews: No. We never did. Actually, what happened was as the national organization began to take off, BAPHR scaled down and the national organization scaled up, so we became less important. And another major thing is, as the AIDS epidemic continued, we began to see a multitude of institutions handling this. The AIDS Foundation took care of education; there were physician referral lists from Shanti; there were lots of other things. In the very beginning, there was no organization, so people looked to us for a lot. Afterwards, we weren't the central organization any longer, and we didn't have the staff or the resources to handle the intensity of what was going on. Other groups were doing it.

Hughes: Did you willingly cede those functions to the other organizations, or was there a little bit of competition there?

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1 See the oral histories in the AIDS physicians series with Drs. Perkins, Silverman, Conant and Volberding.
Andrews: I don't think there was competition. Often BAPHR leaders and members were represented in those other organizations. The AIDS Foundation, Shanti, different task forces were very interested in our input. So we had a voice there. And as time went on, what happened was these organizations began to be composed of their own members, perhaps with their own doctors, maybe BAPHR members, maybe not. And then there just wasn't the kind of interconnection, because everyone had their own agenda.

BAPHR and the AIDS Foundation

Hughes: I saw a reference to BAPHR providing medical advice to the KS Foundation at about the time it became the San Francisco AIDS Foundation [March, 1984]. Amongst the leadership of the KS Foundation, there were a few medical people, but apparently it was felt not enough. Do you remember that particular relationship?

Andrews: Yes. A couple of our members were either advisory members to the AIDS Foundation board or maybe even board members.

Hughes: Bob Bolan is one.¹

Andrews: Right. Jim Campbell, I think, did something with the AIDS Foundation. I don't know if he was an advisor or what. So we had these networking activities. But again, we became less and less the command post, because other organizations had the resources, the federal funding, the staff. We didn't have any of that, and we didn't really want any of that. Because we were an organization primarily of docs, our main work wasn't to do this; it was to practice medicine.

Hughes: Did it suit BAPHR members to have these functions taken on by other organizations?

Andrews: Certainly it was fine with me. Maybe some people felt like we gave up center stage, but I think most of us realized there was just too much to be done; we couldn't even begin to do it. We were happy to have other organizations forming to take over.

¹ See oral history with Robert K. Bolan in this series.
Hughes: Did you go to the National Lesbian/Gay Health Conference in Denver in 1983?

Andrews: Yes, I did.

Hughes: Apparently, that was a very hot meeting. I guess BAPHR's safe sex guidelines had just come out, because there was a reference to secretions and excretions, and that precipitated a lot of fireworks. Do you remember any of this?

Andrews: Sorry, I don't remember too much. I know I was there; I remember it being very intense. My recollection is that our safe sex guidelines were, as I said earlier, the first ones really formulated anywhere in the country. And when we brought them there to talk about them, the people that had not been a part of the ongoing discussion about what is safe and safer were very worried about saying things like "secretions and excretions," secretions—sweat, saliva. I remember things like, "Totally safe is dry kissing. Wet kissing, questionably safe." Who knew how much virus was in saliva and how infective it was? And people responded, "What do you mean, we're going to say people can't kiss? Come on!" It was: "Well, we don't know. Are we going to reassure people about something that may get them infected? We don't know if this is like hepatitis or what." Of course we realized that if the virus could be easily transmitted by kissing, then everyone would have been infected, and this clearly wasn't the case. So that was a very, very hot thing, and it was the breaking in of our safe sex guidelines to a national audience.

I remember a lot of people thought they were very good and were using them. There was just controversy about them. There was support, and there was wariness about them. And of course there would be, because no one had any definitive answers.

Hughes: Would it also have been the first opportunity for many of the attendees to learn in detail about the epidemic?

Andrews: I think so. I think not only learn about the epidemic, but [also about] the bathhouse stuff.

There was discussion about what to do even then, and most of these people who were coming in from all over the country really hadn't had the intense prolonged discussions that we had been having here in San Francisco. So I think [the conference] was a first exposure for a lot of people to upsetting stuff.
Then in May of 1984, Marcus Conant and others at UCSF organized a symposium to develop guidelines on AIDS risk factors. In other words, doing what BAPHR had already done. And there must have been some ruffled feathers, because apparently nobody from the community was invited to participate, and in fact, BAPHR was explicitly not invited.

I don't remember that. I certainly knew Marc Conant and all those [UC] people; we talked to each other on the phone quite a bit during those times. [tape interruption]

Hughes: What I'm showing Dr. Andrews is a comparison of the UCSF-generated safe sex guidelines and the ones that BAPHR had come up with. The safe and the definitely not safe categories are not that far apart, but it's the middle ground that's very different.

Andrews: The middle ground has always been the point of contention. Massage, cuddling--we all knew that was safe. It was the possibly safer--they call it the suspected high risk--where all the controversy was, because no one knew at that time [whether it was safe or not].

UCSF said that documented high risk was fisting and anal intercourse, and we said unsafe was fisting, anal intercourse without a condom, rimming, blood contact, sharing sex toys, semen or urine in the mouth. What's interesting is that all the activities that we said were documented high risk, we know now are high risk, very high risk, with the exception of urine. I think we were right on.

The months that we spent on those guidelines, and we revised them several times, really reflected pretty accurately [our] epidemiological knowledge of how disease is transmitted and what we knew of sexual practices. We were pretty frank about sex toys: if you insert one toy and then insert it in the other partner, you could have disease transmission. It was so frank that it was sort of distasteful, even to some gay men. I mean, you had to look at all these sexual practices and say, "Sex toys and rimming--oh, my god." That had hardly even been talked about in the gay community, and now we were starting to have to talk about oral-anal contact. That was not a popular thing to be talking about. [laughter]

Still isn't.

That's right, absolutely.

Has the federal government come out with guidelines that use that terminology?
Andrews: My understanding is that some of the safe sex guidelines that came out—now, this would have been some years ago—did have this kind of terminology, because they were written in the language the community could understand. This was when [Dr. C. Everett] Koop was surgeon general. But at the same time, there was primarily Republican conservative backlash to try to stop all funding, and they did pull back all funding to anyone that said anything that was offensive, so we had to use only scientific terminology. So you had to educate people with words they didn't know what the hell they meant. It was a typical American puritanical response to how you handled social problems. Pathetic. [laughter]

Hughes: As of August of '84, BAPHR offered safe sex guidelines in a variety of formats. I'll just refresh your memory?

Andrews: Yes, please.

Hughes: One was a wallet-sized card which was passed out in many places, including the Gay Pride Day parade, and was also available at the baths.

Andrews: That's right.

Hughes: Then there was a short brochure in the form of a letter in street language—just what you were talking about—written by one gay man to another. And then there was a longer brochure which had a scientific bent.

Andrews: That's right.

Hughes: And then there was an update of the original brochure. So there were four different formats. It seems to me that the attempt here was to draw in as many different segments of the population under as many different circumstances as you possibly could.

Andrews: That is exactly right. For several years when we marched in the parade, we had those little cards. Every one of us passed out hundreds of cards as we were marching, in addition to being at the booth. The brochure [produced] with the Sisters of Perpetual Indulgence was written in street language, and they helped support it. We came up with the wording, and then the Sisters of Perpetual Indulgence helped do some of the publishing. They did lots of distributing, even though it was from us. They took what we had. And then ultimately, the AIDS Foundation.

Hughes: The AIDS Foundation came out with guidelines. Are they yours?
Andrews: Yes. I think if we were to look at them, they are almost identical, because we had major input into what their guidelines were.

Hughes: So the AIDS Foundation was a mechanism for getting them out in the community.

Andrews: Right.

Hughes: What was the handkerchief code?

Andrews: I have a hunch that that might have been started under the direction of Will Warner. I don't know if he was president then, but Will, as I said, had been very active in the leather community, and I think this was a personal interest of his to help people identify what people were into sexually so they could link up better. That's what it really was. The handkerchief was all the guides to what people were into sexually. Passive, active, oral sex, rectal sex, toys, rimming, golden showers--a lot of sort of fringe-y stuff that only the cult knew about. It was like shorthand. "Now I know what you and I can do because you're wearing that handkerchief, so I don't have to ask you; I know what I'm getting."

Hughes: The code didn't really have anything to do with safe sex, did it?

Andrews: I don't think it did. I don't know if part of that card had safe sex guidelines or if it was strictly just a hanky identification. It may have been just that.

Hughes: In the write-ups, I didn't see any juxtaposition of those two things. I thought that the handkerchief code had something to do with safe sex, but it doesn't sound that way.

Andrews: There may have been a handkerchief that said, "Safe sex only," or "Condoms only." I don't recall that at all.

Hughes: The guidelines were revised in 1986. Did you have any part in that?

Andrews: I don't remember.

Hughes: Is there anything general to be said about the tenor of the guidelines over time? Do they get more definite, for example?

Andrews: I think that over time and with the identification of the virus, they became clearer, but I think there's very little alteration over time from what we thought in the very beginning. There were some little changes, but we were fairly accurate about the fact that if you don't wear a condom, that's the risk. Now, early on,
there was all this controversy about, Can the virus go through a condom? So we just had to say anal intercourse was high risk whether you wore a condom or not. We didn't even use the word condom. And I think it was Conant who did the studies on transmissibility of the virus through the condom, and the study said that it didn't make it through the [latex] condom, so then there was clear evidence. And then the message became: always use a latex condom and a water-based, not oil-based, lubricant. But the basic guidelines we came up with, although they were refined, I think in general stayed pretty much the same.

Hughes: Around 1983-1984, the rate of new [HIV] infections, and also the rate of other STDs, dropped. Was some of the drop because of the pervasiveness of these guidelines?

Andrews: I think it must have been. Before AIDS, we saw a speeding "train" pushing every frontier toward every kind of sexual expression. And then the train began to derail. As the years went on and there were more and more cases and it became more and more clear that this was a sexually transmitted disease, a larger percentage of people began to be convinced that totally unprotected, frequent sex put you at extreme high risk for death. Some people changed, some people didn't. But I think it had a huge impact on the people that might have had unprotected, frequent sex. It was once perceived as, "Okay to and there's no big deal; you just get a shot [to cure whatever STD you might get]." [And changed] to: "Whoops, now the stakes are, I may die, and die quickly." The whole epidemic had a huge sobering impact on everyone.

Hughes: I would think one of the most sobering impacts would be seeing your friends and lovers die.

Andrews: Absolutely.

Hughes: And not only die quickly, but--

Andrews: Horribly.

Andrews' Video Interview Project on AIDS

Hughes: In 1983, you went to the AAPHR meetings in Hawaii. Do you remember?

Andrews: Ah, yes, I do.
Hughes: You and I think one or two others started a video project.

Andrews: Yes. That was my lover and me, actually. We did that strictly on our own. I have some of those interviews; I haven't looked at them in probably ten years. We decided to take a video camera with us, and go to the gay beach, and go to the conference, and just randomly ask people what they heard about AIDS.

The interview I remember most was being on the beach talking to this very intelligent, very handsome dentist from somewhere on the mainland. I said, "What do you know about AIDS?" He said, "That's that diet candy, isn't it?" In the early stages of AIDS, ADS, that diet candy, was a big joke. I remember him joking about that, and then saying, "Well, I'm just kidding." But that was a normal reaction.

We not only interviewed people in Hawaii, but also in San Francisco, and in New York when we were back there for some meeting. We went to Greenwich Village and interviewed a lot of people on the street and some people from the Gay Men's Health Crisis. At that meeting in Hawaii, we interviewed Bruce Voeller, who was the head of the National Gay Task Force, and a number of other doctors at the meeting. We got their impressions. And it would probably be really interesting to listen to those again.

Hughes: What was the purpose?

Andrews: I thought that this was such a major thing that was happening, sociologically, epidemiologically, and politically, that it would be really interesting and a wonderful opportunity to just capture some impressions without any kind of professional format. It was just me and my lover holding the camera and going up to people and saying, "Can we talk to you for a little bit?"

Hughes: Yes. Good for you.

Andrews: We never did anything with it. We got all the rights to the material; we had the interviewees sign releases, and we never did anything with it. It's still sitting upstairs somewhere.

Some of the stuff is quite amazing. You listen to men in New York on the piers talking very candidly about what they thought was the risk, or who felt the disease was a conspiracy by the government.
Blood Donation and the Gay Community

Andrews: That AAPHR meeting in Hawaii was primarily to talk about the blood banks, and donations, and what to do about contamination of the blood supply. At that meeting was Herb Perkins, who was the head of the [Irwin Memorial] blood bank here, as I said Bruce Voeller, some AAPHR people, I think Harold Jaffe or James Curran, but I'm almost positive it was Jaffe.

The government was wondering what to do, and some of the gay folks were saying, "You better not try to exclude us, because if you do, we'll go donate blood and contaminate the blood supply." It was a threat, which seemed totally crazy to me. My response to this, because we had thought about it and talked about it a long time before we went, was that we should ask and encourage all gay men to not donate blood, to not put a prohibition on it, but to ask us to use our heads, for god's sake. And after a lot of discussion, that was what prevailed, and that was exactly what the blood banks did.

We came back here and we had a press conference with Dr. Perkins and myself and Bob Bolan for the TV cameras. I've got that on tape somewhere, because I taped it myself as well as the TV cameras. And it was really the first response of the blood bank industry about what to do about possible contamination of the blood, that a gay sexually active man should not donate blood. That became the policy of the blood banks initially.

Hughes: One of the concerns of the blood banks was that they were losing good donors, that the gay community had a reputation for really turning out for blood drives. I believe some blood banks were trying to devise a policy that eliminated so-called fast-lane, high-risk gays--

Andrews: Yes, the high risk, that's right.

Hughes: --but encouraged others to donate. AAPHR was saying: No way. It's all or nothing. Is that what you're saying?

Andrews: That's really what BAPHR said, and AAPHR adopted it. Yes, that the only safe thing was to say that if you have been sexually active as a gay man, you should not donate blood. As simple as that.

Hughes: Was there an element that felt this was scapegoating?

1 See the oral history with Herbert Perkins in the AIDS physicians Series.
Andrews: Well, that was the worry. That was why it took a lot of debate and discussion around them having this stance, "Don't threaten us." The way we got around this scapegoating issue was saying, "We'll be the ones to say that, we'll be the gay doctors saying we recommend to our own community not to donate blood, instead of the government." It was exactly the same model I tried to do with the bathhouse. This one worked. The bathhouse didn't. This was much simpler than the bathhouse.

**BAPHR's Social Concerns Committee**

Hughes: The Social Concerns Committee of BAPHR, I understand, is a mechanism for receiving complaints of discrimination in general, but also in terms of medical care.

Andrews: That was the letter-writing component of BAPHR. That was the group of people--and I was one of them; there were about five of us that met--that would compose letters to anything we saw in the paper. If Strom Thurmond or someone else was coming out with something very homophobic, we would send a letter to our newspaper or to *Time* or whatever. We just tried to counter the crazy stuff and promote the positive stuff as much as possible, primarily through letter-writing.

Hughes: Was there a problem at Kaiser--I think it was Kaiser San Francisco--in its care of AIDS patients?

Andrews: I have a vague recollection of gay patients that were enrolled in Kaiser feeling like they were either getting bad care or homophobic care. At some point we met with some Kaiser administration people, and through that, Kaiser developed this referral source to physicians that were either gay-sensitive or gay. Probably most of the time they were gay, but they were identified just as being referral sources. So they began, I don't know if it was because of this, to route people to those care givers that would be the most sensitive to them. And that seemed to help the situation.

Hughes: Did you have anything to do with the definition of ARC, AIDS-related complex? Because in 1986, BAPHR published a "workable and medically practical" definition of ARC, implying that there had been confusion around that issue.

Andrews: Well, I remember discussions. I just can't remember it precisely enough to know where I was in position to all of that.
Hughes: Do you remember the incident when a Florida patient was flown up here and more or less dumped on San Francisco?

Andrews: Yes, I do remember that. I know that we wrote a letter about that.

Hughes: That would be the sort of thing that the Social Concerns Committee would respond to.

Andrews: I'll bet you in the [BAPHR] office, all those letters are on file.

Hughes: I'm afraid that's not the case. [laughter]

Andrews: If they're not, Sam Thal may have them or know where they are. He was our official-unofficial historian. [tape interruption]

More on Antibody Testing

Hughes: Denny McShane, who was president of BAPHR in '84 during the bathhouse issue, commissioned a task force on the ethical implications in AIDS, which was comprised of BAPHR members, community leaders in law, journalism, religion, and medical ethics, to develop a plan and recommendations for responding to AIDS screening. This was October '84. I suppose by then you knew that the antibody test was on its way?

Andrews: I think we knew.

Hughes: Probably so, because it seems to me the original date when the test was supposed to be commercially available was January 1985, and for whatever reason, it was actually not available until a couple of months later.

Andrews: But we knew it was just right down the pike.

Hughes: Did you have any direct involvement with that task force?

Andrews: You know, I cannot remember.

Hughes: October 1984 was the date that the bathhouses were closed.

Andrews: Oh, well, that was right in the middle of everything. And even during the years I wasn't active, my closest friends were mostly gay doctors, so I had my ear to what was going on.

Hughes: BAPHR produced a brochure called, "Should I Take the Test?"
Andrews: Aha, yes, I remember that. Gosh, I'd love to see that again.

Hughes: Well, I didn't find a copy.

Andrews: I know that I was a part of the discussion about that pamphlet. I don't remember all the details.

**Personal Impact of the Bathhouse Episode**

Hughes: You said off tape what an emotionally trying experience the bathhouse episode was.

Andrews: Well, when I remember the most trying and emotionally wrenching time of my entire life, it was during the bathhouse episode. It was a time when I, like all of us, was pulled asunder by my own dismay and concern and anger and regret and fear, and more by other people's reactions to what looked like a serious problem that was evolving. [I was] on sort of a tightrope, trying to be a mediator and an educator and a facilitator in a situation in which there didn't seem to be any way to win. The politically popular thing [in the gay community] was to say, "You can't tell us what to do. We're going to mount the barricades. Civil rights now and forever," and all that.

But that didn't make sense to me. I could understand why those people felt so strongly about that, but it didn't make sense to be blind. As I think I've said before, my goal was to try to help people see why it made sense that they were feeling the way they were, but that they were only seeing part of what was going on. They were blinded by their fear and anger [concerning] our liberation and our civil liberties, and they just weren't able to look at the risk and the danger that was involved here. It was understandable why people were upset, but that didn't mean we had to act on our upsetness. If we could just understand why, maybe we could see the bigger picture. But I was unsuccessful in doing what I wanted to do, and even knowing what to do.

I remember going to Merv's meetings, and there were a couple of times that we talked until ten-thirty or eleven at night. We had food brought in, and we had these intense discussions. I was the primary person in that group of maybe twelve to fifteen physicians arguing for trying to educate the community, supporting Merv's stance that if we simply [impose] a government regulation, we're going to have hell to pay and it won't be as successful.
At the same time that I was pushing for us to try to keep the community in mind, the community looked at me as a traitor to the community. So it was almost surreal. And yet it all made sense why they were so angry. I was just racking my brains to try to figure out what to do, and not being able to sleep at night. I remember waking up and writing down little notes on what I could do to communicate successfully. And I obviously never did it to the satisfaction that I wanted, because it didn't turn out the way that anyone really wanted. It was very disappointing.

As I said, the hardest part was that some of my closest friends, other doctors who had supported me in BAPHR, said to me, "You're a traitor; you let us down; you copped out." That just left me with, "Gosh, you guys, at the meetings I was the one saying, 'We've got to consider the community.' I was the lone voice, and now you're saying I'm a traitor." It was a bad LSD dream.

Hughes: Do you have some bitterness?
Andrews: Yes, probably some bitterness, but it's understandable. I think I've come to resolution about why people were so upset. It's just like, Darn it, why couldn't we have turned the corner? And I think I have some regret that I [wasn't] more daring. I should have tried to talk two or three people into doing our own posters and [standing] out in front of the bathhouses. I should have done that by myself if I had to, and I didn't.

Hughes: Well, that would have been pretty scary.
Andrews: Well, so maybe I was too afraid to do that. It was too unpopular for me to do that. I feel like I let myself down on one level. Yet on another level, all I know is that I tried harder than anything I've ever tried in my life to work on something positive, and felt like people were saying I was a traitor, or I was working toward the negative, or I was being short-sighted. I was crying, "I'm trying as hard as I can!" and it wasn't good enough. So that was horrible.

But looking back, it gave me the opportunity to see how fortunate, in a way, I was to be at the very center of a controversy that was affecting a whole community and a whole nation. It was a model for how communities and nations affect anything where there's fear and a stigmatized group and something scary like death and disease. It was so fascinating that I had the opportunity to be at the very heart of this, making all those phone calls, knowing those people. Not exactly "lucky me," but seeing a process of human evolution was fascinating for me.
Hughes: An amazing experience.

Andrews: In telling you this, it sounds like I was the good guy. [sighs] I wasn't trying to be the good guy; I was just trying to help. Everyone was trying to do what they thought was best. I really think they were. But so many people were so angry and so suspicious that they were blinded by their anger and their suspicion. I saw Bill Owen yesterday for an appointment, and he said, "Gosh, it's so amazing how the things that were going on then, we look back on them now and think, How could we have been so blind? We were just reacting." And I can see why we were so blind. There was so much at stake.

Hughes: Do you think it helped that you were a physician and not only had rigorous training and education but also came from a position of stature in society?

Andrews: I think it had enormous luck for me. It was fortunate that I had an M.D. behind my name, because otherwise, I would just have been another wild-eyed person. I'd worked my way up through a gay organization that had gotten a lot of respect. People listened to me [when] they could have easily dismissed me. And many of them still dismissed me, many of them, but I felt like the times I got to sit down and talk to someone on a one-to-one basis, or in a group like at the Pride Foundation, I think a lot of people heard me.

I remember before that meeting [at the Pride Foundation] that it seemed like there were days and days when I didn't do any work; I was on the phone with one person for an hour and then another person. It took that long to get them to see--no wonder we're upset. I felt at the end of a conversation that people were beginning to open up and understand why they were so upset. And that was really exciting, because it meant to me that I was doing the best I knew how, and that people could learn. It really was a model for me in so many other things in my life. It really showed me that individuals can make a difference.

Let me say a couple more things about all these events. First, it is important to realize that I am relating this to you many years after the actual events happened. There is no doubt in my mind that my memory of these specific events has been influenced by my reaction, and other's reactions, to everything that happened. That is, looking back and trying to remember, I am no doubt influenced by using my hindsight into the whole process. My understanding of all this wasn't clear to me at the time and I know I had my own "blind spots" to contend with. If we had a videotape of everything that happened, I am sure it would look differently than I have presented it. And [telling] my side of the story is naturally going to be influenced by my
own blind spots and my internal desire to not make myself out to be the villain or the dumb one. I think it's important to keep that in mind whenever you are talking to anyone.

**Sixth International AIDS Conference, 1990**

Hughes: You were president of BAPHR [1990-1991] when the Sixth International AIDS Conference met in San Francisco in 1990.

Andrews: Yes. At the same time, I was also on the board of directors of Shanti Project [1988-1993]. I had been an emotional support volunteer for three years [1985-1988], and then I joined the board of directors. So I was intimately involved with people giving care and emotional support to PWAs [people with AIDS], their family and friends.

So when it came on the horizon that we were going to have this meeting here, it was at the same time that the INS [Immigration and Naturalization Service] was saying that no one who was HIV positive would be allowed to come into the country. That set the stage for another major ideological confrontation among gay organizations. Shanti took the strong stance that we would not participate at all, we would actively boycott the conference, because we were serving people with AIDS, and the government was saying they can't come to the conference from other countries.

The AIDS Foundation, on the other hand, was saying, "We think this is reprehensible, but we think it's important to go to the conference because it's an educational experience, and we cannot pass up this opportunity here in San Francisco to disseminate this knowledge."

So there was a great controversy in BAPHR about whether we should or should not attend. A large number of us felt we should boycott, that it made sense to boycott. We had a meeting where I came up with the idea that we should go but protest, and we could combine those two things. I thought that the best way to do it would be to wear an armband of some kind.

I got that idea because a few years earlier the American Psychiatric Association met here in San Francisco, and it was the time that people were wearing a black armband in support of the the ERA [Equal Rights Amendment]. I attended the first caucus meeting of gay and lesbian members of the APA. There was controversy about whether the gay and lesbian caucus should wear armbands in support of the ERA. Many of the men said that they
thought this wasn't our issue, and we shouldn't wear armbands. I remember getting up and saying, "How in the world can we not support something like equal rights for women? What are we thinking?" It seemed like my words swayed the group to go with wearing black armbands. At that APA meeting I helped a lot of other people pin on black armbands.

So that gave me the idea when the AIDS conference came: Let's have a symbol. My first idea was to wear a lavender armband. But then we decided in our discussion that a red armband was more appropriate because it represented blood, and because it was the red badge of courage. I remember that phrase, we thought of that.

So I wrote an article, that I have, that went in the BAPHRON, talking about the AIDS conference. It outlined that there again was this polarization: Don't come or do come. The BAPHR executive board had decided that we would go but we would wear red armbands as an active sign of our protest against the INS policy.

I went to the flower mart and bought rolls of red satin. Then we had 5,000 ribbons cut, and we had some signs made. I know I've got some pictures of it somewhere. I don't think I went to any of the meetings. I stayed outside and pinned about 1,000 armbands on people. Before the very first conference, I had already called Paul Volberding and John Ziegler. They were the two co-chairs of the meeting. I knew them because they had been on Merv Silverman's AIDS Task Force, where we had spent countless hours together. I called them beforehand telling them what our intention was, and I got them to wear these red armbands, and I pinned them on them myself. So as the conference opened they were wearing our ribbon armbands.

That meeting started, and the cameras were on them. By the time people had seen that, the participants, especially the gay ones, were very eager to have these armbands. So it was a very hot commodity. Everywhere I went, I was carrying armbands and safety pins, and pinning them onto their shirts or their suit coat or whatever. As the meeting went on, you could see more and more of these red armbands.

On the last day, Louis Sullivan (the head of Health and Human Services), was coming to the meeting and we knew there was going to be a big protest. On the podium that day--and there are photographs of it--everyone but Sullivan had a red armband on. Every other doctor up there. Many of the people in the hall had red armbands, and there was a massive protest. Whistles and shouting, no one could hear a word he said. We disrupted his speech with nonviolent civil disobedience.
Right after that meeting we led a large group of doctors who were attending the conference to join the Gay Freedom Parade that coincided with the conference. We were there behind the banner with Volberding and Jonathan Mann, who was the head of the World Health Organization at the time. We left the Moscone Center where Sullivan had just spoken and joined the parade. So there was this huge outpouring of protesting people.¹

##

Andrews: Some weeks after this AIDS conference, I got a phone call from a friend who had watched some awards show on TV. He said, "You wouldn't believe what happened. There were people wearing these red ribbons for AIDS awareness. And somebody called and said, "Do you realize that these red ribbons that we started passing out have become a symbol?" We were all amazed. By the end of the conference, one of the things that we had noticed is that a few people, especially women, didn't want this big red armband pinned on their silk blouses, so they were taking a part of it and bending it and attaching it to something else. So it was a smaller fragment, but it was still the red ribbon. And as we know, the red ribbon became the symbol of AIDS awareness, which started as BAPHR's protest against the INS policy at the International AIDS meeting.

Hughes: An amazing story.

Andrews: An amazing story.

Hughes: You don't know who took it from there?

Andrews: We don't know who. Someone saw it, because of course this conference was internationally telecast. I specifically asked Paul Volberding in the opening comments for that conference to mention why he was wearing it and where he got it. He mentioned in the opening statement to that international conference that he was wearing this ribbon because a group called Bay Area Physicians for Human Rights were protesting this [INS] policy. So we knew that people were seeing it as a sign of protest, and then later someone decided to carry it on and wear it again at an awards ceremony, and then it just caught on.

Hughes: It's also a story of activism and acknowledgement by the medical establishment that PWAs and other activists should be part of AIDS activities

¹ For John Ziegler's reaction to this experience, see his oral history in the AIDS physicians series.
Andrews: That's right.

Hughes: Did you feel that indeed was the attitude of the Sixth International Conference?

Andrews: Very much. Paul Volberding and John Ziegler did an incredible job of organizing a scientific meeting that also included input and participation from AIDS and gay groups. It was, far more than any earlier international meeting, a meeting that addressed the psychosocial and political issues involved with AIDS. It was no coincidence that this happened in San Francisco. What was amazing is that it coincided with this crazy, Reagan-style government position by the INS. It made no sense to discriminate against HIV-positive individuals, by attempting to prevent them from entering the country to attend the meeting, when we all knew that there was absolutely no way the virus could be passed by casual contact. To the many scientists and doctors attending the meeting, it painted a very clear picture that AIDS wasn't just a disease but had an enormous social impact. Many of the conference attendees told me they had never been politically active before, but they were eager to wear our red ribbons and join the protest. For the first time, they began to understand the implications of this disease, that this was also a social and political situation that had to do with homophobia, AIDS phobia, fear and ignorance.

Hughes: John Ziegler told me that he actually marched in the Gay Pride Day parade.

Andrews: He did.

**Children and Family**

Hughes: Please tell me about your children.

Andrews: My daughter is thirteen. Eighteen years ago at Thanksgiving, two lesbian physicians that I had gotten to know through BAPHR had me over for Thanksgiving, and at the end of the meal they said, "Can we ask you a personal question?" I had no idea what they were about to ask me. What they ultimately asked me was, would I consider donating sperm for Patty, the obstetrician of the couple, to have a baby.

I was completely flabbergasted. I had never thought about having kids. I was quite touched that they would even think to ask me. I was very, very honored, because these two women were the ones that founded that Lyon-Martin Women's [Health Services]...
Clinic here, which is the lesbian health care clinic. Patty Robertson and Leslie Anderson together started the lesbian physicians' group here.

So we talked about this, and for five years we discussed it. They moved to Santa Monica where Leslie did her residency in orthopedics. She was the first female orthopedic resident at UCLA. So we did the artificial insemination, and as Patty became more and more pregnant, we began to talk about how was I going to be identified? Father? Friend? Uncle?

And as we knew each other more and more and got more comfortable, they asked if I wanted my name on the birth certificate, and I said, "Absolutely." I had signed initially a waiver saying I was an anonymous donor; I had no rights to the child; I had given up any claim. But as time went on, we got to know each other, got more comfortable with each other. So I was on the birth certificate as the father. They moved up here when my daughter was, I think, two, so I began to have an active parenting role.

When my daughter was three, Les and Patty split up. About a year after that, Patty, the birth mom, asked if I'd be interested in donating for a second child. And I did, and we did, and my son was born. He's eight now.

My kids are over on Wednesdays and Fridays and live only a few blocks from me, so I see them very frequently and do all the "fatherly" things that any parent would: soccer practice, birthday parties, et cetera. We have always been open with them about the fact that we are gay. Of course, I am totally in love with them both and am so grateful to have this opportunity to share in the parenting experience. Every parent is totally biased about their own kids, but judging from the input we get from their teachers, friends, and friends' parents, they are truly wonderful, intelligent, caring, delightful human beings. I am so proud of both of them.

Hughes: A wonderful place to end.

Andrews: Oh, good.
THE AIDS EPIDEMIC IN SAN FRANCISCO: THE RESPONSE OF COMMUNITY PHYSICIANS,
1981-1984

VOLUME I

James M. Campbell, M.D.

AIDS CLINICIAN AND MEDICAL EDUCATOR

An Interview Conducted by
Sally Smith Hughes, Ph.D.
in 1996

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INTERVIEW WITH JAMES M. CAMPBELL, M.D.

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INTERVIEW HISTORY--James M. Campbell

James M. Campbell is an internist with a thriving private medical practice in downtown San Francisco. He was interviewed for this oral history series because from the earliest days of the AIDS epidemic, he provided medical care for gay men, a distressing number of whom went on to develop the new immunological disease. He was in the battle lines in the effort to define the new syndrome and implement diagnostic and treatment procedures.

Campbell's story is that of a primary care clinician diagnosing, treating, counseling, and caring for patients with AIDS. He provides a poignant picture of what it was like for a physician, before the syndrome was well defined and before there were many effective treatments, time and again facing patients complaining of puzzling symptoms and all-too-frequently declining and dying of them. He provides a glimpse of the hectic schedule, as the epidemic advanced and the numbers of AIDS patients relentlessly grew, of a physician in the trenches, grappling professionally and personally with patients' medical and social problems and attempting to keep abreast of breaking medical information on AIDS.

Bay Area Physicians for Human Rights has a high-profile role in these interviews. At the outset of the epidemic, Campbell assumed the self-appointed role of tracking the medical literature on AIDS and attending conferences, his education at Yale and Columbia showing through in the guise of educator/informant for his medical colleagues. It was he who reviewed journal articles and AIDS conferences for The BAPHRON, BAPHR's newsletter and, with his gay physician colleagues, served as advisor and information source at a time when information about the disease was scarce and hard to come by.

Campbell was engaged in the many iterations of BAPHR's safer sex guidelines, distributed in several versions during the 1980s. For him it was particularly upsetting to attempt to establish guidelines for personal safety in the face of uncertain etiology and the gay community's newly won sexual liberation. Campbell also co-edited Medical Evaluation of Persons at Risk of Acquired Immunodeficiency Syndrome, a booklet produced by BAPHR in a number of editions, which was intended "to alert health professionals throughout the country to the protean manifestations of AIDS in its earliest stages, so that proper treatment, referral and counseling can be implemented without delay."1

The Oral History Process

Two interviews were recorded on May 16 and June 26, 1996 in Campbell's busy medical practice. Fully engaged in the interviews, particularly in the discussion of constructing safer sex guidelines, he was intent on conveying his dual and sometimes conflicting interest in preserving health and freedom of sexual expression. He returned the interview transcripts in record time, making a few changes and additions.

Although Campbell has seen his primary role in the epidemic to be that of physician and educator and has used his medical training to distance himself from his patients, his emotions nonetheless run deep:

I love to see plays or movies or pieces of art that have to do with the AIDS epidemic, like the quilts and the play Early Frost. Some of these things that have come out are very, very important for me to see, because I can sit back and be a spectator and become emotionally involved. I don't have to play my role as doctor, and I can sit back and cry about things.

The Regional Oral History Office was established in 1954 to augment through tape-recorded memoirs the Library's materials on the history of California and the West. Copies of all interviews are available for research use in The Bancroft Library and in the UCLA Department of Special Collections. The office is under the direction of Willa K. Baum, Division Head, and the administrative direction of Charles B. Faulhaber, James D. Hart Director of The Bancroft Library, University of California, Berkeley.

Sally Smith Hughes, Ph.D
Research Historian and Principal Editor

October 1999
Regional Oral History Office
The Bancroft Library
University of California, Berkeley
BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name: James Marvin Campbell

Date of birth: 1 April 1936
Birthplace: South Bend, IN

Father's full name: Marvin Rudolph Campbell

Occupation: Manufacturing (Boxer)
Birthplace: South Bend, IN

Other's full name: Ruth Frances Rasmussen Campbell

Occupation: Physician (Clinical Pathology)
Birthplace: Albert Lea, Minnesota

Your spouse: 

Occupation: 
Birthplace: 
Your children: 

Where did you grow up?: South Bend, IN

Present community: San Francisco, CA

Education: BA Yale 1958, MD Columbia 1962

Occupation(s): Physician, Internal Medicine, private practice

Areas of expertise: HIV Disease

Other interests or activities: Piano, voice, bridge, skiing, reading

Organizations in which you are active: BAPHR, Trinity Episcopal Church
INTERVIEW WITH JAMES M. CAMPBELL, MD

I  EDUCATION AND EARLY CAREER

[Interview 1: May 16, 1996] ##
[San Francisco, California]

Education

Hughes: Dr. Campbell, would you start with where you were born and educated?

Campbell: I was born in South Bend, Indiana, and went to undergraduate school at Yale, class of '58; medical school at Columbia, class of '62. I interned at San Francisco General [Hospital] and did my residency in internal medicine at UC San Francisco.

Choosing San Francisco

Hughes: Why San Francisco?

Campbell: Everybody said San Francisco was such a wonderful city. I came here in the fall of my fourth year [1961] of medical school, just to see what California was all about and to have internship interviews. I applied to various hospitals in New York, San Francisco, Los Angeles, and Seattle, and the computer just spewed out "San Francisco General," although I think I had mixed feelings about it. I was sort of hoping to stay in New York. But then I realized that San Francisco was a much easier lifestyle than New York, and it seemed less competitive. So I was glad to stay here.

1## This symbol indicates that a tape or tape segment has begun or ended. A guide to the tapes follows the transcript.
Hughes: You made the decision not so much on medical terms, but on quality of life?

Campbell: Definitely. It wasn't really for advancement of a medical career. I had a lot of friends in New York and I very, very much liked New York, but I saw San Francisco as a town that might be just as good. But for the first two years, I just kept comparing it to New York in kind of a negative way, and then I finally said, "Well, I've just got to stay in one town." So I decided to stay in San Francisco, because it seemed like the programs available to me would be better here.

Hughes: Were you thinking professionally?

Campbell: Yes.

**Internship, San Francisco General Hospital, 1962-1963**

Hughes: What did you find at San Francisco General (SFGH) when you arrived?

Campbell: I thought it was like a country club, compared to Bellevue (Hospital, New York City). We had rotated to Bellevue for a couple of months in fourth year (medical school), and it just seemed like a real zoo. [telephone interruption] The patient population at San Francisco General Hospital was more like the population that one would see at the Presbyterian Hospital in New York, which was kind of middle class. I had fully expected to see a real derelict population at SFGH.

Hughes: Because it was a county hospital?

Campbell: Because it was a county hospital.

The first time I ever arrived in San Francisco [1961], I stayed in the YMCA on Turk Street, and I thought, Well, gee, this isn't a bad neighborhood at all--not knowing that this was not one of the best neighborhoods. I just couldn't get over the fact that I didn't see poverty in San Francisco, compared to New York. And it seemed like apartment rents were so cheap. Everything was just easier than in New York.

Hughes: In those days, there wasn't a strikingly poor subgroup?

Campbell: I think there was, but after having spent two months at Bellevue, and riding the subways every day in New York, the
poverty in San Francisco wasn't particularly apparent to me when I compared it to New York. It seemed like a city in which welfare people lived relatively well.

Hughes: What happened next?

Campbell: I went into the service in 1963, because I was drafted. It wasn't one of the things I wanted to do; I went to Korea for a year. Then I came back to Fort Hamilton in Brooklyn, which I loved because it was New York.

Residency, Internal Medicine, San Francisco General Hospital, 1965-1968

Campbell: I had misgivings about going back to San Francisco for my residency, but I did it, and I stayed here. Then I got to like San Francisco better and better. I stopped comparing it to New York.

Hughes: Do you want to comment on your residency?

Campbell: It was at UCSF and San Francisco General in internal medicine. Then I took a year of fellowship in endocrinology and psychosomatic disease. Then I went into private practice.

Hughes: Which had always been your goal?

Campbell: Not always, but it just seemed that I was moving in the direction of something general. I wasn't attracted very much to the clinical subspecialties or doing a lot of medical procedures. I preferred patient contact.

Hughes: Why had you chosen psychosomatic medicine as an interest?

Campbell: When I was in the service at Fort Hamilton, I treated many patients with psychosomatic problems, and felt that addressing the psyche was as important as physical exam and laboratory tests. I was quite effective in that type of work. Later I rotated through psychiatry for a couple of months when I was a resident. I liked those two months better than any of the others. So I felt that that was something I would like to do, but then I'm sort of glad I didn't go into psychiatry. I think that it's a difficult field.

Hughes: Why endocrinology?
Campbell: Well, I was always interested in it. At that time most medical residents felt that they really needed a subspecialty to survive in private practice in California. Endocrinology wasn't one of those subspecialties that involved a lot of procedures, like cardiology. I had worked in chemistry labs before, and I enjoyed that type of work.

Private Practice in Internal Medicine, 1969-present

Hughes: When did you set up your practice?

Campbell: I went into practice in 1969 with Wayne Bayless. He had a very attractive practice because of the nice distribution of patients. He had a number of gay patients, some young patients, some old patients, and he was a wonderful person to work with. I feel very blessed because that opportunity came up when it did. It was too good to have passed up. We remained in practice together until he retired in 1987.

Hughes: So a long association.

Campbell: Yes, and it was a very, very good association.
II THE AIDS EPIDEMIC

Early Experiences with the New Disease

Gay-Related Diseases

Hughes: In the course of those years, did you notice conditions that now you realize indicated that something was beginning to happen in the gay community?

Campbell: That gets me to the subject of gay-related diseases. I remember when I rotated through infectious disease at San Francisco General--this was about 1965 or '66--Haight-Ashbury was just flowering, and lots of people came in with hepatitis. They always said, "Well, we shared needles," and there they were with hepatitis. We didn't know hepatitis A, B, or any of that.

Hughes: It was all just hepatitis.

Campbell: It was just hepatitis.

I remember one young man who came in with hepatitis who didn't share needles. I just knew instinctively that this was a young gay man. But of course, we didn't talk very specifically about it, but it just seemed like we started talking the same language. And he knew that I knew how he got it, but it wasn't discussed at all. Of course, when I went into private practice, I saw lots of hepatitis, parasitic diseases, enteric bacterial diarrhea, and many, many of the STDs [sexually transmitted diseases].
Campbell: In 1979, BAPHR did a little series in the Sentinel, which was a local gay newspaper, on the approach to diseases which are common in the gay community. We did a hepatitis series, an enteric pathogen series, gonorrhea, syphilis, and others. Of course, we didn't do anything about immunodeficiency, because in 1979 it was not suspected that this was a problem.

Most of the articles were geared to reassure people about these diseases. In other words, either a disease has a treatment, or, you'll get over it; so don't worry. I think there was even an article that a proctologist wrote on fisting and the hazards associated with this particular sexual practice. It was not in any way putting it down, but just saying, it must be done with safety to avoid trauma to the individual. The bottom line of the articles echoed the theme of the seventies: sexual liberation.

Sexual and Gay Liberation

Campbell: Many of these articles were done to inform and reassure the gay community, and to orient them as to what there was to be expected and not to get too worried about it. I don't remember any of these articles ever saying things about wearing condoms, or abstaining from certain sexual practices. This was the peak and the tail end of the seventies when sexual liberation was extremely important.

Hughes: Was it a conscious aim on your part not to say, "Stop and desist"?

Campbell: It just didn't even seem to be an issue at that point. It seemed like the whole community was so oriented toward pleasure from sex, and getting to know oneself sexually, that saying, "This stuff has got to stop," would be really out of step with the culture.

I don't remember any gay people putting out such messages at that point. Even the straight community would be in the direction of sexual liberation at that time. The people who would like to close the bathhouses or opted for safer sex were not being heard.
Hughes: Do you think there were those voices?

Campbell: I'm sure there were a lot of those voices, but they may have felt themselves politically incorrect.

Hughes: Now, you're talking pre-AIDS, right?

Campbell: Yes. I'm talking 1979, and even 1980; there would have been absolutely no awareness.

**The Centers for Disease Control**

Hughes: Well, I have a quote from the March, 1980 *The BAPHRON* [BAPHR's monthly newsletter] by an "executive consultant", whatever that means, to BAPHR by the name of Jeff Richards. Does that name mean anything to you?

Campbell: No.

Hughes: There was no other identifier. Anyway, he said, "It is recognized that sexually transmitted diseases in the gay population is [sic] a real and growing problem for a variety of complex reasons." Then later in that same column he said, "The CDC shares this concern with most gay health professionals," as though the problem in San Francisco was not an isolated event.

Campbell: Hmm.

Hughes: William Darrow, who was a sociologist with the CDC wrote an article before recognition of the AIDS epidemic on the rising incidence of sexually transmitted diseases in the gay population. Those are two pieces of evidence that the CDC in 1980 recognized that STD's were on the rise in the gay population.

Campbell: Yes, and certainly in my articles and my editorials, I stressed the fact that sexually transmitted diseases were a problem, but I don't think BAPHR at that point was handing out specific guidelines.

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1 Vol. 2, #3, March 1, 1980.

Hughes: No, I didn’t see any signs of that in going through the pre-AIDS The BAPHRONs.

One backdrop for recognizing the epidemic is precisely what you were talking about: the movement towards gay liberation which had started in the sixties but, you tell me, was really reaching a peak in San Francisco about the time that the epidemic was recognized.

Campbell: Oh, yes, definitely.

Hughes: How do you see that playing into the response?

Campbell: I feel the response to the epidemic was gradual. From 1981 to 1985 in San Francisco, each month, more and more people were feeling the impact of it. Of course, if you were in medicine, you felt the impact very early, because you saw the disease and the devastation of the disease. If you didn't live in San Francisco, you might see it much, much later, because you might not know anybody who had AIDS or have any conception of what AIDS was all about.

But when the first articles came out in 1981 about Kaposi's sarcoma and Pneumocystis, I don't think that I immediately felt panicky.¹

Hughes: Were those articles your first awareness of what later became the AIDS epidemic?

Campbell: Yes, 1981.

Hughes: So you were informed through the written word?

Campbell: Yes.

Retrospective Recognition of AIDS Cases

Campbell: I had seen, between 1979 and 1981, retrospectively, people who came in the office with fevers that lasted for a few days, maybe a rash, and maybe some lymph nodes. It wasn't that I was

immediately saying, "This represents something terrible." I would just make notes, and most of these people in follow-up a week later felt fine. I would say, "Well, you had a viral illness."

However, in 1982, I became very aware that many patients didn't seem right, not just those with Pneumocystis or Kaposi's sarcoma.

Hughes: In what way not right?

Campbell: If they had Pneumocystis, it was kind of easy, because there was a certain treatment for that. You just said, "You have that syndrome," GRID [Gay Related Immune Deficiency] or whatever, "and this is Pneumocystis, and this is how it's treated."

Hughes: PCP is mainly what you were seeing?

Campbell: A few cases, but more often I would see people who had unexplained fevers, weight loss, diarrhea, or lymphadenopathy that didn't have a particular cause. It was very, very mysterious. Many people came in because they were extremely worried about this new syndrome. They seemed otherwise healthy.

Hughes: Did you associate those people with weight loss, et cetera, with this new syndrome?

Campbell: In the summer of 1982, the acronym "AIDS" was coined, and I think later that summer I became very, very involved, and started going to all of the meetings of the BAPHR Kaposi's Sarcoma Ad-Hoc Committee. The committee met every two weeks and we discussed diseases which seemed to be linked to the new syndrome. Later that year, or early 1983, we put out the guidelines.

I remember grand rounds, I think July or August, 1982, at UCSF, was the discussion of GRID. I don't think it had yet been named AIDS. The next month it was named AIDS. Dr. Larry Drew talked about how he thought it was transmitted, i.e., the sexual activities that were at risk for transmission, based on his previous work with CMV [cytomegalovirus]. Someone presented a study about T-cell subsets in the gay community and the fact that many seemingly healthy gay men had increases in the T-suppressor subset.

Hughes: Prior to that had you associated these various conditions with immunodeficiency?
Campbell: Just vaguely. It wasn't much on my mind until early 1982. I knew it was something that we might see, but I just wasn't completely into it.

Hughes: Well, for good reason, right? From 1981 until the summer of 1982, how many cases which you now recognize to have been AIDS do you think you might have seen?

Campbell: In January of 1981, we had somebody who was extremely sick with an encephalopathy and died after four months. There was zero association; it was just a weird disease. I think in retrospect, this person had AIDS, but we don't have any way to prove it retrospectively.

Hughes: Was it a young person?

Campbell: It was a man of about fifty who had two weeks of fever, then encephalitis. He died four months later.

Hughes: Did that stand out in your mind at the time?

Campbell: I didn't link it to the AIDS epidemic until about two years later. That summer [1981], they first talked about KS [Kaposi's sarcoma]. But I didn't link the two. They were just isolated diseases. At the end of the year, I had a patient who came in with bilateral upper lobe infiltrates; he didn't have medical insurance, so I sent him over to San Francisco General. They called me to tell me it was Pneumocystis.

Hughes: Why did you send him to San Francisco General?

Campbell: He had no medical insurance, but needed to be hospitalized.

My partner, Dr. Wayne Bayless, was seeing somebody that we put in the hospital in May 1982. He had a mysterious breathing problem with a negative chest x-ray. Then he became really sick. He had Pneumocystis.

Hughes: Did you know how to diagnose Pneumocystis?

Campbell: It was somebody I had never seen, and it was my partner's day off. I looked at the chart when Pacific Medical Center emergency room called. It just seemed to me like one of those mysterious GRID cases with Pneumocystis. A bronchoscopy confirmed the diagnosis. In 1982 those people with Pneumocystis were extraordinarily sick. They presented with very advanced disease, as did this person who died. The other person whom I talked about died soon afterward with CMV.
Later that summer I had another patient who was brewing a similar disease which was diagnosed as Pneumocystis in the hospital. He recovered from his Pneumocystis; a couple of months later he presented in my office with a lymph node which was actually a bag of cryptococcus.

Recognizing a Syndrome

Campbell: Starting with spring 1982, I was highly aware of the presence of the new syndrome. Everything that I saw seemed to become associated with it. I started attending all AIDS-related conferences in the summer of 1982.

Hughes: For some years, you had been dealing with young men who had infections.

Campbell: Yes.

Hughes: A lot of your patients had sexually transmitted diseases.

Campbell: Yes.

Hughes: But wasn't it startling when young people began to die? That must have been a new experience for you.

Campbell: Yes, it was very, very startling. When Larry Drew in July 1982 said, "These are samples of the T cells of certain gay men in San Francisco," I knew something was happening. Then two months later when I read all about this in the New England Journal, I knew there was something out there that was very pervasive, and it sounded like many people might have contracted whatever it was. Of course, I immediately had my own T cells checked, and they were very good. For some reason, I wasn't worried the first time I did that since I felt fine and was rarely ill. But a whole lot of other people felt very well, and they would have these very strange T-cell ratios.

Hughes: Larry Drew is a virologist, right?

Campbell: Yes.

Hughes: But he was doing immune studies as well?

Campbell: He might not have presented that aspect of that particular grand rounds. I know that he talked at that grand rounds, as
Marcus Conant did, and somebody else. Maybe somebody else presented the T-cell findings of a survey.

Hughes: Art Ammann, who is a pediatric immunologist at UCSF, did some of those early studies.¹

Campbell: Maybe he did. He was at that conference.

Hughes: So you were slowly putting together pieces of the puzzle as we now know it to be composed. It must have been difficult to associate isolated cases with different aspects of what we now recognize to be a syndrome. But there was no real rationale for putting them together, was there?

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Campbell: I think many people were putting the pieces together, because they coined that term acquired immunodeficiency syndrome in August 1982.

The Terms GRID and AIDS

Hughes: Did you have any feeling about the term GRID [Gay-Related Immune Deficiency]?

Campbell: No. It seemed to describe the sporadic cases we were seeing in 1981 and 1982.

Hughes: Certain groups objected to the name of the disease being linked with the gay community.

Campbell: Yes. Of course, that term was only in use for about one year. They started talking about GRID in the summer of 1981 when those first cases of *Pneumocystis* were reported. In August 1982, "GRID" went out and "AIDS" came in.

Hughes: One of the rationales for choosing "AIDS" was not only is it descriptive of the syndrome, but it also could not be taken as discriminatory.

Campbell: And furthermore, they were reporting it in IV drug users, blood transfusion recipients, and hemophiliacs. This just filtered through in 1982—all of these risk groups who had GRID.

¹ See the oral history in the AIDS Physicians series with Arthur Ammann, M.D.
Hughes: I'm gathering from your comment that you too thought of it initially as a gay disease, because all the people you were seeing with it were gay. Is that true?

Campbell: Yes.

Hughes: While the infectious diseases that you had previously seen in gay patients occurred at a high frequency, they were nonetheless diseases which could also appear in other populations. In other words, they weren't strictly gay diseases.

Campbell: Yes, and furthermore, they were treated and they went away, and people seemed to feel well again. These symptoms in AIDS were much more severe, longer lasting, and just didn't respond to treatment.

Hughes: Dr. [Richard] Andrews said that there was an assumption in the gay community that if you got a sexually transmitted disease, you went to the doctor and got an antibiotic and it would go away. In other words, no big worry.

Campbell: That was a thrust of this 1979 series in the Sentinel about all of the diseases that you might encounter out there. It was almost like advertising for BAPHR: we're here to treat these diseases, and these diseases do have treatments. Most of them go away, but with some, like hepatitis, a few people do end up with chronic hepatitis. That may be the worst thing that could happen to someone.

Theories about Etiology

Hughes: Did you have any theories about what was causing the AIDS epidemic?

Campbell: Oh, yes. It seemed abundantly clear by the middle of 1982 that it was some sort of a virus, and that it was transmitted sexually. It would seem that rectal sex would be the highest risk, since transmission seemed to require bloodstream invasion. Some people thought that cytomegalovirus might have something to do with it. I thought maybe it was some strain of cytomegalovirus.

1 See the oral history in this volume with Richard Andrews, M.D.
Hughes: Cytomegalovirus had been seen in gay populations, and I'm sure other populations as well, so how would it explain this new epidemic? It was thought to be a mutant form?

Campbell: Yes, some form of cytomegalovirus that might have been a little more virulent. Larry Drew had shown that cytomegalovirus in itself will suppress the immune system, and maybe the new CMV—or strain—was one that really suppressed the immune system. But he had shown also that a lot of people eventually recover from the immunosuppression of CMV. So in the early years, there was some hope that people who were immune-suppressed with abnormal T cells may improve in a year or two. However, it seemed that every time I read reports or did serial T cells on such patients, they always got worse.

We had a huge discussion in our BAPHR scientific affairs committee about ordering T cells. There was a lot of resistance to doing that particular test on people who were just worried, because the fact of the matter is that it would just make them worry more.

Hughes: And you couldn't do anything about it.

Campbell: Right.

Hughes: Was the test expensive?

Campbell: It cost about what it does now; it wasn't that expensive. It gave you a huge amount of information, and it was really good for the clinician to have that information. But unless it turned out normal, it wasn't very good for the patient.

Hughes: How could you use that information?

Campbell: You could certainly identify patients who were likely to get opportunistic infections.

Hughes: And take prophylactic measures?

Campbell: Occasionally we would prophylax people for Pneumocystis, but most people we didn't prophylax for Pneumocystis. But if there was somebody who just was not feeling well, or had a little bit of pneumonia, or unexplained complaints, occasionally I would do the T cells and find that they were normal. It was just wonderful news: well, it doesn't seem to be this new disease.

However, most of the time, the T cells would be just what I expected: they would be really terrible, and you would have to wait and see what evolved. At that time there were no
guidelines about *Pneumocystis* prophylaxis of patients with fewer than 200 CD4 cells. We looked more at ratios rather than absolute numbers; a high CD4 to CD8 ratio usually meant there was no problem with AIDS; a very low one usually meant infection with the "new virus." The ratio seemed to be more telling than the absolute numbers.

**Information Channels**

**Hughes:** How informed were your patients, and how early in the epidemic, and how did they become informed?

**Campbell:** The people that were coming to the office became informed very early, because they were concerned and they wanted as much information as possible.

**Hughes:** Where were they getting their information?

**Campbell:** They got their information from friends who were sick; they got information a *little* bit from the gay press, but not very much.

**Hughes:** Why was that? You might think that the gay press would be moved to get as much information as possible out to the community.

**Campbell:** They did talk about AIDS in the gay press, and sometimes they talked about it quite responsibly, and sometimes it was irresponsible.

**Hughes:** But there was nobody in San Francisco in the early days along the lines of Lawrence Mass who wrote article after article for the *New York Native.*¹

**Campbell:** Yes. I used to get the *New York Native* because there was a lot of information there. It had the statistics about how many people in each state had AIDS, how many reported cases. So I would get that every week too. But then there were some people that wrote for the *New York Native* who were very irresponsible.

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Hughes: Wasn't that something new for you as a medical person, to go to a nonmedical paper to get information on a disease?

Campbell: Oh, yes, and the San Francisco Examiner and the San Francisco Chronicle were always ahead of any journal article when it came to reporting something new.

Caring for the "Worried Well"¹

Hughes: Were you seeing a lot of "worried well" in your practice?

Campbell: Oh, huge numbers.

Hughes: Who just wanted you to give them your seal of approval that they didn't have this disease?

Campbell: Yes, and that was one of the very difficult things about practicing medicine then, seeing people with AIDS then as opposed to now. Now, it's so easy, because it seems like everybody is identified as either HIV-positive or HIV-negative. It's very rare that I run into anybody that's untested, and most of the people that I run into now who are untested probably are negative. I have one or two people in the practice that I see year after year for a physical exam. There may be something about them that makes me think that they have it, and they don't want to take the test. But those people are in the minority.

1983 and 1984 were probably the highest anxiety years, because nobody was tested. Many people were very worried. Many felt vaguely ill. The whole thrust of seeing people was to reassure them, and there was sort of a false thing about it. I would reassure them, but deep down, I was very, very worried, and they continued to worry. People often went from doctor to doctor because they really did not feel reassured, because there was something about the way they felt that wasn't right.

Hughes: Do you think they were also picking up on your lack of certainty?

Campbell: Oh, yes. It was very difficult. Some people wanted a whole lot of testing, wanted a lot of information, wanted to have

¹ For better continuity, the order of discussion topics has been reorganized.
their T cells done and all of this, and other people did not want that stuff done. "Please just tell me I'm okay. But don't do all of these scary tests." There were others that would take the bull by the horns and say, "Well, do the T cells." And if I did the T cells and they were abnormal, it was sometimes difficult to know what to do next.

Hughes: What did you do about the group that wanted to be assured but didn't want you to do any tests?

Campbell: Well, some of them would come back, and a lot of them would go off to other doctors. It's a very, very difficult group to handle. When the antibody test came out in 1985, there were some gay groups, including BAPHR, that discouraged people from taking that test. That was the scariest test of all. That was scarier than T cells.

Hughes: Yes, that was very difficult to deny, wasn't it, if it came out positive?

Campbell: Yes.

AIDS-Related Activities at BAPHR

Campbell: I started the journal club in BAPHR, and we went through journal articles that would give state-of-the-art reports about AIDS, mostly anecdotal--anything from T cells in gay men, to treatment of Pneumocystis, or new syndromes such as thrombocytopenia. It was just little bits of the puzzle. I started subscribing to many journals just to be sure that I didn't miss any articles. We met monthly.

Hughes: You also wrote short journal article reviews in The BAPHRON as well.¹

Campbell: I went to all of the conferences in the city of San Francisco, and there were probably three or four every year that pertained to the subject; the speakers always brought much new information.²

¹ See for example: "AIDS update," The BAPHRON, vol.6, #11, November 1984: 292.

Hughes: What were you hoping to gain when you went to these symposia?
Campbell: Just more information.
Hughes: On how to treat your patients? You had a practical orientation?
Campbell: How to treat, how to diagnose, or how to recognize--just to get oriented. It was a disease that there was no straightforward information on. I had to get the information from symposiums or looking through the mainstream journals. Or looking at the Chronicle or the Examiner; information appeared there before it would appear in the New England Journal. Talking to members of BAPHR who were apt to be seeing a lot of patients with AIDS was also helpful.
Hughes: Was there coverage in the lay press because San Francisco was a major center of the early epidemic, or was there more to it than that?
Campbell: It seemed like the journalists certainly did have a responsibility to cover it.

Etiology

Campbell: Everything that I knew about viral transmission seemed to confirm my suspicions about the viral etiology of the disease.
Hughes: Did you ever consider some of the alternatives? For example, poppers, immune overload--there were all kinds of early theories about etiology.
Campbell: The poppers I thought was a little bit unlikely. I would have liked to have thought that immune overload was the cause, because it seemed like if you gave the immune system a rest, the disease would go away.
Hughes: Did you ever counsel your patients along that line?
Campbell: Yes, it did seem that if you did have something that looked like immune deficiency and you were subjecting yourself to more new pathogens, you wouldn't get any better.
Hughes: Do you think because you'd had experience with hepatitis in your practice that you were predisposed to favor a viral,
sexually transmitted, blood-borne disease when this new disease appeared?

Campbell: Yes. I don't know as it was my original thought. Dr. Larry Drew made some of these suggestions; hepatitis, CMV, this new thing: blood-borne. Tissue trauma. Direct bloodstream inoculation. Bloodstream inoculation via the rectal mucosa made sense, because the disease did not seem to be going into the straight community.

Duration of the Epidemic

Hughes: Did you have any feeling about how long this epidemic was going to last?

Campbell: I thought it would last a long time.

Hughes: Why did you think that?

Campbell: Because the T-cell studies that were being done showed such a pervasive abnormality in large segments of the gay community. I saw that in the foreseeable future, we were going to see many people become ill. I didn't think how many years, but I just thought that it was going to be around for a long time.

Hughes: So this wasn't something like Legionnaire's disease, that science was going to dash in and solve?

Campbell: No, and I also felt that it probably had been around for quite a while.

Attempts to Reduce the Risk of AIDS Transmission

Patient Counseling

Hughes: Did you counsel patients along the lines--I mean early--"Maybe you'd better cut down on your sexual activity"?

Campbell: I think starting in 1981 or 1982, definitely. When they showed the charts about the T cells in the gay community, it didn't seem like it was just a few isolated cases of KS. It seemed
like there must be something that many, many people in the gay community, maybe more than half, were suffering from. Since it was most likely contagious, sexual contact had to be modified, regardless of who the partner was, since one really did not know who out there might have it.

Hughes: So you talked along those lines with patients?


Hughes: How was such advice received?

Campbell: Variably. Some people thought it was very good advice, and there were a few that would say, "Well, we don't really know that that's the case, and so I am going to do what I want to do." Some people rejected it. And some people felt very angry that they were given such advice. But I don't think most people.

When we started formulating risk-reduction guidelines, about certain things like monogamy and safe sex, it seemed to me that the only answer at that point was safe sex with everybody. There were a number of people that said, "Well, monogamy is okay," implying that monogamy would protect you from whatever this was. However, I thought many seemingly healthy persons carried the virus. The problem was that if you were out there trying to meet somebody to become monogamous with, you had a 50 percent chance of meeting the wrong person. If you were a gay man in San Francisco, and even if you met somebody two years ago and you were monogamous all of that time, you still might not be safe.

The Position of the Centers for Disease Control

Hughes: But was that way of thinking common in the population at large? Maybe it wasn't used to the concept of a latent infection. You had sex with somebody who for all intents and purposes looked perfectly healthy. Wasn't it unusual to expect people to question a partner who looked as fit as could be about whether they were a danger?

Campbell: Yes. Dr. Curran talked to BAPHR in 1983 at our conference, and he presented his detective work on AIDS in the USA. We had just put out our first set of safe-sex guidelines, and I was so anxious that this topic be discussed at a conference like that,
that I raised my hand and I said, "Have you come up with any particular sex practice which is likely to transmit this virus?" And he said, "No. There isn't anything in our studies that seems to have been more associated than other things." CDC had done a study, but somehow, it didn't seem to factor out that one thing [sex practice] was any worse than another thing.

However, he said, "I think if you're monogamous that this disease might not be such a worry." I had a couple of friends that were in BAPHR that had been monogamous since 1981; they met in 1981. They were doing everything together, but they were monogamous. They didn't have nearly the anxiety that I had. A lot of people like that felt relatively safe. And those people both have AIDS. Because early in 1981, I think, one of them had contracted it. But this was very typical.

Hughes: So you objected to Curran saying that if you were monogamous, you were safe? That wasn't necessarily the case.

Campbell: Yes. Monogamy would be nice, but I think it would be very difficult for many people in the gay community to suddenly become monogamous, and [it was] not a realistic expectation. The realistic thing was safe sex with everybody. Even if you were in a monogamous relationship, safe sex should be the rule. Several years later, when many started getting tested, if you looked at gay couples in San Francisco, maybe a third were testing positive-positive, and another third were testing negative-negative, and a third were testing negative-positive. Those latter third were really the ones who had to be on the guidelines.

Hughes: So Curran at that stage as spokesperson for the CDC wasn't advocating safe-sex procedures for every encounter?

Campbell: Well, he never came out and said, "If you are in a monogamous relationship, you should be on safe-sex guidelines." Many people who were in monogamous situations then--regardless of how long they'd been monogamous--seemed not to be worried. And people who were really worried were people who were having multiple partners.

Hughes: A study published by the CDC in 1983 found the factor putting people most at risk for AIDS was number of partners.¹

Campbell: That is correct. What that study showed was the number of partners [as the main risk factor]. I think this led to saying, "Monogamy is like one partner, and celibacy is zero, and this is the best way to avoid getting AIDS."

Hughes: Also, because some of the early publications had associated promiscuity and AIDS, it predisposed certain people to say, "Well, I'm not promiscuous; I only have a few partners; I don't have a problem." You didn't even have to try to be monogamous.

Campbell: Yes, and I know that our [BAPHR's] first set of risk-reduction guidelines advised general things like, "Get to know your partner first." It sounded very good, but it didn't make a lot of sense to me, considering that what you really want to know is what nobody could know, unless you had eyes that had DNA probes in them. [laughter]

Hughes: You couldn't know at that point, because there was no antibody test.

The Bathhouses

Campbell: My feeling about this, which gets to the bathhouses, is that so many people then were of the thinking that if you met somebody decent, who was seemingly healthy and agreed to a mutually monogamous relationship, there was no risk of AIDS virus transmission.

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Hughes: Was there an unstated assumption, then, that there were good gay men and there were bad gay men? That some, just the way they presented themselves, as you were saying, must be okay?

Campbell: Yes.

Hughes: Maybe those bathhouse people were the bad guys? Did it ever get to that?

Campbell: My feeling was that if you went to the bathhouses, you just assumed that you were in a place where many people were infected. Therefore, any contact needed to be very, very safe. You would instinctively put up your armor, because you were in a real high-risk population.

Hughes: You mean you make it safe by taking safe-sex precautions?
Campbell: Yes, if you were in a bathhouse, it would seem reasonable to take the maximum precautions.

Hughes: But did that happen?

Campbell: I don't know if that was happening, but to me, it seemed like the reasonable thing. I thought, rather than having the bathhouses closed down, safe-sex instruction should start there, with monitors and behavior codes. The bathhouse could still be an erotic place to meet people, but with the understanding that high-risk activities were definitely verboten. Some people who met their partners in more proper places would often think that they were really meeting a much safer person and might feel more comfortable doing more.

Hughes: Do more that was potentially dangerous.

Campbell: Do more dangerous things; it's sort of a paradox.

Hughes: Yes, I can see that.

Campbell: People said, "Well, if we close down the bathhouses, the epidemic will go away," or, "We won't have as much transmission." To me, it seemed a bathhouse really could be an arena where you post lots of signs on walls. Bathhouses have to be set up in a way that people realize that there's a code of behavior, that there's only so much you do. It could be compared to rules of safety and etiquette which are found in sports.

Hughes: Which would be enforced by social pressure, not by outside force?

Campbell: Yes. And I know that some time around then, they did start having these, quote, "safe-sex clubs," in which people were touching, hands-only contact. There was a lot of peer pressure: you do only this and that's it. And people felt very safe, but yet it was erotic and many people enjoyed it.

Hughes: And that happened in the bathhouses?

Campbell: Those were other organizations that started to crop up.

Hughes: A problem with this argument would seem to me to be that some people were in denial. Regardless of guidelines, they continued their lifestyle. And because the bathhouses were built on the idea of anonymous sex, wouldn't they attract people willing to take sexual risks?
Campbell: Some people, yes. I don't know if you read about Patient Zero in Randy Shilts's And the Band Played On?

Hughes: Yes. Gaetan Dugas wasn't Patient Zero, as we know.

Campbell: He went into the bathhouses and infected all these people. My feeling is that if you go to a bathhouse, you had better suspect that there are sick people there. You put so much blame on this particular person, who was already ill, but then there were so many people who were very well and really enjoying their sex lives who could potentially be carrying the virus. The message that I thought had to go out in 1982 is that everybody, including you yourself, may be carrying this virus. And it's your responsibility, no matter where you are, in the baths or at home, to operate on that assumption. You don't operate on the assumption that you don't have the virus and other people do.

BAPHR's Safe-Sex Guidelines

Hughes: You were on BAPHR's scientific affairs committee from the start?

Campbell: Pretty much from the start, yes.

Hughes: Is that where these safe-sex guidelines were being discussed?

Campbell: Yes.

Hughes: Can you remember when you might have begun to talk about them?

Campbell: Yes. We started talking about them in late 1982. We put out a draft of guidelines for blood donation in January 1983.¹ Then for the health fair that came up in April 1983, we had our first set of guidelines. Bob Bolan² and I did those together with the scientific affairs committee.

Hughes: Can you recreate some of the discussion that went into those guidelines?

¹ For the statement by BAPHR and Irwin Memorial Blood Bank released at a press conference on February 7, 1983, see The BAPHRON vol.5, #3, March 1983.

² See the oral history in this series with Robert Bolan, M.D.
Campbell: We didn't talk so much about bathhouses and whether they should be opened or not. I wanted to make sure that we had it in black and white that the most dangerous thing that one could do was rectal intercourse without a condom.

Hughes: Now, how did you know that?

Campbell: Because of things that Dr. Larry Drew had been talking about the previous summer. I had just gone to a symposium in March 1983 at NYU at which Michael Marmor gave some pretty good data on it. We published those guidelines just a few days after, April 1983. I wanted to make absolutely sure that that warning was in them.

Some of the things that we said were general, like "reduce the number of your sex partners"--things that seemed to make sense, but they were subject to a broad interpretation. [laughter] There was certainly not a message to stop having sex.

Hughes: But did some people interpret it that way? Did you get attacked?

Campbell: No.

Hughes: The guidelines were accepted pretty well?

Campbell: Yes, and obviously, people did start reducing the numbers of sexual partners, and I think the majority of people can do that only very, very gradually. But there are a few that cut it off completely and haven't had sex since. I've talked to many patients like that.

Hughes: There was a statement: "As health care professionals we recognize the importance of physical and emotional intimacy for overall health." You said something along those lines in the very first guidelines?

Campbell: Yes: don't give up sex. Then there was a message to reduce the number of your sexual partners, get to know your sexual partner first, lean toward having one sex partner.

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Hughes: Even though you didn't think that that was adequate, right?

Campbell: No, I definitely didn't think that that was adequate. I thought that it should be stated clearly that certain types of sex were dangerous no matter who it was with.

Hughes: So why didn't the guidelines say that?

Campbell: I think I did get that into the first guidelines. That would be a very interesting document to read. I guess I just eventually threw it away, because it didn't seem to have much meaning.

Later Iterations of BAPHR Guidelines

Hughes: By 1984, the guidelines appeared in several guises. For example, there was a wallet-sized one that was passed out at Gay Pride Day.

Campbell: Yes, that's right.

Hughes: And then there was a version that was in street language.

Campbell: That's right.

Hughes: There was another version that was academically oriented. I suppose that's different than the medical evaluation?

Campbell: Well, we did three [editions of guides for use by physicians for] medical evaluations of persons at risk for AIDS. I think I probably sent you the most recent one, which was 1989 or '88, but I think we did one in 1984 and maybe 1986.¹ They always had the safe-sex guidelines in them. We did them in conjunction with the Department of Public Health and the San Francisco AIDS Foundation to get their seal of approval. But the first ones we did in early 1983 were just our BAPHR committee, and we just got them out for the health fair, and that's all.

Hughes: That was why you were hurrying it?

Campbell: Yes. We worked on that for about a month or two.

Hughes: It seems to me there would be three categories of people in your potential audience: the people who knew that they had this disease, the people who didn't know but maybe later learned they were infected, and then the people that were just worried about it. Right?

Campbell: Yes.

Hughes: Was it in your consciousness that the guidelines had to be broad enough to draw in all these people?

Campbell: In those days, it was just a small number of people that knew that they had it, because they'd had Pneumocystis or KS. And then there was a huge number of people out there that were worried, worried and a little bit sick, and worried and mostly well. And then there were a number of people who were well and not worried.

Assessing Risk

Hughes: You had to decide what sexual practices were safe, what wasn't safe, and what were possibly safe. BAPHR tried to categorize what was high risk, what was low risk, and what seemed to be safe. How did you reach those decisions?

Campbell: That category that said "possibly safe": those were my words. I think a lot of people on the committee, and of course, most of the gay community, wanted something that said "safe" and "unsafe."

Hughes: No gray area.

Campbell: I just thought we had to have that gray area. Otherwise, it would be misleading. It's just how much risk does one want to take?

Hughes: Where did you get information to categorize risk?

Campbell: A lot of it was based on knowledge of anatomy, of certain tissues, and concentration of viruses in certain tissues, and common sense. We put mouth-to-mouth kissing in "possibly safe." One could assume that if the virus was in very high concentrations in saliva that the virus would be in the community at large. So it didn't seem very likely that kissing
was a common way of transmission. Most of this categorization was by inference.

Hughes: It's inference based on the little medical and scientific information that was available and on your knowledge of the gay community. Did you become authorities, in a way? Were there people at the CDC, for example, who would be able to combine these different sources of knowledge and come up with some reasonable safe-sex guidelines?

Campbell: When we were doing that, the CDC was not saying anything, except something to do with risk for AIDS associated with numbers of partners. Therefore anything that they said just did not seem to be particularly relevant. There were a few people who were talking about transmission of other diseases. Larry Drew was talking about the transmission of CMV, and how that correlated with receptive anal intercourse and seropositivity for CMV. Michael Marmor was talking about instances of KS correlated with sexual practices, and was able to get statistically meaningful data.

Then you look at the anatomy of various bodily organs, like the rectum, the vagina, the penis, the mouth, the skin, the hands, as to how many cell layers does something [a pathogen] have to go through until it gets to the blood. Much of that was based on histology, and tissues with only one cell layer such as the rectum would facilitate transmission more readily than tissue like skin which has many cell layers.

Hughes: This was the kind of conversation that was going on in BAPHR?

Campbell: This was the postulate, yes. We felt that we had to give some guidelines, and it seemed, and I guess still does seem at this point, irresponsible to say, "Well, this is safe and this is unsafe." You have to have a middle ground. You have to have a very high-risk category to make sure that everybody avoids the high risk, and that nobody is afraid to go for the safe. The middle ground is where you tread with caution as to how much risk you take. Some people are willing to take a lot more risk than others. Some people will do only things that are totally safe. But the object was to keep as many people as possible out of the high-risk category.

Hughes: Did you find that your medical colleagues that were not gay, and perhaps representatives of the CDC, whom I understand came to San Francisco with some frequency, were consulting you because you had knowledge that they didn't have?
Campbell: Yes, there were some symposiums. I remember one that I think Marcus Conant gave in 1983 or 1984, to which a lot of authorities, like Roger Detels, came. Roger Detels runs the Los Angeles Men's Study of Multicenter AIDS Cohort Study and is a good epidemiologist. He had written on various sexual practices and risk of T-cell abnormalities. Representatives from the CDC were also in attendance. Some BAPHR physicians attended. We had a dialogue about what we thought was safe, possibly safe, and unsafe. We tried to stratify everything. This happened as a prelude to the re-publication of the guidelines that came out in the spring of 1984.

Guidelines for Blood Donation

Hughes: What were the guidelines for donating blood to the Irwin Memorial Blood Bank?

Campbell: There was a statement from BAPHR that came out very early in 1983 that went to Irwin Memorial. It said that gay people should refrain from donating blood.¹

Hughes: Was there controversy over that?

Campbell: Yes. I think almost everybody in BAPHR thought that that was a reasonable thing to do, but I think a few people thought it was not right to target the gay community and say that they were tainted or anything like this.

Hughes: Were you thinking about hepatitis when you were formulating these guidelines? Did that model play any role?

Campbell: I think I remember Paul Volberding or Don Abrams say, "The new virus seems to follow the hepatitis B model for transmission." Which means, it seems to be something that gets introduced straight into the bloodstream. That was why it seemed reasonable to use hepatitis B core antibody as a surrogate marker for AIDS exposure; the risk groups were similar.

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¹ Bay Area Physicians for Human Rights (BAPHR) "Position on Acquired Immune Deficiency Syndrome Related to Transfusion," statement included as separate page in The BAPHRON, vol. 5, #3, March 1983. It is reproduced in the appendix to this volume.
Campbell: The thinking was, if you somehow subjected yourself to hepatitis B, you might have also subjected yourself to HIV.

Hughes: Was this a way of getting around asking potential donors if they were gay?

Campbell: Starting January 1983, blood banks requested that anyone having had homosexual contact with a man since 1977 not donate blood. The same applied to intravenous drug users. Once you donated blood, it was then checked for the surrogate marker, hepatitis B core antibody.

Hughes: Surrogate markers threw the net wider than just the gay community, didn't they?

Campbell: Oh, yes.

Hughes: So that was the point of having the screen for gay donors, plus the surrogate markers?

Campbell: The surrogate markers would include a large number of people that may not have admitted to being in a risk group, such as gay or IV drug user, plus a few people that weren't in those risk groups who had really had hepatitis B, and they might have gotten it without being in those risk groups. That blood was not used either. If you've ever had hepatitis, you're not supposed to donate blood. I don't know if they're still checking for hepatitis B core antibody or not. I'm sure they check for hepatitis C antibody, which they couldn't [test for] until 1989. They must certainly be checking for hepatitis B surface antigen.

Guideline Distribution

Campbell: The first set of guidelines was done for the health fair that took place in the Castro District, Health Center Number 1, April 1983. Every spring, there was a health fair--there were health fairs at several health centers in San Francisco. That particular one, Health Center Number 1, had many gay people at it, because it was in the Castro District. But it also had some straight people and some elderly people who attended. The guidelines went out at that particular event, and were probably passed out at the Gay Pride Day parade that occurred in June. They might have even been in bathhouses. I don't know just how wide the distribution of that one was.
Hughes: What about distribution outside the city, outside the state?

Campbell: I don't know if the first set of guidelines was widely distributed outside of the city. I do know that the next one (1984) must have been, because I saw them at the New Zealand booth at the international AIDS meeting. I'd say, "Oh, these are the ones that we wrote." [laughs]

Hughes: They were almost verbatim?

Campbell: Yes, or BAPHR had been acknowledged.

Hughes: What other guidelines were out there when yours came out in 1983?

Campbell: The Gay Men's Health Crisis in New York had guidelines.

Hughes: How did they compare?

Campbell: I think that they were even stricter.

Hughes: Did theirs come out before yours?

Campbell: Probably about the same time.


Hughes: BAPHR's position that, "secretions and excretions are the most likely vehicles for AIDS virus transmission," apparently met with an adverse reaction at the National Lesbian and Gay Health Conference in Denver in 1983. Do you remember that?

Campbell: There was an earlier meeting where they coined the phrase "AIDS," and I think that was in '82. I didn't attend that meeting.

Hughes: The one in 1982 was in Houston. The 1983 meeting was held in Denver.

Campbell: There was an AAPHR, American Association of Physicians for Human Rights. I know there was a meeting that February 1983 in Hawaii. I didn't go to that one either. I wasn't even in AAPHR. But it seemed like starting in late '82, most people in

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BAPHR thought that the body fluids were what transmitted "AIDS virus." It was really a minority in 1983 that thought it could be poppers, steam from the bathhouses, or "immune overload."

I talked to groups as late as early '84 that thought it was something else: the CIA is doing it; something was planted somewhere. But it didn't have to do with sex.

Hughes: I believe it was the 1983 Denver conference where the People with AIDS movement got off the ground. So some of the people there had an activist orientation.

Campbell: We had said early on in the guidelines that it's the body fluids that transmit it. I know that that was a big thing on that first set of guidelines: "This [disease] is transmitted by body fluids."

Hughes: Did you say what those body fluids were?

Campbell: That was one of the problems. I thought that "body fluids" was a really vague term about which most people don't have a good concept. I mean, it could be saliva or sweat.

Hughes: Yes. And is semen a body fluid?

Campbell: I think the term body fluid just seemed to be an eponym for semen. I wasn't pleased with those guidelines, because I thought there was so much vagueness. You really should talk to Bob Bolan, because he was the chair of the committee that formulated the guidelines. I just kept needling him, because I wanted them to be more specific. I was not totally happy with those guidelines, because they were just too vague. They gave mixed messages about meeting people, numbers of partners, and other warnings that people could interpret too broadly.

Hughes: Was leaving the guidelines open to individual interpretation somehow tied in with the idea of not saying "no" to sexual expression?

Encouraging Sexual Expression

Campbell: That was part of it. We were saying, "Yes, you can still have sex, but try for monogamy." [laughter] If that doesn't work,

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1 See the oral history in this series with Robert Bolan, M.D.
practice safe sex, and be careful of body fluids. I think people were afraid to go out on a limb to say, "Well, semen has it in it, but saliva doesn't," or, "sweat doesn't." Some people were very, very worried about saying specific things about things that were still theoretical. We were so vague about our theories that we just couldn't say these things with conviction, other than it just did seem reasonable that the virus was in some body fluids, as opposed to, let's say, the atmosphere or skin. You could touch people and breathe with them, but beware of body fluids.

Hughes: In a report in The BAPHRON in August, 1983, you wrote, "Heretofore we have never had any written rules as to what constitutes a "moral" or "safe" sex life, as is prescribed in heterosexual marriage." Then you go on: "We must bear in mind that sexual habits do not change overnight. Furthermore, new data on transmission of AIDS may be forthcoming. Consequently it may be several years before the gay community can establish its "sex code" which is both emotionally fulfilling and medically safe."¹

Campbell: That sounds like something I could have written. It doesn't sound very specific.

Hughes: My interpretation of what you're saying, and please comment, is: we're doing the best we can to give you some guidelines, but we frankly don't have all the information that we need to make these guidelines very explicit. Therefore, the ultimate sex code for the gay community is off in the future.

Campbell: Yes.

Hughes: But for your own safety, you've got to take these interim steps. Is that more or less what you were saying?

Campbell: Yes. And I suspect that, if that was August 1983, it was probably the report on the symposium that we had at the end of June.

Hughes: Yes. [pause as Campbell reads the report]

Campbell: [laughs] Well, there was a heavy component of psychiatry in the meeting that we had in June, 1983. "Morality" and "safety" were discussed at great length. That's probably why I used the words in quotes in my report. That may have been the home-

going message from that symposium. Some of that report could have been paraphrased from some of the speakers there. It was run by psychiatrists, asking what can the gay community do about sexual fulfillment?

The 1983 and Later Guidelines

[Interview 2: June 26, 1996] ##

Hughes: I have a few more questions on safe-sex guidelines. The BAPHR guidelines first came out in 1983.¹

Campbell: Yes, our first guidelines were published in the spring of 1983.

Hughes: And then there were several revisions. The revisions that I know about were in 1984, 1985, 1987, 1989, and there have probably been some more recent ones.

Campbell: The revision that we made in 1984 put sexual activities in the safe, possibly safe, and unsafe territories. And I think that since that time, there doesn't seem to have been an essential revision of the guidelines, other than the fact that many of the things that were in the "possibly safe" category, people now may call low risk, but not zero risk. It's more a change in wording and certain precautions.

1985 was the first time we came out with a booklet in which we elaborated on each sexual practice, and precautions to be taken when engaging in any of those practices, and why some of the ones that were possibly safe might not be safe under certain circumstances.²

Hughes: I am interested in knowing what the general types of changes were.

Campbell: I think we remained firm on what was definitely safe, and firm on what was definitely unsafe, and we just elaborated on that

¹ BAPHR Guidelines For AIDS Risk Reduction [1983]. (AIDS Resource Center Archives, Ward 5A, San Francisco General Hospital, unlabeled off-white file box.)

big middle ground and changed the words a bit. I think that these days most people would still put them in a middle ground.

**BAPHR Guidelines as a Model**

Hughes: We talked last time about another set of guidelines, which were those of the Gay Men's Health Crisis, which you thought might be a bit more stringent. In the early days of the epidemic, were those the only two sets of guidelines? And did they become models?

Campbell: As far as I know they were, and I have a feeling that they did become a model, because when I went to the AIDS conferences around 1988 or 1989, I was noticing the guidelines for people from New Zealand, and they were just the same as we had written in San Francisco five years before.

Hughes: What about the guidelines that were eventually put out by the federal government? Did those follow the BAPHR model?

Campbell: They weren't in that "safe, possibly safe, unsafe" category, but I think that they said in essence the same thing that we had been saying: unprotected rectal and vaginal intercourse are unsafe, and there is reduction of risk if a condom is used. I'm not sure what it said about oral sex, because those guidelines change from time to time.

Hughes: There is the recent research on monkeys, indicating that oral sex is not as safe as it was originally thought to be.

Campbell: Yes, rectal sex seems to be safer than oral sex for monkeys, from what I heard. However, SIV is a different virus and it's a different species, and epidemiologically that doesn't seem to make sense with the AIDS epidemic.

**BAPHR Collaboration with Other City Organizations**

Hughes: The AIDS Foundation merely distributed the BAPHR guidelines, or was it more than that?

Campbell: In 1983 at the health fair, when we published our first set of guidelines, they were the BAPHR guidelines. In 1984, I think in preparation probably for Gay Freedom Day, which would have
Hughes: Last time we discussed the several types of publications that came out. I think the one you're talking about is the wallet-sized version.

Campbell: Yes, and I think that the BAPHR guidelines came out in three versions.

Hughes: Yes, exactly.

BAPHR's AIDS Evaluation Booklet, 1985

Teaching AIDS Recognition


Campbell: I think that would be right.

Hughes: The 1985 edition was edited by you and William Warner. What prompted you to create something as formal as this booklet?

Campbell: I think we wrote most of it in 1984. [looks at it] Yes, copyright 1985, and it did get revised three times.

In the first run, I think we knew that the HTLV-III antibody test was available on a research basis, and July 1, 1985, it became generally available to the community. There...
was at that time a great resistance in the gay community to either ordering that test on somebody, or somebody taking the test, because it seemed like a very final test to be taking. Either you have it or you don't. And it was just fraught with too much fear.

Hughes: So it was more fear, rather than the possibility of being discriminated against if a person were found to have the virus?

Campbell: Well, I think there were a lot of issues. There was the issue of, one, you were getting some very bad information [if the test was positive], and with not very much to do about it except worry and wait to see what would happen. That was probably the major argument against the test. Many other people said, "Don't take this test, because it will go on your record and there will be insurance discrimination." It was for several reasons that people were advised not to take that test, or if they did take it, never, never to divulge the results to anybody, except maybe your doctor. The first printing of this booklet must have discussed that.

The first printing is written along the lines that the physician is dealing with somebody who doesn't know the results of the antibody test, and the test is not exactly the first thing that he does to work up somebody at risk for HIV. The physician might listen more carefully to the patient's sexual history and the symptoms that he presents, and the physical findings that might be suggestive of immunodeficiency, or general lab work that might be suspect of somebody with AIDS, rather than immediately doing that particular test.

Hughes: That edition is copyrighted 1985?

Campbell: This has the copyright 1989. This edition has been considerably revised, because so much happened in four years.

Hughes: In the 1985 introduction, you stated: "The purpose of this brochure is to alert health professionals throughout the country to the protean manifestations of AIDS in its earliest stages, so that proper treatment, referral, and counseling can be implemented without delay." You were trying to teach people how to recognize the various manifestations of AIDS as opposed to just reading an antibody test?

Campbell: Yes. I think we wrote it mainly because many of us had seen more cases of AIDS than had occurred in entire states.

Hughes: You expected this brochure to reach a nationwide audience?
Campbell: Yes.

Hughes: And did it?

Campbell: I think we got orders for that brochure from people all over the country.

Hughes: How did they learn about it?

Campbell: I don't know. Of all of the organizations of that type, BAPHR was the first one, and I think that many people looked to BAPHR as the leader in that field, as opposed to NYPHR, which would be New York City, or SCAPHR, which would be Southern California, or even AAPHR, which would be American Association of Physicians for Human Rights. I think BAPHR did play a strong leadership role early on.

Hughes: But a physician in Des Moines wouldn't know to contact BAPHR if he encountered a patient that had symptoms of AIDS.

Campbell: No, he would probably contact the CDC or something.

Hughes: But would CDC have referred people to BAPHR?

Campbell: Well, I think one of the reasons that we did this brochure is that there was such a scarcity of well-written articles on the subject. What came out in the medical literature was discoveries about this and that applying to AIDS, but nothing had really been written on the clinical approach to a person who may be at risk for HIV, which people all over the country were seeing more and more of. Probably in Iowa, it would be even more challenging, because you might not know who was at risk.

Here in San Francisco, we pretty well knew who in the private practice office was at risk and who wasn't. It was not difficult to take sexual histories here in San Francisco, because most people were quite up-front about what they were doing. Whereas in other areas, it could be very difficult to take a sexual history, especially about something that frightening. So that was really the focus of that article; there's quite a bit on how to take a sexual history and establish that somebody really is at risk, rather than just testing everybody and finding out who had HIV and who didn't.
The Worried Well

Hughes: The brochure was concerned with evaluating two groups: the worried well, and "patients with specific symptom complexes which may arouse suspicion of AIDS." What was your point in drawing a distinction between the two groups?

Campbell: Again, the antibody test was not in widespread use then. So the worried well were people who could be at risk, maybe at high risk, maybe at low risk, but at some risk, and who from time to time did not feel well, or might have minor ailments, and how really to sort that cluster of symptoms that they presented with and distinguish them from that other group which seemed to have even more symptoms or a more unique set of symptoms. This was a real grey area, and sometimes we would do the T cells to distinguish those two groups.

Hughes: Isn't there yet another distinction before the antibody test? Amongst those worried well there were those who actually were infected.

Campbell: Yes, there definitely were some that were infected. There was a real, real grey area in that worried well group.

Hughes: And there was nothing much you as a physician could do until you had the test?

Campbell: Yes. Those were the most difficult people. People who had very definite symptom complexes associated with AIDS--they had KS, or they'd had Pneumocystis, or they had cryptococcus--yes, you have AIDS, and that's what we're treating you for.

But then there was this grey area with persons that might have a little fever once a month, or they maybe have lymphadenopathy, or their skin isn't right. Those people were the most difficult to deal with, because you were dealing in a very grey area. We did not know if everybody who was like that would eventually have AIDS. And a lot of the things that they were dealing with were things that normal people have, except that there was an extra concern about them. If a cold doesn't go away in two weeks, they might not have worried about it ten years before, but in this setting, there is a great deal of worry.
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Symptom Complexes

Hughes: Well, in the booklet, a different physician wrote on each symptom complex, and they were lymphadenopathy, fever, pulmonary, gastrointestinal, neurological, and dermatological manifestations. Were those standard categories for discussing symptom complexes, or were they categories those writing this booklet devised?

Campbell: We devised those categories, because they seemed to group around specific symptom complexes. I don't know if anybody else has classified them that way, but that was the way we approached it.

Hughes: Would that be the approach that you would take in a physical exam?

Campbell: Yes, moving through the symptoms, and looking at, let's say, the medical and sexual history, and the physical exam, which would embrace almost all of that.

Neurological Aspects

Hughes: The neurological category was relatively new, was it not?

Campbell: It was relatively new, but nonetheless, we knew that we were seeing people who had peripheral neuropathy, people who were confused, people who had symptoms that would suggest that they'd had a stroke or paralysis--neurological complaints. Headaches. All of these things were seen by primary care physicians or neurologists.

Hughes: In the very early literature on AIDS, to my knowledge, there's not very much mention of neuropathies, for example, associated with this syndrome. Were the neurological aspects of AIDS slower to become recognized than conditions like PCP and KS?

Campbell: One reason that I think we're seeing so much more neurology now than we were then is because antiretroviral treatment can cause neuropathy, but it also prolongs the life span so that patients may have an opportunity to develop those late-stage neurological problems which didn't develop so often early in the epidemic because people were already dead from PCP. Also, if you prophylax somebody for PCP and you prophylax them for CMV and you prophylax them for this and that opportunistic
infection, eventually they're going to get something that might be directly related to HIV, and it might be neurological, e.g., the AIDS dementia complex or progressive multifocal leukoencephalopathy.

Pulmonary Manifestations

Hughes: Well, you and Walter Blumenfeld wrote on the pulmonary manifestations of AIDS in this booklet. Who is Walter Blumenfeld?

Campbell: He's a pathologist. I know he did quite a bit of research; I think he was a research fellow then. He was doing research on Pneumocystis and how to make the diagnosis of Pneumocystis from sputums--gene probes or things like this.

Hughes: He was at UCSF?

Campbell: Yes, I think his fellowship was over at the VA [Veterans Administration Medical Center, a UCSF affiliate]. He's since moved out of the area.

Hughes: Why did you choose to write on PCP?

Campbell: Probably because I'd seen so much of it. And it seemed to be one of the things I felt quite competent with, because I'd gone to many lectures on it and had sort of a formula for working up people with PCP. I think Steve Follansbee also did some editing on that one, too. All the people who wrote these articles were on the BAPHR Scientific Affairs Committee.

BAPHR's Scientific Affairs Committee

Hughes: The epidemic was the stimulus for forming that committee?

Campbell: Yes. The first committee was, I think, started in 1981, and I don't think I was on that. It was the Kaposi's Sarcoma Ad-Hoc Committee. I think in the summer of 1982, it was renamed Scientific Affairs Committee, and I think that's when I joined it.
Hughes: Well, the reviews of scientific articles on the epidemic that appeared sporadically in *The BAPHRON*, as far as I know were always signed by you.

Campbell: Yes.

Hughes: Nobody else was doing that?

Campbell: No, I started doing that. Every time there was a major conference about AIDS, I wrote it up.

Hughes: But you also reviewed AIDS literature.

Campbell: [pause] Hmm, I don't know if I reviewed literature.

Hughes: Yes, you did. [tape interruption; Hughes shows example of a literature review which appeared in *The BAPHRON*.]

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Campbell: Yes, I think whenever I saw an article on AIDS that was particularly important, I would do a little update.

Hughes: It seems to me that in the early years of the epidemic you were serving as the scientific voice of BAPHR.

Campbell: Yes, I was chairman of the committee.

Hughes: Which I suppose makes it logical that you would be doing all this. But it's also a role that you chose to take on.

Campbell: Yes.

Hughes: Do you have any more to say about it?

Campbell: I think the reason for taking it on was that it just didn't seem like anybody else was taking it on. Bob Bolan had been doing it. I think the first set of safe-sex guidelines [1983] were a little too general, not quite specific enough, and so I was very anxious to take it on because I wanted to make sure that very specific things were heard.

Hughes: Well, BAPHR is not just any AIDS organization; it's an organization of physicians, most of whom are dealing with AIDS patients. It's not the AIDS Foundation or another organization.

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Hughes: Did it almost exclusively deal with science as related to the epidemic?

Campbell: Yes. All we talked about was the epidemic. Things were moving so fast in the epidemic. I think we met two times a month, and every time we met, there was something new that we brought up and that nobody else, other organizations included, was talking about patients. It's not the AIDS Foundation or another organization with a general membership; its membership is physicians.

Campbell: That's correct.

Hughes: So of course, it's very important that members of BAPHR be up to date on the latest scientific information. But I'm also wondering if there's another dimension. Is BAPHR trying to project to the gay community and to the San Francisco community at large that BAPHR physicians have a different sort of information, an important different sort of information, than you're going to get from any other group? If so, it's important for many reasons that you project yourself as scientific experts. It's an image thing.

Campbell: Yes. I felt that we were uniquely involved, because we felt very personally involved from our own lives or our own risk, and then we were seeing a huge amount of this new syndrome in our medical practices. I think we were in a unique situation because nobody else was in that situation. Most physicians weren't seeing that much of the disease, or if they were seeing a lot of it, they may not have been personally at risk. So we had a lot invested in it emotionally. And nobody else was coming out with guidelines for medical management of the disease or guidelines to prevent transmission. What we were seeing was brand new; nobody had seen it before, so it was very important to get out there and write about it or speak about it. It was new, and it was urgent throughout that summer and fall of 1981, because they were seeing more and more of that syndrome there.

**BAPHR's Annual Conference, June 1981**

Hughes: Do you recall if you attended BAPHR's annual conference in June of 1981?

Campbell: I didn't attend that one, but I know they presented something on PCP, and they presented something on KS.
Hughes: I've heard that Friedman-Kien spoke, and that he had slides.¹

Campbell: On KS.

Hughes: On KS. I hadn't heard about the PCP presentation.

Campbell: I think he was there.

Hughes: It was the first that some people had heard about this new disease.

Campbell: I think it was the first that anybody had heard, unless they happened to have somebody walk into their office that had those conditions. Nothing was ever published on it until, I believe, June of 1981.²

Hughes: When you talked about the conference with colleagues who had been there, was it noteworthy to them that PCP and KS were occurring in the gay community?

Campbell: Yes. People started talking about it immediately in the summer of 1981. The medical community in general was talking about it. And people at San Francisco General were very, very much attuned to it.

The Kaposi's Sarcoma Clinic and Study Group, UCSF³

Hughes: How closely in touch were you with people at UCSF and the General?

Campbell: In 1981, I wasn't so closely in touch, but in 1982, I believe I started going almost every week--I think Marcus Conant had a meeting almost every week.⁴ It occurred Thursday noon at UCSF.

¹ For more on this conference see the oral history with Angie Lewis in the AIDS nurses series.


⁴ See the oral history with Marcus A. Conant, M.D. in the AIDS physicians series.
Hughes: Yes. It followed his Kaposi's Sarcoma Clinic.

Campbell: Yes, and Thursday was such an easy day for me, because I wasn't in the office on Thursday. I went to almost all of those, probably starting some time in 1982. But I think that those meetings might have started in '81.

Hughes: They did. And did those meetings become a major source of information for you?

Campbell: Oh, yes.

Hughes: Is there a link between BAPHR's Scientific Affairs Committee and the KS Clinic? You would transmit the information that you got from the KS Clinic to your colleagues at BAPHR and perhaps write about it?

Campbell: Yes. And then we had our little journal club. I think that met once a month, and Scientific Affairs met once a month, so that there were two meetings a month that had something to do with the epidemic. We would always bring in new information and sometimes talk about it informally.

The Professional and the Personal

Hughes: Well, maybe this is the time to say a bit more about the dual role that all of you seem to be playing, and how that enhances, or perhaps creates, tensions in your lives. I'm meaning, you are gay men, and you are physicians. Those two roles don't necessarily always go in sync.

Campbell: No.

Hughes: Do you want to say something about that?

Campbell: It was a very stressful time for me. I was never a hypochondriac, but as soon as that epidemic came on, I became terribly hypochondriacal. I would see somebody who had a particular illness in the office, then do tests which may suggest an AIDS-related illness, not come up with any conclusion, and would go on to this and this and this, and start having similar symptoms myself. In 1983 and 1984, I don't think a day went by that I wasn't somehow preoccupied with my own health. There was always something didn't seem to be right.
Hughes: Did your state of mind have an effect on your practice of medicine?

Campbell: I think it did inasmuch as I became much more focused on it. Because when I did see people like this, I really took them very seriously. But then a lot of times I was very frustrated because of the uncertainty of what was happening.

Hughes: Off tape you mentioned the emotional aspects of dealing with patients who had a disease that you very well could get yourself.

Campbell: Oh, yes.

Hughes: How did that affect the distance that a physician supposedly tries to maintain between himself and his patients?

Campbell: I think a lot of us were prejudiced by that, like just ordering an antibody test on somebody when you were too scared to take the antibody test yourself. I mean, it's [laughs] something that you don't like to do. And in the first two or three years of antibody testing, the majority would not take that test, or we would stall on it.

Campbell's First AIDS Antibody Test

Hughes: Is there a story connected with the first time you did take the antibody test?

Campbell: I was in the Los Angeles Men's Study and I still am. It is part of the Multicenter AIDS Cohort Study (MACS). Enrollment was limited to homosexual men who did not have an AIDS diagnosis as of 1984, when the study began. Presumably no one knew his antibody [status] at the onset of the study since the test wasn't available. I really wanted to be in a study because I thought it was so important. I knew I wasn't going to be in the San Francisco study because I lived west of Stanyan Street.

Hughes: Was that the cutoff?

Campbell: They rang every fourth doorbell between Stanyan Street and Van Ness or something--I don't know what it was, but they made random selections. So I enrolled in the Los Angeles Men's Study. I had my first test done in June, 1984, which was a month after the test was invented but a year before it was
approved. They wouldn't tell us the results of the tests, and of course, I was very glad that they didn't tell us. However, I kept getting T-cell results, and the T cells were looking okay, so I thought that probably everything was okay.

Hughes: You got T-cells results because you were ordering them for yourself?

Campbell: No, the study did it. In March of 1986, almost two years after I started to take the test, they sent us something in the mail that said, "You can make an appointment at any time to get your antibody test results." So I phoned them and said, "I have just read in your publication about getting an appointment to take the antibody test result." And the person that was at the desk said, "Oh, you live in San Francisco. Why don't you just call this number and you can get your antibody test result." And I said, "Is it that easy to do? I thought you'd have to come in person." But he said, "Oh, since you live far away, you can just call this number."

And that made me feel rather good, because I thought, Well, if they're letting me do this by phone, maybe I'm negative. So I called that number, and somebody answered the phone and said, "You can only get your tests in person." I said, "But I've been told that I can get them over the phone." At that point I felt I was going to get an emergency flight down to Los Angeles to see what the results were. And she said, "Oh, well, what is your code number?" And so I told her my code number, and she told me I was negative. So that was how I got my antibody test result, which was a little bit irregular. I was just really in panic when she said, "You have to come in person." [laughs]

Hughes: Why the two-year gap between taking the test and releasing the results?

Campbell: I think that they didn't yet trust the test. That was already several months after it had been approved by the FDA. That was the month of March of 1986, and the previous July, the test had been approved. I wasn't anxious to get any information; I was just sort of letting sleeping dogs lie. But I was starting to order the test on a whole lot of people at that point, but mostly they were people who wanted it done.
More on BAPHR

BAPHR's AIDS Survey

Hughes: Well, in 1983, BAPHR started an AIDS survey in which physicians contributed their experience of seeing people with AIDS. Do you remember participating?

Campbell: Yes. I think Will Warner was the investigator on that. We had a little data sheet that we were supposed to keep on people we were seeing, and I think I might have collected maybe twenty-five or thirty people. I don't think they were supposed to have full-blown AIDS, but they were just supposed to be suspect individuals. We were supposed to write down if they'd had candida, or what their T cells were if they had been done, or if they had lymphadenopathy or neuropathy. We checked off various things, and then I think one or two years later Will Warner came out with results of what happened to all of those patients. As I recall, a couple of my patients turned out to be negative. One had just a little bit of lymphadenopathy, so I put him down. And there was another one that had T cells that were a little bit off, but it turned out to be due to intercurrent infection.

Hughes: And was the study published?

Campbell: I don't think it was formally published, but it was discussed in the BAPHR meeting.

Hughes: This study was to try to define this new disease more closely?

Campbell: Yes. We were just trying to get a handle on the natural history of the disease.

BAPHR's Social Concerns Committee

Hughes: I saw mention of the Social Concerns Committee of BAPHR. What was its purpose?

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Campbell: I think the purpose of that committee was to discuss any issue that had to do with discrimination against gay people, and later on, of course, people with AIDS.

Hughes: In a medical setting? For example, a hospital that wouldn't take an AIDS patient or didn't give proper care?

Campbell: It would be something like that. The committee did some work with the blood bank, I believe. I think they became active on this issue along with the Scientific Affairs Committee. What else did they discuss? I think anything which had gotten into the political arena, and a lot of it did have to do with AIDS.

BAPHR's Liaison with California State Government

Hughes: Did members of BAPHR have specific contacts in government at the local, state, and maybe even federal level?

Campbell: Some did. I think we had a liaison person that went up to Sacramento every other Friday when the [California State] Assembly convened, in response to things like the LaRouche amendments.

Hughes: But not on a routine basis?

Campbell: I think that right along, there was always something in the legislature that pertained to AIDS, and so that was an ongoing thing. There were always bills that affected people with AIDS. And I think for a period of three or four years, Dr. Seth Charney went to Sacramento regularly to deal with that. There were also people who met with the Department of Public Health on a regular basis.

Hughes: How did people juggle these new responsibilities with their practices? How could a physician take time off on a regular basis to drive to Sacramento and presumably spend the day?

Campbell: The person who did that was semi-retired. I think Will Warner became very active in some of those things, and he did not work full-time.
**Political Burnout**

Campbell: Early on, my practice wasn't so terribly busy, and so I could do a few things like this, but by 1987, it became so incredibly busy that I didn't want to do any of it. I was really burned out of any of those political activities by 1987.

Hughes: Did you drop out at that point?

Campbell: I sort of dropped out. I've continued to be a member of BAPHR, but my [medical practice] partner, Wayne Bayless, retired in the fall of '87, and the practice responsibilities became incredibly onerous. I was probably an officer in BAPHR and doing a little bit with the Scientific Affairs Committee in 1987-1988. What was the latest publication of this booklet? 1989, yes, I was actually working on that in 1989. It really became a hardship. I was working harder than I wanted to.

Hughes: According to your CV, you were a member of the Scientific Advisory Committee of the AIDS Foundation until 1990.

Campbell: Yes, but not very much into it. Those dates might be stretched a bit. It was mainly about '84 to '86 that I was very active on that committee.

Hughes: According to your CV, '86 is the last year that you were on the Scientific Affairs Committee of BAPHR.

Campbell: That's probably not accurate. I think that I probably got them turned around. I think probably '84 to '86 would have been the Scientific Advisory Committee of the San Francisco AIDS Foundation, and probably '82 to 1990 would be the BAPHR Scientific Affairs Committee.

**AIDS as a Disease Spectrum**

**AIDS Related Complex**

Hughes: Please comment on AIDS Related Complex [ARC] as a diagnostic category. Is it still used?

Campbell: That is still used as a diagnosis and there's still an ICD-9 code for ARC. ARC would really be anybody who does not have a
CDC definition of AIDS, which now includes everybody who is 200 or less CD4 cells. So if you have, let's say, 225 CD4 cells and a specific symptom related to HIV, such as fatigue or diarrhea, you have ARC. ARC may be grounds for disability, but not automatically.

Hughes: So it is a useful category.

Campbell: Yes. It doesn't have a very clear-cut definition; it's that grey zone that's not AIDS but is symptomatic HIV infection. There was a 1982 CDC definition of AIDS, then there was a 1987 definition, and then there was a 1992 definition. Prior to the 1992 definition, ARC was very important, because there were many more people who had ARC, because they had never had an opportunistic infection and you couldn't say that they specifically had the wasting syndrome, which had fairly strict criteria for diagnosis. I think the term "wasting syndrome" was invented in 1987; this put many of the ARC people into the AIDS category.

Current Diagnosis and Prediction of Disease Progression

Hughes: Do you put people with ARC in a slightly different category, or do they all have AIDS in your mind?

Campbell: Well, when I put down a diagnosis for HIV infection I'll put down viral load da da da, CD4 da da da, history this, this, this, this. Like I might say, "HIV infection, asymptomatic, low viral load, CD4 500." Such a person is far from AIDS. Or I would say, "HIV infection, viral load 1 million, CD4's twenty, history, Pneumocystis, M. [Mycobacterium] avium, CMV." That's somebody who's on the extreme other end of the HIV disease/AIDS spectrum. The disease is staged by the CD4 number, the viral load, and all the specific illnesses which a patient has had. A typical ARC patient may be described like this: "HIV infection, viral load high, let's say 100,000, CD4 count 300, history: hairy leukoplakia, recurrent diarrhea." However, this is not a classical AIDS-defining illness. So that's the way I do it.

Hughes: So in your mind, the disease is a spectrum.

Campbell: It's a spectrum. You think of it in the dimension of the viral load, the strength of the immune system, the specific infections the person has had, and maybe also their ability to function. Because you might get somebody who has a high viral
low and very few CD4 cells, who's had Pneumocystis but is still working full-time, and let's say Karnofsky score ninety, ninety-five. I don't always put the Karnofsky score down, but I think somebody who's making a strict definition of a particular person would include the Karnofsky, the viral load, the CD4's, and the specific AIDS-defining illnesses.

Hughes: So this is a very mutable system too, isn't it? Because of all these scientific parameters that you now are able to obtain, you can place people along a spectrum, but with the understanding that when you go back six months from now, they very well may be in a different place on that spectrum. So none of this is static?

Campbell: None of it is static, but I think that these days when we see people, it's really fairly cut and dried. We know who's apt to be getting ill fairly soon, and we know who's not. If somebody has, let's say, a stable 200 CD4 count and, let's say, a viral load of 5,000, which is relatively low, and they're tolerating a bunch of antiretroviral drugs, and they don't have anything else which is AIDS-defining, we know that we're just going to see that person every three months for a routine visit, and they're not going to be getting sick in the near future.

But if you see somebody whose viral load has gone from, let's say, 10,000 to 500,000, and they're having little fevers, and they've had thrush for the first time, you know that something is going to happen soon, or they've become intolerant or resistant to a particular antiretroviral drug.

Hughes: That really is pretty predictable? People really do tend to progress in that fashion?

Campbell: Yes, and I think you get a lot of predictability through the viral load. If you take into consideration the viral load and the CD4's, plus just the way the person feels, you can get tremendous predictability as to who is going to be around a year or two or longer.

Hughes: This predictability became possible with the ability to detect accurately the viral load?

Campbell: I think there was predictability on the basis of the CD4 cells long ago, and predictability on the basis of what specific opportunistic infections somebody might have had. But then in August 1994, right after the Tokyo meeting [of the International Conference on AIDS], we started doing these viral loads. That added a much sharper dimension to somebody's profile, as to whether they were going to do well or not. Some
people run very low CD4 numbers but have very low viral loads; those people just tend to do much better than persons with low CD4 counts and higher viral loads.

Hughes: What you're describing is a syndrome that is being defined increasingly more exactly because of technological advances. Right?

Campbell: Yes.

**Hepatitis and Evolving Disease Concepts**

Hughes: Have you experienced anything else like this in your career, where you had a general definition of a disease, but as the years went on, it became much more scientifically specific?

Campbell: Yes, I am thinking of hepatitis C, which is a disease that's probably been around a little bit longer than AIDS, but maybe not, and that we were calling non-A, non-B hepatitis, or transfusion hepatitis. Only in the last year or two, people have been doing studies about the natural history of hepatitis C. Now people are doing work on the gene types of hepatitis C. There are certain gene types of hepatitis C that are more amenable to interferon therapy than others. So that's a disease that's conforming very much to the same model as HIV.

Hughes: Are you saying that now we have the technology to define it more precisely?

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Campbell: Hepatitis B became definable around 1971, and screening of the blood supply for hepatitis B was introduced in the early seventies. Many cases of transfusion hepatitis were eliminated, but not all of them, because some of them were non-A, non-B. A few years later, in 1976, we could define hepatitis A, so eventually in the late seventies, we had non-A, non-B. And now they have E and F, so there's non-A, non-B, non-C, non-E, non-F. So the waste basket is getting smaller and smaller, but never ends. I don't know if anybody knows how long hepatitis C has been around. We don't know if the people who died of a viral hepatitis or cirrhosis twenty years ago had hepatitis B or hepatitis C or what they had.
Hughes: The bloods that were stored for the hepatitis B vaccine trials in the early eighties don't provide information about hepatitis C?

Campbell: It could be. I really never thought much about it from a researcher's point of view. I think in many, many diseases, AIDS included, the natural history changes from decade to decade because the treatment changes.

Hughes: Yes, and in the case of the AIDS epidemic, also the populations being affected. I'm thinking of the disease in Africa, for example, which manifests itself differently in many ways than it does here.

Campbell: Yes, because the interventions are not quite the same. Coronary artery disease is another one in which there are so many new interventions such that people with that particular disease have specifically different problems than they did twenty years ago. Or diabetes.

Hughes: So this evolution of disease concept is nothing new to medicine.

Campbell: No, and there are always new infectious agents, like the hantavirus and [the micro-organism of] Legionnaire's disease. New infectious diseases that may have been seen sporadically before may emerge in epidemics now.

**Early Physical Diagnosis of AIDS**

Hughes: Please describe what happened when a patient presented himself in your office for the first time, before you had the virus, so up to mid-1983?

Campbell: I think up until 1983, I would focus on the symptom complex. If it was a pulmonary problem, I would get a chest x-ray. You would know whether it was somebody at risk of HIV or at risk of GRID or whatever.

Hughes: Because of the sexual history that you'd taken?

Campbell: Yes. And you would culture many areas of the body, trying to find an answer just why somebody had an infection, why somebody had a fever. Fever would probably be the most difficult thing to work up in those days, and sometimes you would never come to an answer, because it might have been just the HIV running.
wild, and you didn't have a handle on what that was. The person didn't have pneumonia; they didn't have a urinary tract infection; they didn't have colitis; they didn't have meningitis; they didn't have anything but fever, and those cases were the most difficult to diagnose.

But certain of those people who specifically had pneumonia or shortness of breath, I would go through a little workup like I describe in this booklet, getting induced sputum or bronchoscopy for PCP, and treating them for PCP. That would be sort of the end of the story, but often the patient would be back a few months later with something else. You knew that they would be, because you knew that the immune system was impaired. In some of those patients, you would do T cells. Not all, but select patients would get T cells.

Hughes: How would you make that decision?

Campbell: If I really just did not know whether somebody was immunologically impaired or not, and did not have a handle as to what the problem was. And that [T-cell test results] would at least say that this was falling into that category of immunodeficiency.

Hughes: If you knew somebody was immunologically impaired, you didn't order the test because there was nothing you could do with that information?

Campbell: No, there was nothing we could do.

Hughes: Until AZT came along. Is that when the level of immunological impairment begins to make a difference?

Campbell: Yes. To somebody that you thought might be immunologically impaired, you certainly wouldn't give AZT without an antibody test. I heard of persons who went on AZT because they had taken the T cells, and the T cells weren't particularly good. And it turned out that they were negative. Anecdotally, I know of a couple of cases like that.

Let's say starting about 1987, or maybe even '85 or '86 when the antibody test was available, many people would come in who had taken the antibody test, and they said, "What am I supposed to do now?" I would always get the T cells on them. That would give me some notion as to whether they were in any immediate danger of coming down with an opportunistic infection. And if they were below 200 [T cells], I would prophylax them for Pneumocystis. And then starting in 1987, I think, if they were below 200, I would put them on AZT, or even
some with higher T cells. When we had to send in for expanded-access AZT, we had to state that it was less than 200. Consequently there was a little bit of fudging going on.

**Drug Therapy**

**Expanded Access to Experimental AIDS Drugs**

Hughes: Well, explain expanded-access AZT.

Campbell: Every one of these antiretroviral drugs starting in 1986 or '87 first came out under expanded access. One couldn't just write prescriptions; we had to send away for the drug and have it delivered to a specific pharmacy or the office. Then the patient picked it up. But we had to fill out a lot of forms.

Hughes: The patient had to fit strict criteria in order to have access to the drug?

Campbell: Yes. You had to fill out these forms saying this and that, and there were some people that didn't exactly fit those criteria.

Hughes: So that's when you fudged.

Campbell: I did have to fudge some, yes.

**Current Therapy**

Campbell: With the HIV seropositive patient, several things are done to evaluate the patient: the viral load, T cells, and a history to find out if anything has happened that could be referable to HIV. There are specific recommendations about the start of antiretroviral therapy based on T cells and the viral load, and previous use of antiretroviral agents. It's become much more simplified.

All of that, of course, is tempered by the patient's particular desires. There are some that would still prefer not to be on any antiretroviral drugs; and some will want to take four of them at once, or the more the better. I know somebody now who's been on AZT for five years and only AZT, who has a
rather intermediately high to high viral load, and who does not want to be on combination therapy or any other regimen.

Hughes: What is your approach?

Campbell: I just explained to him the reasons for the current recommendation of combination therapy. He listened and replied, "Well, no, I still don't want to take anything other than AZT, because I'm feeling fine, and AZT seems to be working, and I don't want to try anything else at this point."

Hughes: You present the information and then it's up to the patient?

Campbell: Yes. I don't feel I can force a patient to take any drug. I can only educate and recommend.

Alternative Therapies

Hughes: What is your attitude towards alternative therapies?

Campbell: Unless they seem quite harmful, I say, "That's okay for you to do." I try not to comment a lot about it, because I don't know a whole lot about it, for one thing, and many of them place a lot of faith in alternative therapy. I think that if they really find them empowering that they should be encouraged to do them, unless it seems that they're taking things in toxic amounts. I did have one patient who had unexplained diarrhea and was taking about thirteen or fourteen different herbal medicines a day that I thought really needed to stop all of them because it could be causing the diarrhea problem.

Hughes: And you said that?

Campbell: Yes, and he agreed to do it.

Hughes: What about cases in which people are using alternative therapy and are not taking orthodox therapy? Is that again their decision?

Campbell: Yes. I think my role is that of an educator, and I can explain to them exactly what has been found: if you do take triple [drug] therapy the viral load goes very low, and we have certain studies that would suggest that people with very low viral loads will do much better. If they're not convinced of that, I can't say, "You'd better take these anyway." The pendulum goes back and forth regarding the efficacy of
antiretrovirals. Two or three years ago, people were generally against antiretrovirals because of the Concorde study, and now they're pro-antiviral therapy because of protease inhibitors and various combinations that seem to be reducing viral load. So the pendulum's probably going to swing someplace else in a couple of years, depending on what the technology is.

Social Services

Hughes: Where do social services fit in?

Campbell: Well, certainly for somebody who has just taken an antibody test and found out that they're positive, I emphasize the importance of being in a group in which they can talk to other people who are seropositive, through some seropositive groups in the city, or through AIDS Health Project, and make sure that they're becoming adapted psychologically. Social service comes in at a time of retirement. That's another step. Another step is when activities of daily living become difficult, and somebody has to come into the house to help out.

Hughes: You consider part of your responsibility to link patients with these services?

Campbell: Yes. And very frequently, the hospital social worker will be helpful for people who need help at home. People need benefits counseling when they are trying to decide whether to retire or not. I think several steps are identifiable as social crises: the antibody test, coming out to an employer or whatever, or retiring, the diminished activities of daily living, and finally the dying process.

Hughes: I read that case management in San Francisco was not formalized nor centralized until 1986. Is that your experience?

Campbell: You mean how long people should stay in the hospitals?

Hughes: Yes, but also coordination of hospital discharge and community social services.

Campbell: I don't know if it occurred at any specific time, but it just seems like over the years, there has slowly been a movement away from the hospitals, with more and more things done by home infusion services and visiting nurses.
AIDS Admissions at San Francisco Hospitals

Hughes: Where do you admit patients?

Campbell: The California Pacific Medical Center [PMC], and some at St. Francis [Memorial Hospital]. The bulk at California Pacific.

Hughes: What was the attitude of San Francisco hospitals towards taking on AIDS patients? Were there hospitals that were receptive and others that were not?

Campbell: In my experience, they've all been very receptive. I don't know if that's the general rule outside of the Bay Area. It just happened that the hospitals I was dealing with were--PMC was very good, and so was St. Francis, and I think I had a couple of patients at Ralph K. Davies [Medical Center] and a couple at UC Moffitt [Hospital]. All were very geared up for it. It was no hardship. The availability of consults was always excellent. I always felt that we were very much supported by everybody in the medical community in San Francisco.

Hughes: When did you refer patients to UC?

Campbell: The first couple of AIDS patients that I had in 1982-1983 went to UC. I put them in UC because it seemed like they might have known a little bit more about it at that point. The housestaff was very much aware of what to do.

Hughes: But then it began to even out, from what you're saying. Other hospitals became adept as well?

Campbell: Oh, yes.

Hughes: Do I conclude that there isn't just one AIDS hospital in San Francisco; there are many places with AIDS services?

Campbell: Oh, yes.

Hughes: I'm talking about the early days.

Campbell: I think early on, they were all very aware of AIDS. There were no hospitals that I would single out as places never to send somebody.
The Bathhouse Crisis

BAPHR's Role

Hughes: Well, you told me last time that you wanted to talk about the bathhouse issue.

Campbell: Oh, yes.

Hughes: According to a The BAPHRON editorial in 1984, Silverman, who of course was director of public health at that time, requested community leadership by BAPHR in the bathhouse crisis. Why did he turn to BAPHR?

Campbell: In 1984, we were really considered to be the experts about AIDS transmission. We had published the guidelines, and we were seeing people with AIDS, and we had a knowledge of gay lifestyle. And so he consulted BAPHR as sort of a panel of experts.

Hughes: He also consulted academics at UCSF and San Francisco General, because some of those people sat on his AIDS advisory committee, as did people from BAPHR. But from that statement, it sounded as though he prioritized advice from BAPHR. Is that how it felt at the time?

Campbell: Yes, but I think he was going to the academic people too.

Hughes: In July of 1984, Will Warner wrote to Silverman on behalf of BAPHR's AIDS Resource Group.¹ Now, is that the same thing as the Scientific Committee?

Campbell: I don't know what the AIDS Resource Group would be. About that time, there were between twelve and twenty people in BAPHR who were either BAPHR officers or chairs of committees that took a vote on that issue.

Hughes: Warner said, "BAPHR stands ready to assist the [health] Department in transferring the main issue of safe sex and role of the bath houses back to the gay community, if that is indeed

¹ W.L. Warner to Mervyn Silverman, July 25, 1984. (Dean Echenberg papers, San Francisco Department of Public Health, Bureau of Epidemiology and Communicable Disease Control, drawer: Bathhouses, folder: 10-10-84 Declarations in Support, vol. 1.)
possible. We can reactivate our dormant program that was being developed several months ago for working with bath house owners. We also have some ideas for setting up a monitoring system with the assistance of other non-medical gay organizations." In July 1984, the bathhouses were still open. They were not closed until October.

Campbell: That's correct.

Hughes: Do you remember this period?

Campbell: Yes.

Hughes: What was behind this statement?

Campbell: I think the bathhouses had posted guidelines, but they might not have been everywhere where one could see them. They did have supplies of condoms. I know that by then, they had to have those two features.

Stances on Bathhouse Closure

Campbell: It was my feeling, and the feeling of many members in BAPHR, that the bathhouses could stay open as long as there was some sort of monitoring system in place to make people extremely aware of everything that they were doing, and precisely how they could transmit AIDS, or how they could contract the virus. That was the general recommendation of BAPHR at that point, which I think is reflected in that editorial.

And then three months later, the bathhouses closed, I think due to political pressures. The academic people at UC--Marcus Conant and Don Abrams--were very much for having the bathhouses closed.

Hughes: Why did they have a different opinion from BAPHR? They were also physicians.

Campbell: I don't know. I don't know if they were active in BAPHR then.

Hughes: They are gay physicians, and they were both seeing AIDS patients. Why did they take a different stand?
Campbell: I don't know if they were persuaded into the stand, or if it was their own personal conviction. It seemed like the BAPHR officers were uniquely for keeping the bathhouses open. Our reasoning was that if one is standing around nude in the steam, it's not going to transmit HIV. The big issue was specific behavior rather than specific location of behavior. What our stand was all along was that the place of meeting a person was not so relevant as what specific sexual behavior took place in that meeting place. And that's why we continued to say that it wasn't the bathhouses that were causing AIDS; it was specific types of sexual behavior. Many people felt that there was a lot of unsafe sex happening in the bathhouses. Our feeling was the unsafe sex didn't have to happen in a bathhouse with proper education and monitoring.

Hughes: How much did the fact that the bathhouses are symbolic of gay liberation influence your conclusion that the baths should stay open as long as there is an adequate monitoring system? Or said it a different way: what if the locale were not the baths but the San Francisco Zoo? Do you think BAPHR's stand would have been different?

Campbell: You mean people go to the zoo to meet each other for--

Hughes: [laughs] Well, no, it's preposterous. What I'm trying to get at is: the bathhouses I understand to have been taken as symbolic of the strides that the gay community had made in terms of its own freedoms.

Campbell: Yes.

Hughes: And a government authority was threatening to shut them down. BAPHR was striving to make a decision based on medical and scientific grounds. On the other hand, you are gay men; you're a part of the gay community.

Campbell: The bathhouse represented a civil liberty unique to the gay community. It was an arena in which people could meet and become erotic without a lot of social barriers. Attendance at the bathhouses did not necessarily equate with viral transmission. In a utopian situation, the bathhouses could exist, they could be erotic, people could meet, and there would be no virus transmission because everybody was highly aware,

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1 See the oral histories with Marcus A. Conant, M.D., and Donald I. Abrams, M.D. in the AIDS physicians series.
and doing everything absolutely safely, because they knew that they were in a place that could be very unsafe.

Maybe the city officials, or whoever, concluded that the bathhouses should be closed, because although one is supposed to behave in a certain way in the bathhouses, many people were irresponsible. So they decided the bathhouses should be shut down because certain people were behaving irresponsibly. And they said because the bathhouse gives one the license to have sex with many different partners in a short period of time, if some of these encounters are unsafe, that equates with viral transmission to many individuals.

However, that's going on the presumption that people who go to the bathhouses have unsafe sex. Whereas I think that BAPHR's idea was a little bit more utopian: people will go to the bathhouses and meet, but be highly aware and have very safe sex. I think even Will Warner made a comment that, they will probably have safer sex, because they are in a place where one really has to have his armor on. One would assume that in a bathhouse situation one would be more careful since other clients would seem to be at high risk of HIV transmission, as opposed to a person that one might have known for many months, or years, and was seemingly monogamous.

Hughes: An aspect of the safe-sex guidelines was, Get to know your partner, meaning, Get to know a bit about his sexual lifestyle. So it's almost the opposite argument, isn't it?

Campbell: Yes.

It was people who were saying things like, "Get to know your partner," that made me feel like I needed to take a proactive stance on AIDS risk reduction guidelines, because I felt that that advice could be very misleading. It sounded like a good thing to do, but it's not necessarily the only thing to do to be sure that you're preventing viral transmission. If you don't even know whether you yourself have the virus, how would you know that somebody that you met had it?

Hughes: Did BAPHR have contact with the bathhouse owners?

Campbell: There may have been. I wasn't involved with it. I know we had a couple of town meetings in which bathhouse owners attended, and BAPHR was there, and we discussed the issue. I think the bathhouse owners were certainly not very anxious to do a whole lot to post many signs, or make everything very light and visible.
Hughes: Because they'd lose business.
Campbell: Yes.
Hughes: Were the meetings hostile?
Campbell: Some of them were a little hostile.

Paul Lorch's "Traitors' List"

Hughes: Well, in April of 1984, before the baths closed, but as a result of, or at least encouraged by, the bathhouse crisis, Paul Lorch listed sixteen people who supported bathhouse closure on a so-called "traitors' list".¹

Campbell: That was probably about the time we had one of our town meetings. I have to think who Paul Lorch was--

Hughes: He was an editor at the Bay Area Reporter. The traitors' list underlines the divisions in the gay community, because many, if not all, of those sixteen were members of the gay community.

Campbell: Weren't Marcus Conant and Don Abrams on that list?
Hughes: Conant, yes. I don't know about Abrams.

Robert K. Bolan

Hughes: Bolan thought the baths should be closed?
Campbell: I think so. But don't quote me! You'd better get it directly from him. His views weren't clear to me.

Hughes: I think there's no doubt that he endorsed closure of the baths. For a time, he seemed to serve as BAPHR's spokesperson.

Campbell: He was president-elect for a while, but for less than a year. He resigned, because he was president of the San Francisco AIDS Foundation [1983-1986]. The bathhouse issue really escalated, and it was clear that his opinion was probably not the same as most people in the leadership of BAPHR.

Hughes: Your perception is that he resigned because his opinion did not coincide with that of the majority of BAPHR membership?

Campbell: That may have had something to do with it, or maybe he was just doing too much already.

Hughes: Do you remember it causing dissention within BAPHR that the president-elect supported bathhouse closure?

Campbell: I just remember that in some vote that we took, and I think it had to do with the baths, that he was the dissenting vote. It seemed that thereafter he was not quite so active in BAPHR. But he continued to be in BAPHR. You'd better ask him for the specific details.

Turbulence within BAPHR, 1984-1985

Hughes: There's a period when BAPHR seems to question its goals. There is an editorial, for example, written in June of 1984 during the bathhouse crisis, which referred to "...two months of turbulence within and without" BAPHR. And then in February of '85, BAPHR held a forum called "Community in Crisis: What is BAPHR's Role?", and you were one of the speakers. It seemed to be an attempt by the membership to decide if it wanted to play a political role, and if it did, in what areas did it want to play a role. Do you remember?

Campbell: Yes. I think that was a meeting of the general membership of BAPHR. I don't think it was open to the public. That was a rather difficult meeting, as I recall.

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1 Bolan was president-elect of BAPHR [1983-1984], but never president. On April 19, 1984, he resigned as president-elect of BAPHR. (Bolan to Kent Sack, M.D., April 19, 1984. The BAPHRON, vol.6, #7, July 1984, 271.) For the stresses and strains of these years, see the oral history with Robert K. Bolan, M.D. in this series.

Hughes: "The meeting was a direct outgrowth of the perception that the membership was restive because of recent public actions taken by BAPHR leaders." That quote comes from an article in The BAPHRON about the meeting that had taken place the previous month.\(^1\) The article went on, "The guidelines for safe sexual practices, a 'position paper' on the bathhouses, and recent public recommendations about HTLV antibody testing have thrust BAPHR into the public arena." What the article implies but doesn't state is that BAPHR's political stance caused some unrest within BAPHR itself. Some of the membership questioned whether taking a political stance was an appropriate role for BAPHR.

Campbell: Yes. I think probably Denny McShane was one of the chief spokespersons. He probably replaced Bob Bolan as president-elect, and Denny McShane was very much in the other direction from Bob Bolan.

Stances on the AIDS Antibody Testing

Hughes: Meaning what?

Campbell: Well, Denny McShane was very concerned about any political people taking away the liberties of people who were gay. And with HTLV-III testing, he took a very firm stance that if that test was to be done, it had to be extremely secret, or maybe not done at all.

Campbell: At that forum, I probably came out and said that the test could be quite helpful. I think I registered some concern about the fact that safe-sex guidelines needed to be awfully strict. I felt that I left that meeting rather unpopular.

Hughes: In June of '86, you participated in a program on the antibody test in which you discussed its clinical applications, highlighting the "exceptional" situations in which the test was useful for gay men.\(^2\)

Campbell: I know we'd had a series of Scientific Affairs Committee meetings on who should be tested and who should not be tested.

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\(^1\) Ibid.

\(^2\) "BAPHR co-sponsors meetings," The BAPHRON, vol.8, 34, July/August 1986, 347.
Hughes: That was still before AZT, and we were still probably not recommending the test for everybody.

Well, a year earlier the Executive Board recommended against antibody testing except for "certain special circumstances", which the minutes didn't detail.¹

Campbell: Yes. And I think almost every gay publication in 1985 came out, like the New York Native came out, with things like, "Don't take the test." There was really a strong movement against the test until AZT was available. When AZT became more broadly available in the spring of 1987, gay men were encouraged to be tested.

The Epidemic's Professional and Personal Impact

Hughes: You've been involved in the epidemic since the start. What impact has it had on you as a physician and also as an individual.

Campbell: As a physician, certainly I have gone from a fairly low-key practice to a very busy practice, which has continued to be very busy since the epidemic.

Seeing so many people with AIDS and with tragedy in their lives, what happened is that while being here in the office and just going through the intellectual steps of what to do for such people, I have become rather detached from them emotionally. I've never had AIDS right in my home, and I have never lived with anybody, or was extremely emotionally involved with anybody, who had AIDS. I've had friends who have had AIDS, and I have been their physician, but I wasn't their primary "hands-on" caregiver, which I think is far more difficult.

I love to see plays or movies or pieces of art that have to do with the AIDS epidemic, like the quilts and the play Early Frost. Some of these things that have come out are very, very important for me to see, because I can sit back and be a spectator and become emotionally involved. I don't have to play my role as doctor, and I can sit back and cry about things.

We had a little support group for people who are HIV caregivers five or six years ago. My main problem was that I was feeling just intellectually and physically exhausted. There were a couple of other doctors in the group who would break down in tears because of all of the things that they'd seen that day. They were having a very hard time holding themselves together with the death of their patients; they became visibly emotionally involved. One of them spent extra time in the evening at the skilled nursing facility massaging patients. This had become the main thing in her life.

I always continued to do many things outside the office, and I had hobbies that didn't have anything to do with medicine. I remained committed to these hobbies. I continue to be determined not to take the work home with me. I guess that's been my way of getting through it, but then it is wonderful when somebody does present an art form [about] which I can feel very emotional. But there is really no permission to get emotionally involved when you're seeing twenty patients a day in the office.

Hughes: That distancing came naturally?

Campbell: I suspect for somebody who had just started practicing medicine in the throes of the AIDS epidemic, it might be pretty hard to take. I'd been practicing for ten or fifteen years at the time of the AIDS epidemic and been through internships at San Francisco General. I became inured to seeing all this tragedy and continue to think about it in a scientific way. It's just something that I have had to do for survival. I'm not saying it's a very good thing to do, but I think I have to do it to get the work done. But I always thought that I'd like to have the luxury of becoming emotionally involved.

Hughes: Do you have anything else to add?

Campbell: No, I don't think so. I certainly like the work that you're doing, and you're asking such wonderful questions. You must have done a lot of research.

Hughes: Thank you very much.
THE AIDS EPIDEMIC IN SAN FRANCISCO: THE RESPONSE OF COMMUNITY PHYSICIANS
1981-1984
VOLUME I

James R. Groundwater, M.D.

DERMATOLOGIST TREATING THE FIRST KAPOSI'S SARCOMA PATIENT DIAGNOSED IN
SAN FRANCISCO

An Interview Conducted by
Sally Smith Hughes, Ph.D.
in 1996

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Dr. Groundwater's Current Practice 165
James Groundwater, a dermatologist with a private practice in San Francisco, was interviewed for the AIDS oral history series because he treated the first person in San Francisco to be diagnosed with Kaposi's sarcoma, a cancer now known to be associated with AIDS. It was November 1980, approximately six months before the first cases of the new syndrome were officially reported. The patient, whom Randy Shilts later identified in And The Band Played On as Ken Horne, consulted him about a two-year period of ill health and the appearance of two purple skin lesions on his chest and leg. Groundwater was puzzled by the symptoms and sent biopsy material to several pathologists in town. After a few misdiagnoses, Richard Sagebiel, a UCSF pathologist, in April finally made what proved to be the correct diagnosis: Kaposi's sarcoma, a cancer heretofore found mainly in immunocompromised patients or elderly Jewish men from the Mediterranean region. Groundwater was understandably puzzled by the appearance of the lesions in a young man who did not fall into either of these categories.

Troubled and curious about his patient's complaints, Groundwater tells in the oral history of attending a conference at UCSF shortly after Horne's diagnosis and a few months before the first AIDS cases were officially reported by the Centers for Disease Control (although not yet identified as "AIDS"). He learned from a conversation at the conference with the dermatologist Marcus Conant that similar cases were being seen in New York City, likewise in homosexual men. (The reader may wish to compare Conant's version of this episode related in his oral history, also in the Bancroft Library AIDS series.)

In the interview, Groundwater describes following Horne who was ravaged by one opportunistic infection after another and ultimately died in November 1981, half a year after diagnosis. Although Groundwater tells the story in matter-of-fact manner, the experience must have been profound. Not only was he a dermatologist and hence unaccustomed to treating patients with fatal conditions, but he also had to deal with a difficult patient who was persistently angry that modern medicine could not explain his litany of ailments nor, more importantly, administer a cure. As a result, Horne died in distress, blinded and demented by the infections which Groundwater and the expanding number of medical consultants had no adequate means to control. Thus Groundwater's story, limited though it be largely to this one episode, not only describes the early recognition of a cancer symptomatic of AIDS but also provides a glimpse of the horror of the disease--for patient and a physician--at a time when the syndrome was an enigma, adequate treatment unavailable, and death often sudden and agonizing.
The Oral History Process

One short interview was conducted with Dr. Groundwater on July 24, 1996 in his office at 450 Sutter in downtown San Francisco. The interview, scheduled at lunchtime between patient appointments, was brief because the significance of Groundwater's role in the AIDS epidemic, although he continues to see occasional patients with HIV disease, is largely limited to the episode with Ken Horne. Groundwater lightly edited the transcript and returned it after a little prompting. The interview provides insight into a celebrated case in the earliest phase of AIDS in San Francisco and complements what Marcus Conant, Donald Abrams, Paul Volberding, and other physicians have described in this series about the condition of and caring for AIDS patients at this time.

The Regional Oral History Office was established in 1954 to augment through tape-recorded memoirs the Library's materials on the history of California and the West. Copies of all interviews are available for research use in The Bancroft Library and in the UCLA Department of Special Collections. The office is under the direction of Willa K. Baum, Division Head, and the administrative direction of Charles B. Faulhaber, James D. Hart Director of The Bancroft Library, University of California, Berkeley.

Sally Smith Hughes, Ph.D
Research Historian and Principal Editor

January 2000
Regional Oral History Office
The Bancroft Library
University of California, Berkeley
BIOGRAPHICAL INFORMATION

(Please write clearly. Use black ink.)

Your full name: James Richard Groundwater
Date of birth: April 9, 1937
Birthplace: Cleveland, Ohio
Father's full name: John Livingston Groundwater
Occupation: Supervisor, East Ohio Gas
Birthplace: Cleveland, Ohio
Mother's full name: (omitted for security reasons)
Occupation: Teacher of retarded children
Birthplace: Indianapolis, Ind.
Spouse: Lorna
Occupation: Housewife
Birthplace: Oakland, Ca
Children: Andrew 13, Katherine 11

Where did you grow up? Caldwell, Ohio
Present community: Hillsborough, Ca
Education: Lakeview High, Dartmouth College, Case Western Reserve University, Kaiser Hospital, SF
U. C. S. F., San Francisco
Occupation(s): Dermatologist in private practice
Areas of expertise: HIV dermatology, allergic contact dermatitis, cosmetic dermatology

Other interests or activities: my kids, sports, and music activities, local cultural activities

Organizations in which you are active: Assistant Clinical Professor Department of Dermatology, UCSF, Stanford Health Care: Advisory Board, Dept of Dermatology, UCSF-San Francisco
INTERVIEW WITH JAMES R. GROUNDWATER, M.D.

I DR. GROUNDWATER'S EARLY EDUCATION AND EXPERIENCE

[Interview 1: July 24, 1996]
[San Francisco, California]

Education

Hughes: Dr. Groundwater, would you give me a thumbnail sketch of where you were born and educated?

Groundwater: I was born in Cleveland, Ohio, April 9, 1937. Grew up in Lakewood, Ohio, which is a suburb of Cleveland. Went through the Lakewood schools through Lakewood High School, and then went on to Dartmouth [A.B. 1959]. There I majored in medical science and went on to Case Western Reserve and received an M.D. [1964].

Subsequently I came to San Francisco, did my internship at the Kaiser Foundation Hospital in San Francisco [1965-1966].

Hughes: How did that come to be?

Groundwater: Well, I was getting a divorce at that time. In Cleveland, I had been married to a medical student, and she apparently had schizophrenia. I wanted a complete change, and I'd heard that San Francisco was an interesting place to have a complete change. So I came out here and did my internship here. I had a rotating internship at Kaiser, so I gained experience with all the fields of medicine.
Military Service, 1965-1967

Groundwater: Then I went into the navy; that was in the Vietnam era. I was on a troop carrier that took marines from San Diego and also Korean troops from Korea to Vietnam. We were stationed briefly in Danang. The first year, I just did general medicine. Appendectomies, setting fractures, and so forth.

The second year, I was stationed in Newport, Rhode Island. That second year, I spent quite a lot of time tagging along after the navy dermatologist, Bruce Burgess, who's now in Fort Lauderdale. Worked in his clinic with him, and also in the general clinic in Newport. I had a couple weeks with the frogmen school. [laughs] During that year I decided that I was most interested in treating skin disease. So I inquired into residencies.

Residency at the University of California, San Francisco [UCSF], 1967-1970

Groundwater: I came back here to San Francisco, did my residency in dermatology at the University of California, San Francisco. Marcus Conant[^1] was the chief of clinic, actually, at least initially, and then, I think, Dave Cram became the chief subsequently.

Hughes: What year was this?

Groundwater: Let's see.


Groundwater: Yes, right.

Anyway, I rotated through several different hospitals, the U.S. Public Health Hospital, San Francisco General Hospital, Moffitt Hospital, UCSF. At the U.S. Public Health Hospital I worked with Axel Hokl and Paul Fasal, where we managed a lot of leprosy patients. That was a good

experience in public health. [tape interruption]

At UCSF, Marc Conant, as I said, was chief of the clinic, and so I had a good relationship with Marc and with Howard Maibach. I later taught in the Environmental Dermatitis Clinic at UCSF with Howard for ten years. I spent several months working in Rees B. Rees's office in the third year, which was in this building [450 Sutter Street, San Francisco].

**Private Practice, 1970-present**

Groundwater: And then I opened up private practice; I hung out a shingle in this building as soon as I finished the residency, 1970. And I've been here ever since. I was in a smaller office for about five years, and then moved to this office. Then we took over a dental office next door, and we have another little office down the hall that we use for a lunch room and storage of charts. But I've been in this building for a long time.
II ENCOUNTERING THE AIDS EPIDEMIC

First Patient in San Francisco Diagnosed with Kaposi's Sarcoma

Hughes: When did you first encounter a patient with what we now know to be HIV disease?

Groundwater: I think it was the fall of 1980.\(^1\) 1981 was the--

Hughes: 1981 was when the epidemic was recognized.

Groundwater: Right. So it was in 1980, I think, probably about September, October. The patient was a guy who worked for BART [Bay Area Rapid Transit], and he had retired because he was fatigued, and he was just too weak to work. Seeing him at that time, he was thin, but didn't look terribly ill. He had a few little purple lesions on his skin at that point. I have pictures of him; I probably should have pulled some of those pictures out. Maybe I could find them.

Lesions and Multiple Biopsies

Groundwater: Anyway, he had probably five or six two- or three-millimeter purple bumps on his skin, and he also had enlarged lymph nodes on the right side. I remember the primary physician, Richard Hamilton, who referred him had noticed these nodes and had biopsied the nodes. The biopsy report indicated hyperplasia without any specific diagnosis. I biopsied one

Hughes: Why did you think that?

Groundwater: They just didn't look like anything benign that I knew of. They didn't look like just angiomas, for example, that so many people get; cherry angiomas that sometimes can look really purplish. These lesions were somewhat poorly defined, and they just had the look of malignancy to me. So I suspected from the beginning there was something serious going on, certainly with these nodes, as well as the purple bumps.

The primary physician kind of pooh-poohed it; he didn't think it was terribly serious. He thought it was a viral sort of thing or something like that. And the lymph node biopsy showed only hyperplasia.

So I sent the biopsy of a purple bump off to a pathologist [Herman Pinkees?] who read it as an angioma, really of no significance. But I felt that it couldn't be just an angioma.

So I started sending the biopsy specimen around to different pathologists. I think one of them read it as systemic angioendotheliotheliomatosis, which is just a benign entity, a proliferation of blood vessels, in a slightly different way. I sent some of the lymph nodes around too, and kept getting back pathology reports of benign hyperplasia.

Kaposi's Sarcoma Diagnosis

Groundwater: But finally, I think it was Dick Sagebiel, a dermatopathologist over in the melanoma clinic at Mt. Zion, who was the first one who made the diagnosis of Kaposi's sarcoma [KS] on these lesions.¹ We sent it to Bernard Ackerman in New York also, who confirmed the diagnosis of Kaposi's sarcoma.

Hughes: Had you ever seen a case of--

¹ The diagnosis was received by Groundwater on April 9, 1981. (Shilts, p. 60.)
I had never seen a case of Kaposi's sarcoma, but I'd read about it in the medical literature. It typically occurred in Jewish Mediterranean-born men, and typically they had it on their legs, and they were treated with x-ray, and the lesions would clear. Rarely, it would go on to internal lymphoma, and when patients did develop lymphoma internally, for the most part, they didn't die of the disease. It was just part of their life, but it wasn't fatal to them.

**Initial Management of the Patient**

So we had this young gay male who had these purple bumps that had finally been diagnosed as Kaposi's sarcoma. And he had adenopathy in his armpit, and ultimately we were able to confirm a diagnosis of Kaposi's sarcoma of the lymph nodes, too.

Initially, I had sent the patient to an oncologist, Kathleen Clark, to evaluate him, because of the swollen lymph nodes, and the oncologist was unable to make a specific diagnosis. She felt that the lymph nodes were benign hyperplasia, and that there was nothing serious going on with him.

So, I had this man who had these purple bumps that had been diagnosed as Kaposi's sarcoma, and was experiencing fatigue, and that was about it. Maybe at that point he looked a bit--well, he was thin. I guess he did look a bit ill. Not markedly so, but some hyperpigmentation, as I recall.

**Discussing the Case with Marcus Conant at Grand Rounds, UCSF, 1981**

I remember going to a lecture that Marc Conant gave at UC on cytomegalovirus [April 23, 1981]. He pointed out that in Africa, cytomegalovirus had a possible association with Kaposi's sarcoma. So I went up and talked to him afterwards, and I told him, "Marc, I have a young gay male with Kaposi's sarcoma."

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1 Shilts, p. 65.
Among all the various tests that we did on this guy to try to figure out what was going on with him, I had done cytomegalovirus antibodies, and they were positive. Because here we had this man who was fatigued and couldn't work, and we didn't know why. Why did this young gay male have Kaposi's sarcoma, and why were these little purplish bumps on his chest and not on his legs? They were usually found on the legs of elderly Jewish Mediterranean males. Perhaps cytomegalovirus was related, we thought.

Marc said that he knew that Alvin Friedman-Kien in New York had some cases of Kaposi's sarcoma in young gay males. So I called Alvin Friedman-Kien, and Marc had just talked with Alvin the day before or something like that. At that point, Alvin had, I think, six, seven, or eight cases of these young gay males with Kaposi's sarcoma. So we ended up publishing those cases. Friedman-Kien included my case in the paper that he published on the young gay males with Kaposi's sarcoma.¹

Hughes: Let me ask you more about this encounter with Conant, because the way he tells it, and the way it's depicted in Randy Shilts' book, is that you were at dermatology grand rounds at UCSF. Conant had talked with Alvin Friedman-Kien the night before, and he asked the group at UCSF whether anybody had seen a similar case. You raised your hand. You were the only one in the audience that said yes, you had, and it was this same patient that you've been talking about to me.²

Groundwater: I didn't recall him specifically asking the question. I remember going up to him afterwards; but maybe he did, I don't know. It's possible.

Hughes: And that was--?

Groundwater: No, I really don't remember that. I remember asking him, and then his telling me that Alvin had these cases.

Hughes: So was [Conant] giving grand rounds?

Groundwater: Oh, he was giving the lecture, yes. Maybe it was grand rounds. It probably was, yes; the same eight o'clock


² Shilts, p. 65.
lectures that I went to just this morning, that we have every Wednesday that I continue to go to over the years. We have a meeting between eight and ten where we have a lecture first, and then we present difficult patients and discuss them afterwards.

Hughes: So from the way you remember it, then, you initiated the discussion of--

Groundwater: That's the way I recall it, yes.

Hughes: And you don't remember him bringing up--

Groundwater: I just went up to him afterwards.

Hughes: You don't remember him bringing up in the course of his lecture anything about the cases that Alvin Friedman-Kien had been seeing?

Groundwater: I don't think so. I really came up afterwards and--he was just talking about cytomegalovirus and KS.

The CDC Reports, Summer, 1981


Groundwater: The first report was on the Pneumocystis pneumonia.

Hughes: That's right. That was the month before.¹

Groundwater: The fellow down in L.A.

Hughes: Michael Gottlieb reported the cases.

More on Case Management Issues

Hughes: But did you know about the PCP [Pneumocystis carinii pneumonia] report at the time?

Groundwater: Yes, oh, yes, of course.

Hughes: Why would you have been interested?

Groundwater: Well, our patient had begun to develop some of these opportunistic infections. I'm not sure when they started; I think it was probably back in 1980. The first thing he got was cryptococcal meningitis. He had headaches, and that made it so difficult for him, and for us to deal with him. He developed one after another of these opportunistic infections, and we didn't know what was going on at that point as to why he was developing them. Apparently, he was immunocompromised, because he was developing these infections.

Hughes: What kind of tests were you ordering?

Groundwater: We'd done T-cell helper-suppressor ratios, and his T-helpers-suppressors ratio was diminished. His blood counts showed decreased lymphocytes.

Hughes: And that was an unusual test for you to order, was it not?

Groundwater: Yes.

Hughes: It was pretty unusual, period. I mean, as I understand it, that test was new overall, but I'm thinking particularly for you as a dermatologist, that wouldn't be in your normal armamentarium would it?

Groundwater: No, not really. But he was developing these opportunistic infections, and we were looking for something that could explain it. He was immunocompromised in some way. So as I said, the cryptococcal meningitis came along and we treated that.

Hughes: And who--

Groundwater: Who was the man who did that? Dr. John Gullett. He's a man you probably should talk with, because John Gullett, although I don't think he is mentioned in Randy Shilts' book, played a major role in the management of this case, if not a more significant role than I did, really. In Randy's book, it looks like I'm admitting the patient again and again, when it was really John who was admitting him.¹ Randy didn't get it entirely accurate in terms of how that

¹ The patient was first admitted to St. Francis Hospital, San Francisco, on March 30, 1981. (Shilts, p. 59)
was done. I'm not a primary physician; I'm a dermatologist, and so I'm not going to be personally admitting him for Pneumocystis pneumonia or cryptococcal meningitis, or the cytomegalovirus retinitis, which he ultimately developed, and which really gave him—which lost the battle for him, I felt.

We followed him for over a year before he finally died, and he was a really angry sort of guy. He was angry at us because we couldn't find out what the heck was going on with him. Although he had to quit work because of fatigue, he was determined to find out what was going on and determined to survive, to get through all these things. And he went through one horrendous experience after another with these various opportunistic infections.

But I think when he began to lose his vision with the cytomegalovirus issue, he gave up the battle. When he went blind, he died within a couple of weeks. I think he gave up. He had given a hard time to all of his doctors; he was a tough patient.

Difficulties in Reaching a Diagnosis of KS

Hughes: You said that Sagebiel made the diagnosis of KS. Why had the others not been able to do that?

Groundwater: Well, I think because it was such a rare disease, and it's such a subtle diagnosis. Even today, pathologists who have not been used to reading KS in the AIDS patients will make a misdiagnosis. I can think of a case recently where a biopsy specimen was read as Kaposi's sarcoma and then we took it over to the UCSF pathologist Dick Sagebiel. The general pathologist had initially read this man's lesions as Kaposi's sarcoma, but it turned out that the UCSF pathologist diagnosed it to be eosinophilic folliculitis, something totally unrelated. But this general pathologist, you know, had heard about all the KS in the AIDS epidemic, but hadn't heard about eosinophilic folliculitis, which is another thing we see. So he just totally misread it, and as a result the primary physician treated him with x-rays for his supposed Kaposi's.

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1 For more on the response of this patient (Ken Horne) to illness and hospitalization, see Shilts, pp. 47-48, 59-60, 77-78, and 99-100.
That's the kind of thing that even today happens, particularly if a general pathologist rather than a skin pathologist reads it. They will not uncommonly mistake the diagnosis. In the early days of the AIDS epidemic, very few dermatologists, dermatopathologists even, had seen much Kaposi's sarcoma. This was very rare. And so they missed the diagnosis. They read it as hemangioma and proliferating angioendotheliomatosis, et cetera.

And so finally, we got the KS diagnosis confirmed by Bernard Ackerman and Dick Sagebiel. Sagabiel was chief of the dermatopathology department at that time at UCSF (later he became the Chief of the Melanoma Clinic at UCSF/Mt. Zion), and I'm not quite sure why we didn't send it to Dick right away.

Anyway, I ultimately got the slides to Bernie Ackerman, who was the dermatopathologist for NYU [New York University], where Alvin Friedman-Kien works, and he had made the diagnosis on some of those other cases that Alvin had seen.

Hughes: You need a pathologist to be sure of a KS diagnosis? I mean, it's not something you can diagnose visually?

Groundwater: Yes, these days people are so used to seeing Kaposi's sarcoma—although I feel that it always should be biopsy proven. Many times the primary physicians diagnose it by sight and without the biopsy, because it's pretty obvious now when you see a young gay male with a purple bump or several purple bumps, that it's probably KS. But the problem is that there are some other conditions that can simulate KS, bacillary angiomatosis, for example. That condition can be missed, and can be fatal ultimately, unless it's treated with antibiotics.

Hughes: Well, according to Shilts, this did go on for a while, because you apparently saw this patient first in November of 1980, and it wasn't until April 9, 1981, that you received the diagnosis of KS.¹

Groundwater: That's right. It went on for a long time, and I don't know how many pathologists I sent the biopsy to, probably eight or ten, before we finally got the correct diagnosis. And here we had this sick guy who had to quit work because of fatigue, and had these purple bumps that just had to be

something more than an hemangioma or some benign condition. We kept getting these benign diagnoses back from the pathologists. The same with the lymph nodes. The lymph nodes had persisted.

Hughes: And was he getting more KS as well, more outbreaks of the lesions?

Groundwater: Ultimately, he continued to get more KS lesions. He developed them around his mouth. I have some pictures—I might be able to pull those pictures out if you're interested.

Hughes: Yes, I'd like to see them.

KS Cases at Stanford

Hughes: Also reported by Shilts was the fact that there was a second case of KS, at Stanford, apparently also mentioned at that meeting, whether it was grand rounds or whatever it was, at UCSF. Do you remember that?

Groundwater: I definitely don't remember that being mentioned at Marc Conant's grand rounds. That came along later. Maybe Marc recalls something about that, but I don't remember anything about that early on.

Hughes: The Stanford patient was the editor of one of the gay publications. I would have thought that if that case had been mentioned at the same time, you or Conant or somebody would have gotten in touch with the doctor who saw that case.

Groundwater: I don't remember that. One Stanford connection I remember is that there was a Stanford pathologist who later, in around 1983, sent me a whole series of slides of KS involving almost every internal organ, which I used in some lectures subsequently. And he himself died of KS ultimately.
Pamphlet Distributed at the American Academy of Dermatology Meeting, San Francisco, December, 1981

Groundwater: Marc Conant and I and Friedman-Kien made up a little pamphlet--I wonder if I can figure out when. I may be able to find it.

Hughes: I know when that was. That was December, 1981.

Groundwater: Oh, it was 1981. Yes, I lose track. Did Marc have that pamphlet?

Hughes: Yes, he did have a copy of it.

##

Groundwater: The pamphlet was prepared for the annual meeting of the American Academy of Dermatology in 1981. At that point in time, not many people knew about this problem, and it wasn't getting a whole lot of attention. I don't think the seriousness of it was widely appreciated--the potential for major problems in the future. I gave a lecture to an organization in the city, Bay Area Physicians for Human Rights [BAPHR], on this subject at that point, sort of raised the awareness of it. I felt at that time that KS was going to be significant. As the year progressed I learned even more about this; it really looked like it was going to be a serious problem and very few people were aware of it. So I think I got the idea just before the Academy of Dermatology meeting to come up with this pamphlet, because there was not time to get something published before the meeting. I talked it over with Marc--I don't know whether he proposed it or I did; I think I did--and we decided.

We talked to Alvin, and we got together with a graphic artist that Marc worked with. Who actually wrote the copy on the thing? I think I did. And Craig Johansen edited it. We used the pictures from my case, and I think there's one where my patient had these KS lesions around his teeth. (And that was a problem for him, too; he would eat and kept bleeding.)

Marc and I, and I guess Friedman-Kien, distributed those pamphlets at that meeting. We stood at the front of the convention hall and passed them out to various people.

Hughes: And how did people react?
Groundwater: I don't think they were terribly interested. I mean, it was hard to tell, because I don't think that any of us spoke at the meeting. Alvin, of course, and Marc have since then done a lot of speaking on the subject at various meetings. Did Marc speak on the subject at that meeting?

Hughes: Not that I heard about.

Groundwater: I mean, the awareness of the significance of this was just coming up too quickly to really prepare much in advance. The brochure was one way to do something on the spur of the moment.

Hughes: Do you remember who paid for it?

Groundwater: I think one of the drug companies. I think Marc had some drug company--Neutrogena, maybe.

Hughes: Yes, I think you're right.

Groundwater: I don't think we made a heck of a lot of these brochures.

Hughes: Some were sent on to Alvin Friedman-Kien and other physicians in New York, and they apparently distributed them as well.¹

Groundwater: Oh, yes. I mean, it's a most unusual way, looking back on it. Why would we do something like this? But I don't know, somehow we got the idea to do it.

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Early Premonitions about the AIDS Epidemic

Hughes: There were only a handful of cases of KS in the city. Why did you think it was going to be important?

Groundwater: That's a good question. Well, it looked like something that was contagious, that would spread through sexual activity, since these were all gay males, and we had no idea really what was spread. Also, we knew at that time that there was very widespread sexual activity, one-night stands and that sort of thing taking place in the gay community, within bathhouses. So an organism spread sexually in that environment would be dangerous and likely to involve a lot

¹ Conant to Robert K. Bolan, M.D., December 1, 1981. (Bolan papers, Special Collections, UCSF Library.)
of people quickly. We had no idea what this organism was at that point. It was scary just to contemplate what might happen, and how rapidly an epidemic might develop, because there was promiscuous sexual activity going on in this community.

Hughes: Well, to some people, it wasn't clear that it was an infectious agent. There were several other hypotheses about what the cause might be, including poppers [amyl nitrate]. Do you remember that one?

Groundwater: Yes. There's still a man in Berkeley who believes that it's not the AIDS virus.

Hughes: Oh, yes, Peter Duesberg.¹

Groundwater: He's about the only one who believes that sort of thing now. Have you interviewed him?

Hughes: No, I haven't interviewed him. I'd like to; it would be an interesting variation of the story.

Groundwater: Oh, yes, poppers were definitely among the things that were initially suspected.

Hughes: But what do you recall thinking might be the cause? I mean, early on.

Groundwater: Hmm. I thought it was an infectious agent of some sort.

Hughes: Why would you think that?

Groundwater: Because it wouldn't make sense to have all these gay males developing this otherwise. It just seemed that if we were developing this condition in New York and here in this promiscuous community, there might be something being spread sexually. I think I suspected that early on, as I recall, but you know, it's hard to remember that far back.

Hughes: Yes. Well, it's hard to remember when your thinking might have changed, too.

Groundwater: Yes, that's true, to get the sequence right. I remember the

¹ See, for example, P. H. Duesberg, AIDS acquired by drug consumption and other noncontagious risk factors, Pharmacology and Therapeutics, 1992, 55(3):201-277.
popper thing definitely.

Hughes: Do you remember having conversations with Conant? Because you'd known him for some time.

Groundwater: Well, Marc eventually set up what was called the Kaposi's Sarcoma Clinic once this developed. I'm not sure when that clinic started.

Hughes: The first meeting of it was September 21, 1981. So very early in the epidemic.

Groundwater: It was that early, right, he got that going. I think that clinic was held once a week, or at least fairly frequently.

Hughes: Yes, it was once a week.

Groundwater: And we all met.

Hughes: You used to go to them?

Groundwater: Oh, I went to those meetings, you bet--week after week. Jay Levy, I remember, was involved in it, and the Greenspans. I think we were just trying to keep in touch with what was going on and anything that was being published, and come up with various ideas as to what we could do about it. How did Marc express that?

Hughes: Well, he organized both the clinic and the study group.

Groundwater: Yes. Maybe it was the study group that I attended, and then he had the KS Clinic over at UC.

Hughes: Yes, there was a two-hour clinic one day a week, and then the study group met for an hour after the clinic and brought in more people.

Groundwater: I definitely remember going to those meetings for a long time, maybe at least a year or two.

Hughes: What did you do about treatment?

Groundwater: Basically we just treated the opportunistic infections that came along. John Gullett, who was an infectious disease

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2 See the oral histories in the AIDS physicians series with doctors Deborah and John Greenspan. Jay Levy's oral history is forthcoming.
specialist at St. Francis Hospital, really deserves the credit, I think, for most of the case management. But he saw me as--how did he express it?--the scholar or something like that. I would tend to grab every article that was available, and I'd discuss it with him, and put it in the patient's chart. Even though I wasn't primarily admitting them and treating the *Pneumocystis*, I saw the patient every day, or frequently, and maintained close contact with him. I knew this was something serious, and that we needed to find some answers.

John, I think, was the guy who first reported this whole problem to the CDC.¹

Hughes: Oh, is that so?

Groundwater: John called the CDC and told them, and he was sort of ignored; that was before Gottlieb published his article [on PCP in June 1981].

Hughes: Gullett reported this first patient that you had seen?

Groundwater: He reported to the CDC the first patient that we had seen, and that was the first case, I think, that was reported to the CDC, even before Gottlieb, I think. John would know a little more about that.

**Disease Progression in the First KS Patient**

Groundwater: John was the guy who followed the patient through all those admissions at St. Francis Hospital, who basically admitted him and managed the various opportunistic infections that he developed. I was continuing to follow his skin problems. I think he developed molluscum contagiosum, and what else? Warts, I guess, and the usual infections that were later identified as AIDS-related. But I also followed him very closely in the hospital.

The KS lesions were not his major problem for much of this period. Later on, they became more of a problem, but they weren't what really killed him, and they really weren't what was predominantly affecting him adversely. It was

¹ John Gullett reported cases of KS to the CDC on April 24, 1981. (Shilts, p. 65.)
these various opportunistic infections that he'd develop one after another. He was angry through every one of them. He had a lot of pluck, though; he hung in there. And we knew he was going through really difficult times, and yet he was determined to get some answers. Even though we didn't have any real answers for him at that point, he was determined. And he did hang in there with me and with John.

Hughes: Until he got the retinitis.

Groundwater: Yes, that was the thing that really hit him. I remember that. He just sort of lost that energy that he had all the way through to the end. He had tremendous energy—even though he was fatigued and couldn't work. He had energy to find an answer to this problem and know what was going on and get well.

Hughes: Some patients read the medical literature. Was he one of those?

Groundwater: I don't think so, no. There wasn't much to read. But I just remember that he was angry at us because we didn't know what was going on with him, yet he did hang in there with us.

Other KS Patients

Hughes: Do you remember when you encountered another KS patient?

Groundwater: I don't remember specifically, but I remember those early years particularly having these people referred to me. I've had a lot of these patients referred to me because I had seen that first case, and I developed a relationship with the primary physicians who had treated these cases. So I got a lot of referrals of these patients.

My wife was here working as a receptionist for my office. We both remembered this one guy who looked like an all-American—blond, blue-eyed, muscular. He came in with a KS lesion, and three months later was dead. That guy really made an impression. Within three months he was just skin and bones, and died. It was amazing how rapidly the disease progressed in some people; and in others it would go on for long periods of time.
I remember there was a nineteen-year-old guy at San Francisco General Hospital. When they set up the AIDS Clinic over there, I consulted as the dermatologist in the clinic for a while [1981-1983]) I remember that one young guy, nineteen years old, developed horrendous KS--big purple necrotic-looking lesions on his legs.

And it was quite variable. Some patients really just went downhill very quickly with KS and died of the KS, and for others it was a minor aspect of their problem. In subsequent years, at least for most of the patients that I've seen, the KS has not been the major problem. Now there's the Pneumocystis or whatever that got to them.

Hughes: How does KS kill?

Groundwater: Well, it seems to be able to infect internal organs. As I said, that pathologist at Stanford sent me slides of the histology of virtually every organ of the body where he was able to find the KS in this one patient. You can get KS on internal organs: the adrenal gland and throughout the GI tract; it's not uncommon for it to be in the GI tract. If it gets into the lungs, [patients] have trouble breathing and it can be very scary. They can get into major trouble because internal lesions are hard to treat. Many of the treatments themselves are immunosuppressive, unfortunately.

Community Physicians' Brochure on AIDS Treatment

Hughes: You also contributed a section to a booklet entitled "Medical Evaluation of AIDS and AIDS-Related Complex."

Groundwater: Oh yes. I revised that for several years. I think Jim Campbell asked me to do that.

Hughes: And you wrote on the dermatological--

Groundwater: Dermatological manifestations of AIDS, right.

Hughes: So it was Jim Campbell who asked you to participate.

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Hughes: What was the purpose and distribution of the booklet?

Groundwater: It was sponsored by the [San Francisco] AIDS Foundation. And I think it was to inform primary physicians. I wasn't really too involved with that; Jim organized the effort, and he's the one who asked me to write the section on dermatology. I think the booklet was meant for primary physicians who managed AIDS patients.

Hughes: And so this was to provide the basics, so that a primary-care physician or whomever it would be, would be able to recognize the various manifestations of AIDS?

Groundwater: Yes. [reading] "Guidelines for the evaluation of patients with specific symptoms in the context of HIV infection, laboratory evaluation. So it was initially the San Francisco AIDS Foundation, and later, I guess, Bay Area Physicians for Human Rights.

Dr. Groundwater's Current Practice

Hughes: Well, because I think we have to wind up because you've got patients coming, is there anything that you'd like to add to this story?

Groundwater: No, I think we've pretty much covered it. Certainly my role is relatively minimal, I think, compared to people like Marc Conant and Friedman-Kien, who made it almost their life's work. My practice is primarily general dermatology, and I have maybe 15 to 20 percent HIV/AIDS patients. But 80 percent of my cases are patients with the usual run-of-the-mill skin problems--a lot of skin cancer, psoriasis and eczemas; things of that sort.

I have maintained a very close association with UC over the years, with Howard Maibach particularly, in contact dermatitis; I spent ten years teaching residents with him in the patch test clinic. Howard is probably the world's expert in contact dermatitis--so that's been kind of an interesting experience, along with some of this cosmetic stuff, which I really enjoy doing--collagen, and therapy for spider veins, chemical peels, et cetera.
But I've certainly maintained an interest in HIV, which is kind of far afield from some of the other things that I do.

Hughes: Yes, I would say so.

Groundwater: But you know, I feel responsible to these people, and they deserve to have someone who cares and is willing to listen and is knowledgeable and can help them. And I enjoy treating them—I wouldn't say enjoy is quite the word, but I'm glad to treat these patients.

Hughes: Well, thank you very much.

Groundwater: Thank you.

Interview with Richard L. Andrews, M.D.

Interview 1: April 12, 1996
Tape 1, Side A 1
Tape 1, Side B 12
Tape 2, Side A 22
Tape 2, Side B 32

Interview 2: April 19, 1996
Tape 3, Side A 37
Tape 3, Side B 47
Tape 4, Side A 57
Tape 4, Side B

Interview with James M. Campbell, M.D.

Interview 1: May 16, 1996
Tape 1, Side A 73
Tape 1, Side B 84
Tape 2, Side A 94
Tape 2, Side B 101

Interview 2: June 26, 1996
Tape 3, Side A 106
Tape 3, Side B 114
Tape 4, Side A 125
Tape 4, Side B 134

Interview with James R. Groundwater, M.D.

Interview 1: July 24, 1996
Tape 1, Side A 146
Tape 1, Side B 158
APPENDIX

Curriculum Vitae, Richard L. Andrews, M.D.  

Related materials


Correspondence between Carolyn K. Harvey, D.P.M. and Marcus A. Conant, M.D. (Marcus Conant's Kaposi's sarcoma notebook, 1-5/1983, AIDS History Project, UCSF Library).


Memo, Infection Control Precautions. (BAPHR office documents).


Curriculum Vitae, James M. Campbell, M.D.

Related materials


Minutes of the Executive Board, November 6, 1983. (BAPHR office documents, folder: Board minutes).


"Guidelines for AIDS Risk Reduction," published by BAPHR.

Curriculum Vitae, James R. Groundwater, M.D.

Related Materials

Memo, Kaposi's sarcoma, from Dr. Marcus Conant, September 2, 1981. (Marcus A. Conant's Kaposi's sarcoma notebook; 1981-2/82, AIDS History Project, Special Collections, UCSF Library).

CURRICULUM VITAE

Richard L. Andrews, M.D.

Identifying Information

Residence: 179 Lower Terrace
San Francisco, CA 94114
Phone: 415/621-6291
Date of Birth: 20 July 1947
SSA: 442-48-4257

Private Practice in Psychiatry

Office: 177 Lower Terrace
San Francisco, CA 94114
Phone: 415/861-5756
July 1977 to present

Consultant in Psychiatry

Children's Home Society of California
3000 California Street
San Francisco, CA 94115
Phone: 415/922-2803
June 1984 to present

Consultant in Psychiatry

Social Security Administration
Medical Quality Review, Regional Office
75 Hawthorne
San Francisco, CA 94102
Phone: 415/744-4474
June 1977 to Present
Attending Staff/Instructor in Supervision

St. Mary’s Hospital & Medical Center/
McAuley Neuropsychiatric Institute
450 Stanyan Street
San Francisco, CA 94117
415/668-4050
July 1977 to 1987

Consultant in Psychiatry

Bayside Adolescent Day Treatment Center
2020 Hayes Street
San Francisco, CA 94117
Phone: 415/386-8750
August 1981 to June 1984

Consultant in Psychiatry

Oceanside Adolescent Treatment Facility
45 DeSoto
San Francisco, CA
September 1977 to December 1978

Consultant in Psychiatry

Westside Adolescent Residential Treatment Service
2020 Hayes Street
San Francisco, CA 94117
July 1977 to July 1979
Chief Resident and Fellow in Child Psychiatry

McAuley Neuropsychiatric Institute
450 Stanyan Street
San Francisco, CA 94117
July 1976 to June 1977
Board Eligible in Child and Adolescent Psychiatry

Resident in Psychiatry

McAuley Neuropsychiatric Institute
450 Stanyan Street
San Francisco, CA 94117
July 1973 to June 1976
Board Eligible in Adult Psychiatry

Student in Medicine

University of Oklahoma School of Medicine
Oklahoma City, Oklahoma
August 1969 to May 1973
M.D. Degree 1973

Undergraduate Student

Trinity University
San Antonio, Texas
September 1965 to June 1969
B.A. Degree 1969

Memberships in Professional Societies

American Association of Physicians for Human Rights

American Psychiatric Society

American Academy of Child Psychiatry
Bay Area Physicians For Human Rights
California Medical Association
Northern California Psychiatric Society
Regional Organization of Child and Adolescent Psychiatrists
San Francisco Medical Society

Medical Licensure
California License C36416

Professional/Community Activities
Bay Area Physicians for Human Rights
Vice President, 1981, 1988, 1989
Treasurer, 1980
Co-coordinator, National Medical Symposium
June 1980; June 1981

Shanti Project
Board of Directors
February 1988 to November 1993
Emotional Support Volunteer
February 1986 to February 1988

St. Mary's Hospital
AIDS Community Advisory Board
July 1987 to July 1989

San Francisco Medical Society
AIDS Task Force
November 1985 to November 1989
San Francisco Arts & Athletics
Board of Directors
June 1983 to September 1985

American Association of Physicians for Human Rights
Founder and Treasurer
July 1981 to June 1982

San Francisco Department of Health
Director's Medical Advisory Board on AIDS
May 1983 to October 1984

Mayor Diane Feinstein's Gay Task Force
Advisor on Health/Community Issues
June 1982 to June 1984

San Francisco District Health Center #1
Chair, Community Advisory Board
September 1981 to August 1982

San Francisco Band Foundation
Board of Directors
September 1980 to August 1982

Community Health Fair
San Francisco District Health Center #1
Director/Coordinator 1980, 1981
October 16, 1981

Richard R. Hamilton, M.D.
General Family Medicine
2000 Van Ness Avenue
San Francisco, CA 94109

Dear Dick,

Just a note to thank you again for inviting me to join you and the members of the Baffra Special Committee in a discussion of the progress we have made in establishing a Kaposi's Sarcoma Clinic here in San Francisco.

Paul Volberding and I truly appreciate the support that we have received from your organization, and we look forward to a continuing close association as we work together in an effort to solve this dreadful problem.

Sincerely yours,

Marcus A. Conant, M.D.

MAC: mek

cc: Paul Volberding, M.D.
Dear Paul, (V. O. R. B. W.)

Please excuse the informality of this letter; I'm leaving town Mon. Am. x 5 days & wanted to get some word to you in next week.

I talked to Merle Silverman who was enthusiastic about the formation of a 'Task Force' or whatever the group should be called. He mentioned he would like to set up the first meeting within the next few weeks, as he will be out of town for several weeks (beginning, I'm not sure). He asked that we (I mentioned I had already discussed this with) just give him the names of the people or organizations that we thought were appropriate.

He initially thought this might be MD's only but was agreeable to others if the purpose of the 'task force' was defined.

Personally, I think a small group (8-12) of people representing those who are directly involved in research, service, education or support service, might be indicated.
off the top my head, the following groups came to mind:

1. KS Foundation (either you or DeCenzo, or possibly either Crane or Armistead)
2. Rep. from SFMS
3. "...Swain Mem. Blood Bank (Herb Perkins)
4. Rep from BAPHR (either myself, our U.P. who is coordinating all AIDS Projects for us = Kent Sack, or Chair J. Scientific Affairs - Bob Bala (Perhaps two of above might come)
5. Rep from AAPHR (the Male Gay Doctors' Group - their Pres. lives in Menlo Park & is interested (also a member of BAPHR) & could help get info. to other gay doc groups around the country
6. Pat Norman
7. Perhaps one of the UC Epidemiologists - Gordon or Mads
8. Perhaps Rep from Shanti Project - Selma Britz

I'm sure this is an incomplete list. Some on here may not be appropriate. It seems to me (confidentially) that we can diffuse some of the "doctor attitude" that is perceived negatively by some members of the gay community, including, at
times, Pat Norman, Glen Crane & Armstrong.)

I hope my ramblings are making some sense; I would envision this group serving as a way to exchange information, improve communication, and provide a strong group to offer advice on what needs to be done, etc. I sure don't want to step on anyone's toes—we just need to have a more coordinated effort.

I will be back next weekend and if you wish to call me at home (621-6291; answer 201-5756) please feel free to. In meantime (I know how extremely busy you are), please feel free to discuss this with either Kent Sach (872-7321 or office = 676-7689) or Bob Bolan (921-5762). If not, I'll try to reach you next Monday.

I am very hopeful that the formation of such a group will be a major positive step. I look forward to seeing you soon. Thanks much.

Sincerely,

[Signature]

P.S. Perhaps someone from Nemaphilios Foundation also?
P.S. We are delighted you will be able to speak at our June Symposium.
March 23, 1983

Marcus Conant
Board of Directors
KS Foundation
P.O. Box 14227
San Francisco, California 94114

Dear Mr. Conant,

I spoke with Rick Crane by phone today and he suggested that I write to you and the Board of Directors to request a donation for the upcoming Health Fair sponsored by BAPHR. Please let me give you some background information and discuss the event we hope you will support.

As you know, Bay Area Physicians for Human Rights (BAPHR) is an organization of gay-lesbian physicians, podiatrists, dentists and friends, which is sponsoring a Health Fair on April 23rd and 24th in conjunction with Health Center #1 at 17th Street in San Francisco. This is part of a nation wide project sponsored nationally by Chevron Oil Company and the National Volunteer Health Screening Project. The objective of this event is to increase participant health awareness through screening examinations and the dissemination of health information.

The BAPHR screening site at Health Center #1 is the only site that is physician coordinated and staffed. Additionally, it is the only Health Fair developed and publicized specifically to meet the needs of the gay-lesbian community. This Health Fair is also designed to reach out to the senior citizens in the area who are an important part of this local community.

Last year, this weekend event screened 650 people. This year we are expecting well over 1000 participants. Lesbian-gay health problems to be addressed include: intestinal parasites, hepatitis, colo-rectal pathology and sexually transmitted diseases. The screening will include complete breast and pelvic examinations with pap smear. Comprehensive oral and podiatric screenings pulmonary function testing and individual mental health interviews are available, as are screening tests for glaucoma, anemia and urinary tract problems. Educational information will center around general health, nutrition, heart disease, cancer, AIDS, and smoking. A strong emphasis is placed on gay-lesbian social health issues and appropriate support services indicated in regards to parenting, alcoholism, drug abuse and legal rights.
This year is the 5th annual Heal Fair at Health Center #1. Although our two national sponsors provide some assistance, the actual organization of the Fair and financing are left to BAPHR.

The budget for this year's Fair is approximately $7000. (Please see the enclosed). A list of groups and individuals who have donated or been contacted to donate to this cause include:

- George Riley, M.D. (BAPHR member and KS patient) $500 restricted to filmstrip production.
- Northern California Dentists for Human Rights, $900 matching above, restricted
- Tavern Guild, S.F. $500
- Atlas Savings and Loan Association, $500
- Golden Gate Business Association, $400
- East Bay Bar and Tavern Owners, $1000 requested

Numerous small businesses are also being contacted in hopes that they will make some small donation to the event.

We are hoping that you can also give us support. Unless you direct us otherwise, every attempt would be made to recognize the KS Foundation as a supporter in the newspaper and pamphlet publicity for the Fair and in a list of donors given to each of the participants at the Fair.

If you can help us, please make your check out to "BAPHR-Health Fair" and mail it to:  
BAPHR  
2940 16th Street  
Suite 200-7  
San Francisco, California 94103

Should you have need for additional information, please feel free to call me at my office at (415) 391-2093 or call the BAPHR administrative office at (415) 558-9353.

Thank you for your consideration.

Sincerely yours,

Carolyn K. Harvey D.P.M.  
Chairwoman, BAPHR  
Financial Committee  
Health Fair, 1983

CKH/ckh
Letter to the Editor

Many of you, or will likely have in the near future, patients who develop AIDS. I feel strongly that you continue to have an important support role after you have referred your patient to UC or SFG for definitive diagnosis, staging and treatment. You are and may remain indefinitely your patient’s primary resource for reassurance and information. The first month or two after diagnosis is especially a bewildering and emotional time. Make it clear to your patients that you have a continuing interest in them and that you remain available even though the primary care for this illness will be in the hands of others.

Robert Scott of the Critical Care Medical Group in Oakland has followed me during the past two years of chronic illness. During this time he not only became a trusted physician but a trusted friend. During December when I was in so much pain and discomfort with shingles and during January when I was struggling with initial fright and depression, we were in almost weekly contact. His voice more than anyone’s provided me with reassurance. If he did not hear from me for a week or 10 days he would call to ask how I was feeling and what was happening in my work. When I was scared and emotionally over reactive, he was available and calming. I have his home phone number. As most patients I respect his need for rest and privacy and have not and will not abuse this access to him. It is very reassuring to patients to know that they can be in direct contact with you in an emergency.

The other role you can more effectively and easily provide is monitoring the use of minor tranquilizers and pain medication. You generally know your patient’s pain threshold and how they manage anxiety as well as their compliance pattern with medication and abuse potential. Many will be hesitant to accept them for fear of dependency or seeming weakness. Reassure them and give them instructions for their use.

-George Riley

AIDS Outreach Task Force Formalized

Increasing complexities of the AIDS crisis prompted the Executive Committee to formalize a Task Force at its February meeting. The objective is to coordinate and avail BAPHR’s services to the community during this crisis.

The awareness of this need has been growing among the officers of committees and that advocated within BAPHR for a period of time. The leaders of demand to BAPHR. This is not only the importance, but the need to prevent blood plasma donations when more information is available. Because the current awareness, many gay donors have voluntarily stopped whole blood donation. The question of plasma donation, for which most donors are paid, remains.

February marked the mid-winter meeting of the General Board of BAPHR. This writing that meeting is just getting under way, probably swaying palms and with less around winter-pace necks. Let us agree that the soft environment will not prevent them from developing guidelines on blood donation policy that will help clarify this dilemma.

As we said, it’s been a busy month.

The BAPHR position statement on AIDS enclosed in this 1983 March issue went through multiple revisions before setting on its final wording. At one time the approach was quite close to that taken by the medical blood banking community. At the last minute we retracted to a more politically conservative approach. Some observers consider this approach too conservative and think that all gay blood donors should voluntarily refrain from being blood plasma donors until more factual information is available. The statement was revised and placed in the March BAPHR in the first place.

AIDS Outreach Task Force Formalized

The Executive Committee, in an intense study session, developed working guidelines. It was decided to utilize the existing committees to accomplish the various tasks currently identified as well as those surfacing in the future. This action is cognizant of the work load now existing and the additional work to be assumed by many of the committees. Simultaneously, a plea is extended to the general membership to become active in the committee of their greatest personal interest. This first Executive Committee study session developed six broad areas of responsibility. These six are: 1) public and professional education 2) public relations with the media, allied health organizations and the public 3) emotional, medical and physical support services for BAPHR members, patients and their social and biological families 4) medical and social research 5) personal and legal injustices or discrimination and 6) financial capabilities to conduct internal and external funds. This initial session expanded these areas into specific projects and tasks with assignment to the standing committees and the Journal Club. It was stressed that our approach must not mirror committees or individuals. All areas of responsibility are not to be action areas. In many areas BAPHR will avail itself as an advisor, monitor, innovator and occasional adversary, covering many parameters of our new community leadership role. A cooperative and unifying posture with all of the agencies and organizations engaged in AIDS endeavors will trademark BAPHR.

The Task Force coordinator was charged with an AIDS agenda for the March Executive Committee; this includes developing priorities for the over-all project, detailing specifics of the assignments given to the committees, and recruiting member-power appropriately. The March Executive Committee will meet one hour early, to direct BAPHR’s coordinated AIDS effort. Ambitious and motivated members are urged to activate in this outreach project. Details are available from the Task Force coordinator or any officer or committe chair, or by calling the Administrator’s Office at 558-9353.

The challenge is ours for this time: “IT IS LIFE, NOT LIFE STYLE”!!

TO: Health Fair Volunteers, April 23 & 24

RE: Infection Control Precautions

As most of you are aware, it is expected that this year's Health Fair will draw a large number of persons concerned about the Acquired Immunodeficiency Syndrome (AIDS). It is hoped that this occasion can be used to educate not only persons in the high risk groups, including gay men, but also others who live in our community and are concerned about the possible contagiousness. The Health Fair should be an opportunity not only to educate about AIDS, but provide an opportunity for the practice of sensible infection control precautions.

Although the identification of a transmissible agent or agents has yet to be made, the CDC has recommended Hepatitis precautions be enforced when dealing with AIDS patients or those suspected of having AIDS. Obviously, these are minimum precautions and do not obviate the need for other common sense practices. These recommendations are based on extensive epidemiological work which suggest that, if there is an agent, it can be transmitted in blood products and through intimate sexual contact. In addition these recommendations are based on the known appearance of other infectious agents in the urine and other body secretions.

The principles apply to ALL patients and include:
1) Those volunteers having direct patient contact should carefully wash their hands before their shift, before and after any breaks during the shift, and at the end of the shift.
2) Sites at which interviewing and dispersal of education information occur are not considered to offer any increased risk of disease transmission.
3) Volunteers involved with anemia screening, phlebotomy, and direct contact with urine specimens should be gloved during direct contact with patients.
   a. Any spills of urine and blood should be immediately cleaned and the surfaces of the table wiped with a dilute bleach solution.
   b. Any articles contaminated with blood should be discarded into a plastic container provided.
   c. Lances for the anemia screen and needles for phlebotomy should be dropped into puncture proof plastic containers provided. Most needle sticks occur during recapping. If vacutainers are used, particular attention should be paid at this point to prevent direct exposure to a patient's blood.
   d. At the end of each shift all table tops and other surfaces should be wiped down with a dilute bleach solution.
4) Volunteers involved with dental examination and the male and female genitourinary examination and proctoscopy should wash their hands before and after each patient examination. In addition gloves are necessary during direct patient contact. Disposable items for examination should be placed into plastic bags provided for this purpose. Any surfaces contaminated with patient's excretions or secretions should be immediately cleaned and wiped with a dilute bleach solution.

Again, it is important to emphasize that neither Hepatitis B virus nor the presumed agent involved in AIDS are thought to be transmitted via routine daily contact. Therefore, additional efforts to "isolate" individuals at high risk for developing AIDS are inappropriate. In addition they are counter-productive since they tend to divert attention from the more reasonable and sensible precautions. Please direct any questions to your site leader or myself as the situation arises.
Physicians Urge Caution on Antibody Test

Recently, the availability of a test for antibodies to a newly discovered virus called HTLV-III was announced, and its possible correlation with AIDS was suggested. Apparently some confusion has arisen in the Gay and bisexual communities concerning the application and significance of this test.

The Bay Area Physicians for Human Rights (BAPHR) wish to point out that the test is part of a research protocol, and a positive correlation with AIDS is only one of the possible conclusions. At this time any such correlation is hypothetical.

BAPHR wholeheartedly supports and encourages the participation of the Gay community in AIDS research programs, but it must be understood that these are designed to answer specific questions at the conclusion of the project after collection of large amounts of data.

Until the subject has been thoroughly studied, it is not appropriate to assign medical significance or interpretations to the results of these tests, either positive or negative.

It may require months or years of research before the results of such tests can be meaningful for widespread application. In the meantime, BAPHR cautions the Gay and bisexual communities against making any decisions about sexual practices or lifestyles on the basis of the results of these tests.

If there are further questions or concerns, referral to a knowledgeable, Gay-sensitive physician can be obtained by calling the BAPHR referral number, (415) 673-3189.
Dear Colleagues and Friends,

Recent events, especially the closing of the baths (generic) and the issues of confidentiality related to HTLV-III testing, have caused many of us to be alarmed. As our April 2 Board Position stated, "In these difficult times, let us act with concern and responsibility for each other." Along with Denny McShane, Kent Sack, Dave Kessler, and Seth Charney, I was one of the people who drafted that document. We chose our words with deliberation, and were striving for a thoughtful, measured response to the problems before us. However, all around the community, even within our own organization, "Word Wars" continue to be waged. Knee-jerk reactions are likely to present any situation in an unbalanced and polarized manner. Polarization I define as the presentation of only two extreme viewpoints: one's own, which of course is correct, and "their" viewpoint, which is almost totally wrong. In these situations, anyone who does not agree completely with you is immediately seen as "the enemy" who supports "the wrong side." The trouble with a polarized world or situation is that it is usually very difficult to get anything resolved, as illustrated by the ridiculous and dangerous breakdown in arms control talks between "us" and "The Evil Empire." Neither side will admit they have any problems, and neither side will really listen to the other long enough to understand what is being said, much less begin to work on solutions.

Now, I do not agree with everything Merv Silverman has done, including many of his decisions regarding the baths. But he is not hoping to put us away in concentration camps. Yet some of us, with a few broad strokes of the brush, have tried to "blackwash" all of Merv's thoughts and actions about the baths as an example of his homophobia. This is an unbalanced and polarized viewpoint. In a similar vein, I have disagreed with Mayor Feinstein on a number of issues, but "Lady Di" is not Anita Bryant. And the ideas of Marcus Conant, the recipient of our Achievement Award last year, should be critically examined, not automatically discounted. It is not only unfair but ultimately self-defeating to make these people the focus for our anger and frustration.

As you may have surmised, I have difficulty supporting what I call the "radical rhetoric" in recent statements by BAPHR's leaders, although I do share many of their concerns. The November BAPHRON read a bit like it was competing with the B.A.R. editorial page. The membership survey re: AIDS and the baths, seemed a somewhat biased group of questions which, intentionally or not, would likely support a particular viewpoint.

I know our leaders; they are good and bright and dedicated people. I chaired the Nominating Committee that recommended every one of our current officers and I have confidence in each one. I am certain that all of us are really just doing what we feel is best; my plea is only for moderation, for more balance.
I think our organization would benefit from an opening up of discussion on these issues and would respectfully like to make a suggestion as to one way this might be achieved: How about a meeting at the first of the year in which BAPHR coordinates a panel discussion with other professional groups (GGBA, BALIF, BACW, etc.,) on AIDS-related topics that are important to all of us? Some examples: 1) Is it possible, as a community of businesses, organizations, and individuals, to more successfully decrease the spread of AIDS (whether at sex establishments, public places, or our bedrooms) while at the same time preserve our civil liberties and our human dignity? 2) How can we protect our confidentiality and at the same time continue to contribute to the valuable research that can eventually lead to a vaccine? Etc., etc. Get the picture? I would be willing and interested in working with the Executive Board or Executive Council to see if such an idea could become a reality.

In my mind, Fate and Faith continue to be the determining forces in our world; whatever our fate, I am yours faithfully. Onward and Upward!

Warm regards,

Ric

P.S. I encourage others to write letters; communication and the exchange of ideas is the first step to making things better.
MANY VOICES

The gay community, and in particular the gay physicians’ community, has been under siege from the curse of AIDS for three years. We are being tested with the greatest imaginable heat. We have, for the most part, maintained remarkable unity and equivocation in the face of this monstrous threat, this slow killers preying among us.

Human communities under attack tend to respond initially with unity and solidarity. If the attack persists, however, people may fall to bickering among themselves, pointing their fingers at each other in frustration and blame.

A healthier course occurs if the people of the community can confront this stage, energy is dissipated, strength is wasted, and defeat invited.

The meeting was a direct outgrowth of the perception that the membership was revolting because of recent public actions taken by BAPHR leaders. It was hoped that a forum would provide the opportunity for the expression of competing and conflicting views, would inform the leaders about the opinions of the membership, and would educate all of us about the many sides of the complex issues with which we all grapple day after day.

The guidelines for safe sexual practices, a “position paper” on the bathhouses, and recent public recommendations about HIV-antibody testing have thrust BAPHR into the public arena. Those actions, and the wearying cacophony about what should shouldn’t be done about the baths have raised questions about 1 what BAPHR should be taking public positions at all, and 2 what positions are acceptable.

As is usually the case with volunteer groups, those who hesitate to leadership roles are likely to be of more “activist” mind than the average member. Therefore among most card and committee members it has appeared that our existence as “human rights” group is derivative of our membership by definition commits us to taking some public or “political” stance. Furthermore, the current crisis has at its center a medical, public health matter. It is not analogous to wartime when a physician is expected to heal the sick, treat the wounded, and disregard the politics. The nature of AIDS is such that our silence would deprive the community of useful knowledge that we have. Some of us further contend that the health of our community and quite possibly its future will depend on our addressing these issues in an honest and forthright manner.

At the forum on Sunday evening, four of our recent and current leaders led off with statements reflecting their particular experience with and perception of the crisis. Ric Andrews described the polarization that has occurred, with its wasteful effects; Jim Krajekian emphasized the complexity of the issues with their multiple ramifications; Jim Campbell concentrated on the most recent scientific revelations; and Bill Lipil forcefully presented the effects of bigotry on planning, financing, and treatment.

It appeared to be the general consensus (though it was by no means unanimous) that we must involve ourselves in the public health and the civil rights issues, and that public positions are acceptable, especially if we admit the limits of our knowledge.

There appeared to be no longer any serious disagreement regarding safe sex practices and blood donation deferral.

The baths question still generated the most intense emotion, although the climax of that issue may now be behind us.

The current most and not yet resolved issue is the public health need for research versus the civil rights need for confidentiality. Those doing research contend that confidentiality is well protected; those sensitive to civil rights maintain that still greater legal safeguards are needed to protect participants from likely loss of insurance, possible loss of jobs, ... and more.

The questions of an AIDS hospital, the specter of quarantine and the possible usefulness of spermicides were not addressed in my presence.

I was left with the impression that the baths quarrel has been our first major battle and is now past its peak. Dare I hope that the intense controversy created by it may have strengthened us for the tests ahead?

Robert Akeley
Education Committee

CHANGES IN NEWSLETTER

Largely for financial reasons, the BAPHRON will be published only six times per year (every two months) instead of monthly. The calendar will be presented for at least two months so that important meeting dates should not be missed. With increases in postage costs and the generally high costs of publishing (the newsletter is the largest single budget item of the organization), the savings should be significant.

Another step which should save money is the computerization of input as well as typesetting by Cole Valley. To take full advantage of this capability, the Editors must submit computer diskettes with all the text of articles along with commands that the typesetting computer uses to format the articles. In this issue, most of the articles and letters were entered in that mode. It requires more effort and time by the Editors, which means “please don’t wait until the deadline for submission of items and letters!”

The deadline for the March/April issue is Feb. 15, and the issue should be mailed early in March.

So if this issue looks a little strange, blame it on the IBM!
Curriculum Vitae

James M. Campbell, M.D.
Born April 1, 1936 South Band, Indiana

Education

B.A. Yale University 1958
M.D. Columbia University College of Physicians and Surgeons 1962

Post Graduate Training

Intern, University of California Service, San Francisco General Hospital 1962-1963

Residency- Internal Medicine, University of California, San Francisco, 1965-1968

Fellowship- Endocrinology. University of California, San Francisco

Military Service

Captain, US Army Medical Corps., 1963-1965

Academic Appointments

Clinical Associate Professor of Medicine, University of California, San Francisco

Boards

Certified, American Board of Internal Medicine, 1970;
Recertified 1977

Organizations

American College of Physicians; member
San Francisco Medical Society, member
Bay Area Physicians for Human Rights, chairman
Scientific Affairs Committee
San Francisco AIDS Foundation, member Scientific advisory committee
San Francisco County Community Consortium (AIDS Research)
   Member, executive board
   Member, scientific advisory commettee
A Letter To BAPHR

Three pronged approach is the interim response of the San Francisco Department of Public Health to the newly recognized possibility of MS contamination of the Bay Area blood bank supplies. This approach responds to the proposals made by members of a panel which the Center for Disease Control convened to assess the problem on January 4, 1983. This approach is also in general agreement with the 1983 report of the Department, the Irwin Memorial Blood Bank, and physicians who treat members of the San Francisco gay community. (Nationally, 75% of all AIDS cases are reported in gay or homosexual men.) Pending still is a unified position statement of national leaders.

The apparent possibility of blood borne transmission of an infectious agent for AIDS has been increasing, beginning with reports of confirmed cases of pneumocystis carinii pneumonia in three hemophiliacs late in 1982. Five additional confirmed cases and three possible ones are still under study, adding to the sense of urgency of the situation. A case of very probable AIDS has also been reported in a man transfused with blood products from a San Francisco man who seven months later developed AIDS, and at least two other possible transfusion-associated cases in adults are under study on the East Coast.

It is difficult for Public Health and Blood Bank officials to make precise recommendations, because no one can yet identify a cause or causes of the outbreak. The problem is very serious, as more than 850 cases are now reported nationally, with an overall mortality rate of nearly 40%. A definition of the population at risk is also not clear, although the greatest numbers of cases are in gay or bisexual men (approximately 75%), heterosexual men (20%), women (5%), and small numbers of Haitian immigrants and hemophiliacs. The pattern of distribution and development of the disease resembles that of hepatitis A more closely than any other, and seems to be most prevalent in the same population groups. Therefore, lacking an exact test for a presumed AIDS agent, the first approach is to screen bloods for hepatitis B (the core antibody), as a marker for donors considered also at the highest risk for AIDS. These bloods would have to be processed for other uses, or discarded. Secondarily, donors whose blood is found positive for the core antibody would be directed to discuss the findings with their personal physicians, and could be advised voluntarily to defer donating blood until more exact methods are devised to identify blood contaminated with a possible AIDS-producing agent. It is important to point out that such an agent is strongly suspected by experts in the field, although there is no means to test it. Use of the core antibody test might eliminate about 5% of the usual donors to voluntary blood banks. The Department and the Irwin Memorial Blood Bank join in urging that more donations of blood be made by those persons whose blood is continued on page 192.

Blood Bank Survey

In an effort to determine the tenor of response of the blood banking and plasma collection establishments to the questions of donation by gay men, a telephone survey of the four major plasmapheresis — plasma fractionators, a trade association of these companies, and a sampling of commercial and non-profit blood banks was carried out during the week of Jan. 10 — 14. Respondents were presidents of the companies or Medical Directors of the establishments.

All respondents were reacting to the meetings held at the Center for Disease Control in Atlanta and the subsequent meeting at the concerned groups in Washington during the previous week. The formal recommendations resulting from those meetings are not available at this writing, but it is generally presumed that, while the subject of AIDS and donors’ exposure to AIDS will be addressed, there will be, for the moment, no official prohibition against donation of blood or plasma by gay men specifically. However, the position taken by the National Hemophilia Foundation to exclude plasma from high-risk gay men for Factor VIII products has had the effect at some levels.

The attitude of plasmapheresis establishments, probably the most important from the standpoint of transmission of AIDS in plasma products, ranges from “we don’t think we have many gays in our donor pool”, to “we know they are gay, we discourage them” to the more strident approach taken by one company. That company distributed a pamphlet to their collection centers and contract suppliers that asks males if they have ever had sex with another man, and if the answer is yes, they are refused as donors. Some have posters in their centers describing the problem; several respondents felt that their gay donors probably were more intelligent and altruistic than the straights and would voluntarily withdraw when reminded. All attempts to control the situation are viewed as educational and not discriminatory. When plasma is collected from known gay groups, for high-titer hepatitis B gamma globulin, that plasma is not mixed with pools used for other products.

Several respondents expressed chagrin and mild antagonism directed to what they view as failure of the gay community and gay representatives to take a stand to discourage their own community members from refraining from donating. They are sympathetic, for the most part, to the avoidance of discrimination, but the facts remain that plasma and blood components from gays have been strongly implicated in AIDS transmission. To view blocking blood donation as anti-gay seems illogical to them, since that kind of activity certainly not an expression of individual freedom or civil rights. The parallelism is frequently drawn to hepatitis B before the development of antigen testing — there was no question of discrimination on the basis of a history of hepatitis for blood donors.

It is thought that the impact of loss of “gay blood” at the blood bank level will be small but is an unanswered question.

This time specify that your United Way contribution go to BAPHR.
A new disease of unknown cause and characterized by severe, abnormal function of the body's immune system has appeared. Although most of the reported cases have occurred in homosexually active men, about 10% of cases are Haitian immigrants, intravenous drug abusers, hemophiliacs and others. The disease has been called Acquired Immune Deficiency Syndrome (AIDS). Preliminary information suggests that the immune suppression is initiated by an infectious agent which may be acquired sexually or by receiving blood products. It is not known whether the disease may follow a single exposure or requires multiple exposures.

Continued transmission of this agent is cause for grave concern. The incubation period - the time between acquiring the agent and the development of signs or symptoms of illness - appears to be at least seven to eighteen months and may be longer. During that period, an infected person may be able to transmit the agent to unwitting sex partners or recipients of his donated blood products. To date no agent has been isolated and there is no test for the disease or for potential carriers of the agent. Thus, our immediate efforts to reduce possible blood product spread of AIDS must be aimed at discouraging blood and plasma donation from people likely to be carrying this agent. Therefore, persons should not donate blood if they have definite AIDS or if they have unexplained weight loss, prolonged and unexplained fevers, night sweats, or generalized lymph node enlargement. In addition, it is advisable that sex partners of these persons should not donate blood.

It is impossible to be precise about the number of different sex partners that would constitute a "significant risk" for acquiring an AIDS agent. Therefore, the decision whether to withdraw from the blood donor pool if one is apparently well must be an individual one. BAPHR views this voluntary withdrawal as a temporary action until a test to identify the AIDS agent is developed. The gay community's altruistic donation of blood may represent a significant percentage of the total supply of vitally needed blood products and so to help avert any shortage, we encourage those gay men who remove themselves from the donor pool to urge another person (friend, colleague, parent or other relative) without the above constraints to donate in his place.

This position will be updated as new information becomes available.

In this unprecedented health crisis, humanism must guide our decisions. We think our recommendations are a positive step; we will continue to encourage vital communication and cooperation between the gay community and the federal and local health agencies as well as research scientists and the legislature. We think that unprecedented research funds should be committed by governmental granting agencies so that we may soon be able to understand and hopefully quell this growing health threat.
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AIDS: Facts, Fears, Common Sense and a Measure of Hope

By James W. Campbell

Los Angeles Times

Tuesday, May 31, 1983
THE RETREAT: A REPEAT — Part I: THE PARADE

The KENT SACK GONG SHOW got off to its well planned start at 6 A.M. Saturday July 16, 1983 at the Wildwood Resort at Guerneville. It was a super place, but more about that in a later article. Following the review of the past year by the BAPHR outgoing officers, the Audit Committee presented a summary of the past year. It was a good year, presented by the various committee chairs. Kent Sacks (in absence of Bill Owen) noted that the Administration/Bylaws Committee developed a job description and perquisites of the Administrative Assistant. The organization’s Bylaws were considerably revised in conformity with changes in structure and function. The BAPHR completed its fifth year!

Social Concerns (Will Wilner for George Riley): The primary concern and accomplishment of this committee was the enormous success of the Health Fair.

Publications (Jack Mangum, Will Warner, Sam Thal, Charlie Rason): Aside from the clearly successful monthly appearance of the BAPHRON in its sleek new format, the committee was requested by the San Francisco Medical Society to present an article on AIDS in the SFMS Bulletin, the first such request tendered a Gay Physicians’ organization! Will Warner responded with a most creative piece.

Finance (Ted Winn): The primary concern was and is the ongoing support of the BAPHR organization to a 501(c)4 (and the development of a BAPHR Foundation 501(c)(3) so as to provide a legal basis for a politically active organization and a tax-free Endowment structure.

Membership/Support (Jack Wilkie): Certainly one of the most creative and effective of the BAPHR committees this last year, developed a new membership brochure, instituted a series of introductory cocktail parties and brunches for new members, set up a membership directory and AIDS Support Group (headed by the indefatigable Don Brown) that continued the tradition of New Year’s Eve parties at Jerry Goldstein’s palatial estate.

Education (Ian Barlow): The just completed June Symposium (unfortunately, the only one this year as the committee was usurped all the time of this intensely active committee. The new format of lectures/small group sessions was overwhelmingly approved by the conference participants.

Scientific Affairs/Journal Club (Bob Bolan): Essentially this took over into the ‘AIDS Committee’. Probably the most publicized BAPHR activities were generated here: A position paper on nitrates for HIV positive people that was a hot issue, a consultative position with the blood bank, review of possible AIDS donors, the development of the currently ongoing AIDS survey protocol being analyzed by Will Warner. The most notably the AIDS Risk Reduction Brochure now well distributed throughout the country.

Hold your breath folks! In next month’s BAPHRON: The Retreat A Repeat — Part II, The Future!

Larry N. Abraham
within one group could range from anything from scientific data on pathogenesis of AIDS to how we as individuals were modifying our sex lives to reduce the risk of AIDS.

My own personal reaction after attending the symposium is that the gay community is facing an enormous challenge. Heretofore we have not had any written rules as to what constitutes a "normal" or "safe" sex life as is prescribed in heterosexual marriage. Individual conscience has been the guide to conducting a reasonable sex life. Now we are faced with the epidemic of AIDS; it seems to be contagious; the incubation period may be two years; there are no marks and the determinate who is a carrier, who is immune (hopefully that exists), and who is susceptible. The reaction of individual gay men has been everything from total denial of any sort of contagion leading to celibacy and social isolation. Those in between have adopted other solutions which reduce anxiety about AIDS, i.e., "As long as I am monogamous I can't get AIDS" or "I won't get AIDS because I don't do that certain sexual practice which causes AIDS". Given the unknowns, it is difficult to say who is correct. Fortunately there are some knowns about AIDS and its transmission and we as physicians can transmit this information to patients in form of risk reduction guidelines. We must bear in mind that sexual habits do not change overnight. Furthermore, new data on transmission of AIDS may be forthcoming. Consequently it may be several years before the gay community can establish its "sex code" which is both emotionally fulfilling and medically safe.

I have summarized below the speeches giving scientific data on AIDS.

James Curran, M.D. - Chairman, AIDS Task Force, Center for Disease Control.

Dr. Curran emphasized the few positive aspects of the current AIDS epidemic; it is occurring at a time when medical technology may be sufficiently sophisticated to solve the problem.

Moreover, the gay community is now sufficiently organized and identified that its musters support to AIDS patients both financially and emotionally. Through awareness and risk reduction guidelines, it can protect itself from further destruction by the disease. Had the epidemic occurred in 1960 none of the above may have been possible.

Through June 20, 1983, 1641 cases have been reported to the CDC; 641 of these have died. Currently 5-6 cases are being reported daily. On June 7, 1983 case breakdown per city was as follows: New York 717, San Francisco 380 (12%), Los Angeles 113, Miami 61, Newark 54, Elsewhere USA 477.

The most likely etiology is a new infectious agent, probably a retrovirus. At this point, Dr. Curran feels there is insufficient evidence to implicate cytomegalovirus, Epstein-Barr virus, or nitrogen as causative although they may serve as cofactors. Risk factors include: homosexual contact, intravenous drug abuse, hemophilia with multiple lyphofiled virus VIII infections, and Haitian descent.

There are 90 AIDS patients (58%) in USA without any of the above risk factors. Thirty-one have died with insufficient information about sexuality or history of IV drug use; 11 had received blood transfusion prior to onset of AIDS, 10 had Kaposi's Sarcoma with normal immune studies (5 classical Kaposi's Sarcoma), 10 were female sex partners of AIDS patients, 15 were children of parents with AIDS or similar immunologic alterations (presumed placental transmission). Still 28 (2%) have no conceivable risk factor.

Paul Volberding, M.D. - Chief of Oncology, San Francisco General Hospital.

Dr. Volberding raised several questions in regard to the bottom side of the AIDS iceberg; i.e., What is the infectious agent which causes AIDS? What is the incubation period? Are hospital personnel at risk or hospital personnel with AIDS at risk to patients? Is AIDS spread by blood transfusion? Does successful chemotherapy of Kaposi's Sarcoma improve immune competence? What is the prevalence of 'carrier state' in asymptomatic gay men with abnormal lymphocyte function? He did propose that the spread of the epidemic, the risk groups identified, and the long incubation period are consistent with the model of hepatitis B virus spread and have led to risk reduction guidelines based on this model. Therefore, AIDS patients should refrain from sexual activity involving passage of semen and should not donate blood.

He discussed several of the treatment options in Kaposis's Sarcoma (KS). He had treated 22 patients with vinblastine with at least partial remission in 7 patients lasting only about six months. Since March 1982 he has treated 20 KS patients with high dose interferon. Of these there has been one complete remission, 8 partial remissions, 8 without change. 4 with increased lesions and 3 who are too early to evaluate. Four patients have developed opportunistic infections. This is comparable to the incidence in those treated with single agent VP16 by Dr. Linda Laubenstein.

Roger Enlow, M.D. - Beth Israel Hospital, New York.

Dr. Enlow discussed his experience in following 120 homosexual men with lymphadenopathy as defined by: 1) over 1 centimeter lymph nodes in two or more separate extra inguinal areas; 2) nodes have been present for over three months; 3) nodes have no evidence for infectious or neoplastic etiology at onset of study. Median duration of adenopathy was 11 months. Features of the syndrome include:

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<td>Hypergammaglobulinemia</td>
</tr>
</tbody>
</table>

T cell studies done on 35 lymphadenopathy patients showed:

<table>
<thead>
<tr>
<th>Lymphadenopathy (N=35)</th>
<th>Controls (N=35)</th>
</tr>
</thead>
<tbody>
<tr>
<td>T₃ (Pan T)</td>
<td>62%</td>
</tr>
<tr>
<td>Range</td>
<td>32-94</td>
</tr>
<tr>
<td>T₉ (Helper)</td>
<td>21%</td>
</tr>
<tr>
<td>Range</td>
<td>11-47</td>
</tr>
<tr>
<td>T₈ (Suppressor)</td>
<td>49%</td>
</tr>
<tr>
<td>Range</td>
<td>24-73</td>
</tr>
<tr>
<td>T₉/T₈ Ratio</td>
<td>0.42</td>
</tr>
<tr>
<td>Range</td>
<td>0.04-1.57</td>
</tr>
</tbody>
</table>

Less than 400 T₉ (helper) cells correlated with increased incidence of infection or malignancy. In the lymphadenopathy group five patients developed Kaposi's Sarcoma and one T cell lymphophatosis.

Certain HLA types were associated at increased risk for lymphadenopathy syndrome - namely DR5 with risk factor of 2.5 (P < 0.2) DR7 with risk factor of 2.9 (P < 0.6). DR2 was associated with decreased risk (P = 0.014).

He mentioned certain other treatment modalities which have been used in AIDS. Obliterating of OK T₉ suppressors with plasmapheresis has been tried unsuccessfully. Anti OK monoclonal antibody also has been ineffective. Trials with terleukin II may show promise.

Dr. Stephen Follansbee.

Dr. Follansbee presented risk reduction guidelines appropriate to the 1) heterosexual community, 2) hospital workers, 3) homosexuals and 4) AIDS patients.

He emphasized the fact that so far there has been no evidence to suggest that AIDS is transmitted through sweat, food, respiratory secretion, or household contact. Thus far no hospital workers...
body members with non-sexual contact with AIDS patients have contracted AIDS.

So far, risk of acquiring AIDS has been associated with

venereal disease, male homosexual activity, transfusion of

food products, and geographical background, i.e. Haiti.

Risky male homosexual activity which have been identified in

arious studies include passive rectal sex, multiple partners,

onymy and active anilingus. He cited a study done by Roger

etels, et al, in Los Angeles relating T cell ratios to various forms

tal-genital activity. Participants included 89 presumably healthy

men, median age 27.

<table>
<thead>
<tr>
<th>Table 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>N</td>
</tr>
<tr>
<td>No anal activity</td>
<td>2</td>
</tr>
<tr>
<td>Active anal only</td>
<td>6</td>
</tr>
<tr>
<td>Passive anal only</td>
<td>1</td>
</tr>
<tr>
<td>Active &amp;</td>
<td>80</td>
</tr>
<tr>
<td>Passive anal</td>
<td>2 vs.</td>
</tr>
</tbody>
</table>

In comparing the T cell subsets in the group who refrained from

al passive activity (1 & 2) to those who had anal passive activity (3 & 4), there was a statistically significant difference in their ratios

solve suppressor cell number but not in helper cell number.

In conclusion, he recommended that risk reduction needed to

knowledge the fear of AIDS and other sexually transmitted

eses and at the same time reinforce the concept of fun and

ally sexual activities.

Herbert Perkins, M.D. - Chief, Irwin Memorial Blood Bank.

Dr. Perkins discussed the implications of AIDS with respect to

od donation. Thus far 16 cases of AIDS have been reported in

ophiliacs. All have received commercial Factor VIII concen-

ates which are manufactured from pools of greater than 5000

ors. Receiving such concentrates is correlated with reduced

help/suppressor T lymphocyte ratios in hemophiliacs without

clinical AIDS. Curiously enough T lymphocyte subset abnormality

among hemophiliacs in Scotland where there has been no

clinical AIDS as yet.

Thus far there has been one well documented case of AIDS

related to blood transfusion. This was the infant studied by Dr.

Arthur Ammann at UCSF. He received 19 units of blood at birth

because of Rh incompatibility. One unit was traced to a man who

developed AIDS several months after donation. The infant has

some of the clinical features of AIDS as early as four months after

birth. Twelve other patients with AIDS have received transfusions

which are under investigation.

If these twelve donors all indeed transmitted AIDS to the recip-

ients, one could extrapolate that one's chances of contracting AIDS

through a blood transfusion are one in a million since about 1

million persons have received blood donations in the past two and

one half years corresponding to the AIDS epidemic.

Currently screening of blood for AIDS at Irwin is done through

donor questionnaires only. Those ineligible to donate include in-

travenous drug users, Haitian immigrants, homosexually active

ales, sex partners of these risk groups, and those with AIDS or cer-

tain symptoms thereof.

It was originally proposed that hepatitis B core antibody may be

a useful marker to identify AIDS risk groups, but this is not being

used currently at Irwin Memorial Blood Bank since cooperation from

the San Francisco gay community has been excellent.

Other surrogate markers to identify donors at high risk of AIDS

are tabulated below, some may be in effect in other blood banks.

| Table 3: |
|---|---|---|---|
| Test | General Public | Male Homosexual | AIDS |
| TH/Ts | (N%) | (N%) | (N%) |
| = 5 | 3.1 (33) | 19.7 (61) | 77.4 (53) |
| Total Lymphocytes | 5 | 12.1 (58) | 69.6 (56) |
| Anti-HBc | 5 | 79.2 (49) | 88.2 (93) |
| Immune Complex (ClqBA) | 2.6 (114) | 455.3 (33) | 55.6 (45) |

James M. Campbell, M.D.

The 983 Retreat: 800-90009583-793

983 Retreat

Over the (Golden Gate) Bridge,
And through the (red) woods,
Hi-ho, the dairy-o,
Retreatin' we will go-o-o-o!

red, sixty BAPHR-members, affiliates, and "significant others"

ed at Wildwood Ranch for that purpose over the weekend of

y. Wildwood's setting, five miles north of Guerneville and

t a thousand feet above it, approaches the montane idyllic

s, from the lowest of bryophytes to towering redwoods,

ast been tastefully supplemented by a variety of their

ested cousins of both flowering and fruiting species - ad-

appreciably to our sense of "belonging."

The Ranch's recreational amenities include a lovely pool, indoor

door lounging areas, miles of spectacular hiking trails, and

quinsness of the California life-style, a hot tub.

y means, however, was it all play for members and affiliates

for those of the "SO's" who chose to attend business sessions?

is of those, under the quasi-Draconian Iron Hand of our able

president - what shoes he has been called upon to fill - will be
d elsewhere in this issue of The BAPHRON. Read on!!!

C.W.M.

Our Favorite Hooker!

Evelyn Hooker clearly enjoyed herself waving, hugging and chattering

with delighted fans from the rear of 'Ric Andrew's elegant white

Mercedes convertible which was our 'float' in the 1983 San Francisco

Gay Parade. BAPHR was very much in evidence this year, most

tly thanks to Ric Andrews. A bright new Banner (prominently

featured on the 11 O'Clock News), signs, and brilliant red card-

handouts (Get the facts, Get the funds, Get involved) and our logo-

imprinted preppy T shirts.

Dykes on Bikes aren't everything; Will Warner and his leering 'slave'

'preceded the BAPHR contingent in full black leather drag on his

huge black bike.

It was, finally, a glorious sunny day as the small group gathered

South of Market, barely enough to carry the banners (BAPHR, AAPHRR)

and signs. As usual the contingent grew throughout the march to

over a hundred BAPHR members and friends so that by the
time we reached the Civic Center there was a smart number
to man the BAPHR booth, set up as usual, by the indefatigable Bob

Akeley. All the regulars popped up (Sam Thal, Jerry Strong, Denny

McShane, David McEwen) etc and put hand BAPHR referral service cards.

AIDS Risk Reductions Brochures and to answer the wild questions

of the heterogeneous crowd.

All in all it was a beautiful day and we can all be proud of

ourselves.

Iary N. Abramson
MINUTES OF EXECUTIVE BOARD - November 6, 1983

The meeting was opened at 7:00 p.m. by Kent Sack, M.D., President. The following items were discussed under announcements:

A) 1984 BAPHR Budget: Each Committee is to take the budget to committee meeting for review. The Executive Council will again review budgetary items at its November meeting, and final approval will be voted upon at the December Executive Board meeting. It was noted that budget figures do not touch the Endowment, and that each project will carry its own cost. Committees must have revisions to the Executive Council by November 20. The January BAPHRON will feature budget, Referral Panel Information, and news on Membership.

B) Incorporation papers are in the hands of attorney, Matt Coles, Esq. A mechanism is needed to record hours of lobbying, especially with the thrust coming in January for AB 1. Seth Charney needs names, addresses and phone numbers of physicians residing outside of San Francisco; the Information Office will be handled by Norm Woodfruff (media). The Administration Committee will monitor the activities of this group.

C) Banquet Chair, Steve Walters, was congratulated as was Ric Andrews and Doug Carner. Suggestion to have hosts serving as guides for dignitaries in the future mentioned by Kent.

D) The BAPHR IDS grant was not awarded to BAPHR this year - it went, instead, to organizations dealing with direct services to patients.

E) Will Willner, M.D., of the Social Concerns Committee, sent a letter to the hospital in Florida responsible for the transfer of the AIDS patient to San Francisco. Suggested that letter be sent to media and health agencies, as well.

F) The Kubler-Ross AIDS Workshop at Wildwood Ranch was attended by Kent as Medical Officer. He said it was most intense and emotional. Suggested too, that other physicians may want to attend a similar seminar in the future, but that they should be comfortable with the AIDS emergency. He gave high praise to the San Francisco AIDS Fund for their work in the community.
E) Sam Thai and Bill Owen are in charge of keeping the archives; they have garnered much information, including a wide variety of BAPHR slides. The need to work on long-range planning for this project was mentioned.

Task Force News:

A) BAPHR Task Force: They will meet with persons from AIDS Clinic and the S.F.G.H. Ward to ascertain how money from Frontrunners may be used, with another possibility being the establishment of classes. NOTE: All AIDS-related information, etc., must use this Task Force as a clearing house.

B) City Task Force (now called AIDS Advisory Committee): Will Willner reported the statistics are still grim; volunteers are needed for Shanti and AIDS clinics. The Task Force may write a letter to the New England Journal of Medicine regarding a recent article that appeared on resuscitation. Will also showed a city-wide directory compiled for city AIDS health providers.

C) Health Director's Task Force: Most of the time at the last meeting dealt with the transfer of the Florida patient to San Francisco. MOTION: To send a letter from Social Concerns Committee to this task force regarding the reviewing of the possibility of establishing regional diagnostic/treatment centers for victims of AIDS. Passed. This would be other urban areas, such as Los Angeles, New York, Chicago, etc.

D) State Task Force: Kent reported that there will be a mini task force committee meeting this week in Sacramento, presumably to discuss the State AIDS Guidelines brochure. No further word from Sacramento received.

Committee Reports:

Membership: The telephone tree is not off-the-ground yet, as committee chairs have not submitted to Jack Wilkie members' names, addresses and phone numbers. A major membership drive will be held in December, with a thrust being given for new members. Two Cocktail parties have been scheduled this month, one at Jack Wilkie's, one at Bill Kapla's home. Jack also reported the success of two physician support groups, headed by Don Brown. Discussion of how to handle the category of membership for
podiatrists, dentists, psychologists, as well as Lifetime/Honorary membership criteria. Jack said that his committee prefers not to be in charge of a spring fund raiser, but rather, simply have a dinner meeting for the membership.

B) Finance: Discussion of the Endowment Fund by Peter Middendorf, who used charts to explain the functions of the Endowment program. Detailed information will be forthcoming, but it should be noted that the Endowment Fund is designed to add support to the ongoing BAPHR programs, and its three main areas of concern are education, advocacy, direct services.

C) Administration: The recommendation to purchase a typewriter for the Administrative Office by this committee was tabled for one month so that prices, etc. can be overviewed more concisely.

D) Sam Thal stressed the need to meet all deadlines for the BAPHRON. Contributors to the Endowment Fund will be recognized in the BAPHRON, and the need to raise $1200 for advertising was mentioned.

E) Scientific Affairs/Journal Club co-chair Jim Campbell mentioned that plans are under way for the January General Meeting dealing with the worried well and sick. Other areas of interest: the committee is updating the AIDS Guidelines brochure to make the language more specific; Jim will be running a series of two articles in the BAPHRON dealing with a symposium he attended recently; Bob Bolan has drafted a letter dealing with the contesting of the sale of poppers.

F) Social Concerns: Will Willner stated that there will be an ad placed in the BAPHRON and other gay papers regarding the committee's willingness to review AIDS patients claims concerning discrimination, etc. MOTION: That BAPHR NOT fund the Harvey Milk Archives March November 27. Passed.

There was no other pressing business. The meeting was adjourned at 10:00 p.m.

Respectfully submitted,

Lary Abramson, Secretary
Douglas Garner, Administrative Assistant
AIDS — A Multidisciplinary Enigma
Part 1, November 3-4, 1983

This symposium took place at the new Hotel Meriden (Air France) in downtown San Francisco. It was sponsored by the Division of Infectious Diseases, Department of Medicine, University of California School of Medicine, San Francisco.

Because much of the material was a recapitulation of material presented in earlier BAPHRONs, I will attempt to summarize only the newer data and concepts. The second and final part will be published next month.

Epidemiology of a New Worldwide Disease, James W. Curran, M.D., CDC, Atlanta.

As of October 3, 1983, 2640 cases of AIDS had been reported nationally: 41% are now dead. Currently there are about 350 cases reported to CDC monthly. There is no longer doubling of new cases each six months, but case reports are still not leveling off. Occurrence rate of AIDS per single man in New York and San Francisco are now approximately equal. The CDC definition of AIDS is essentially the same and includes individuals under 60 years with previously normal immune systems who have developed any of the following tumors: 1) Kaposi’s Sarcoma (KS); 2) Lymphoma of the Brain, or opportunistic infections: 1) Pneumocystis Carinii Pneumonia (PCP), 2) Toxoplasma gondii, 3) Cryptosporidiosis of greater than one month’s duration, 4) Candida esophagitis, 5) cytomegalovirus of central nervous system or intestine, 6) mycobacterium avium — intracellular, 7) cryptococcosis. This excludes the 30 cases reported in children, all of whom are under four years.

The major risk groups include homosexual men 71.8%, IV drug users 16.6%, Haitians 4.8%, hemophiliacs 0.7%. Six percent of men and women do not fall into these risk groups. Persons in the “no risk” group can be classified as follows:

- Female sex partners of persons at risk: 20
- Blood transfusion recipients: 22
- Heterosexual patients 60 years with normal immune function with KS, presumably Classical KS: 13
- Dead before interview: 38
- Others: 37
- Total: 130

Thus the “no risk” group may actually be as low as 2% of the entire AIDS population.

Mortality from AIDS based on half year of diagnosis is as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>1st half</th>
<th>2nd half</th>
</tr>
</thead>
<tbody>
<tr>
<td>1979</td>
<td>100</td>
<td>86</td>
</tr>
<tr>
<td>1980</td>
<td>1st half</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>2nd half</td>
<td>96</td>
</tr>
<tr>
<td>1981</td>
<td>1st half</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>2nd half</td>
<td>75</td>
</tr>
<tr>
<td>1982</td>
<td>1st half</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>2nd half</td>
<td>43</td>
</tr>
<tr>
<td>1983</td>
<td>1st half</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>2nd half</td>
<td>18</td>
</tr>
</tbody>
</table>

Those living over eighteen months after diagnosis have all had without opportunistic infections.

The Immunology of AIDS — John Stobo, M.D., Professor Medicine; Head, Section of Rheumatology/Clinical Immunology, UCSF.

In the normal immune system there are two basic steps involved in production of cell mediated response to a given antigen: 1) Sing T cell activation: This requires a linkage of antigen and class molecule from IR gene to an accessory cell (macrophage, monocy or Kupfer cell). Under the stimulation of interleukin 1 this compl linkage will activate the T cell; 2) Expansion of T effector cells: The activated T cell will multiply under the stimulation of interleukin 1. T cells can be identified in the thymus and peripheral blood with monoclonal antibody markers as follows:

<table>
<thead>
<tr>
<th>Thymus</th>
<th>Peripheral Blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>T5 (immature T)</td>
<td>95</td>
</tr>
<tr>
<td>T8 (cytotoxic, suppressor T)</td>
<td>80</td>
</tr>
<tr>
<td>T4 (inducer, helper T)</td>
<td>75</td>
</tr>
<tr>
<td>T3 (all mature T)</td>
<td>100</td>
</tr>
</tbody>
</table>

As thymocytes migrate from cortex to medulla of the thymus th differentiate into T4 and T8 cells and normally lose the T10 (i immature thymocyte) marker before reaching peripheral circulation.

In AIDS the following immunological abnormalities have been identified:

A. T cell
1. decreased circulating T cells
2. decreased T4 and T8 cells (helper)
3. normal or increased number of T8 cells (suppressor)
4. low T4/T8 ratio
5. increased T10 cells in circulation; i.e. accelerated release immature thymocytes
6. decreased interleukin II production, decreased expansion of T effector cells in response to antigen
7. blunted or absent delayed hypersensitivity reaction

B. B cell
1. normal or decreased circulating B cells
2. increased serum IgG and IgM
3. decrease in specific antibody production
4. decrease in mitogen stimulated immunoglobulin production
5. increased spontaneous immunoglobulin production

Since interleukin II has been shown to be one of the missing co components in the cell mediated response, it is hoped that administration of this immunomodulator will restore immune function AIDS.
Protozoa:
1. Pneumocystis carinii — to be discussed later.
2. Toxoplasmosis gondii: It presents as fever and changing mental status. Diagnosis: Brain scan and brain biopsy. Treatment: pyrimethamine and sulfadiazine. Results are often poor.
3. Cryptosporidia: to be discussed later.

Mycobacteria:
1. Mycobacterium avium — intracellular. It presents as fever, wasting pancytopenia, hilar adenopathy and/or lung infiltrates. Diagnosis: blood or bone marrow culture, tissue examination for acid fast bacilli. Treatment is unsatisfactory with multiple antibiotics.

Dr. Conte also discussed hospital infection control guidelines for AIDS. These are well summarized in his article in New England Journal of Medicine, 309:12, p. 740, Sep. 22, 1983

The Gay Lymph Node Syndrome — Donald Abrams, M.D., Clinical Instructor in Medicine, UCSF.

Two hundred homosexual men with this syndrome have been evaluated at UCSF. Definition includes persistent lymphadenopathy with nodes larger than one centimeter in diameter for greater than six months. Two or more extragenital sites must be involved. It has been described in other AIDS risk groups such as hemophiliacs, IV drug users, and female sex partners of AIDS patients.

One half of the men at UCSF have had biopsies. These have revealed follicular hyperplasia with increased plasma cells and vascular channels in paracortical T cell areas. All have axillary and inguinal adenopathy and 75% have splenomegaly demonstrated on CT scan.

Of these men, 3,200 have developed AIDS (two KS, one probable PCP). It is noteworthy that these three men all demonstrated regression in lymph node size prior to onset of more severe illness. In a similar study of lymphadenopathy patients in New York, 15% have progressed to AIDS. These patients demonstrated “follicular involu-

Part II will include diagnosis and treatment of gastroenterology problems associated with AIDS, pneumocystis, Kaposi Sarcoma and theories on the pathogenesis of AIDS.

James Campbell, M.D.
BAPHR Produces New Education Pieces

In preparation for Gay Pride Week and the Democratic Convention, three new publications teaching and promoting safe sex practices were prepared by the Scientific Affairs Committee and coordinated by the AIDS Resource Group. Copies are enclosed with your issue of the Baphron.

The wallet-size card was passed out freely during the parade down Market Street on June 24 by BAPHR members and by the AIDS Foundation; this card lists the main practices and the categories of safety thought to be associated with them. These will probably be made available to baths and clubs for distribution at the time of entry. The same principles were treated in a short brochure, presented as a letter from one gay man to another in “street” language, to put across the same points in a conversational manner; in addition, discussion of the importance of safe sex with potential partners was encouraged as well as using pornography as a way of fantasizing unsafe practices without engaging in them. The brochures and cards were available at the BAPHR and AIDS Foundation booths in Civic Center.

The third brochure, a replacement for the previous and somewhat outdated Risk Reduction Guidelines, has now been completed in time for the Democratic Party Convention. While embodying the same sex principles, it explains the background and rationale for the categories in language understandable by at least most readers of average education. Another publication, an academic one with references giving a current status report on AIDS, is planned for completion in the fall.

As usual, reactions by BAPHR members, either positive or negative, are welcomed. If you have comments or suggestions, please contact either Dr. Jim Campbell, Chairman of the Scientific Affairs Committee, or Dr. Will Warner, Head of the AIDS Resource Group.

BAPHR Picnic Set for September

Mark your calendars for the Annual BAPHR Picnic on Sunday, September 16. It will be at the East Bay home of one of our members this year. Sunning and pool-swimming are planned, plus croquet and volleyball. Nearby is access to running and biking paths as well as tennis and golf.

Grilled hamburgers will be provided and members will be asked to bring a side dish or dessert. For details see the September issue of Baphron or call Doug Carner at 558-9353.

Officers Nominated for 1984-85

The nominating committee has proposed the following slate of candidates for office the next year. Additional nominations may be made up until the election which will be held at the September general meeting.

Dennis McShane will succeed as president from his present position as president-elect. Dennis is an internist and rheumatologist in practice in Redwood City. He is a founder and the first president of AAPHR. He has served BAPHR on the education and support committees and has been circulation editor of the Baphron.

Stephen Walter, M.D. has been nominated for vice-president. He is a psychiatrist in practice in San Francisco. He has also served on education and support committees and has organized several major events including the annual banquets and the hospitality suites and information booths for the Democratic National Convention.

Sam Thal, M.D. has been nominated for secretary. He is an internist and has been an editor of the Baphron and has served on the membership and scientific affairs committees and the archive subcommittee.

Jack Wilkie, M.D. has been nominated for treasurer. He is an ophthalmologist and has been chair of the membership and internal support committees and has coordinated the annual retreats.

Bill Kapla, M.D. has been nominated as president-elect. He is in family practice in San Francisco. He has served as treasurer for three terms and has been on the education committee at administration.

Last Call for Retreat Registration

The 1984 retreat scheduled for August 17, 18, and 19 at Wildwood Ranch is fast approaching. Space is still available and if you have yet registered you should do so promptly if you don’t want to miss this great event. Details have previously been published in Baphron but if you need additional information or registra-
tions forms you are urged to call the BAPHR office at (415) 558-9353, return these with your check.

Member Donates Copier

Steven Mehalko, M.D. has donated a Savin copy machine to Baphron for use in our office. This has greatly improved the efficiency of office and has reduced costs of reproduction which is a major expense. Thank you, Steve, for this generous contribution.
GUIDELINES FOR AIDS RISK REDUCTION

What is AIDS?

- AIDS is shorthand for Acquired Immune Deficiency Syndrome
- AIDS is a disease that damages the immune system of otherwise healthy persons
- AIDS is a life-threatening disease
- AIDS may be a sexually-transmissible disease

The message is clear:

AVOID THE DIRECT EXCHANGE OF BODILY FLUIDS.

Strong evidence indicates that AIDS is transmitted by direct contact with the bodily fluids of a person who is infectious. The most common way in which bodily fluids (semen, saliva, urine, blood, and even stool) are exchanged is through intimate sexual contact.

As with other sexually-transmitted diseases like gonorrhea, syphilis, hepatitis, herpes, etc., it may take only ONE contact to acquire AIDS.

BUT WHAT ARE THE SYMPTOMS OR SIGNS OF AIDS?

Many symptoms associated with AIDS are nonspecific and can occur with benign ailments such as a cold, bronchitis, or stomach flu. What characterizes many AIDS symptoms are their duration (much longer than harmless, self-limited conditions), their unrelenting waxing and waning, their severity, and frequently their coexistence with an increasing debility or failure to thrive.

General symptoms of AIDS may include the following:

- Unexplained increasing and persistent fatigue.
- Periodic or regular fevers, shaking chills, drenching night sweats not accompanied by a known illness and lasting longer than several weeks.
- Weight loss that is unexpected and greater than approximately 10 lbs. in less than 2 months.
- Otherwise unexplained swollen glands (enlarging lymph nodes with or without pain, usually in the neck, armpits, or groin) lasting for more than two weeks.
- Pink to purple flat or raised blotches or bumps, usually painless, occurring on or under the skin, inside the mouth, nose, eyelids, or rectum. Initially they may look like bruises that do not go away and they usually are harder than the skin around them.
- Persistent white spots or unusual blemishes in the mouth.
- Persistent or often dry cough that is not from smoking and has lasted too long to be from a usual respiratory infection.
- Persistent diarrhea.

WHAT HAPPENS TO PEOPLE WITH AIDS?

They are susceptible to a wide variety of illnesses which are neither "new" illnesses nor unique for AIDS patients. These include serious infections caused by some microscopic parasites (e.g., pneumonia caused by Pneumocystis carinii), some bacteria (including one related to the agent of tuberculosis), some fungi (e.g., cryptococcal meningitis), and some viruses (e.g., prolonged herpes rectal ulcers). Certain cancers, particularly Kaposi's sarcoma, have been the major manifestation of AIDS in many individuals. Not all people with AIDS get all these diseases.

HOW IS AIDS CONTAGIOUS?

This answer requires some understanding of general principles that apply to all contagious diseases. In general, disease transmission requires a vehicle carrying a significant number of germs into a susceptible person. A vehicle can be microscopic amounts of blood such as in the case of some types of hepatitis. It can be urine or semen in the case of cytomegalovirus (CMV). It can be pus or stool or the objects contaminated with these. Not all germs are present in all bodily fluids or secretions.

If you are uncertain about your health, please see a health care provider knowledgeable about AIDS and its manifestations.
HOW ARE WE SUSCEPTIBLE TO INFECTIONS?

We are susceptible either by 1) exposure to germs that are very invasive and that respect none of the natural barriers most people have, or 2) damage to natural barriers allowing invasion of germs that otherwise might not have a chance to cause infection.

WHAT ARE THESE NATURAL BARRIERS?

They include intact skin and mucous membranes of the nose, throat, urethra, and rectum. They include stomach acid which kills many swallowed germs. They include healthy cells of the nose and lungs which can filter and expel inhaled germs. They include normal mucus and saliva production which can coat and "neutralize" many germs.

ARE THERE ANY OTHER BARRIERS besides THESE NATURAL ONES?

A hand can be held over the mouth when coughing; a tissue or handkerchief can be held over the mouth when sneezing, a condom can be used when having sexual intercourse with a man. These and other means of avoiding direct contact with the excretions and secretions (urine, stool, blood, semen, saliva) of other persons represent barriers that limit the chance for you to acquire germs those people may harbor—even if they don't appear ill.

YOU MEAN I CAN CATCH AN INFECTION FROM SOMEONE WHO DOES NOT APPEAR ILL?

Yes. Many infections are contagious even during the "incubation period." This means that during that time after a person is infected but before he or she feels sick, the germs for that illness may be transmitted to other people. It is proposed that the incubation period for AIDS may be 7-24 months or longer. Thus, there may be two years or more between the time the person is infected and he feels sick with AIDS. It is therefore possible and probable (but not proven) that the AIDS agent may be spread during this time.

WHAT DOES ALL THIS HAVE TO DO WITH AIDS?

As stated earlier, no one knows if AIDS is caused by a germ. If it is, we do not know (1) what the vehicle(s) is/are that carries it, (2) how many germs it takes to cause disease, (3) whether all people who come into contact with the germ are equally susceptible to its consequences, or (4) how long the infectious period may be. We also do not know if there are other factors that make an individual particularly susceptible to the disease.

Reducing Risk

Reducing risk for AIDS may mean making changes in sexual practices but it does not mean denying the sexual part of one's life. Fear of AIDS can and probably will stir homophobic responses in many of us. Gay sex and intimacy with gay men may be seen as bad and to be avoided at a time when we need more intimacy and self-affirmation. We may need to create a kind and rational "gay parent" in our heads that counteracts such negative thoughts and guides us toward a healthy regard for our bodies and the bodies of those we love. However, we urge careful consideration of the following points and their implied suggestions.

There are general factors agreed upon by virtually all researchers as representing significant risk:

1) Sexual activity in which bodily secretions are exchanged;
2) The more partners with whom sexual activity includes secretion exchange, the greater the risk. Another equally high risk activity, but not seen with high prevalence in gay men:
3) The injection of illicit drugs or the shared use of needles for such injections. By logical extension, sexual contact with those known to use intravenous drugs would represent significant risk.

Certain sexual practices are known to be associated with an increased risk of sexually transmitted diseases. Unless you and your partner have been monogamous for two years or more, eliminating, reducing, or modifying these practices may decrease your risk for AIDS. Remember the principles of protective barriers and blocking the spread of germs in blood, secretions and excretions from person to person.

- Fisting (both giving and receiving): With the microscopic and frequently visible injury to the rectal tissues, germs may penetrate into the bowel and bloodstream; also the inserting partner's fingers or hand is exposed to all the bowel germs and with the tissue injury involved, is exposed to his partner's blood. This is one practice for which correlation with AIDS has been demonstrated.
- Oral-anal contact (rimming): The "active" partner is at risk of ingesting multiple infectious agents in feces; the receptive partner may absorb his partner's saliva into his bloodstream through small tears or fissures in the anal skin.
- Anal Intercourse receptive (being fucked): This is another practice for which AIDS correlation has been shown. Because the rectal lining can be easily injured during anal intercourse, foreign material or germs in your partner's semen can gain direct access to your
bloodstream. The use of condoms for intercourse would provide the logical barrier to reduce the likelihood of this happening. If a condom is not used, withdrawal prior to ejaculation would be a "next best" precaution. Since inanimate objects not only can induce tissue injury but can carry germs, using only your own douche equipment or toys is prudent.

- Anal Intercourse insertive (fucking): It is not certain whether significant trauma regularly occurs to the penis during anal intercourse so that infections can enter the bloodstream. However, use of a condom will protect the wearer against many of the sexually transmitted infections.
- Note: Lubrication for anal intercourse is important. Saliva, though present, is a poor lubricant. First, it is loaded with germs from the mouth; second, its ability to reduce friction is very short lived. Thus, tissue injury results more readily and this enables those mouth germs to gain entry into the bloodstream. The best lubricant should be non-perfumed and in closed containers which can't be contaminated with fecal germs to be transmitted to the next partner.
- Oral-genital insertive (being sucked): If there are no cuts or abrasions on your penis to be infected by mouth germs, probably no extra precautions need to be taken except to avoid trauma done by the teeth.
- Oral-genital receptive (sucking): With the intact barriers of unbroken skin on your partner's penis and your unbroken oral mucous membrane, this activity probably presents minimal risk. Remember that semen is a bodily secretion that may contain germs or other material foreign to your body. Either not having your partner cum in your mouth or not swallowing the cum are ways to minimize your exposure. If there is uncertainty about the recent whereabouts of your partner's penis, requesting a shower never hurts.
- Water sports: Urine on intact skin probably represents little risk but when it enters the body, it becomes the exchange of an excretion.
- Kissing: Providing neither partner has open cuts or sores of the mouth, lips or tongue, kissing probably represents little risk. Although the degree of infectivity of saliva by the various routes of access into the body (as mentioned above) is not known, it is unlikely that an AIDS agent could be transmitted easily through kissing.
- Hugging, cuddling, sensual massage, mutual masturbation: Since no bodily fluids are exchanged, these activities are sexual, offer no risks for AIDS transmission and could easily be encouraged.

### SOCIAL AND COMMUNITY RESPONSIBILITY

The uncertainty about AIDS will be overcome. In this health crisis there are the seeds for positive social growth. We think that thoughtful consideration of the facts will help achieve:

- Recognition of our fear through a sharing of feelings with partners, friends and strangers in discussion groups and other organized efforts and hopefully the channeling of those fears into effective action.
- Emotional and financial support for those who have or who are suspected of having AIDS.
- A community network that provides a supportive atmosphere in which the principles in these guidelines can be accomplished.
- A community that assists anyone affected by AIDS or AIDS-like conditions to maintain intimacy and sexual contacts without risking their health or the health of their partners.
- A knowledge of AIDS based on fact and not on rumor.
- Continued development of gay-influenced support, education, referral services, and research (SHANTI and AIDS-KS Foundation).

As we offer these guidelines, we are actively working to marshal the energy and funds necessary to solve this health crisis as soon as possible.

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This brochure was prepared by the BAPHR Scientific Affairs Committee with invaluable counsel of many gay community leaders.

For referral service, call:
BAPHR — (415) 673-3189
AIDS-KS Foundation — (415) 864-4376

For reprint requests, contact:
Bay Area Physicians for Human Rights
P.O. Box 14546, San Francisco, CA 94114
Curriculum Vitae

Jim R. Groundwater, M.D.: 

Born : Cleveland, Ohio, April 9, 1937

Graduated :

1) Lakewood High School, Lakewood, Ohio, 1955 (with honors)
   • Awarded Scholarships to:
     Dartmouth College (Otis Scholarship)
     Yale University
     Cornell University
     Columbia University

2) Dartmouth College, Hanover, New Hampshire 1959 (AB)

3) Case Western Reserve University, Cleveland, Ohio 1964 (MD)

Internship : Kaiser Foundation Hospital, San Francisco, 1965 to 1966

Military Service :

1) LT, MC, USNR, Active Duty
   • Medical Officer, USS Calvert 1965 to 1966
   • Medical Officer, US Naval Station, Newport, R.I. 1966 to 1967

Residency : University of California, School of Medicine, Dept. of Dermatology, San Francisco, California 1967 to 1970

University Affiliations :

1) University of California, San Francisco, California
   • Environmental Dermatosis Clinic, Dept. of Dermatology 1971 to 1981
      (This clinic evaluates patients with allergic contact dermatitis to cosmetics and other allergens.)

Dermatology Consultant, AIDS Clinic, S.F.G.H. 1983 to 1984

Private Practice : 450 Sutter Street, San Francisco 1970 to Present

Jim R. Groundwater, M.D.
Curriculum Vitae

1) Former practice associates:
   - Marek Lorenc, M.D. 1985 to 1989
   - Harry L. Arnold, M.D. (deceased) 1985 to 1989
   Dr. Arnold was the past president of the American Board of Dermatology and the American Academy of Dermatology.

Hospital Affiliations:

- California Pacific Medical Center
- Saint Francis Memorial Hospital
  - Vice-president, St. Francis Hospital Physicians Medical Group
  - Member, Quality Assurance and Utilization Review Committee
- Saint Mary's Hospital
- University of California Medical Center
  - U.C.S.F. Dermatology Advisory Board
  - U.C.S.F. Promotions Committee
- Davies Hospital
- Mount Zion Hospital

Medical Societies:

- American Academy of Dermatology (fellow)
- American Contact Dermatitis Society
- American Medical Association
- American Society of Dermatologic Surgery (fellow)
- California Medical Association
- Pacific Dermatological Association
- San Francisco Dermatological Society
- San Francisco Medical Society

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University of Minneapolis, Minnesota,

Jim R. Groundwater, M.D.
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KRON News, 1984

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- Sun Burn, Poison Oak, Bug Bites and Heat Rash
- Alopecia Areata (in conjunction with the Alopecia Areata Foundation)
- Poisonous Plants
- Moles and Skin Cancer

AIDS Clinical Grand Rounds, S. F. Community Consortium Nov. 16, 1994
Dermatological Treatment of Kaposi's Sarcoma
Roundtable Discussion on Kaposi's Sarcoma

CPMC Noon Medical residents conference, HIV Dermatology Nov., 1994

450 Sutter Noon Lecture, Cosmetic Dermatology 1994

Dermatologic Skin Care and Corrective Camouflage Course 1989 to Present
Advanced Skin Care Clinic, 450 Sutter St.
Dermatology for the Aesthetician

Dept. of Medicine Noon Lecture, St. Francis Hospital Jan. 12, 1995
Common Dermatologic Problems in HIV Disease

St. Francis Hospital Primary Care Group Sept. 1994
Dermatology and the Primary Care Physician

Jim R. Groundwater, M.D.
TO:  Dr. William Epstein  
      Dr. Paul Volberding  
      Mrs. Magdalen McMullen  
      Mrs. Lucy Whybrow  

FROM:  Dr. Marcus Conant  

SUBJECT:  Kaposi's Sarcoma  

A combined Dermatology-Oncology Clinic will be established for the evaluation and treatment of patients with Kaposi's sarcoma. Dr. Paul Volberding has graciously consented to volunteer his time to serve in this clinic on Mondays from 12:00 until 1:00. I will make my time available to be the dermatology consultant to the clinic.  

We will schedule the first clinic for Monday, September 21st, and we will plan to have clinic each Monday thereafter. Would you please notify the residents to refer patients to us at that time, and I will ask Mrs. Whybrow to put the clinic on the residents' teaching schedule.  

Dr. Van Fletcher has expressed interest in being assigned to this clinic and we would welcome his assistance.  

I will return from the Kaposi's sarcoma meeting in Washington on September the 15th, and I look forward to sharing with you the information which I acquired.
February 27, 1984

William Epstein, M.D.
Professor and Chairman, Department of Dermatology
University of California Medical Center
3rd and Parnassus Avenues
San Francisco, California

Dear Bill:

I will be available to cover for Steve Baker in the AIDS Clinic if he is ill or on vacation. I am not, however, interested in rotating through the clinic on a regular basis. Since I should be on staff at San Francisco General soon, I could cover "legally", and be paid on an "on call" basis. If any such funds did accrue for such coverage, I would be pleased to donate them to the AIDS Clinic. Thanks again for thinking of me, Bill.

Sincerely,

James R. Groundwater, M.D.

cc: Axel Hoke, M.D.
Steve Baker, M.D.
Paul Volberding, M.D.
Marc Conant, M.D.

JRG:ls
Hughes: And was it also something that you as physicians felt particularly responsible for addressing? Because you had two overwhelming reasons: you were not only physicians but you were gay men.

Andrews: That's right.

Hughes: And it was your community that was being hit.

Andrews: That's right. The fact that we had done the health fair and been trying to work with sexually transmitted diseases and everything else, and suddenly most people were saying, "There's something infectious here. We don't know what the hell it is," but it began to greatly alarm us. "It's killing people, and what the hell is going on?" So it was very, very relevant to each one of us, personally and professionally, because there was so much talk about it.

Scientific Affairs Committee

Hughes: BAPHR formed, I think the first name is the AIDS Task Force, am I right? Or was it even not even AIDS?

Andrews: First we had a scientific affairs committee, which was like the same thing with social concerns—we had all these different committees and Scientific Affairs took on the Safe Sex Guidelines, and all that kind of stuff. They quickly became the...
the clinician to have that information. But unless it turned out normal, it wasn't very good for the patient.

Hughes: How could you use that information?

Campbell: Well, you could certainly identify patients who were likely to get opportunistic infections.

Hughes: And take prophylactic measures?

Campbell: Well, occasionally we would prophylax people for Pneumocystis, but most people we didn't prophylax for Pneumocystis. But if there was somebody who just was not feeling well, or had a little bit of pneumonia, or had a number of unexplained complaints, occasionally I would do the T cells and find that they were normal. It was just wonderful news: well, it doesn't seem to be this new [disease].

However,

but most of the time, the T cells would be just what I expected: they would be really terrible, and you would just see

and see what evolved. At that time, there were no guidelines about

you should prophylax people with fewer than 200 CD4 cells for Pneumocystis. We looked more at ratios rather than absolute numbers; because a high CD4 to CD8 ratio usually meant there was no problem with AIDS, and a very low one usually meant that somebody had been infected. That was more telling than the absolute numbers. The ratio seemed to be
Lesions and Multiple Biopsies

Groundwater: Anyway, he had probably five or six two- or three-millimeter purple bumps on his skin, and he also had enlarged lymph node on the right side. I remember the primary physician [FULL NAME?] who referred him had noticed these nodes and had biopsied the nodes. The biopsy report indicated hyperplasia without any specific diagnosis. I biopsied one of these. I looked at these purple lesions on his body at that time, and of course, in residency we learned—PLEASE COMPLETE—and I thought they must be something serious.

Hughes: Why did you think that?

Groundwater: They just didn't look like anything benign that I knew of. They didn't look like just angiomas, for example, that so many people get; cherry angiomas that sometimes can look really purplish. [These lesions] were somewhat poorly defined, and they just had the look of malignancy to me. So I suspected from the beginning there was something serious going on, certainly with these nodes, and with the purple bumps.

The primary physician kind of pooh-poohed it; he didn't think it was terribly serious. He thought it was a viral sort of thing or something like that. And the biopsy specimen showed only hyperplasia.

So I biopsied one of the purple lesions, and I think we sent it off to a pathologist [NAME?] who read it as an angioma, really of no significance. But I felt that it

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Sally Smith Hughes

Graduated from the University of California, Berkeley, in 1963 with an A.B. degree in zoology, and from the University of California, San Francisco, in 1966 with an M.A. degree in anatomy. She received a Ph.D. degree in the history of science and medicine from the Royal Postgraduate Medical School, University of London, in 1972.


Presently Research Historian and Principal Editor on medical and scientific topics for the Regional Oral History Office, University of California, Berkeley. Author of The Virus: A History of the Concept, Sally Smith Hughes is currently interviewing and writing in the fields of AIDS and molecular biology/biotechnology.