THE OFFICIAL NEWSLETTER OF THE

NATIONAL COALITION OF GAY STD SERVICES

Volume 4 #5 May, 1983

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CASTDS CANCELLED; ATTENDANCE AT DENVER OR SEATTLE CONFERENCES ENCOURAGED

It is with great regret that the NCGSTDS must announce the cancellation of Current Aspects of STDs Symposium--III, scheduled for August 4, 1983, in Seattle. The "Cruise the Puget Sound Aboard the Virginia V Steamship," fundraiser scheduled for the evening of August 3, is also cancelled. Cancellation was announced to NCGSTDS members & friends and CASTDS supporters in a letter dated April 18th, by NCGSTDS Chairperson and CASTDS Codirector Mark Behar, after extensive discussions with other Codirectors Robert Bolan, MD, David Ostrow, MD, PhD, and Robert Wood, MD, and others. Insufficient program submissions was the chief reason for cancellation. Special thanks to Josh Joshua and Susan Kaetz, for their interest & dedication in helping plan for CASTDS and the Cruise.

Individuals are encouraged to attend the American Association of Physicians for Human Rights (AAPHR) Symposium, which will be held in conjunction with the Fifth National Lesbian & Gay Health Conference (FNLGHC) and the Second National AIDS Forum, June 9-12, 1983, in Denver, or the Fifth International Meeting of the International Society for STD Research, August 1-3, 1983, which will be held in conjunction with a Centers for Disease Control sponsored Clinical STD Update on July 31, in Seattle. Official NCGSTDS representation is expected at both Conferences. See related articles in this issue of the Newsletter for details about both Conferences.

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NCGSTDS TO RECEIVE JANE ADDAMS-HOWARD BROWN AWARD IN DENVER

The National Gay Health Education Foundation recently announced the recipients of the 1983 Jane Addams-Howard Brown Award (JAHBA) as the National Coalition of Gay STD Services and the National Association of Gay Alcoholism Professionals for their outstanding efforts, dedication, and advances to the lesbian/gay health care community, as well as the lesbian/gay community at large, according to NGHEF Board President Dr. Paul Paroski, MD. The JAHBA was created by the National Gay Health Coalition in 1978 to honor individuals and/or organizations that have mad significant contributions to the lesbian/gay health care community.

The Award carries the names of Jane Addams, a lesbian, who as founder of the Hull House, demonstrated her great social concern, and Howard Brown, a gay physician, who publically acknowledged his homosexuality while serving as Health Commissioner of New York City and provided an awareness of the special needs of gay/lesbian individuals in the process of health care delivery. The Award has traditionally been granted at the National Lesbian/Gay Health Conferences. Since the take over of the production of these Conferences by the National Gay Health Education Foundation, Inc., the granting of the Award has become the responsibility of the Board of Directors of the Foundation. Previous recipients of the Jane Addams-Howard Brown Award include Evelyn Hooker and Walter Lear. The 1983 Awards will be granted Sunday, June 12, at the National Lesbian/Gay Health Conference in Denver by Paul Paroski.

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NCGSTDS CHAIRPERSON NAMED TO WISCONSIN GOVERNOR'S COUNCIL ON LESBIAN & GAY ISSUES

NCGSTDS Chairperson Mark Behar was recently appointed, along with 13 other Wisconsin residents, to the newly formed Governor's Council on Lesbian & Gay Issues. Democratic Governor Tony Earl is asking that the Council work on ending discrimination against gay/lesbian people in employment, public health, child custody, and other areas. The executive order creating the Council specifically instructs it to work with the state's Departments of Industry, Labor & Human Relations, Employment Relations, Registration & Licensing, and Health & Social Services to see that Wisconsin's gay rights law is enforced. "I'd like to see the Council promote a health care delivery network for Wisconsin's gay & lesbian citizens, and to address such issues as STDs, AIDS, alcoholism & drug abuse, as well as mental health concerns," Behar stressed, the only Council member with extensive public health & medical experience. One of the Council's first tasks at its first meeting, April 23, was to draft and approve a resolution urging President Reagan, Secretary of Health & Human Services Margaret Heckler, and the Wisconsin Congressional delegation to support increased funding for research into the cause, transmission & cure of AIDS.

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LESBIAN & GAY HEALTH PROJECT OF DURHAM, NC SEEKS ADVICE & INFORMATION

by Aida Wakil, Carl Wittman, & David Jolly

The Lesbian & Gay Health Project of Durham seeks to improve the health care for homosexuals in central North Carolina, and seeks advice and information from others who have undertaken similar projects or who share the concern that lesbians & gay men have access to quality health care. We realize that we often face barriers to quality health care within the medical community. These barriers include overt discrimination, insensitivity to our concerns, and ignorance of our problems. When we discuss the epidemic of STDs afflicting gay men in urban areas, we realize how dependent we are on national media for what we know; often we do not know where ot turn for local information or advice. We are fully aware that we must be our own advocates, that our health care needs will not be met unless we are active in defining those needs and implementing the services to meet them. Our first activity will be a needs assessment, which will involve 2 surveys, one of gay men & lesbians to identify the health concerns of the community and one of local health professionals to gauge the attitudes, knowledge, and experience that they bring to the care of homosexual clients. We suspect that lesbians & gay men in central North Carolina constitute a medically underserved community. If the surveys confirm our suspicions, they should also provide information upon which we can base recommendations for improving heatlh care services for our community. The surveys will serve an educational function as well, heightening our community's awareness of important health issues and increasing providers' sensitivity to our health needs. If you or your group has performed similar surveys/needs assessments, we would appreciate receiving sample questionnaires and summaries of your results. Because we foresee the survey of health professionsls as an especially sensitive and problematic venture, we are especially interested in ideas on approaching this group.

Upon completion of the two surveys, the Project wants to work closely with area health professionals to implement any recommendations it makes. In addition, we plan to provide a health information and referral system to the community, a support system for gay & lesbian health professionals in this area, and a support network for lesbians & gay men with chronic health problems. Any information you might have on potential funding sources for the above projects would also be appreciated. Finally, we are compiling a library of lesbian & gay health resources. Bibliographies and the names of books, reports, and journal articles that you recommend would be greatly appreciated. We'd like to hear from you! Please address correspondence to: LGHP, PO Box 11013, Durham, NC 27703.

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HAWORTH PRESS PUBLISHES HEALTH & MEDICAL CARE CATELOG

Included with this Newsletter is The Haworth Press's new Health & Medical Care Catelog, featuring almost 200 books & journals in such areas as aging, alcoholism, homosexuality, women's studies, and more. Discount coupons are also included. ***** ***** *****

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MMWR NOW AVAILABLE AT REASONABLE COST

On October 1, 1982, the Centers for Disease Control stopped free distribution of its Morbidity & Mortality Weekly Report (MMWR), and a paid subscription system through the National Technical Information Service was initiated ($70 for third class mail, $90 for first class). This very high cost discouraged most readers from continuing their subscriptions. There are now two national sources that provide the very same MMWR at reasonable cost: Ochsner Clinic, (address: Dr. V. Alexander, Chairman, Occupational Medicine, Ochsner Clinic, 1514 Jefferson Highway, New Orleans, LA 70121), and Massachusetts Medical Society Publications (address: MA Med. Soc. Publ., CSPO Box 9120, Waltham, MA 02254). Details follow (the NCGSTDS will continue to subscribe & reprint relevant articles in the Newsletter):

Date of First Issue	March 4, 1983	July 1, 1983
Mailing Day for Each Issue	Friday	Friday
SUBSCRIPTION PRICES	**Ochsner Clinic**	**MA Med. Soc.**
52 Weekly Issues and Annual Supplement (1st Class Mail)	$25.00	$38.00*
52 Weekly Issues and Annual Supplement (3rd Class Mail)	$20.00	$20.00*
52 Weekly Issues and Annual and 4-6 Periodic Supplements (1st Class Mail)	$30.00	$45.00*
52 Weekly Issues and Annual and 4-6 Periodic Supplements (3rd Class Mail)	$25.00	$25.00*
Overseas Subscriptions	$50.00	**

*Subscription requests submitted to the MA Medical Society Publications before 5/1/83, are $2.00 less than quoted price.
**Inquire at MA Medical Society Publications.

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HEPATITIS B VACCINE FOR $25.50!

by Laurel Stolpe, RN

Some good news from Anchorage, Alaska! We now offer the hepatitis B vaccine for $25.50, which includes all three injections. The blood test is being done at no cost. We have just begun advertising to the gay community and we plan to do a mass screening at one of the local gay bars.

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HEPATITIS BROCHURE FOR GAY MEN AVAILABLE FROM ABBOTT LABS

Enclosed with this Newsletter is the excellent brochure, "Viral Hepatitis--Risks/Precautions/Prevention for Gay Men" distributed by Abbott Laboratories, Diagnostics Division, one of the manufacturers of the hepatitis B diagnostic tests. The brochures and display packs are available for your clinic at no cost from Ms. J. Bolino, Marketing Services Manager, Abbott Laboratories Diagnostic Division, Abbott Park, North Chicago, IL 60064 (800/323-9100). Please send the NCGSTDS your comments about the new brochure and we'll forward them to Ms. Bolino.

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VD NATIONAL HOTLINE HAS NEW ACTING DIRECTOR

Helen Shaw was recently appointed acting director of the VD National Hotline, to succeed Bea Mandel, who resigned to take a position at a local hospital. The VD National Hotline is a part of the American Social Health Association, which also runs the Herpes Resource Center and the VD Research Fund. The ASHA's national headquarters is at 260 Sheridan Av., Palo Alto, CA 94306 (415/321-5134, 800/227-8922), and has regional offices in Atlanta, Boston, Columbus, and Washington, DC.

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HEALTH PIONEERING IN THE 80'S: FIFTH NATIONAL LESBIAN/GAY HEALTH CONFERENCE

The theme of the 5th National Lesbian/Gay Health Conference, "Health Pioneering in the 80's," will be the primary place where lebian & gay healthworkers will meet to address the health and survival issues facing our community at this time. It will be a unique opportunity to educate each other, to share resources, and to network on a national basis. As Margaret Mead wrote, "Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it is the only thing that ever has." A very special and exciting Conference awaits you in Denver, at the Executive Tower Inn, June 9-12. Spekers, workshops, and sessions will focus on lesbian & gay participation in health, including helath delivery, definitions of health, health research and health politics. Also highlighted will be the lesbian & gay role in creating a new paradigm of health delivery and philosophy. The Conference includes the Second National Forum on AIDS, the annual meeting & medical symposium of the American Association of Physicians for Human Rights (AAPHR) and organizational time for national lesbian and gay health groups (including the NCGSTDS). The Conference is cosponsored by the National Gay Health Education Foundation, Inc., AAPHR, and the Gay & Lesbian Health Alliance of Denver. For registration information write to: Health Pioneering in the 80's, PO Box 9413, Denver, CO 80209 (303/777-9530). (A recent special mailing to all NCGSTDS members & friends included a detailed brochure describing the Conference.)

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GAY PUBLIC HEALTH WORKERS COSPONSOR TALKS AT APHA IN DALLAS, THIS NOVEMBER

According to Viktor Anderson, five presentations will be sponsored by the Gay Public Health Workers Caucus at the Annual Meeting of the American Public Health Association this November in Dallas, Texas. A special session AIDS Symposium with nationally known speakers will be one of the highlights of the Meeting. Other topics include: herpes, lesbians growing older, changes in labeling (homosexuality: medicalization & demedicalization), and guidelines & recommendations for healthful gay sexual activity (cosponsored by the NCGSTDS). Details on APHA's November Meeting and the GPHW Caucus will be presented in future Newsletters.

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HEPATITIS B VACCINE AT YALE

with special thanks to Chicago's Gaylife

The Yale University Health Plan has bowed to pressure from a local gay health organization and lowered its hepatitis B vaccine fee form $106 to $35 for YHP members, according to Boston's Gay Community News. The Gay Health Task Force has alleged that because all other vaccines are provided free, except those needed for international travel, the policy was discriminatory. YHP's Board stated that the charge was justified because of a relatively low incidence of hepatitis B at the University, and because gay men "voluntarily expose" themselves to it by their sexual behavior. More than 22 people turned out for a March 3rd protest demonstration organized by the GHTF, and some 1900 YHP members signed a petition supporting the GHTF's position before the organization changed its mind.

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THE TV INTERVIEW

by Mark Behar, Chairperson, NCGSTDS

Recently, I had the misfortune/fortune of being interviewed by a local television station for the "gay community's reaction" to the newly promulgated Food & Drug Administration and Office of Biologic's new regulations on blood donations. I had successfully avoided the "video-cam cyclops" up to this time but my luck ran out--no one else was available for interview (conveniently out of town!!) and any response would be better than a terse "no comment" statement on the evening news. To hell with my discomfort with speaking for "the gay community;" I made it clear that I spoke only for myself.

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THE TV INTERVIEW, Continued

Although I had considerable experience in speaking in front of large groups and even newspaper reporters, the idea of a TV news interview was rather intimidating. No matter how well intentioned the reporter or how extensive the interview, you and the story are still subject to the arbitrary editing of some unseen & ostensibly objective (read that nonsympathetic & sensational seeking) director. I am not accustomed to such loss of power!! But here I was, a novice unaware of the ground rules of TV reporting & interviews, about to be interrogated. Now was not a good time to reflect on my unpreparedness! What advancepreparation may have been helpful? Gay political, media, or health leaders, to the best of my knowledge, have never established or circulated guidelines for working with the electronic (or print, for that matter) media, for their less experienced colleagues. So, I have decided to address the issue and request feedback from you, our readers. Special thanks to the public affairs department of Planned Parenthood of Wisconsin for their suggestions and access to their resources.

The definition of public relations is positively influencing public opinion through two-way communication. You are delivering information to the community about your agency/concerns/etc. and to bring back information from the community (reactions during or after the interview via phone calls, letters, etc.). Be prepared!! 1) Know your topic. Reread your notes, recent articles, etc., so it is all fresh in your mind. It may be helpful to jot key points down on a card or sheet but this must remain out of view of the camera (sit at a table)--but don't depend on these notes. 2) Select three major points (more or less as time allows--prioritize). Decide on your key issues & stick to them; this will keep you from rambling. 3) Prepare potential questions. Try to figure out what the interviewer might ask and design answers. 4) Fill in your interviewer beforehand. Send background information on yourself and/or your topic to the interviewer. Also send a list of possible questions. Some interviewers appreciate this, while others won't. But even if they don't use your questions, it will help them to understand your topic. 5) Watch (or listen) to the show before your scheduled interview. This will give you a feel for the interviewer's style, biases, quirks, etc. 6) Reherse in a mirror. It sounds silly, but it might uncover some unnoticed mannerisms (figgeting, nodding, lip smacking, glasses pushing, other annoying habits) which are unsightly in a TV interview. 7) Practice with a friend. It helps to keep your answers spontaneous and also to field potentially "tough" questions. 8) Dress comfortably and neatly. Avoid bulky jackets, loud prints, stripes, or bizarre styles. TV exaggerates these and you set yourself up for looking like a clown. Simple styles in solid colors look good; avoid garrish make-up for the same reason. [One of my interviews was conducted at work, and I was appropriately dressed in my white lab coat; the interviewer objected, saying that I would give the viewer the impression that I was a doctor--I am a physician assistant; I insisted to wear the lab coat as a matter of principle--the interviewer was interviewing me, on my terms. She relented! The interview went well.]

On the air: 9) Be pleasant, warm, sincere, and professional. You want to present yourself (and the cause) as someone the audience can trust and like. Remember back to high school days? Your most memorable teacher & the one you learned & like best was the one you established a rapport with--who presented an image you could identify with. 10) Return to your key issues. If the interviewer strays from your agenda, you should steer it back again. Handy phrases are: "That is an important point, Carol, but something else to consider is..." OR "Yes, I agree. And another related point is..." 11) Mention your agency's name or gay/lesbian community or your cause frequently. Audiences probably have no idea who you are or where you're from, so give them something to identify with. 12) Answer questions concisely and directly. Rambling will bore your audience and hide your key issues. 13) Answer "tough" questions carefully. Stall if you need time (if it's videotaped, the pause will be edited out). A useful tip is to ask them to repeat the question or say "I am unclear as to what you are asking." This may give you time and it also may get the interviewer to rephrase the question so it is easier to answer. Do not refuse the answer unless it is a direct, personal and private topic. Saying "I don't know" is better than bullshiting. 14) Speak clearly. Don't talk too fast. No gum! Avoid medical or gay jargon without explaining. The audience may have no idea what "coming out," "AIDS," "STDs," or other similar terms are. Don't talk down to the audience. 15) Stay cool. Remain honest and friendly even if the atmosphere is hostile. You will be the credible

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THE TV INTERVIEW, Continued

one if you remain calm while others become vehement and inflamed. The best defense against a verbal assault on TV is a pleasant smile. Avoid grimaces, shock and frowning. 16) Relax! Easier said than done! Remember, the reason you are there is because you are knowledgeable on this subject and you have something to say. You are the expert! You know more about this than 99% of your audience. Avoid quick or expansive gesturing, loud or greatly varied voice tones, or excessive laughter--all signals of nervousness. 17) Recover at all cost. Everyone blunders at least once. Getting yourself out of a bad spot is what is important. Following the previous tips will set the stage for you to safely recover your composure. 18) Have fun! This can be a fun and energizing experience. 19) Debriefing: after the interview, and after the interviewed is aired, have a debriefing session with your colleagues. Learn from your mistakes. 20) If the interview goes all wrong, you have the right to request that it not be aired; or that it be retaped. Of course, the interviewer has the right to refuse. Don't feel bad or lose any sleep about what happened, if you feel it was a bad interview. Chaulk it up as a valuable learning experience. But in most instances, you'll get much more positive feedback than expected.

Oh yes: notify your mother, family, friends, & colleagues so they can share your excitement and not hate you forever for finding out about the interview by surprize--seeing it on the tube unexpectedly, or from friends--quite a potential embarrassment--unless, of course, you don't care. Consult your public library for other resources on conducting an interview. My interviews turned out much better than expected (thanks in part to excellent editing!!); and my mother and her friends loved it!

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HEPATITIS VACCINATION PROGRAM AT BOSTON'S U OF MASS

by John Birmingham

Several members of the University of Massachusett's Lesbian & Gay Center in Boston became interested in investigating the Student Health Service's (SHS) hepatitis B vaccination program. We thought it would be informative to share our findings with NCGSTDS members. *****In the two month period since the SHS's executive director announced the availability of the hepatitis B vaccine (on 2/11/83), sole notice was published in a 2 x 3" notice on the back page of the student newspaper. Two misimpressions were apparent: that the screening and vaccine cost to certain students was $120, and that for other at-risk members of the University community, screening & the first vaccination occurred simultaneously and costed a total of $85. In fact, screening for all members of the University community costs $15; the cost of the vaccine for students who filed a health history & evaluation form is $45; all others must pay $105.*****During the first 2 months of the vaccine's availability, there were few inquiries, and virtually no screenings or vaccinations.*****Among the person's noted to be at risk were "sexually active homosexual men," rather than "homosexually active males." *****Prior to April 22, there was only one call from SHS to the Lesbian & Gay Health Center about the vaccination program.*****The executive director of the SHS inconspicuously posted a memo about the availability of the vaccine until we met with him on April 15. A dozen copies of the memo was delivered to the Lesbian & Gay Center shortly after our meeting. At that meeting, we showed the director Dr. Neil Schram's article, "Why such poor acceptance of the hepatitis B vaccine?" in the March, 1983, NCGSTDS Newsletter. He requested a copy of it.*****A nursing student who asked SHS personnel about the vaccination program was told about the possibility of transmission of AIDS via hepatitis B vaccination. This was subsequently brought to the attention of the SHS director, referring him to the MMWR (32:134) & JAMA (249:745) references refuting that claim. We have reviewed the current literature on hepatitis B and Merck, Sharp, & Dohme's literature on the vaccine, and are meeting once again with SHS's director in May. Details of our progress will be reported in a future Newsletter.

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KEY WEST GAY COMMUNITY PUBLISHES QUARTERLY DIRECTORY OF SERVICES

How does a gay person find help in coping with problems in Key West, Florida? Allan O'Hara, member of the Board of Advisors of the AIDS Medical Research Foundation of South Florida and the education committee of the Keys to the Kingdom Metropolitan Church, spearheaded the project to publish a regularly updated directory of sources available for problems with alcohol, substance abuse, crisis assistance, health problems (physical & emotional), legal problems and a variety of other areas where one may need help or want to get involved. It also includes notices of particular interest to the gay community in Key West. For additional information, please contact: Allan O'Hara, PO Box 4073, Key West, FL 33040.

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NCGSTDS ANNUAL MEETING IN DENVER

The annual meeting of the NCGSTDS is tentatively scheduled for Sunday, June 12, 1983, at 10 am (exact time and location to be announced) in conjunction with the 5th National Lesbian & Gay Health Conference at the Executive Tower Inn, Denver, Colorado. The meeting is open to the public, and members are encouraged to attend. The following topics will be discussed: 1) Reports & handouts from NCGSTDS member services and friends; 2) new membership dues proposal for subscription classification and overseas subscription classification; 3) Current Aspects of Sexually Transmitted Diseases Symposium; 4) 3rd Edition of the Guidelines & Recommendations for Healthful Gay Sexual Activity; 5) NCGSTDS and Newsletter's role in AIDS; 6) New directions, goals, objectives; 7) Proposal to sponsor NCGSTDS representation to Seattle's Fifth International Meeting of the International Society of STD Research; 8) Next NCGSTDS meeting at APHA in November in Dallas; 9) Election of chairperson; and 10) Other business. A full report of the meeting will be published in the next issue of the Newsletter.

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SEATTLE GAY CLINIC PLANS SECOND MOONLIGHT CRUISE FUNDRAISER

The second annual Moonlight on the (Puget) Sound Boat Cruise Benefit for the Seattle Gay Clinic and the Seattle Counseling Service is scheduled for Friday, July 8th. Tickets cost $15 each or $25 for two. For more information: SGC, PO Box 20066, Seattle, WA 98102 (206/623-1799 or 545-7165).

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AAPHR SYMPOSIUM IN CONJUNCTION WITH 5TH NATIONAL LESBIAN/GAY HEALTH CONFERENCE

The annual meeting of the American Association of Physicians for Human Rights (AAPHR) and its medical symposium will be held in conjunction with the 5th National Lesbian/Gay Health Conference in Denver, June 9-11. The preliminary program includes three major areas. Directions in Medical & Scientific Aspects of AIDS will take place on June 9, and will include an immunolgical overview & research directions in AIDS; AIDS as a transmissible disease in blood products; and AIDS: etiological investigations from a viral standpoint. Hepatitis B and the heptavax vaccine will be June 10's topic. Clinical aspects & epidemiology of hepatitis in gay men; transmission of hepatitis B in gay men & efficacy of the vaccine in preventing disease transmission; development, manufacture & safety testing of the vaccine; AIDS incidence in persons receiving heptavax vaccine 1975-82; developing an effective hepatitis B vaccine program for gay men; sliding scale charges for the vaccine; & hepatitis in rural gays Saturday, June 11th will feature general discussions on STDs, Lesbian Health, and Risk Reduction. Specifically, topics will be women's health issues; intestinal syndromes in gay men; and counselling patients on risk factors. If you haven't yet registered, address your inquiries to: PO Box 9413, Denver, CO 80209.

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GUIDELINES & RECOMMENDATIONS FOR HEALTHFUL GAY SEXUAL ACTIVITY--3RD EDITION

The 3rd edition of the NCGSTDS's popular Guidelines & Recommendations for Healthful Gay Sexual Activity is enclosed with this Newsletter. Comments for the revision were solicited from NCGSTDS members & friends, and at meetings of the American Public Health Association and the National Lesbian/Gay Health Conference (Houston, June, 1982). Your comments are always invited! Bulk ordering information is available by writing directly to the NCGSTDS, PO Box 239, Milwaukee, WI 53201. Individual copies are available for $1.

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REPLIES TO HERPES HYSTERIA EDITORIAL

*****"I wanted to drop you a quick note in response to your excellent editorial on "Herpes Hysteria." [Last issue of Newsletter, Volume 4:4, p. 7] I have perceived this reaction for sometime--ever since the article in Time magazine last year. I was in fact toying with the idea of writing a book--The Hysterical Herpes Hoax--but I figured that would be suicidal to my career and there are yet a few things left that I am interested in doing. I think this whole phenomenon reflects a general anti-sex consciousness within western society. You know there is a book out entitled, The End of Sex and of course the ultra-moral majority think that God has visited gay people with AIDS...." [And sexually active people with herpes, and menstuating women with toxic shock, and elderly veterans with Legionnaire's, etc.--Ed]

--F.A.L. [wishes anonymity]

*****"I applaud any effort to diffuse the hysteria surrounding the herpes issue. I would like to especially commend the NCGSTDS for the much needed comment on how we dispense information to the public and patients. I would like to comment on my own experiences as a counselor and HELP support group facilitator as it relates to this issue. (HELP is the name of herpes support groups around the country.) Over the past year and a half I have seen the escalation of fear in the community about herpes. Through my contact with those diagnosed with herpes, I have learned how we, as health care providers, can give everyone the tools to understand and deal with the herpes virus. Every counselor and medical professional with herpes patients must understand the "Herpes Trauma Syndrome." Patients usually progress through 5 levels of awareness: 1) Shock; 2) Anger; 3) Fear; 4) Withdrawal; and finally 5) Acceptance. Through telephone or individual counseling, I can decide at what point the person is in the Syndrome and what the person needs, has, and/or wants. Not only does this protocol eliminate unnecessary information giving, but it lets the person know that you understand what he/she is going through right now. Probably one of the most important events in the life of a person who thinks they may have herpes, is their first encounter with a medical professional or counselor. It is this encounter that best predicts how the patient will view him/herself, their partner(s), and the virus. It is up to health care providers to provide accurate information and the tools necessary to deal with prevention and education of others. We must be aware of the media's and other "well-meaning" professionals misguided interpretation of herpes. As was stated in the herpes editorial in the last Newsletter, herpes is nothing more than a cold sore, either oral or genital. Comparing the herpes virus to a cold virus may also diffuse the hysteria. It is very similar in that you are more likely to contract it when you are run down and under stress, but that for most people it comes out only occasionally, and is basically just an aggravation. We can also diffuse the fear by the vocabulary we use. It is ironic that the [former] Director of Education Services of the American Social Health Association (including the VD National Hotline) made an appeal for funds for the Herpes Resource Center used the words "incurable" and "disease," when in a recent issue of the Herpes Resource Center's newsletter, The Helper, such words & descriptions were specifically proscribed; unless the individual understands the medical definition of such words, they may be detrimental to the explanation of herpes. We as health care providers are obligated to provide accurate and caring information to patients about any medical issue. Herpes is one issue that especially calls for this care because of the controversy surrounding it."

--Juana Sabatino, Human Sexuality Counselor

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PHYSICIAN WANTED FOR ESTABLISHING GAY/LESBIAN PRACTICE IN MILWAUKEE

Enterprising physician wanted to establish gay/lesbian medical practice (family practice or internal medicine) in Milwaukee, Wisconsin. Golden opportunity for pioneering in a city and state that has gay rights laws; outstanding outdoor recreation; cultural activities; a short drive to Chicago; low crime; on the shores of beautiful Lake Michigan; large gay/lesbian community with many diverse organizations. Address inquiries to: POB 239, Milwaukee, WI 53201.

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NCGSTDS PROVIDES AIDS INFORMATION

The NCGSTDS Newsletter was designated "The Official Interim National Communication Device" for desseminating information about AIDS by the participants of the First National AIDS Forum, National Gay Leadership Conference, Dallas, TX, August 13-15, 1982. Information about the Acquired Immune Deficiency Syndrome (AIDS) is relegated to this special section in the back of each issue. Your literary contributions are invited! Address all inquiries & comments to: NCGSTDS, POB 239, Milwaukee, WI 53201-0239 (414/277-7671).

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MILWAUKEE'S BEST CLINIC ACTS ON AIDS

Although there are only three documented cases of AIDS in Wisconsin (according to the CDC), Milwaukee's Brady East STD (BEST) Clinic has produced a wallet-sized informational card on AIDS to help educate the city's gay/lesbian community in the hope of averting the crisis that grips many other large metropolitan areas.

The card was printed with the financial backing of The Blood Center of Southeastern Wisconsin.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

For Information & Referral

(414) 272-2144
Brady East STD (BEST) Clinic
(414) 291-9463
Mandala Hotline
(800) 221-7044
AIDS Crisisline,
National Gay Task Force

WHAT IS AIDS?
Acquired Immune Deficiency Syndrome (AIDS) is a breakdown in the body's ability to fight off diseases. AIDS was initially recognized in previously healthy, young, homosexually active men, Haitians, IV drug users, and others. Although the cause of AIDS is not yet known, the first signs may be the development of a skin cancer, Kaposi's sarcoma, or a severe pneumonia, Pneumocystis carinii pneumonia.

WHAT ARE THE SYMPTOMS?
- Swollen glands (lymph nodes) in the neck, armpit, or groin that may or may not be painful, and have been present for several months
- Red to purplish, flat or raised blotches, bumps, or spots, usually painless, occurring on or under the skin, inside the mouth, nose, eyelids, or rectum, that don't go away. Initially, they may look like bruises and usualy are harder than the skin around them
- Persistent white spots or unusual blemishes in the mouth
- Weight loss of more than 10 lbs. in 2 or less months for unknown reason
- Fevers (greater than 99 degrees) or drenching night sweats that may occur on and off and last for several days to weeks
- Severe tiredness unrelated to exercise, tension, or drug use
- Persistent dry cough or shortness of breath unrelated to smoking, that has lasted too long to be from a usual respiratory infection or cold
- Persistent diarrhea unexplained by other causes
- Personality changes, memory loss, confusion, or depression unexplained by other causes

HOW CAN I REDUCE MY RISK?
While the cause(s) of AIDS remains unknown, current thinking is that a communicable agent such as a virus may be involved. An individual's chances of developing AIDS increases with the **NUMBER** of **DIFFERENT** sexual partners, especially if those partners themselves have a large number of sexual partners. It is the number of different partners, not the frequency of sexual activity, that is related to increased risk. Injecting drugs not prescribed for you, or having sexual contact with IV drug users also increases your risk for AIDS.

WHAT POSITIVE THINGS CAN I DO?
- If you have any of these symptoms, see your doctor at once, or call the above numbers for the name of a physician familiar with AIDS
- Take good care of your body and general health (adequate rest, good nutrition, physical exercise, reduction of stress, reduction of toxic substances — alcohol, tobacco, marijuana, inhalents, nonprescription drugs).
- If you are at risk for AIDS — because of symptoms or because of your lifestyle, or if you have sexual contact with someone at risk, please do not donate blood because of the possibility of spreading AIDS, until a specific test to identify AIDS is developed. Altruistic donations of blood represent a substantial contribution to the total supply of vitally needed blood products. In order to help prevent shortages, if you are unable to donate, please urge a family member, friend or colleague without the above constraints, to donate in your place. Because of our current incomplete state of knowledge and due to the seriousness of the disease, we believe that it is better to be overly cautious now, than to find out later that we have not been cautious enough.

This material has been prepared by the Brady East STD (BEST) Clinic (1240 E. Brady St., Milwaukee, WI 53202), the American Association of Physicians for Human Rights (AAPHR), and the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS) with the kind assistance of The Blood Center of Southeastern Wisconsin.

The wallet-sized format was chosen on recommendation from the First National AIDS Forum last August in Dallas, and on the experience of the Philadelphia AIDS Task Force & the Philadelphia Community Health Alternatives who printed a similar card (see Newsletter, December, 1982, Volume 4:3, p. 19). Revisions were based on the recommendations of the American Association of Physicians for Human Rights (AAPHR), which were included in the March, 1983 Newsletter (Volume 4:4, pp. 30-34). For additional information, please contact the BEST Clinic, 1240 E. Brady St., Milwaukee, WI 53202.

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AIDS EPIDEMIOLOGY UPDATE

As of May 9, 1983, the Centers for Disease Control AIDS Task Force reports a total of 1410 United States cases of AIDS (KS, PCP, and other opportunistic infections), and 103 foreign cases from 16 other countries. 71.1% of the cases are identified as homosexually/bisexually active, 16.9% IV drug user, 5.2% Haitian, 0.9% Hemophiliac, and 5.9% in no apparent risk group or unknown/unidentified. This data reflects US cases only. 21.7% are from individuals aged 20-29, 47.7% from ages 30-39, and 21.3% from ages 40-49; the remainder are in all other age groups. 36 states have reported cases, with New York State having 47.9% (NY City--44.3%); California, 21.1%; New Jersey, 6.9%; Florida, 6.5%; and Pennsylvania, 2.1%; all other of the reporting states have less than 2.0%. It is important to note that these cases represent only those meeting the CDC's strict criteria for what constitutes a case.

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SECOND NATIONAL AIDS FORUM TO PLAN LONG TERM STRATEGY IN DENVER

Taking what gay medical and political leaders called a much needed step towards long term planning, AIDS researchers, organizations, and health care providers will gather in Denver, June 9-12 for an intensive strategic summit conference to map out national planning for patient care, organizational cooperation and political strength. The Second National AIDS Forum will be a workshop-oriented meeting, and will feature Virginia Apuzzo (National Gay Task Force) & Pat Norman (San Francisco Health Department) for discussions on public policies, Roger Enlow, MD (New York Health Department) on medical developments, and Mel Rosen (New York Gay Men's Health Crisis) & Jim Geary (San Francisco Shanti Project) on patient needs.

The Forum is designed to attract those directly working with AIDS, rather than interested information-seekers. General AIDS information will be included in the concurrently held Fifth National Lesbian/Gay Health Conference. "The AIDS Forum is really targeted to those directly working with AIDS care, politics, and research," stated Jeff Richards, Forum Co-chair and San Francisco Board Member of the National Gay Health Education Foundation. Forum Co-chair Helen Schietinger, outspoken coordinator of the University of California's Kaposi's Sarcoma Clinic in San Francisco, reaffirmed, "It's just now dawning on our community that AIDS is not going to disappear tomorrow. We have to plan strategies at every level now, ...and our planning must be cooperative, and national."

Eight intensive workshops will highlight the Forum, and each of them will be chaired by nationally recognized experts and backed by numerous consultants. They include:

1) Public Policy; 2) Examination of Epidemiology; 3) Meeting Patient Needs; 4) AIDS Medical Update; 5) AIDS Network Development; 6) Political Strategies; 7) Creating Positive Changes in Sexual Mores; and 8) Issues in Infection Control.

Both the Second National AIDS Forum and the Fifth National Lesbian/Gay Health Conference are being cosponsored by the National Gay Health Education Foundation, the American Association of Physicians for Human Rights, and the Gay & Lesbian Health Alliance of Denver. AAPHR has applied for Continuing Medical Education credit through the American Medical Association for the medical portion of the Forum & Conference. Said Schietinger of the Forum, "We will probably have controversy because so many of these issues quite literally touch on life and death, and how we see ourselves as a community. But the ultimate result will be a stronger national network and a better grasp of what confronts us--not just today but in years ahead." Added Richards, "The reality is that we're active rather than hopeless regarding AIDS. In no sense is AIDS our issue alone--despite public belief--but our community continues to provide amazing leadership and expertise. And that's what this Forum reflects." Representatives from federal, state, and local health agencies are expected to attend, as well as the nation's major AIDS foundations & organizations.

Registration and additional information may be obtained by writing to: Health Pioneering in the '80s, POB 9413, Denver, CO 80209 (303/777-9530). Site of the meetings will be the Executive Towers Inn in Denver, where hotel accomodations are available. Early registration is recommended.

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AIDS HOTLINE TRAINING PACKET DEVELOPED BY HOUSTON'S KS COMMITTEE

The Kaposi's Sarcoma Committee of Houston has begun training all the community organizations & hotlines (e.g., Gay Switchboard, Cancer Information Service, Crisis Hotline, etc.) on AIDS with an informational packet representing a concise statement of the medical problem, common questions & "canned" answers, and representative articles (good & bad) giving a counselor/hot-line worker a broad understanding of the spectrum of social, psychological, political, and other ramifications of AIDS.

Since information about AIDS is changing so fast, the AIDS Hotline Training Packet was practically out of date when it was distributed. It nevertheless served as a valuable framework for training volunteers. Hopefully, a revised training program will be developed in collaboration with AIDS health workers at the up coming Fifth National Lesbian/Gay Health Conference & Second National AIDS Forum in Denver. Information about the training packet from Houston: Mike Wilson, President, KS/AIDS Foundation of Houston, 3317 Montrose Blvd., POB 1155, Houston, TX 77006.

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SECOND NATIONAL AIDS FORUM IN DENVER

The 2nd National AIDS Forum will take place in conjunction with the Fifth National Lesbian & Gay Health Conference, and the American Association of Physicians for Human Rights (AAPHR) Symposium, June 9-12, in Denver (see related articles elsewhere in Newsletter). Eight workshops will highlight the Forum. A brief discription of each one follows:
1) AIDS Medical Update--State of the Art (Roger Enlow, MD, et al)--In order to bring participants up to current standard of knowledge, there will be a brief overview of medical aspects of AIDS, a review of current data, and directions of research. 2) Public Policy (Ginny Apuzzo & Pat Norman)--to discuss blood banking, future relationship between public & private agencies, outreach to other groups at risk, & public policy implications of AIDS being labeled a "gay disease." Specific objectives include: to develop a policy statement regarding the stance of blood banks which is acceptable to and representative of attending individuals and gay organizations; to explore methods of dialogue and cooperation with other groups at risk; to examine the implications of AIDS being focused on by pubic agencies and the press as a disease of gay men & AIDS occurring primarily in groups of people who are disenfranchised (IV drug users, gay men, Haitians); to propose methods of challenging the sluggish response in many quarters to this most critical public health problem; to foster better understanding within research and medical institutions of the ethical implications of researching and medically treating gay men as a class; to draft a policy statement regarding human subject research. 3) Examination of Epidemiology (Alan Kristal & Michael Gorman)--demystification of epidemiology & examination of epi work done this far; analysis of the implications of a) traditional institutions studying gay men's sexual lifestyle & b) primary epi focus being primary epi focus being directed to gay men and sexual behaviors as risk factors. Specific objectives include to enable AIDS decision makers and clinicians to better understand theory and current applications of epi so as to counteract mistrust of the research & enable intelligent critiques and criticisms of aspects of research which may adversely affect the gay community, as well as other communities at risk; and to enhance communication among groups involved in epi research. 4) Meeting Patient Needs (Jim Geary & Mel Rosen)--social context of the AIDS patient and care provider, with special attention to the gay AIDS patient; emotional impact of AIDS on patients, care providers, groups at risk, and society at large; impact of issues of communication (press, rumors, etc.), finances, medical care, and patient advocacy. Specific objectives: to develop a standards of care check list for institutions caring for AIDS patients, including availability of counselors trained in death & dying, gay sensitivity, etc., patient advocacy, and a patient bill of rights; to compile a packet of information & tools for organizations forming to provide support services for AIDS patients; to develop a position paper regarding patient rights and needs, with special consideration of areas of need which are not being met. 5) AIDS Network Development (Walter Lear & Joel Weisman)--National AIDS interorganizational cooperation and communication, in particular a newsletter; national communication among communities at risk; hot lines: examination of possible need for volunteer training packet, backup medical consultation, means of efficiently updating referral & medical information. Specific objectives: to establish an official interorganizational newsletter, either extension of the use of the National Coalition of Gay STD Services Newsletter, or creation of a new newsletter, including funding sources and personnel; to begin a dialogue among groups shown to be at high risk for AIDS, and develop means of maintaining communication; to examine the state of the art of current AIDS hotline services, develop guidelines for any necessary backup services, and establish mechanisms for providing those services. This is the workshop most resembling a "summit" conference of involved organizations; there will probably be subcommittees formed to deal with specific tasks; and organizations will be invited to send delegates to represent their needs and capabilities and commitments to provide resources in whatever capacity. 6) Political Strategies (co-chairs pending)--organization of gay community political resources and power; direction of political strategies to expedite governmental expenditures for AIDS research & patient care; incorporation of members of other risk groups into the effort. Specific objectives: to develop tactics, with commitments from various groups as to specific responsibilities; to develop a position paper on continuing political action, education, and refinement of specific targets; to develop community & organizational expertise to counteract negative political pressure (e.g., Moral Majority types); to network among AIDS organizations and providers and traditional lesbian/gay political groups as well as organizations representing other risk groups. 7) Creating Positive Changes in Sexual Mores (Tom Smith,

(CONTINUED)

SECOND NATIONAL AIDS FORUM, Continued

Steve Morin & Robert Bolan)--examination of the positive aspects of the gay male sexual revolution; implementation of healthy sexual behavior in the context of the current STD/AIDS crisis; examination of current risk reduction guidelines. Specific objectives: to articulate the positive aspects of the gay male sexual revolution; to develop concrete methods of action for implementing community and media programs; to initiate positive change toward attainable, safe, and satisfying sexual behaviors for gay men within the context of the current STD/AIDS crisis. 8) Infection Control (Steve Follansbee)-- infection control guidelines for health care providers in institutional settings and for AIDS patients, care providers, and others in the community. Specific objectives: to examine and assess current institutional and community guidelines; to address the fear of contagion among health care providers and community members at large; and to assess current institutional and agency infection control policies within the context of human dignity.

A detailed report of workshop guidelines, recommendations, and strategies will be included in the next issue of the NCGSTDS Newsletter. If you are unable to attend the Forum but wish to comment on any of the workshop topics, please address them to the NCGSTDS, POB 239, Milwaukee, WI 53201 by JUNE 7th!

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BAPHR'S GUIDELINES FOR AIDS RISK REDUCTION BROCHURE

Enclosed with this Newsletter is a copy of the Bay Area Physician's for Human Rights (BAPHR) brochure entitled, "Guidelines for AIDS Risk Reduction." It is provided for your review, courtesy of BAPHR. Thanks!! For additional information about reprints, write: BAPHR, POB 14546, San Francisco, CA 94114 (415/673-3189).

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SACRAMENTO AIDS/KS GROUP RAISES FUNDS, STARTS PROGRAMS, OPENS OFFICE

courtesy of The Sacramento Star

The Sacramento AIDS/KS Foundation, established in January as a chapter of the San Francisco based KS Research & Education Foundation, has been busy raising funds, starting patient support services, establishing community education projects, and openning an office. Patient services, including a support group for AIDS patients, are being developed; training for volunteers who wish to provide support to AIDS patients is underway. Educational & medical presentations for lay & medical personnel has been widely received. For additional information, write: Sacramento AIDS/KS Foundation, PO Box 162266, Sacramento, CA 95816.

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APHA EXECUTIVE DIRECTOR MAKES STATEMENT ON AIDS

special thanks to Walter Lear and The Nation's Health (April, 1983)

American Public Health Association (APHA) Executive Director William H. McBeath, MD, MPH, recently filed an affidavit opposing the contention made in a Texas court that homosexual behavior should remain illegal in that state because homosexuals are known to transmit the newly uncovered AIDS. Noting that when a new, mysterious and serious disease has burst upon the human scene, societal reaction has been often dramatic and often prejudicial, McBeath recalled that syphilis was "...widely viewed as divine retribution afflicting primarily deserving groups of hated foreigners." And, he said, control measures directed at "foreigners" were not effective. He added, "While some AIDS cases are associated with a relatively small sub-set of American homosexuals, based on present knowledge it would be both unjustified and ineffective to criminalize homosexual activity.... In my opinion, members of groups at high risk of AIDS, such as very sexually active homosexuals, are increasingly well informed of these risks and are highly motivated, both by self-interest and selfless concerns, to cooperate in AIDS control measures which might reasonably be expected to be effective. Accordingly, they might be asked to voluntarily limit their blood donation, much as recently returned foreign travelers from malaria-endemic areas and people who have had infectious hepatitis are now asked not to donate."

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APHA EXECUTIVE DIRECTOR, Continued

The affidavit was given in a case (Baker vs. Wade) challenging the constitutionality of Texas laws which prohibit homosexual behavior. A group called Dallas Doctors Against AIDS has argued that because of the AIDS threat homosexual acts should remain criminalized.

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NEW BILL TO FUND AIDS RESEARCH

reprinted with thanks, from Colorado Gay & Lesbian News

The Gay Rights National Lobby (GRNL) is calling for all members of Congress to support a new bill introduced by Representative Henry Waxman (D-CA), which could pour as much as $40 million into national public health emergencies like AIDS. The Public Health Emergency Act would establish a special fund equal to 1% of the National Institutes of Health's (NIH) total budget (about $40 million would be set aside). The Secretary of Health & Human Services would determine what constitutes an emergency, and then oversee the expedited allocation of emergency funds. This would bypass the complicated, year-long funding process required for NIH to fund outside medical research. It currently takes NIH at least one year to fund any research proposal. The fund would be replenished each year to bring it up to the 1% total figure.

Cosponsoring thus far are Representatives: Waxman, Levine, Boxer, Burton, Dixon, Lehman, Levine, (D-CA); Yates (D-IL); Frank & Markey (D-MA), Crokett & Wolpe (D-MI), Sikorski (D-MN); and Garcia, Ottinger, Schumer, Towns & Weiss (D-NY). GRNL's AIDS Research Project has also set out the following goals to obtain adequate AIDS federal research funding: 1) Push for a supplemental appropriation to increase funding for the Centers for Disease Control (CDC) AIDS activities. GRNL and its congressional supporters and constituent organizers were successful in securing $2 million last session for CDC's AIDS work. In the last three months, however, the disease has dramatically worsened, meaning CDC is unable to keep up. 2) Gather signatures for Senate and House letters to NIH encouraging it to allocate more money to specific AIDS research. NIH says it will spend $7.9 million in fiscal year 1983 on AIDS, but much of these funds will be spent on administration and patient care, and little if any will be released for outside research. 3) Work with the National Gay Task Force (NGTF) to build a broad coalition of health and related national organizations interested in supporting adequate AIDS research funding. NGTF and GRNL will also be working jointly on increased NIH research. GRNL will coordinate congressional information sharing on AIDS.

Those interested in helping GRNL's AIDS Project shoud write: PO Box 1892, Washington, DC 20013 or call 202/546-1801.

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RN POSITIONS FOR SAN FRANCISCO KS CLINIC

Three positions for registered nurses will soon be available in San Francisco, according to Helen Schietinger. A nurse coordinator for the Kaposi's Sarcoma Clinic of San Francisco, and a research nurse position for the KS Clinic, both for the University of California, are needed. Contact Helen for details (415/666-1407). The third position, for a nurse educator in AIDS at San Francisco General Hospital, is also being advertised. Contact the San Francisco General Nursing Office (415/821-8200) for additional information. When asked if other non-nursing health professionals could apply (e.g., physician assistants, social workers) Helen stated that she didn't know. Anyone who may be qualified certainly may apply.

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CALL WHITE HOUSE EXECUTIVE COMMENT LINE

The White House Executive Comment Line (202/456-7639) should be called to let the President know your feelings about the AIDS crisis. What is most urgently needed is increased, ongoing guaranteed AIDS funding for the National Institutes of Health and the Centers for Disease Control--specific funding, earmarked as a formal budgetary line priority, not thrown in as part of a vague assortment of "health matters." Specific funding to take research into the communities, to the people--from the people's tax dollars. Demand that the government respond --to the statistics, to the need, to the people.***** ***** ***** ***** *****

AIDS RELATED EDUCATIONAL EVENTS LISTING

The nation's first biweekly listing of AIDS related educational events is now available from San Francisco's Kaposi's Sarcoma Research & Education Foundation. The listing includes information about all Bay area and selected national AIDS related educational presentations of interest to both the general public and health care professionals. For more information about the listing, to receive the listing, or to include your talk or activity, please contact Mitch Bart, Coordinator of Public Education, KSREF, 470 Castro St., #207, Box 3360, San Francisco, CA 94114 (415/864-4376). The services of the Foundation's Public Education Program, which includes a Speaker's Bureau, are available to assist you or your organization in any AIDS related educational needs that you may have.

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SEATTLE ORGANIZES "CHICKEN SOUP BRIGADE"

Volunteers from Seattle's Gay Clinic are organizing the "Chicken Soup Brigade," to assist in providing transportation, chore activities, an occasional friendly telephone call, or a pot of chicken soup, or whatever else may be needed for gay men who are ill or housebound. These services are short-term, and volunteers need not commit themselves to large blocks of time. Even an hour every week or two is helpful. "Your talents are needed, and the need is upon us!" For more information, contact Josh Joshua (206/545-7165) at the Seattle Gay Clinic, PO Box 20066, Seattle, WA 98102.

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NEW JERSEY ASSEMBLY INTRODUCES AIDS LEGISLATION

Shortly after New Jersey Governor Thomas Kean signed a proclamation designating February, 1983, AIDS Awareness Month, the state Assembly introduced two bills dealing with AIDS: 1) Urging the President and the Congress to create programs to combat AIDS (ACR3012); and 2) Requiring the NJ Commissioner of Health to establish informational programs for the public, physicians, and victims; an appeal campaign urging pharmaceutical companies & medical laboratories to volunteer resources & services; create an AIDS Task Force Center in Newark; and to appropriate $75,000 to fund the Center (A3220). For additional information, contact the New Jersey Lesbian & Gay Coalition, PO Box 1431, New Brunswick, NJ 08903.

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LAKE MICHIGAN GAY RESORT TOWN SPONSORS AIDS BENEFIT

by Gary Bassett, reprinted courtesy of Metra (Detroit), January, 1983

On New Year's day, Saugatuck's (Michigan, on the eastern shores of Lake Michigan) Douglas Dunes resort launched a one-night extravaganza for Michigan victims of AIDS, with all proceeds benefiting the Howard Brown Memorial Clinic's AIDS Action Project in Chicago. The benefit was supported by bar staff and entertainers from Grand Rapids, Kalamazoo, and Muskegon. Over $1000 was generated for Howard Brown.

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AIDS MEDICAL RESEARCH FOUNDATION OF SOUTH FLORIDA

The new AIDS Medical Research Foundation of South Florida is providing valuable services to the gay & lesbian communities of southern Florida. Some of the projects the Foundation is involved with in addition to traditional referral & counseling services, include fundraising to develop an AIDS educational videotape, and AIDS screening clinics, in cooperation with the University of Miami School of Medicine. One of the goals of the Foundation is to help develop a free gay health care clinic in Key West. For additional information, contact: AIDS Medical Research Foundation of South Florida, Inc., PO Box 431861, Miami, FL 33243 (305/666-6483).

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THE SAGA OF THE INTERNATIONAL SERUM SHIPMENT

by Nancy Lord, MD

In February, 1983, I noticed a small article on Adult T-cell Leukemia Virus (ATLV), published in Lancet by researchers at the University of Tokyo (January 29, 1983, pp. 240-41). Two remarkable things struck me--the striking similarities between ATLV and AIDS; and that virus isolation technology what was highly advanced and successful. This was not surprising from the nation that makes Datsuns, robots, silicon chips, and many new drugs.

The similarities between ATLV and the AIDS agent: 1) The lymphocyte is the infective focus; 2) There are healthy carriers; 3) Transmission is vertical (mother to child) or horizontal (familial clustering, intimate contact); and 4) Sexual transmisssion has been shown for a similar virus in green monkeys, but only from male to female, not female to male. Concerning the virus isolation technology: 1) Cultivation of human lymphocytes to culture and detect viral antigen; 2) Monoclonal antibodies against a core protein of the ATLV virus; 3) Measurement of specific anti-ATLV antibody in serum; and 4) Indirect immunofluorescence staining of viral antigen within the lymphocyte.

To bring this article to the attention of someone who could use the information, I wrote to the Centers for Disease Control (AIDS Task Force), attached the article, and suggested they contact its author for assistance in detecting the AIDS agent. Unfortunately, I diluted this suggestion with an ambitious proposal to trace sexual contacts of hepatitis B vaccine recipients, and compare rates of AIDS to a control group. Copies were sent to the author of the article and several other organizations. Several weeks later I received an air mail letter from the professor in Tokyo whose post-graduate student had written the Lancet article. He agreed that a relationship between the two viri deserved investigation, and offered to help detect the AIDS agent using his ATLV isolating technology. He asked that patient sera be sent to him for anti-ATLV Ab testing, as a first step.

This was very exciting, but problematic. I work in the pharmaceutical industry and have not seen a patient, AIDS or otherwise, for 5 years. Though experienced in organizing and funding research, I have never performed any of my own. I would probably spill something on myself if I tried! Help was obviously needed, so I called the National Gay Task Force, who referred me to Mark Behar at the NCGSTDS, who referred me to the Chicago AIDS Action Project, and the AIDS Study Group in New York. The next day, I called the CDC and informed them of the professor's response, but they did not return my call. The Chicago & New York groups were most cooperative. Nobody patted me on the head or tried to take over the project, but they were willing to provide me with sera.

This was fine with me, because by then I had become shocked by the fragmentation of research efforts and paucity of funds for AIDS research. I had learned that an association with retrovirus such as ATLV was being studied, but results were unavailable. I learned that researchers were so obsessed with winning the Nobel Prize that they were not sharing information with one another. In light of this, I felt as if the Japanese professor were one of my investigators, like those whose research I support through my corporate position. I was determined that he be given a chance.

The next day was spent calling air courier services. Everyone gave me different information on how much dry ice and which forms would be needed. This included five different operators at United, none of whom could locate the one to whom I had spoken to last! It would take at least 3 days for the package to get to Japan, clear customs (at least 24 hours), and be delivered to the University. Alternatively, I could hire someone to bring the package to Japan, however this would be too costly. Approximately 10-20 lbs. of dry ice would last about 72 hours but a delay in customs could destroy the specimens. Complicating things further, several operators had informed me that they would only accept 5 lbs. of dry ice. After the third such proclamation, I asked the unheard of question in our authoritarian society--"Why?!" Apparently, at one time, on one flight, somebody shipped dry ice in the same cargo hold that a pet was occupying. The ice thawed and the pet asphyxiated. So now the airlines refuse shipments of over 5 lbs. of dry ice. My shipment, which was to contain over 5 lbs., was considered a

(Continued)

THE SAGA, Continued

"hazardous substance" and the last carrier referred me to a shipper of radioactive materials. He informed me that the possibly contaminated nature of the blood product, even if packed appropriately, could mean a jail sentence if not processed correctly! The shipper offered to locate an experienced air courier who would handle it, but I never heard from him again. Maybe he didn't want to waste his time without prepayment. (Nobody else gets paid to work on AIDS, who was he to balk?)

At this point I called the Japanese Consulate, who referred me to the Ministry of Health and Welfare at the Japanese Embassy in Washington, who could tell me how to expedite the shipment through customs. It was too late to call the East Coast, so I called the next day, four days after receiving the letter from Tokyo. The Embassy, not having encountered a situation like this (who had?), had to call the Health Department in Tokyo. A funny thing happened just two hours later--the CDC returned my call. Probably coincidence.

The situation now is that I have made an official request for serum to be sent to the University of Tokyo. They will not promise the serum, but agree in principle that Tokyo would be a good additional center for retrovirus (ATLV) investigation. Hopefully, there will be no further problems. The professor in Tokyo has stained ATLV viri within lymphocytes, innoculated monkeys with ATLV, and measured antibody to ATLV. He agrees that the ATLV and AIDS agent may be similar, since ATLV is also immunosuppressive. The offer has been made to use the above described technology to detect the AIDS agent. To refuse this generous offer of help when over 500 people are already dead, and several new cases diagnosed daily, would be unconscionable.

Exactly what does this all mean? Perhaps the following theory may clarify the thinking. The theory I am proposing begins with the purification process for the hepatitis B vaccine. Consider the possibility that a new agent was created through mutation of known viri, possibly hepatitis B virus, cytomegalovirus, or ATLV. The initial subjects who received the vaccine may have developed antibodies immediately, since a large amount of antigen was introduced at once. Their subsequent sexual contacts, however, were infected with raw antigen which multiplied in vivo. In some cases, lymphocytes were attacked to produce an acquired immune deficiency syndrome; in others, antigen was passed on to other individuals who would later develop AIDS. Is it not possible that a "process resistant" viral strain developed just as antibiotic resistant bacterial strains? This theory would clearly explain the prevalence of AIDS in male homosexuals. They were the first to receive the vaccine and could have spread the mutated virus through their community. Because of this tragic coincidence, examination of sociological issues associated with AIDS diverted attention from the possibility of a technological catastrophy. Should this theory seem even remotely possible, an attempt should be made to identify sexual contacts of subjects who were given hepatitis B vaccine in clinical trials, and contacts of these contacts--a difficult, but not insurmountable task. From this data, a prevalence rate for AIDS could be determined and compared to that of nonvaccinated individuals. The Japanese methodology used for assaying ATLV could possibly identify the agent in lymphocytes of AIDS victims. Once monoclonal antibodies have been developed, they could be used to determine if the agent is present in hepatitis B vaccine. *****

[What do you think? Please address your comments for Dr. Lord to the NCGSTDS, POB 239, Milwaukee, WI 53201; we'll pass them on to her, and publish them if you don't object, in future issues of the Newsletter. --Editor]

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MINNESOTA AIDS PROJECT FORMS

The Minnesota AIDS Project, a group of concerned persons from the gay community and health care professions was recently formed to deal with the medical, social, and political issues of AIDS. The Project has organized support groups, a speaker's bureau, information & referral services, and research and political committees. For more information, contact: Minnesota AIDS Project, Lesbian & Gay Community Services, 124 West Lake St., Suite E, Minneapolis, MN 55408 (612/827-5614).***** ***** ***** ***** ***** ***** *****

HUMAN T-CELL LEUKEMIA VIRUS IMPLICATED IN AIDS

According to the May 1, 1983 New York Times, human T-cell leukemia virus (HTLV; also known as ATLV, adult T-cell leumkemia virus) was detected in 25-35% of blood specimens of AIDS victims tested at Harvard University's School of Public Health, compared with less than 5% of blood specimens of controls. Details of these findings are presented in the enclosed Morbidity & Mortality Weekly Report (MMWR). Several papers are scheduled for publication in the May 20th issue of Science, as well. Others actively involved with research include Dr. Robert Gallo's team at the National Cancer Institute; Dr. Max Essex at the Harvard School of Public Health working with Drs. Don Francis and Cyrus Capradilla of the CDC, and by collaborators in France. HTLV belongs to the newly discovered retrovirus family, so named from a molecular biological phenomenon in which they produce an enzyme that leads them to reproduce "backwards." One of the mystifying findings is that antibodies against HTLV were detected in higher numbers among AIDS victims from New York City than those from California. Although the discrepancy doesn't make sense yet, one possible explanation is that the tests now used to detect HTLV are not sensitive enough to find the virus in all cases. A second possible reason may be that some victim's immune systems may have collapsed before antibodies could be produced.

Scientists involved in the research have been reluctant to discuss their findings, even at scientific meetings, much to the displeasure of some colleagues working on AIDS. At a meeting at New York University in March, members of Gallo's group discussed aspects of their work without disclosing specific data, even when repeatedly questioned by participants, some of whom disclosed their unpublished data. One participant reported that people hissed and booed in response to this attitude. Gallo said in an interview that he did not attend and did not release data because the scientific meeting was open to the press and he wanted the data to be published in a scientific journal first. Dr. Jay Winston, a spokesperson for the Harvard School of Public Health, made a phone call following an NBC television report on retrovirus and AIDS to say that Dr. Essex was willing to discuss the findings, but Essex then changed his mind after Gallo refused to comment. Both Essex and Gallo said they would have released the data earlier if it would have saved anybody's life. [A case of nobel laureat inspired cooperation & altruism? --Editor]

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4 AIDS RESEARCH PROJECTS APPROVED BY NIH

According to an April 30th report compiled by United Press International, the National Institutes of Health has awarded $245,721 for 4 studies of AIDS: 1) John Hughes, Children's Hospital Research Foundation in Columbus, Ohio, will examine whether human seminal plasma suppresses immune function in animals; 2) Martin Hirsch of Boston's Massachusett's General Hospital will investigate the possible role of viruses in development of AIDS, using AIDS patients; 3) Walter Hughes of St. Jude Children's Research Hospital in Memphis, will look at potential drug treatments in animals for pneumocystis carinii pneumonia, one of the opportunistic infections in many AIDS patients; and 4) Pearl Ma of St. Vincent's Hospital and Medical Center in New York City, will study a recently identified parasitic disease, cryptosporidiosis, that can cause potentially fatal diarrhea in AIDS patients.

[There are many research projects involving AIDS; these few are listed only to give the reader an idea of the vast nature and scope of that work. --Editor]

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NOVEMBER, 1982 BODY POLITIC ARTICLE ON AIDS REPRINTED

The excellent ten page Toronto Body Politic article entitled, "Living with Kaposi's" & "The Real Gay Epidemic: Panic & Paranoia," (November, 1982) are reprinted, courtesy of that fine newspaper and authors Michael Lynch and Bill Lewis. Your comments are invited; address to the NCGSTDS, POB 239, Milwaukee, WI 53201.

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AIDS ACHIEVES NEW DISTINCTION. . .THE COVER OF NEWSWEEK

by Gary Bassett, reprinted with permission of Detroit's Metra (4/28/83)

Hold onto your hats, folks. AIDS has invaded the living rooms of mainstream America. Seriously, if you haven't had an opportunity to read the feature article on AIDS appearing in the April 18th issue of Newsweek, it's worth your time & energy to pick up a copy or check it out from the library. Seven full-color pages succintly trace the history and provide an update on what is finally being recognized as a public health emergency. The article includes photos and short bibliographical sketches of several AIDS victims; a graphic analysis of present statistics and where AIDS has spread; and a short treatise on how the syndrome has affected gay lifestyles in large urban areas like New York & San Francisco....As the epidemic grows, it is expected that AIDS wil begin appearing with greater frequency among heterosexuals.

Funding for research and treatment of AIDS (and related ailments) is expected to get top priority from the Gay Rights National Lobby (GRNL) and the gay community in general for the remainder of the year. Such funding comes from two agencies, the Centers for Disease Control (CDC) and the National Institutes of Health (NIH), both part of the Department of Health & Human Services. Both CDC and NIH have pledged additional funds for AIDS in fiscal 1983 and 1984 (totaling in excess of $10 million), in addition to which US Representative Henry Waxman and Senator Daniel Patrick Moynihan have introduced companion legislative bills in Congress that will potentially allocate another $40 million for research into diseases like AIDS that qualify as public health emergencies. Organized lobbying activities by GRNL and tireless petitioning by the National Gay Task Force (NGTF) have had substancial effect, as well as grassroots efforts similar to the continuing resolution recently circulated across the country by the San Francisco Board of Supervisors.

The resolution, prepared in consultation with the office of US Representative Phillip Burton (a staunch supporter of Waxman's bill), details the facts of the AIDS outbreak and speaks to some of the specific research needs which must be met by the federal government immediately. The Board is urging all gay people to bring this matter to the attention of local mayors, city councils, state legislatures, and US Congress in order to further solicit support for adequate funding. Moreover, individuals and gay organizations are asked to send letters of support for increased AIDS funding directly to the following national health directors: 1) Margaret Heckler, Secretary, Dept. of Health & Human Services, 200 Independence Av., SW, Washington, DC 20201; 2) Dr. James B. Wyngaarden, MD, Director, National Institutes of Health, Bldg. 1, Room 124, 9000 Rockville Pike Rd., Bethesda, MD 20205; and 3) Dr. Edward N. Brandt, Jr., Assistant Secretary for Health, 200 Independence Av., SW, Washington, DC 20201.

According to Dr. Abe Macher, MD, of the NIH, "[AIDS]...has caught everybody by surprise. Textbooks are being rewritten. We're observing the evolution of a new disease."

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ARE WE STILL 'AN ARMY OF LOVERS'?--OPINION

reprinted courtesy of The Sacramento Star, 2/23/83

We are inclined to view AIDS as a manifestation of our overly technological, increasingly "unnatural" way of life. Is it too farfetched to think of it as a short-circuit, so to speak, in our civilization? When a man describes himself as "somewhat promiscuous" when he has 150 different sex partners in one year, it may be that he, and the social ambience of which he is a product, are out of touch with reality. Isn't it possible that all the "marvels of modern science" have dulled our common sense and lulled us into believing that just about anything can be "taken care of" with an injection or a capsule? Maybe we've lost sight of the fact that the best health care involves taking care of our bodies so that we don't get sick, rather that dosing them with ever stronger drugs when they succumb to infections and other attacks simply because they haven't the resources to resist. Wouldn't a little "preventive maintenance" be a smart move?

Similarly, we have recently heard people say that total sexual freedom is the foundation of the gay movement and the gay lifestyle. This is a change, surely, from what we were talking about 10 and more years ago in the early, tumultuous, formative years of gay liberation. Then, it seems, we were talking about the freedom to live our lives without oppression, without being

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ARE WE STILL 'AN ARMY OF LOVERS'?, Continued

judged and labeled as sick, sinful, or criminal. How has that ideal become transmuted into this new goal of sex anytime, anywhere, any way, with anyone? Gay sexuality is a potent and positive force for liberation in our society and in the world. That old phrase, "An army of lovers cannot fail," has been our rallying cry for years. But maybe that phrase, with its origins in classical Sparta and its implications of general no longer suits us. Now it seems, we're claiming that "an army of fuckers cannot fail." Somehow, it doesn't quite say the same thing. And we seriously doubt that it is true. At any rate, our ommunity must do some serious thinking. If we are in fact an army of lovers, we have something valuable to fight for, and we have to get together and act like what we claim to be. If we are just an army of fuckers, and all we care about is our individual sexual gratification, we are never going to get together for any other purpose, and maybe we have good reason to worry that AIDS will finish us off.

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BAPHR SYMPOSIUM: THE PHYSICIAN IN THE AIDS CRISIS

San Francisco's Bay Area Physicians for Human Rights (BAPHR) is sponsoring the Third Annual Symposium entitled, "The Physician in the AIDS Crisis," June 24-25, 1983, at the San Francisco Medical Society Auditorium. The Symposium which is designed to be of interest to the complete range of medical specialists who provide health care to gay men and women, including allied health providers, is supposed to increase the practitioner's understanding of the medical & psychological aspects of AIDS; to stimulate critical discussion of the psychological, social, and political implications of the AIDS crisis for the practitioner and the gay & lesbian community at large; and to formulate guidelines for practitioners seeking to define their role in the evolving crisis. Up to ten hours of category I continuing medical education (CME) credit may be requested. Faculty involved in the symposium include: James Curran, MD, Roger Enlow, MD, Stephen Follansbee, MD, James Geary, Stephen Goldfinger, MD, Evelyn Hooker, PhD, David Kessler, MD, Stuart Nichols, MD, Pat Norman, Herbert Perkins, MD, Bruce Voeller, PhD, and Paul Volberding, MD. For additional information, please write to BAPHR, PO Box 14546, San Francisco, CA 94114. Following the Symposium on June 26th, will be the San Francisco Gay Freedom Day Parade--representatives of both BAPHR and the American Association of Physicians for Human Rights (AAPHR) will have marching contingents.

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COUNCIL FOR AIDS RESEARCH FORMS

by Rick Pecarovich

The newly formed, non-profit Council for AIDS Research (CAR) is presently conducting a feasibility study to determine how to best contribute to a solution of the AIDS crisis. CAR is evaluating possible methods of fundraising, with particular emphasis on the corporate and institutional sectors, and means of increasing communication among research groups, concerned citizens, governmental entities and community AIDS organizations. CAR hopes to make a meaningful contribution to solving the AIDS crisis by supporting private and public sector research efforts, and to generate substantial support, government and private, for the vital work being done by community AIDS organizations. Any suggestions would be most appreciated. Please address comments, suggestions, or inquiries to: CAR, 8306 Wilshire Blvd., Suite 517, Beverly Hills, CA 90211.

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AIDS PROJECT DEVELOPS IN DENVER

by Carol Lease, Director

The Gay & Lesbian Community Center of Colorado (1436 Lafayette St., POB 18467, Denver, CO 80218) 303/831-6268, 837-1598) has developed an AIDS Project, with an AIDS Patient Support Group, a Worried But Well group, and a group for lovers, family and friends of AIDS patients. Several brochures are available: one on AIDS, one entitled "Be Well" about developing a positive gay self image (which includes information on AIDS, staying healthy, hepatitis, STDs, knowing your rights if arrested, and a short list of health related resources. Please write, and include us on your referral lists. Thanks!***** ***** ***** ***** ***** *****

CHANGING GAY LIFESTYLES

by Dan William, MD

[Excerpts of talk given at the New York University AIDS Symposium, March 17-19, 1983]

"...Sexual activity within the gay community as always been considered a personal choice left soley to the judgement of the individual. In retrospect, it was commonly believed that multiple sexual contacts with different individuals held acceptable health risks. Unfortunately, we were all responsible for reinforcing this misconception. Physicians caring for gay patients reinforced the concept that judicious promiscuity did not entail unacceptable health risks. Up until 1979 when AIDS first appeared this may have been an innocent oversight. Aside from the possible risk of disability from hepatitis, the unpleasantries and inconveniences of the more traditional STDs including syphilis, gonorrhea, nongonococcal urethritis and warts, and the discomfort and expense of recurrent amebiasis, many patients voluntarily chose to accept this price as the health consequence of the sexually active lifestyle. Obviously, the reality of AIDS has changed all this. Over the last 2 years, the sexual behavior of gay men has been drastically altered by the reality of AIDS. Because New York City is the epicenter of this epidemic, nowheres has this change been more noticeable than here. Unfortunately to date the changing sexual behavior of gay men has not been systematically quantitated, however a large body of indirect evidence is accumulating that underscores the dimensions of these changes. Syphilis morbidity is probably the best indicator for measuring gay STDs. Unlike other STDs that are prevalent both in heterosexual and homosexual populations, syphilis today is disproportionately seen in homosexual men. Syphilis morbidity is reasonably accurate since reporting is provided both by laboratories and physicians, and the screening test for syphilis are very sensitive and specific confirmatory tests are widely available. Assuming the constancy of public health control programs, trends in syphilis morbidity may therefore be an excellent surrogate measure for changing sexual behaviors in gay men. The first 7 weeks in 1983, syphilis morbidity in NY City declined 23% compared with 1982. Were there available morbidity statistics reflecting only gay men would probably have shown a more impressive decline. As another example, there has been a 50% decline in positive rectal gonorrhea cultures in gay men seen in my own practice over the last 3 months, compared with the same 3 month interval last year. The New York Blood Center hepatitis B vaccine trial provides another view of changing gay male sexual behavior. Over the last 3 years, participants in the trial have been periodically questioned as to interval sexual behavior. In early 1980, when participants had been followed for 1 full year, they were questioned as to their total number of different sexual contacts over the preceeding month: the mean number was 5.3, median 3.4, mode 1.0. Two years later, in early 1982, when information about AIDS was just becoming widely desseminated, a followup questionnaire was administered. 62% of the men questionned said they had decreased their sexual activity [with different partners] because of AIDS [fear of AIDS]. Compared with the original questionnaire, these men had decreased by 24.5% their mean number of different sexual contacts. There can be no doubt based on my own questioning that these changes have gained momentum and accelerated over the last year. How has such a significant change occurred over such a brief time and is it enough to control the spread of AIDS? What other changes have begun to occur in gay lifestyles, and what will tomorrow look like?

In the last 15 years, a combination of factors have resulted in new culture identified as gay. Modern day gay culture has been nicely dated by a warm night in June, 1969. At that time, a police raid on a popular gay disco [the Stonewall] lead to angry street riots against gay oppression in Grenwich Village in NY City. For gay culture, time is measured in "years after Stonewall." Stonewall riots for many homosexual men and women were very significant and marked the beginning of a new sense of community. Before Stonewall, there were few gay associations, or for that matter there were a very few identifiably homosexual men and women. Few could risk the price society extracted were there sexual preference known to family, friends, or employer. Gradually over the last 14 years, a large and visable community has developed where little had existed before. This new community has been characterized by creativity, vitality, and a new sense of shared identity. It is also surprizingly well organized and very well informed, especially about issues relevant to its survival. In 1969, the thought of the New York City gay community renting out the circus at Madison Square Gardens to raise money for a recently identified disease would seem preposterous. Today, the same gay society that organized the circus is rapidly becoming

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CHANGING GAY LIFESTYLES, Continued

educated about the nature of AIDS. Most gay men are doing something about AIDS. One could argue that the proliferation of gay organizations and groups spanning every interest and need has in fact reflected the success of substituting new and creative pastimes for the now acknowledged unhealthy behavior of the past. Yes, behavioral changes are rapidly occuring. Thousands of men will save their lives by more carefully selecting and drastically reducing their numbers of different sexual partners. But sadly for others, this change may come too late.

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Tricking with AIDS

Should I or Shouldn't I? And What Do I Do Next?

by Tom M. Smith, M.D.

[THE FOLLOWING ARTICLE BY DR. TOM SMITH, WAS ORIGINALLY ENTITLED, "TALKING ABOUT SEX AND HEALTH," MARCH, 1983. IT IS REPRINTED HERE COURTESY OF BAY AREA REPORTER.]

The AIDS and STD health crises are shattering many aspects of our lives, including our sexual activities. Casualness about sex is being modified to include a more logical and a more open worry about sex. The rational fear of the risk of infection or of contacting AIDS has become a motivator for making changes in sexual activities. We ask ourselves, how do I stay healthy, what can I do to avoid infection, what is sexually safe, how do I know if my partner is healthy?

The following is a brief outline of an interpersonal process, asking and telling each other about health and sexual concerns. Intimate discussions of health and limit setting are usually not part of our socially acceptable ways of initiating sexual relations. Time and practice may be required before we become comfortable in our health and sexual needs.

CAUTIOUS PEOPLE

Some men are choosing to establish social and verbal relationships prior to sexual encounters. By talking, the pair can exchange histories and limits and decide upon mutual limits. How do we bring up the topic of health and sex? Head on? Will this scare the person away? Or do we become more indirect? Each of us has the opportunity to find out what works for ourselves and our partner.

I. Bringing up the topic:

"Have you heard about AIDS?" . . .

"I am concerned about AIDS" . . .

"I like you. I want the best for us. I would like to discuss health" . . .

"Recently I have made decisions about new acquaintances" . . .

"You're hot and healthy looking, no question about 'hot' but let's do discuss 'health' " . . .

"Could we talk first. I certainly would like to know you better" . . .

"Because I like you, I would like for us to talk about our health; the state of our health and how we can stay healthy and still be close" . . .

II. Health Appraisal (Health History and Exam):

All of the five senses can help in checking the other person out.

A total exam in good light is optimal.

To give your own health history *first* may help to get the ball rolling and may model honesty and sincerity.

A shower together, massage, sauna, athletic activities, etc., may give you opportunities to view your partner prior to sexual encounters.

Embarrassment is okay. Most of us were not taught how to be comfortable in discussing health matters.

A health appraisal is more difficult if you are stoned.

Some people will be very open to discussing health matters on a first date. However, a full discussion of health and sex may be inappropriate and too "forward" for a first encounter. Perhaps familiarity and friendship will make these discussions easier.

A. What to ask about: The simplest question would be "How is your health?". A more rigorous exam would include the following. However, you may have to get to know the person socially before having the trust to ask these questions: General health status (excellent, fair, poor); Sexually Transmitted Diseases in the past 3 years; Were the STD successfully treated; Frequency of sexual partners; Types of sexual activities in the past three years; Observed signs of illness (their repeated coughs, skin rashes, etc.); Recent weight loss, night sweats, diarrhea, lymph node enlargement; fever, penile discharges, rashes or spots; "Do you have AIDS?"

B. What to observe: - Skin and muscle tone; Rashes; Mouth, genital or anal rashes or bumps; Loud, gurgling abdomen; Smelly farts; Cleanliness of nails, hands, genitals, body in general; Lymph node enlargement; Jaundice.

C. Talking about your own health: - Check out yourself for each area listed above (history and observation). Answer each question as if you were talking honestly and candidly to a potential sex partner. This may help you talk more fluidly about your health and may also help you understand the difficulties other people may have in discussing their health status.

III. Degree of Involvement:

Now that you know more about your partner's health, the next step is deciding and discussing how intimate or how distant you wish to be. (Who will do what to whom and when?) This type of decision making about social closeness occurs with nearly all of our situations in everyday life, however usually without conscious effort. In sexual situations, we may need to decide how much risk we wish to take at *this* particular time. A casual date situation may mean taking no risk or minimal risk until you know the person better. If the person has an illness, then you can weigh the risk of getting close against the degree of communicability. An acutely ill person usually has little sexual interest. However as convalescence continues, sexual interest returns. If the risk of contagion is high in convalescence, then more distant sexual activities (phone sex, mutual j.o. across a room, viewing sex or porn) may be appropriate. The degree of involvement could be contingent upon: 1) how close you wish to get, 2) what is safe in regards to each person's health status, 3) trust, 4) drug/alcohol usage, and 5) a mutually agreeable contract of desires and limits.

IV. Contracts (Mutual Agreements):

Contracts can be carefully delineated or nonverbally implied. Contracts can be clinical and heartless or sexually challenging and stimulating. A contract can be as simple as one person stating their limits and the other person agreeing to abide by the request. Mutual agreements can also be a process where the two (or more) people not only talk about limits but also about their likes, dislikes and fantasies.

With a verbal contract, both individuals can share in the responsibility to follow through. Sex is an altered consciousness event. When entering altered states, judgment and values change. Excessive alcohol and drug use may further alter controls. If one person gets carried away, during sex, then the other person can remind him verbally or (preferably) nonverbally of the limits.

V. Getting Back into the Mood:

You and your partner may have become less than sexually enthusiastic after the clinical discussion. There are countless creative ways to get back into the mood:

First, *End* the discussion about health, sickness and contracts. Change the subject to talking about what attracted you to him in the first place, mutual interests, etc. Share sexual fantasies. If touching is within your agreed upon limits, then become physical (dancing, hugging, touching, massage, etc.). Music often helps. Express your desire to become more intimate (verbally, nonverbally).

VI. Follow Through: — After getting back into sensuously or sexually enjoying each other, the next step is integrating your logical plan into your sexual play.

Sharing responsibility for maintaining limits by mutual discussion is not the only way to follow through. Some people rationally create safe limits.

Sexual abandonment and "animal" sexuality are often cherished aspects of sexuality. These important aspects of sexuality seem to be in conflict with sexually safe limits. But not necessarily. At each level of sexual risk taking (no risk, minimal risk, moderate risk, high risk), a person can enter deep (or high) states of altered consciousness with or without high levels of "letting go" automatic physical activities on organismic control. Sexual abandonment is not necessarily the same as very unsafe sexual practices.

In sexual situations where you have not discussed health matters with your partner(s), responsibility rests solely upon you. Maintaining control may be easy in some settings but temptation may be too great in others. You may have to avoid some situations or some people.

Talking about limits (how did we do?) after sex may reinforce your ability to maintain limits or give you an opportunity to review how situations could have been done differently. ■

Dr. Tom Smith is the director of the alcohol treatment unit at San Francisco General Hospital Medical Center, the psychiatric consultant to the Department of Public Health's substance abuse services (Community Substance Abuse Service, Division of Alcohol Programs), and active on numerous AIDS and Gay health related committees (AIDS Psychosocial Committee, AIDS Coordinating Committee, Lesbian/Gay Health Services Coordinating Committee).

He has given numerous lectures on psychosocial-sexual aspects of AIDS/STD and on risk reduction. He has written several articles on psychosocial/sex aspects of AIDS (Printed in NCGSTDS Newsletters, GMHC Newsletter, K.S. Foundation Newsletter). "I strongly feel that sexuality," Smith says "should be part of the solution. I feel that we should appeal to the majority of Gay men that are interested in positive change and not focus as heavily on the careless (plan for them but not focus on them). I feel that each restriction should be joined with a statement of positive action. I am now writing a paper on 'minimal risk sex'."

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SEX AND THE HEALTH CRISIS

by Tom Smith, MD, San Francisco General Hospital, February, 1983

There are several good reasons for gay men to concern themselves about sex during the present health crisis. The current favored theory about AIDS proposes an infectious agent (a virus?) that is spread both by blood (I.V. drug use, transfusions) and by body secretions shared in sexual contact. However, the exact relationship of sex and AIDS has not been determined. A growing number of gay men with AIDS do not meet the previously stressed "fast lane sex" stereotype. Even if future research finds that AIDS is not sexually transmitted, gay men still need to take precautions in sexual activities because of a second and more long standing STD crisis. Sexually Transmitted Diseases (e.g., syphilis, gonorrhea, Hepatitis B, Amebiasis) are definitely interfering with good times and may also weaken an already compromised immune system. By reducing your risk to sexually transmitted diseases you may also be reducing your risk to AIDS. For some people, taking precautions might mean making sexual changes. Ideally, a change in sexual activity would include fun and healthful practices while continuing to be true to ones own very individualized sexual needs and preferences.

Gay men are reacting to the crisis in many different ways, some by choosing celibacy or avoiding close contact, even friendship. A few are reacting by increased sexual abandonment; many are making changes that include reducing the number of their sexual partners, increasing sexual hygiene, and deleting or reserving some "risky" sexual practices for special times, learning to assert their sexual limits to their partners, learning to say "no" and to say "yes". Since gay men are possibly now on a sexual quota system, quantity is being replaced with quality. Recently a friend observed that gay men are becoming more openly social and intimate in their sexual relationships and thus more sexually responsible and personally satisfied. For many, the seemingly impossible task of cutting down on trips to the baths or stopping rimming has created more of a problem on the psychological level (loss of a favored activity) than on the actual change of the activity. Many have increased dating or have grown closer to their lovers while simultaneously have cut down on the number of different sexual partners. Some men make sudden changes, they decide to stop rimming and presto, they stop. However for many men, changes in a favored activity may occur more slowly, over several weeks. The person requires time to process their deeper feelings about sexual needs and to learn other ways to satisfy male to male desires.

Several concerns arise when making sexual change: reducing homophobia and guilt, having patience, going against current subculture sexual customs, having current knowledge about what constitutes "positive and healthful" sex. Homophobia about AIDS is possibly going to increase. Two major gay male sexual problems with homophobia are viewing gay sex as bad and avoiding intimacy with gay men (especially at this time when we need more intimacy and gay male bonding). We may need to create a kind and rational "gay parent" in our heads that counteracts our own homophobia and guides us toward healthy gay sex. We also may need the support and advice of friends to carry out new sexual goals. Now that the gay male community is mobilized and working toward changing sexual customs, talking about sexual hygiene, health and limits will become easier for individuals. In the past, good hygiene might have been taken for granted. Now it is easier to request a pre-sex bath, to talk about yours or his health status (or halitosis) or to ask that the sex not include oral-anal contact in its many (and subtle) forms. It is easier to substitute sensual massage or hugging and cuddling and not feel a pressure to perform when either of you are not up to par.

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SEX AND THE HEALTH CRISIS, Continued

What are the guidelines for "healthful and positive" gay male sex (and by whose decree)? Actually, the guidelines are just practical suggestions based on current scientific knowledge about AIDS and STD. The main points: 1) to block the spread of infectious agents in blood, secretions and excretions from person to person, 2) to reduce the number of different sexual partners, 3) to communicate these concerns with your partner(s), 4) to know the signs and symptoms of AIDS and STD, 5) to seek early diagnosis and treatment if you become ill, and 6) to participate in wellness programs for yourself (exercise, stress reduction, spirituality, good diet, etc.).

The safest sexual activities in terms of avoiding the spread of an infectious agent would include masturbation, celibacy, possibly monogamy, mutual masturbation, long distance sex (telephone, letters), visual sex (porno, "watching"), sensual massage, hugging, wearing rubbers, and other situations where body fluids are not exchanged. Many of these activities are seen as juvenile, regressive, only foreplay for the real thing and lacking in deep intimacy. However minimal risk sexual activities can also be fun, satisfying, intimate (if a two way communication is established) and sexy. Many gay men have a variety of sexual techniques which already includes several of the above. Perhaps at this time, anonymous sexual encounters (if you choose) should be limited to the above minimal risk activities for the sake of the total community. Even with minimal risk sex, care and hygiene are required (no sores, clean bodies, careful use of rubbers, watch where your hands have been, etc.). Gay men are rising to the occassion and will continue to find many creative sexual solutions that are also safe.

The process of "husband hunting" (finding a mate) will continue to include some sexual risk taking. The joys of a healthy gay relationship far outweigh the fears of illness. Since M and M (monogamy and masturbation) may not be for everyone, we have the happy tasks of discovering creative solutions for a great variety of sexual lifestyles. I'm afraid that some activities are going to be seen as definite "don'ts" (rimming, felching, etc.). However, we still have fantasy, the movies and substitutions.

A barrage of sexual "don'ts" are ascending upon us. For each "should not", we need a "should" - something positive. Sex can be compromised just as easily as the immune system. Sex is a vital biological activity like eating and sleeping. "Do" have sex, do have gay sex, do get close to others, be vulnerable to tenderness, seek out sensuality, help others reduce their tension by sharing intimately with them, give them a hand, a heart, a rational mind; learn the differences and similarities of sex, sensuality and intimacy, share natural highs with others, learn to feel comfortable in asserting your need to stay healthy, learn to be safely sleezy and positively sexual.

Perhaps with this crisis we are given a moment to think and act upon the sexual aspects of our lives that will have a positive outcome for ourselves, our partners, and for society in general.

From "Kaposi's Sarcoma Foundation Newsletter", Issue No. 1 (in press).

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NEW JERSEY AIDS HOTLINE ESTABLISHED IN NEWARK

A telephone helpline for New Jersey residents who have questions about AIDS went into operation in March, and is expected to stay in operation for at least two months. Specially trained volunteers from the lesbian & gay community will be answering calls. The line may be reached by dialing 201/596-0767, between 7-10 pm, Monday-Fridays. For more information, contact: New Jersey Lesbian & Gay Coalition, POB 1431, New Brunswick, NJ 08903.

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NY CIRCUS BENEFIT FOR AIDS

reprinted with thanks from the Philadelphia Inquirer (May 1, 1983), by Donald Drake

More than 17,000 people jammed Madison Square Garden, April 30, to see the Ringling Bros. and Barnum & Bailey Circus. But the greatest show on earth really took place in the stands, where the audience of foot-stomping, arm-waving, laughing gay men cheered the circus and the fact that they had all gotten together like this. Delighted circus performers--clowns, animal trainers, trapeze artists--crowded the entrance ways to the arena to watch the audience watching the circus. The performers said time and time again that they had never seen such an audience.

The entire Garden had been bought out by the New York Gay Men's Health Crisis (GMHC), a group that raises money to fight AIDS, educate the public, & provide patient support services, among other things. Organizers said it was the biggest gay event of all time, with the exception of parades and demonstrations. The audience seemed to be celebrating its existence more than the circus that played out before it. The evening began with the announcement that there would be no smoking in the arena, and so exuberant were the spectators that they cheered for a full minute. Patti Lupone, former star of the musical Evita, opened the circus by telling of a friend who recently died of the disease. She called for an allout effort against AIDS, and again the audience cheered. New York City Mayor Edward Koch walked into the arena and said, "The City of New York will do whatever is within its power to do to fight this disease," and they cheered once again. The biggest cheer of all came after Leonard Bernstein conducted the circus orchestra in the national anthem, which was sung by Metropolitan Opera star Shirley Verrett. GMHC netted approximately $250,000 from the benefit, according to Chicago Gaylife.

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TAINTED BLOOD: BLAMING THE VICTIMS

excerpts reprinted with thanks to author Brian McNaught of Boston, and Au Courant (2/22-28/83)

The gay male community, rocked by the rapid spread of strange life-threatening illnesses, must now face an additional challenge. It has to do with our blood. We are about to be told by some people and encouraged by others to keep our blood to ourselves. One way or the other, our response to this chilling request will have significant repercussions.

The issue is complex and emotional. It is complex because there are so many variables and unanswered questions. It is emotional because no responsible person wants to suggest to at least 11 million men that there is something wrong with their blood. I was forced to deal with the complexity and emotionalism of the issue as I prepared the final draft of a public health brochure on AIDS aimed at Boston gay men. The arguments made were pretty clearly either medical or political. The majority of doctors, most especially the gay physicians, felt that we had the responsibility to eliminate any possible source of AIDS. If evidence suggests that gay men who have been diagnosed as healthy can nevertheless transmit the AIDS agent through a blood transfusion (the incubation period may be as long as 24 months), then we have the moral obligation to protect the lives of healthy blood recipients by voluntarily withholding ours. Many politically oriented people saw asking gay men to refrain from giving blood as a premature, unworkable gesture which "blames the victim" for the disease. They said it would also take the responsibility for a solution off the backs of teh multi-million dollar blood industry which ought to be devising a means of screening blood rather than screening donors. They likewise suggested that any effort on the part of the community to screen itself would be misinterpreted by the public as a recognition that there is something wrong with all gay blood.

I have attempted to do justice to the arguments I heard. Ultimately, I decided against including a reference to blood transfusions because I believed it was premature (no group had formally asked the community to refrain from giving blood) and because the predictable controversy over its inclusion would have distracted all attention away from the valuable infomation we were providing on AIDS. As we wrestle with this issue, we must presume that all parties concerned are operating in good faith. It's a tough issue with no clear and easy solutions. Some of my concerns have already been articulated. And I have others.

To state the obvious, there is no such thing as "gay blood." The word "gay" embrases a multitude of people, some of whom claim to have had up to 1500 same-gender sexual encounters

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TAINTED BLOOD, Continued

and some of whom are celibate monks in Trappist monasteries. Is their blood the same? Is it different than that of the heterosexually married man who stops off for a "quickie" at the baths and comes in contact with the "transmissible agent?" Do we ask all gay men to refrain from donating blood or do we ask all men who have had a homosexual experience? Kinsey suggests that would amount to 37% of the male population!

Suggesting that the gay male community voluntarily refrain from giving blood sets us up for an inevitable failure for which we will be criticized. It presumes there is a "gay male community" and it presumes there is an effective means of reaching that community. It further presumes there is a voice of authority which can motivate the "gay male community" to do one thing or another.

To those who suggest we refrain from giving blood in order to spare the lives of others, I suggest such a plan is not without its own victims. If such a sweeping request were publicly made, I would be concerned about its impact on the young gay person who is struggling with his gay identity. Sensationalized reports about "bad gay blood" would undoubtedly affect his shakey sense of "normalcy." Likewise, the same sensationalized reporting would unquestionably fuel the fires of hatred of the young punks who roam city streets with baseball bats in search of gay skulls to crack. Can we count these as AIDS casualties?

Other victims of such a plan include those people who need adequate supplies of blood. The American Red Cross and other blood banks have become dependent upon the generosity of the gay community for blood supplies and they readily admit they will be hard hit if gay men do refrain from giving blood. Do the handful of AIDS cases which are suspected of being caused by blood from an infected gay person justify eliminating major supplies of blood and indicting the blood of an entire group of people?

For these and other reasons, I hope the gay male community is not formally requested to refrain from giving blood. If we are, I urge caution before our local gay and lesbian leaders jump on the bandwagon. If our motivation is political, do we really have to prove to the straight community that we care about our health? Is it not an insult to suggest that gay people with AIDS would knowingly infect another person? If I were a regular blood donor and, after reading literature on AIDS, believed I was at high risk of being infected, I would decline giving blood. But it is the "high risk" factor and not my being gay which is the issue. Let the medical experts clearly define "high risk" and adjust their donor policy accordingly.

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AIDS CRISIS: YOUR LIFE IS ON THE LINE

by Larry Kramer

[Larry Kramer is co-founder of New York's Gay Men's Health Crisis. This article is abridged and adapted from an article originally published in the New York Native (March 14-27, 1983), & subsequently published in Chicago's Gaylife (April 28, 1983), and is reprinted with permission of the author. Copyright, 1983, Larry Kramer.]

If this article doesn't scare the shit out of you, we're in real trouble. If this article doesn't rouse you to anger, fury, rage, and action, gay men may have no future on this earth. Our continued existence depends on just how angry you can get. Our continued existence as gay men upon the face of this earth is at stake. Unless we fight for our lives we shall die. In all the history of homosexuality, we have never been so close to death and extinction before. Many of us are dying or dead already. Before I tell you what we must do, let me tell you what is happening to us. [I must refer you to the epidemiology update, reported elsewhere in this Newsletter.] The epidemiology does not include the thousands of us walking around with what is also being called AIDS: various forms of swollen lymph glands and fatigues that doctors don't know what to label. The rise in these numbers is terrifying. Whatever is spreading, is now spreading faster as more and more people develop AIDS. And, for the first time in this epidemic, leading doctors and researchers are finally admitting they don't know what's going on. I find this terrifying too--as terrifying as the alarming rise in numbers. For the first time, doctors are saying out loud and up-front, "I don't know." For two years they were'nt talking like this. For two years we've heard a different theory every few weeks. We grasped

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AIDS CRISIS, Continued

at the straws of possible cause: promiscuity, poppers, back rooms, the baths, rimming, fisting, anal intercourse, urine, semen, shit, saliva, sweat, blood, blacks, single virus, new virus, repeated exposure to a virus, amoebas carrying a virus, drugs, Haiti, voodoo, metroniadazole, constant bouts of amebiasis, hepatitis A and B, syphilis, gonorrhea. After almost two years of an epidemic, there still are no answers. After almost two years of an epidemic, the cause of AIDS remains unknown. After almost two years of an epidemic, there is no cure. Hospitals are now so filled with AIDS patients in NYC that there is often a waiting period of up to a month before admission, no matter how sick you are. And, once in, patients are now more and more being treated as lepers as hospital staffs become increasingly worried that AIDS is contagious. Suicides are now being reported of men who would rather die this way than face such medical uncertainty, such uncertain therapies, such hospital treatment, and the appalling statistic that 86% of all serious AIDS cases die after three years time. If all of this had been happening to any other community for two years, there would have been, long ago, such an outcry from that community and all its members that the government of this country would not know what had hit them. Let's talk about a few things specifically.

*****Let's talk about which gay men get AIDS. No matter what you've heard, there is no single profile for all AIDS victims. There are drug users and non-drug users. There are the truly promiscuous and the almost monogamous. There are reported cases of single contact infection. All it seems to take is the one wrong fuck. That's not promiscuity--that's bad luck.
*****Let's talk about AIDS happening in heterosexuals. We've been hearing from the beginning of this epidemic that it was only a question of time before the non-gay community came down with AIDS and when that happened AIDS would suddenly become high on all agendas for funding and research and then we would finally be looked after and all would then be well. I myself thought when AIDS occurred in the first baby, that would be the break-though point. It was. For one day, the media paid an enormous amount of attention--and that was it. There have been no confirmed cases of AIDS in heterosexual, white, non-IV drug using, middle-class Americans. The only confirmed straights afflicted with AIDS are members of groups just as disenfranchised as gays: IV drug users, Haitians, hemophiliacs, black & hispanic babies, and wives or partners of IV drug users and bisexual men. If there have been--and there may have been--any cases in straight, white, non-IV drug-using, middle class Americans, the Centers for Disease Control (CDC) isn't telling anyone about them. When pressed, the CDC says there are "a number of cases that don't fall into any of the other categories." The CDC says its impossible to fully investigate most of these "other category" cases: most of them are dead. The CDC also tends not to believe living, white, middle-class male victims when they say they're straight, or female victims when they say their husbands are straight and don't take drugs.
*****Let's talk about "surveillance." The CDC is charged by our government to fully monitor all epidmics and unusual diseases. To learn something from an epidemic you have to keep records and statistics. Statistics are generated from interviewing victims and getting as much information from them as you can, before they die. To get the best information, you have to ask the right questions. There have been so many AIDS victims that the CDC is no longer able to get to them fast enough. It has given up. The CDC also had been using a questionnaire that was fairly insensitive to the lives of gay men, and thus the data collected from its early study of us have been disputed by gay epidemiologists. The National Institutes of Health is also still fielding a very naive questionnaire. Important, vital case histories are now being lost because of this cessation of CDC interviewing. This is a woeful waste with implications as terrifying for us as the alarming rise in case numbers and doctors finally admitting they don't know what's going on. As each man dies, as one or both sets of men who had interacted with each other come down with AIDS, yet more information that might reveal patterns of transmissibility is not being monitored and collected and studied. We are being denied perhaps the easiest and fastest research tool available at this moment. It will require at least $200,000 to prepare a new questionnaire to study the next important question that must be answered: how is AIDS being transmitted? In which bodily fluids, by which sexual behaviors, in what social environments? For months, the CDC has been asked to begin such preparations for continued surveillance. The CDC is stretched to its limits and is dreadfully underfunded for what it's being asked, in all areas, to do.

*****Let's talk about various forms of treatment. It is very difficult for a patient to find out which hospital to go to or which doctor to go to or which mode of treatment to attempt. Hospitals and doctors are reluctant to reveal how well (or poorly) they're doing with each type of treatment. They may, if you press them, give you a general idea. Most will not show you

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AIDS CRISIS, Continued

their precise numbers of how many patients are doing well on what and how many failed to adequately respond. Because of the ludicrous requirements of the medical journals, doctors are prohibited from revealing publicly the specific data they are gathering from their treatments of our bodies. Doctors and hospitals need money for research, and this money (from the National Institutes of Health (NIH), from cancer research funding organizations, from rich patrons) comes based on the performance of their work (i.e., their tabulations of their results of their treatment of our bodies); this performance is written up as "papers" that must be submitted to and accepted by such "distinguished" medical publications as the New England Journal of Medicine. Most of these "distinguished" publications however, will not publish anything that has been spoken of, leaked, announced, or intimated publicly in advance. Even after acceptance, the doctors must hold their tongues until the article is actually published. Dr. Bijan Safai of New York's Sloan-Kettering has been waiting for over 6 months for the NEJM, which has accepted his interferon study, to publish it. Until that happens, he is only permitted to speak in the most general terms of how interferon is or is not working. Priorities in this area appear to be especially out of kilter at this extreme moment of life or death.

*****Let's talk about hospitals. Everybody's full up, fellows. No room in the inn. Part of this is simply overcrowding; part of this is cruel. New York City's Sloan-Kettering still enforces a regulation from pre-AIDS days that only one dermatology patient per week can be admitted to that hospital. (Kaposi's sarcoma falls under dermatology there.) But S-K is also the second largest treatment center of AIDS in NYC. You can be near to death and still not get into S-K. Additionally, S-K (and the Food & Drug Administration) requires patients to receive their initial shots of interferon while they are hospitalized. A lot of men want to try interferon at S-K before trying chemotherapy elsewhere. Most hospital staffs are still so badly educated about AIDS that they don't know much about it, except that they've heard it's contagious. Hence, AIDS patients are often treated as lepers, even though there have been no cases in hospital staff or among the very doctors who have been treating AIDS victims for two years.
*****Let's talk about what gay tax dollars are buying for gay men. Now we're arriving at the truly scandalous. For over a year and a half, the NIH has been "reviewing" some $55 million worth of grant applications for AIDS research it will eventually fund. It's not even a question of NIH having to ask Congress for money. It's already there, waiting. NIH has almost $8 million already appropriated that it has yet to release into usefulness. There is no question that if this epidemic were happening to the straight, white, non-IV drug using middle class, that money would have been put into use almost two years ago when the first alarming signs of this epidemic were first noticed by New York & California physicians. During the first two weeks of the Tylenol scare, the government spent $10 million to find out what was happening. Hospitals that have been working on AIDS for up to two years are now desperate for replenishing funds. Important studies are going under for lack of money; important leads cannot be pursued. For instance, few hospitals can afford plasmapharesis machines, and few patients can afford this expensive treatment, since few insurance policies will cover the $16,000 bill. The NIH would probably reply that it's foolish to just throw money away, that it hasn't worked before. And NIH might say, if nobody knows what's happening, what's to study? Any good administrator with half a brain could survey the entire AIDS mess and come up with 20 leads that merit further investigation. In any research, in any investigation, you have to start somewhere. You can't just not start anywhere at all. But then, AIDS is happening mostly to gay men, isn't it? All of this is indeed ironic. For within AIDS, as most researchers have been trying to convey to the NIH, may perhaps reside the answer to the question of what it is that causes cancer itself. If straights had more brains, or were less bigoted against gays, they would see that, as with hepatitis B, gay men are again doing their suffering for them. They can use us as guinea pigs to discover the cure to AIDS before it hits them, which most medical authorities are still convinced wil be happening shortly in increasing numbers. As if it has not been malevolent enough, the NIH is now, for unspecified reasons, also turning away AIDS patients from its hospital in Bethesda, Maryland. The hospital, which has been treating anyone and everyone with AIDS for fee, now will only take AIDS patients if they fit into their current investigative protocol, whatever that is. The NIH publishes "papers," too. Gay men pay taxes just like everyone else. NIH money should be paying for our research just like everyone else's. We desperately need something from our government to save our lives, and we're not getting it.

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AIDS CRISIS, CONTINUED

*****Let's talk about health insurance and welfare problems. Many of the ways of treating AIDS are experimental, and many health insurance policies do not cover most of them. Blue Cross is particularly bad about accepting anything unusual. Many serious victims of AIDS have been unable to qualify for welfare or disability or social security benefits. There are increasing numbers of men unable to work and unable to claim welfare because AIDS is not on the list of qualifying disability illnesses. Immune deficiency is an acceptable determining factor for welfare among children, but not adults. Go figure that one out. There are also increasing numbers of men unable to pay their rent, men thrown out on the street with nowhere to live and no money to live with, and men who have been asked by roommates to leave because of their illnesses. And men with serious AIDS are being fired from certain jobs. The horror stories in this area, of those suddenly found destitute, of those facing this illness with insufficient insurance, continue to mount.

I am sick of our electing officials who in no way represent us. I am sick of our stupidity in believing candidates who promise us everything for our support and promptly forget us and insult us after we have given them our votes. I am sick of closeted gay doctors who won't come out to help us fight to rectify any of what I'm writing about. Doctors--the very letters, "M.D."--have enormous clout, particularly when they fight in groups. Can you imagine what gay doctors could accomplish banded together in a network, petitioning local and federal governments, straight colleagues, and the American Medical Association? I am sick of the passivity or non-participation of gay medical associations like the American Association of Physicians for Human Rights, the Bay Area Physicians for Human Rights, New York Physicians for Human Rights, etc. You can count on one hand the number of our doctors who have really worked for us. I am sick of the Advocate, one of this country's largest gay publications, which has yet to quite acknowledge that there's anything going on. That newspaper's recent AIDS issue was so innocuous you'd have thought all we were going through was little worse than a rage of measles. With the exception of New York Native and a very few other gay publications, the gay press has been useless. If we can't get our own papers and magazines to tell us what's really happening to us, and this negligence is added to the negligent noninterest of the straight press, how are we going to get the word around that we're dying? Gay men in smaller towns and cities everywhere must be educated too. You would be amazed at how many people, including gay men, still don't know about the AIDS danger. I am sick of gay men who don't support gay charities. Go give your bucks to straight charities, fellows, while we die. Is the Red Cross taking care of you? The American Cancer Society? Your college alumni fund? The United Jewish Appeal? Catholic charities? The United Way? Any of the fancy straight charities for which faggots put on black tie? Meanwhile, the National Gay Task Force--with its new and splendid leader, Ginny Apuzzo--is broke. Our local gay communities are desperate for the services gay organizations provide for us, and the organizations are all desperate for money--which is certainly not coming from straight people or President Reagan. I am sick of closeted gays. It's 1983 already, guys, when are you going to come out? By 1984 you could be dead. Every gay man who is unable to come forward now and fight to save his own life is truly helping to kill the rest of us. There is only one thing that's going to save some of us, and this is numbers and pressure and our being perceived as united and a threat. I am sick of everyone who tells me to stop creating a panic. How many of us have to die before you get scared off your ass and into action? Every straight person who is knowledgeable about the AIDS epidemic can't understand why gay men aren't marching on the White House. Over and over again I hear from them, "Why aren't you guys doing anything?" Every politician I have spoken to has said to me confidentially, "You guys aren't making enough noise. Bureaucracy only responds to pressure." I am sick of people who say "it's no worse than statistics for smokers and lung cancer" or "considering how many homosexuals there are in the US, AIDS is really statistically affecting only a very few." I am sick of guys who moan that giving up careless sex until this blows over is worse than death. How can they value life so little and cocks & asses so much? I am sick of guys who think that all being gay means is sex in the first place. I am sick of guys who can only think with their cocks. I am sick of "men" who say "we've got to keep quiet or they will do such and such." They usually menas the straight majority, the "moral majority," or similarly perceived representatives of them. Okay, you "men"--be my guest: you can march off now to the gas chambers; just get right in line. We shall always have enemies. Nothing we can ever do will remove them. Southern newspapers and Jerry Falwell's publications are already printing

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AIDS CRISIS, Continued

editorials proclaiming AIDS as God's deserved punishment to homosexuals. So what? Nasty words make poor little sissy pansy wilt and die? And I am very sick and saddened by every gay man who does not get behind this issue totally and with commitment--to fight for his life.

I want to make a point about what happens if we don't get angry about AIDS. There are the obvious losses, of course: little of what I've written about here is likely to be rectified with the speed necessary to help the growing number of victims. But something worse will happen, and is already happening. Increasingly, we are being blamed for AIDS, for this epidemic: we are being called its perpetrators, through our blood, through our "promiscuity," through just being the gay men so much of the rest of the world has learned to hate. We can point out until we are blue in the face that we are not the cause of AIDS but its victims, that AIDS has landed among us as it could have landed among them first. But other frightened populations are going to drown out these truths by playing on the worst bigoted fears of the straight world, and send the status of gay rights back to the Dark Ages.

I am angry and frustrated almost beyond the bounds my skin and bones and body and brain can encompass. My sleep is tormented by nightmares and visions of lost friends and my days are flooded by the tears of funerals and memorial services and seeing my sick friends. How many of us must die before all of we living fight back? If we don't act immediately, then we face our approaching doom.

[EDITOR'S NOTE: This article evokes many feelings and thoughts that may promote discussion at the Second National AIDS Forum and among local AIDS/STD groups. This Newsletter and the information that it carries, is just one small example of the scope of the national gay commitment to those concerned about AIDS. Please share your feelings and reactions with the NCGSTDS Newsletter--write: PO Box 239, Milwaukee, WI 53201. Communicate!]

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CHICAGO AIDS ACTION PROJECT ISSUES SECOND NEWSLETTER

The spring, 1983 issue of the Chicago AIDS Action Project was recently published by the Howard Brown Memorial Clinic. In addition to a local progress report, the newsletter features articles on the hepatitis B vaccine and AIDS, blood donations, what all health care professionals should consider when treating AIDS patients, and an address on recovering our dignity and desire. Contact Sarah Gross, AIDS Action Project Coordinator, 2676 N. Halsted, Chicago, IL 60614 (312/871-5777), for a copy.

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MMWR REPRINTS INCLUDED

Three articles of interest to gay health providers are included with this Newsletter, from the Morbidity & Mortality Weekly Report: "The safety of hepatitis B vaccine," (March 18, Volume 32:10, p. 134); "Penicillinase-producing Neisseria gonorrhoeae--Los Angeles" (April 15, Volume 32:14, p. 181); and "Human T-cell leukemia virus infection in patients with AIDS: Preliminary observations" (May 13, Volume 32:18).

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CANDLELIGHT MARCH & WHITE HOUSE CALL-IN FOCUS NATIONAL ATTENTION ON AIDS

The Kaposi's Sarcoma Research and Education Foundation in San Francisco and the AIDS Project/Los Angeles spearheaded several events in May that attracted national media attention. Since the week of May 1 was designated AIDS Awareness Week in San Francisco, there were attempts to involve several large communities in the country in AIDS activities. On May 2, there was a candlelight march in San Francisco and several other cities; funds raised from selling candles went to sponsoring organizations to help bolster community education & services related to AIDS. Los Angeles had a similar march on May 26th. Similar events in Denver, Chicago, New York, Pittsburgh, Kansas City, Houston, Dallas, Minneapolis, Boston, Seattle, Atlanta, and Washington, DC have been scheduled. According to Matt Redman, Rick Crane, and Mitch Bart, "We pray that the marches will be landmarks of hope and inspiration fro AIDS patients everywhere, and by working together, we can create a media awareness nationwide." Everyone was urged to call the White House Comment Line [see related article] (202/456-7639) to urge additional Federal funding, both within NIH and extramural research.

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CENTERS FOR DISEASE CONTROL March 18, 1983 / Vol. 32 / No. 10

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Current Trends

The Safety of Hepatitis B Virus Vaccine

Since its licensure in 1981 and its general availability in July 1982, hepatitis B virus (HBV) vaccine has been administered to over 200,000 individuals, mostly health care workers. In a collaborative effort, the Centers for Disease Control, the Food and Drug Administration, and Merck, Sharp, and Dohme have collected information on illnesses that developed after receipt of HBV vaccine. All illnesses reported to any of these three groups have been recorded. Serious illnesses have been followed up by telephone or personal interviews. Some illnesses, especially minor ones, probably have not been reported, and many reported illnesses have not been causally related to the vaccine.

As of March 1, 1983, illness had been reported in 118 vaccinees (most illnesses began within 4 weeks of the first vaccine dose). Of the 118 cases, 56 (47.5%) were considered not likely to be attributable to vaccine use because: 1) another specific cause was identified, 2) onset of illness occurred before receipt of vaccine, or 3) the reported event was unrelated to the vaccine (e.g., deltoid pain after gluteal injection). Many of the remaining 62 illnesses may represent "background" disease rather than adverse reactions to the vaccine. Of these 62 persons, 57 (91.9%) had mild or moderate illness that included: six neurologic conditions (five persons with tremors and one with recurrent Bell's palsy); 11 skin or mucous membrane lesions (hives, herpes zoster, psoriasis, and nonspecific lesions); 10 musculo-skeletal ailments (including generalized aches, joint pain, and joint inflammation); five hepatitis-like illnesses (with increased liver enzyme levels and no other identified cause); and 25 miscellaneous complaints (14 persons with a flu-like syndrome, four with injection-site reactions, four with diarrhea, one with headache, one with vomiting, and one with self-limited chest pain with a normal cardiac evaluation).

Six persons had serious illness; illness was defined as serious when it caused hospitalization or other intensive medical care, lasted 14 days or more, caused permanent disability, or was life-threatening. Five of these serious illnesses included one case each of erythema multiforme, aseptic meningitis, grand mal seizure, possible transverse myelitis, and Guillain-Barré syndrome (GBS). A second case of GBS was also reported in a person with antecedent febrile illness, presumptively caused by cytomegalovirus; febrile illness began 11 days after receipt of HBV vaccine, and GBS began 10 days after onset of febrile illness. This case was thus counted among the 56 illnesses not likely to be attributable to the vaccine. Although the numbers of vaccinees and GBS cases are too few on which to base firm conclusions, two cases of GBS do not exceed the number expected by chance alone within 6 weeks of vaccinating 200,000 people (23 GBS cases per million adults per year).

Whether acquired immune deficiency syndrome (AIDS) could be associated with HBV vaccine has been questioned, since the vaccine is made from human plasma. Since 1979, homosexual men, including those from cities with reported AIDS cases, have been the source for much of this plasma. Vaccine produced from these sources has been used in various investigative studies since 1980 and has been commercially available since 1982. To date, no AIDS in vaccine recipients has been reported outside groups with high AIDS incidence. Specifically, no cases have occurred among the several thousand individuals, other than male homosexuals (primarily health care workers), who participated in vaccine studies from 1980 to date. In addition, no cases have been reported from the over 200,000 individuals who have received HBV vaccine since its general availability in July 1982. (The latent period for AIDS, if an infectious agent is involved, appears to be between 8 and 18 months.) Two homosexual men who participated in the original HBV vaccine field trials have developed AIDS. This occurrence is not significantly different from that observed among men who were screened for participation in these trials but who were ultimately not vaccinated. Furthermore, the manufacturing process for HBV vaccine includes several procedures that inactivate representative viruses of all known types (*1*). Thus, both current microbiologic and empiric data provide no support for the suggestion that HBV vaccine might carry an etiologic risk for AIDS.

Surveillance for reactions that may be caused by HBV vaccine is ongoing. The vaccine is recommended for groups at risk of HBV infection (*2*). Health care providers are encouraged to report illness following receipt of HBV vaccine through their local or state health departments to the Hepatitis Division, Center for Infectious Diseases, CDC.

Reported by Div of Hepatitis and Viral Enteritis, Center for Infectious Diseases, CDC; Immunization Practices Advisory Committee.

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1. CDC. Hepatitis B virus vaccine safety: report of an inter-agency group. MMWR 1982;31:465-7.
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SOCIAL SECURITY ALLOWS DISABILITY/SSI BENEFITS FOR AIDS

[The following teletype is being circulated at the Social Security Administration concerning evaluation of AIDS for purposes of entitlement to SSI or disability. Details provided in next Newsletter.]

"...Because of the reported high mortality, an individual with a documented pneumonic or disseminated opportunistc infection or disease [AIDS] should be found to be under a disability on the basis of the requirement of regulations 404.1505(A) and 416.905(A) defining disability as--"...Inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death...." The onset of the disabling impairment will be considered to be the onset of the [disease]. An earlier onset date may be be established if this is dictated by the documented medical findings in the case...." ***** ***** *****

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CENTERS FOR DISEASE CONTROL

April 15, 1983 / Vol. 32 / No. 14

MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

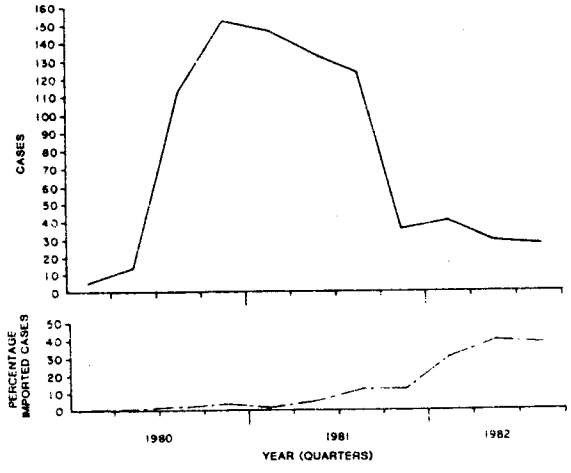
Penicillinase-producing *Neisseria gonorrhoeae*—Los Angeles

An intensified prevention program has controlled the first outbreak of penicillinase-producing *Neisseria gonorrhoeae* (PPNG) infections in a major U.S. metropolitan area. The outbreak in Los Angeles County, California, was initially identified in August 1980 and reached an average of 50 cases per month through March 1981 (Figure 1). Most cases were reported in residents of the central-southwestern part of the county, where rates of reported cases of non-PPNG gonococcal infection have historically been the highest.

In March 1981, the County of Los Angeles Department of Health Services implemented an expanded prevention program with special emphasis in those health districts reporting the greatest numbers of PPNG cases. The strategy included: 1) using spectinomycin as initial treatment for all patients (in health districts reporting the greatest number of PPNG cases) who had or were suspected of having uncomplicated gonococcal urethritis or cervicitis; 2) testing all *N. gonorrhoeae* isolates for β-lactamase production; 3) referring all identified sexual partners of patients with PPNG for prompt examination and treatment; 4) culturing high-risk groups, particularly prostitutes, for *N. gonorrhoeae*; 5) publicizing the outbreak through the media, targeting educational programs for high-risk groups, and educating health care providers through medical alerts, letters, and seminars.

Between March and December 1981, more than 16,000 doses of spectinomycin were administered. At least 19,520 *N. gonorrhoeae* isolates were tested for β-lactamase production. Contact interviews and reinterviews of persons with PPNG resulted in the examination of 924 sexual partners and other suspects. In addition, 8,147 persons were cultured at a county jail (where persons arrested for prostitution are usually sent). Public health personnel spent an estimated 14,700 person-hours on this effort during the first 10 months (March-December 1981).

FIGURE 1. Total penicillinase-producing *Neisseria gonorrhoeae* (PPNG) cases and percentage imported — Los Angeles, 1980-1982



All these prevention activities were designed to improve the timeliness of the appropriate treatment given to persons with PPNG. The average interval between the infected patient's first visit to a health care facility and the administration of spectinomycin or other appropriate therapy, was reduced from 8.5 days (January-February 1981) to 3.3 days (March-December 1981).

During the first 4 months of the intervention program (April-July 1981), the average number of cases reported monthly remained stable. Thereafter, cases decreased and leveled off through 1982 and into 1983, averaging less than 15 cases reported monthly from October 1981 through March 1983. From October 1981 through December 1982, the proportion of all cases attributed to persons returning to Los Angeles from high-incidence PPNG areas increased from less than 5% to approximately 40% (Figure 1). All six patients reported in March 1983 had either histories of foreign travel or exposures to partners with histories of foreign travel or residence.

Reported by S Sidhu, MD, Venereal Disease Control Program, County of Los Angeles; R Barnes, PhD, Public Health Laboratories, County of Los Angeles Dept of Health Svcs; Venereal Disease Control Div, Center for Prevention Svcs, CDC.

Editorial Note: The control of PPNG infections in Los Angeles and the virtual end of endemic transmission are attributable to the comprehensive control effort, including targeted use of spectinomycin therapy, laboratory surveillance, testing and treating sexual partners, screening and educating high-risk populations, and educating high-risk community and professional groups. These measures appreciably reduced the time that the average patient remained able to transmit the disease. However, cases continue to be imported into Los Angeles, and high-quality surveillance and appropriate control measures are being maintained to ensure that endemic transmission does not occur.

In many other areas of the United States, the incidence of PPNG infection is increasing. For the entire United States, 3,424 cases were reported during the first 9 months of 1982, an increase of 1,491 cases (77%) over the same period in 1981. Sustained, endemic transmission continues in New York City and Florida. For the first 9 months of 1982, these areas accounted for 47% of all U.S. cases (*1*); comprehensive control efforts in these areas are being directed toward eliminating endemic disease.

Control of the spread of PPNG in other areas is threatened by the pressure of continued importation. During 1981, 27% of all cases reported by areas other than Los Angeles, Florida, and New York City were in persons returning from high-incidence PPNG areas overseas (*1*). For these locations, CDC continues to recommend timely and appropriate therapy for the maximum number of infected persons. This prevention strategy includes: 1) using spectinomycin, 2 g intramuscularly, for confirmed cases, sexual partners of persons with confirmed cases, and persons with suspected gonococcal infections who have returned from high-incidence PPNG areas; 2) prompt referral and treatment of sexual partners; 3) testing all gonococcal isolates for β-lactamase production; and 4) screening high-risk persons for gonococcal infections (*2,3,4*).

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CENTERS FOR DISEASE CONTROL

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MMWR

MORBIDITY AND MORTALITY WEEKLY REPORT

Epidemiologic Notes and Reports

Human T-Cell Leukemia Virus Infection in Patients with Acquired Immune Deficiency Syndrome: Preliminary Observations

Recent evidence suggests that human T-cell leukemia virus (HTLV) infection occurs in patients with acquired immune deficiency syndrome (AIDS). HTLV has been isolated from peripheral blood T-lymphocytes from several patients with AIDS (*1, 2*), and a retrovirus, related to but clearly distinct from HTLV, has been isolated from cells from a lymph node of a patient with lymphadenopathy syndrome (LAS) (*3*), a syndrome that may precede AIDS itself. Also, HTLV nucleic acid sequences have been detected by nucleic acid hybridization in lymphocytes from two (6%) of 33 AIDS patients (*4*). In addition, antibodies to antigens expressed on the cell surface of HTLV-infected lymphocytes have been detected by an indirect immunofluorescent technique in sera from 19 (25%) of 75 AIDS patients (*5*), including patients with Kaposi's sarcoma alone (10/34), *Pneumocystis carinii* pneumonia alone (7/30), or patients with both diseases (2/11). Similar antibodies were detected in six (26%) of 23 patients with LAS. Such antibodies were rarely found in sera collected from homosexual men in New York City who served as controls during a case-control study in the fall of 1981 (1/81), homosexual men from whom sera were collected in 1978 during visits to a Chicago venereal disease clinic (0/118), and blood donors from a mid-Atlantic state who gave blood in 1977 but were unselected for sexual preference (1/137).

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Editorial Note: HTLV agents are retroviruses that have recently been associated with certain types of adult T-cell lymphoreticular neoplasms of man (*6*). HTLV-1 has been associated with acute T-cell leukemia and a related, but clearly different, viral agent, HTLV-2, with "hairy-cell" T-cell leukemia.

Retroviruses are ribonucleic acid (RNA) viruses containing the enzyme, reverse transcriptase, which allows production of a deoxyribonucleic acid (DNA) copy of their RNA genome. The DNA copy can then be integrated into the genome of the cell. Infections with retroviruses other than HTLV have been associated with a variety of neoplastic diseases in animals including chickens, cats, cattle and gibbons. The feline retrovirus also causes immune suppression.

HTLV agents are the only presently known retroviruses associated with human diseases. Clinically, however, the diseases previously associated with HTLV in endemic areas do not resemble AIDS. Infections are thought rarely to result in malignancies. HTLV may spread from some infected persons to their very close contacts, and concern has been expressed that it

HTLV – Continued

may be transmissible by blood or blood derivatives (7). HTLV infects and immortalizes* T-helper lymphocytes, and the virus can be isolated from infected patients by co-cultivation of their lymphocytes with uninfected human T-lymphocytes.

In the above studies, the reported low frequency of detecting HTLV sequences may reflect depletion of infected T-helper lymphocytes, since patients initially positive for such sequences have had negative tests several months later (*4*).

HTLV-infected cells express specific virus structural and virus-induced cellular proteins. Antibodies reactive with these virus-specific proteins are moderately prevalent (12% of blood donors) in residents of southwest Japan, an area with a relatively high prevalence of adult T-cell leukemia, and in residents of some Caribbean Islands (4% of St. Vincent blood donors); they have rarely been found in healthy Americans or western Europeans, although these population groups have not been studied extensively.

While the above serologic findings associate AIDS with antibody to HTLV-specific cell surface-associated antigens, such antibodies were identified in only about one quarter of the AIDS patients tested. This relatively low frequency of antibody in AIDS patients might represent a lack of test sensitivity, too stringent criteria for positive tests, infection of AIDS patients with an agent related to but not identical with HTLV, nonspecific polyclonal B-cell responses, inability of many AIDS patients to mount antibody responses to these antigens, collection of sera from patients at improper times during disease evolution, or combinations of these and other yet-to-be identified factors. Alternatively, HTLV or an HTLV-like agent might simply represent yet another opportunistic agent in these multiply infected AIDS patients.

Further study is required to determine if any etiologic relationship exists between HTLV and AIDS.

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*The term, "immortalize," refers to the capacity of HTLV to alter a normal human cell so that the cell will reproduce indefinitely in appropriate media.

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STAMPEDED BY FEAR, WE FORGET WE CAN CHOOSE HOW TO DEAL WITH ILLNESS AND DEATH

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MICHAEL LYNCH REFLECTS ON HOW ONE GAY MAN AND AN ENTIRE GAY MALE COMMUNITY ARE MAKING THE MOST CRITICAL CHOICES OF THEIR LIVES

Living with Kaposi's

1

During the last sixteen months, American gay men have suffered their roughest communal turbulence since the Afiita Bryant assaults of 1977. The occasion has been medical: the appearance of an old form of cancer, Kaposi's Sarcoma, in new populations and breakdowns in the immune systems of a number of self-identified gay men. One part of this turbulence has been christened with many names, the *least* sensationalizing of which is "crisis," particularly in the phrase "gay men's health crisis."

I have followed these developments with growing unease. Probably all of us have. Who could ignore the headlines in the American press, gay and straight? Who doesn't know, or know of (this important distinction blurs in times of "crisis"), someone who has become a medical statistic? The illnesses, deaths and the uncertain prognoses of my gay brothers grieve me deeply. They grieve us all. But my unease comes from another base than grief. I suspect that our response to this "health crisis" has involved a communal self-betrayal of gargantuan proportions and historical significance. Have we wielded, ourselves upon ourselves, a major setback in the cause of what we used to call gay liberation?

Another crisis coexists with the medical one. It has gone largely unexamined, even by the gay press. Like helpless mice we have peremptorily, almost inexplicably, relinquished the one power we so long fought for in constructing our modern gay community: the power to determine our own identity. And to whom have we relinquished it? The very authority we wrested it from in a struggle that occupied us for more than a hundred years: the medical profession.

My New York friend Fred has lived with Kaposi's for over a year now. He, his lover Bruce, his close friend Michael, and his parents graciously gave me the interviews which inform the first part of this article. But it is not just individuals who live with Kaposi's and the whole barely charted field of what is now being referred to as AIDS — Acquired Immune Deficiency Syndrome. The modern gay community must live with it too, and the second part of this article will monitor that communal life through, especially, its media, placing our communal relation to illness in a historical context.

But first, let me introduce you to Fred and his circle by taking you back to the day most people remember as the beginning of the thing: 3 July 1981, the muggy first day of a crazy holiday weekend on Manhattan and at Fire Island.

The cabin cruisers in the harbour at Fire Island Pines were as tackily decorated as ever for the Fourth, with red-white-and-blue balloons, streamers, bunting, and even christmastree lights. Some big private parties were planned, one of them with a "Cowboys" theme. "Don't Stop the Train" was establishing itself as the hit of the summer, and people were joking that God in Heaven (sometimes confused with DJ Sharon White in the Pavilion's sound booth) must be hearing it as a repeated supplication, "Don't Stop the Rain." Because rain it did. Only a few breaks in the clouds allowed time on the beach; men booted and spurred for the Cowboys party got their denim and flannels wet. My friend Fred was in his third season at the Pines, sharing a house with seven others including two particularly good friends, a couple.

On that moist Friday, the *New York Times* ran a story headlined, "Rare Cancer Seen in 41 Homosexuals." Most cases, according to the article, "involved homosexual men who have had multiple and frequent sexual encounters with different partners, as many as ten sexual encounters each night up to four times a week." (Read that carefully to spot the lurid misreading allowed by "most," "as many as," and "up to.") Speculation on precipitating factors included recreational drug use (LSD or amyl nitrite), drugs prescribed for treating parasitic infections and, of course, promiscuity. Dr James Curran, of the federal government's Centers for Disease Control, "said there was no apparent danger to nonhomosexuals from contagion," but there was a possibility that homosexuals might catch it from each other.

During the weekend, Fred and his friends discussed the article several times. The couple had a friend, John, who had been diagnosed with Kaposi's some time before, and what struck them now was that this was the first time it had been linked with his sexuality. "It was like reading about a disease you think you'll never get," Fred recalls. "On the train back to the city Monday night I was sitting beside a man whose lover had died of KS. This bothered me because I knew the man and because he was young — not because of the gay connection. It still wasn't gay, gay, gay. What scared the shit out of me was just the fact that this young person, someone my own age, had died of cancer. All we could talk about was that there seemed to be no answers to anything about it. No cures. These people were just suffering."

Born in New York City thirty-four years before, Fred had grown up on Long Island and left the area only to take his BA at the University of Cincinnati and then spend a year and a half in law school in Chicago. At twenty-five he returned to New York, first living with his parents in suburbia, but then moving into Manhattan where, for the first time, he was able to lead a fairly open gay life. For three years he lived with a lover on the Upper East Side, gradually — but only gradually — becoming aware of the bars and disco culture. "We stayed to ourselves," he says. Even during the mid-Seventies he was oblivious to gay political activities. "Except for one friend, we were isolated homebodies. It wasn't until I moved downtown to Ninth Avenue that I became aware that gay men were being suppressed and had certain rights." Still, today, he doesn't define himself as political. "I don't deny my gayness, but I'm not political." He has made contributions to gay groups, but is member of none, and would not support a politician, gay or straight, "simply on a gay issue."

During the three seasons on the Island, Fred was moderate in the amount of sex he had and drugs he took, being very concerned with fitness and good health. He certainly did not recognize himself as a heavy druggie who'd taxed his system having sex with ten men each night four times a week.

On that same weekend, several boardwalks away, a man named Bruce read the *Times* article and discussed it with his housemates. More political than Fred, whom he did not know at the time, "and definitely more heterophobic," Bruce's reaction was to think, "wait till the Moral Majority gets hold of this!" He vaguely recalled that the MM had made a statement that homosexuality was a cancer on society. "I was really pissed off with the sensationalism in the *Times*," he recalls, "but by the end of the weekend I was pissed off with the attitude of the gay people talking about it. All of a sudden, everyone was going to get it! The whole conversation on the beach was about 'gay cancer,' even though the *Times* had not used that phrase."

On the following weekend, he remembers, he was really shocked. "Some guys had erected a soapbox on the boardwalk, collecting donations for 'gay cancer.' It was surreal — the linking of the words 'gay' and 'cancer' was something *we* were doing, and I feared what het society would do with that." Bruce was repelled by the continuing presence of the "soapbox" and its programme, which he calls "cocktails for cancer." "Everyone was acting out of a gut reaction, without thinking," he felt. "Something was wrong, yes, and there may be a connection between being gay and getting the cancer, but no one knew that for sure." He thought the connection inspired fear, and he thought the strategy mindless: "the whole reaction was one of 'let's have a bake sale' — yet where was the money they were raising to go?"

These two reactions — one of puzzled fear, the other of fearful anger — lingered over the following weeks. Back in the city, Fred was working as a designer of children's clothes in the midtown garment industry, and Bruce was making his career with a major Manhattan bank.

Their paths finally crossed two weeks after the *Times* article on what Bruce called the most exhilarating day of his life. Six years younger than Fred, with black curly hair instead of Fred's red shock, Bruce had grown up in the New Jersey suburbs. He left, like Fred, for college in the midwest, at the University of Kansas. Then, like Fred, he returned to New York for work: first in the theatre, then with a major corporation, and finally with the bank. "To my surprise, I was enjoying my work there," he says. "It was like continuing my acting career. I just had a role to play every day, with a certain way of moving and a certain costume. It was going really well. When in 1981 I took a share in a house on the Island for the first time, I felt that everything was going perfect. I wanted dates and affairs, not to settle down, but I wanted the affairs to be more than sexual." The summer had been going just so, and on Friday the seventeenth of July it seemed ready to peak.

"I remember that day from eleven in the morning until six-thirty that evening. It was the first weekend of my vacation. I went in for half a day's work, casually dressed in khaki pants, a sports jacket instead of a suit, carrying my duffel bag. I left the office by cab and went straight to the Island. Even splurged on the seaplane. Flying over the bay, I was looking forward to getting to the house with no one there but myself, to going down to the beach alone, to playing with the dogs.

"I was walking down the boardwalk and this guy comes out — all I saw was red and orange: red hair, orange stripes in the swimsuit. *Real* cute. He turned around." And so they met.

Telling me this nine months later in their apartment, Bruce's voice begins to tremble. "Can we do this alone?" he asks. Fred agrees. After he leaves, Bruce recovers his voice. "I realized the part I was coming to," he tells me. "What I remember most about that meeting..." he pauses, "is the sparkle in his eye. I can deal with most of it now, the hair going, the tits going, the face being drawn and tired. *But I do miss that sparkle.*" Another silence in the room. "It's real strange," he continues, "I remember all these details — at first, I didn't even see his face — but I remember best the sparkle. Yeah, that's what it was, that's what's missing now."

Bruce and Fred were barely separable for the rest of the season. In the city during the week they dated, and on the weekends they danced, sunned, and brunched together as happy new Island couples are wont to do. When they moved back to Manhattan at the end of the season, Bruce moved into Fred's apartment with him. "The best thing about Fred at that time was that I could be with him without being

FRED: "IT SEEMED TERRIBLE — I MEAN, CANCER TO ME RELATES TO DEATH. THAT'S ALL I'VE EVER HEARD OF CANCER."

closed off to everyone else," Bruce say
But there were problems between them
even before leaving the Island. Fred w
often too tired to go out, even when he
wanted to go, and Bruce is a dancer's
dancer. "My autobiography will be
titled," he grins, "*All I Want To Do Is
Dance*." Fred could not keep up with
Bruce's rather ordinary activity level, t
Bruce's occasional impatience. But the
enjoyed each other, and weathered out
the dissonances.

Fred comes from what his mother ca
a "cystic" family. His older brother,
straight and with two children, has hac
fifteen benign cysts over the years, so,
she put it, "cysts mean nothing to us."
Late in September Fred found two cyst
on his ears and nonchalantly went to h
regular internist, Dr Daniel William, tc
have them removed. The initial report
from the biopsy described them as
benign, to no one's surprise. But in
William's office one afternoon three
weeks later, Fred was asked to linger
until the last scheduled patient had left
Dr William told him he'd received a fur
ther report on the cysts. "You have
Kaposi's Sarcoma," he said. "Have yo
heard of it?" A brief discussion of the
disease ensued.

"I was shocked," Fred recalls.
"Shocked. It doesn't happen to me — i
happens to everybody else. I didn't knc
whether to cry, scream, or what. I was
dumbfounded. Finally all I wanted to do was one thing — I wanted to cry. And I could not cry." He went home immediately. "I told Bruce right away, and the two o
us broke down and cried together. It seemed terrible — I mean, cancer to me relates
death. That's all I've ever heard of cancer. I didn't know what was really the case, o
just how bad I was."

Within a few days, Fred was in the office of Dr Linda Laubenstein, the specialist who would guide his treatment, educate him to the day-by-day research findings in K
and AIDS, and support him throughout his long ordeal. She began a period of extensive testing, which involved three days in the new cooperative care facilities of New York University Hospital on First Avenue. It was soon clear that Fred's general immunity system had broken down.

Affiliated with the hospital, the "co-op" is not itself a nursing unit but rather like an attached Howard Johnson's. A patient checks in with his "care partner," and together they keep regular check on his progress. Although the care partner is usually a parent or spouse, Bruce was able to check in with Fred. Together they could go over to the hospital for the tests, together they could take the elevator to the top floor and eat in a cafeteria overlooking the East River. In short, during this period Bruce and Fred were establishing themselves as a gay couple to the straights in the hospital. Fred's condition was serious though not dire. He had no skin lesions, and it appeared that the cancer was restricted to his ears and his lymph system. He began chemotherapy right away.

Initially the chemo routine was boringly predictable. Once a month, for three days in a row, Fred would go to Dr Laubenstein's office for half an hour and take the chemicals intravenously. He came to expect a slight nausea just afterwards that lasted for a couple of days, and then, as regular as clockwork, his white bloodcell count would drop drastically one and a half to two weeks later. During this period, he would experience enormous fatigue and increased susceptibility to ordinary infections such as colds. In the final week before the next treatment, he could expect to feel strong and well. He lost weight, of course. He lost that brilliant red hair that so lingered in Bruce's mind from their first meeting.

The ten-treatment sequence would have been routine except for the occurence of one of the diseases that commonly afflicts AIDS patients: pneumocystic pneumonia, or PCP. That put him in the hospital proper for two weeks and required painful daily shots in his legs. Afterwards, he returned to the co-op and his original medication. But the first pill provoked an allergic reaction throughout his body — 104° of fever and swelling all over. "My body was one big hive, head to toe," he says. "They feared my skin would have burn marks all over it as a result, but it didn't — eventually even the redness went away." Selma, his mother, was very frightened and wanted him back in the hospital. Bruce said no. Dr Laubenstein also said no, on the basis — or so his parents now speculate — that it would have been too depressing for him to find himself back in the hospital, where Bruce could not share his room and care for him.

"It was when he had that allergic reaction and was one immense hive that Fred first cried in our presence," Selma and Roger told me. "He was frightened, too, and kept saying 'I don't want to be sick, I don't want to be sick.' He'd thought he was doing so well. This thing is so unpredictable you never know what it will be the next day."

Selma and Roger, both sixty-two, have experienced several major life changes in the past year. Fred locates them in the upper middle class. While he was growing up, his father was a printer and his mother a housewife. "We had a good childhood," he

recalls, "our parents were very close to us. We never had to do without things. We did lots of things together as a family." Roger has given up the printing business, and Selma now works happily on the editorial staff in an accounting firm. Recently, reluctantly, they moved Selma's mother, who lived with them for many years, to a nursing home. Selma and Roger both like Manhattan, and would like to move there from the suburbs. They come to the city whenever possible, passing hours in its museums, savouring the urban tumult.

"She's a very concerned mother," Fred says of Selma. "She butts in too much sometimes, out-of love, but is learning now, especially with Bruce around, to be less overbearing."

Three years ago, Fred came out to his parents, stimulated to do so by taking The Advocate Experience, a gay therapy programme. "I had to tell them," he says. "Gayness was becoming a very important part of my life." Earlier he had come out to his sister-in-law, and Roger had learned it from her, but the family kept it from Selma until Fred told her himself. "They wanted to protect me," she bristles. "Why I'll never know, because I'm stronger than all of them!" In her heart, Selma says, she had long known Fred was gay. "I knew something wasn't quite right — but I didn't want to classify my child." When he told them, Selma immediately asked if she could attend a therapy meeting with him. Why? "Because the story was for years that the son became gay because of the mother," she recalls. She wanted both to do what she could for Fred and to find out if she was to blame. Fred tried to correct this misconception, but Selma still frets. "To this day, even though Fred and the books now say definitely it's not the mother, there is a little something in me that nudges me — but I don't know what I would have done with Fred that I didn't do with his brother, who's not gay."

In October, Fred did not mention the cysts to Roger and Selma until he had them removed and could report they were benign. But then, Selma recalls, he and Bruce came out to the suburbs for a visit. "The minute Fred walked into the house, Roger and I knew something was not right. Fred was waxen. He'd lost weight." It was the Saturday after his first chemo.

Fred invited his parents into the den, not wanting his grandmother to hear their conversation. "Roger and I looked at each other — we knew something was wrong, we didn't know what."

"Sit down," Fred said. "I want to tell you something. Have you been reading the newspapers?"

"And the irony was," Selma tells me, "that I had seen the article in the *Times* last July. I had seen 'homosexuals' in the headline and I took the page and I said, 'Please God, not my child,' and I read the article very quickly and hid it from myself. I didn't want to dwell on it. I figured if I didn't dwell on it it could never happen."

But now here was Fred, in the den, telling them. It *was* her child. "Selma," her husband broke in, "don't you think the boys are hungry?" She went into the kitchen and made lunch. "And that," she recalls, "was our reaction. The two of us couldn't even talk to each other. We were in terrible shock. Fred came into the kitchen and kissed me. We cried, yes, and I gave them lunch. Later Roger and I drove them into the city, still without mentioning anything to each other, and kept a date, taking Roger's boss and his wife out to dinner. There we talked about everything in the world except what was on our minds, and when we got home that night, then we cried."

Selma and Roger are still not comfortable with Fred's being gay, at least when it comes to the neighbours. "I guess they may suspect, but they've never asked. I'm not going to say, 'by the way, do you know Fred is gay?' " (It is at their request that I am using pseudonyms in this article.) They don't say "Kaposi's" when talking to friends, just "cancer." "They'd make the equation," she expects. Selma noted that Fred, while in the co-op and hospital, persisted in calling his illness "Kaposi's," which to her was his way of saying to everyone he was gay. Shortly before our interview, she noted that he was saying "cancer" instead. "I felt his changing from "Kaposi's" meant that Fred was no longer thinking of himself as a KS patient, but just as Fred who has cancer." Clearly, it would be easier for Selma if the gay connection were not present in this illness.

SELMA: "WHEN HE LEARNED HOW SICK FRED WAS HE FLEW BACK RIGHT AWAY. BRUCE LEFT HIS OWN FAMILY FOR FRED! WE THOUGHT, 'MY GOD, HE MUST CARE FOR FRED VERY MUCH.' "

If the gay connection was difficult in the language itself, it was also difficult with respect to the new man in her son's life: Who was this Bruce who was living with her son and near him at all times of need? And how could she, as the mother with, surely, primary care responsibility for her son, relate to Bruce when *he* seemed to be giving the primary care?

The PCP episode brought this uncertainty to a head. It was on a Saturday, 14 November, that Fred told his parents about having KS. On Tuesday, the 17th, Selma and Roger met with Dr Laubenstein. "The one thing she said we had to worry about," Selma remembers, is pneumocystic pneumonia. And two days later, on Thursday morning, I got a call from Fred. 'Come, mom, I'm on my way to the hospital; I have pneumocystic pneumonia.' "

When Selma and Roger walked into Fred's apartment, Bruce was there. At that moment, Selma felt something she'd not realized so clearly before. "It was Bruce who'd gone through hell the night before when Fred's temperature shot up; it was Bruce who went through the hell of waiting until we came. We took Fred to the hospital because Bruce had an appointment he couldn't miss, but we knew how much he wanted then to stay with Fred." That weekend Bruce had to go to California for his sister's wedding, and wasn't nearby when Fred was put on the hospital's danger list. On Sunday he called and, in Selma's words, "when he learned how sick Fred was he flew back right away. Bruce left his own family for Fred! We thought, 'My God, he must care for Fred very much.' All along, Bruce hadn't looked the other way, as most people do when someone gets sick." Roger adds: "I saw what Bruce did in times of stress and emergency. I think that without Bruce, Fred might have... I don't know what the story would have been. But whenever Fred was falling apart, Bruce was there."

The parents were taking note.

Throughout the year, Selma has had that small voice within her, incriminating her for Fred's gayness. While we were talking, a second voice spoke up. "I do link Kaposi's with gay," she said. "The first time I saw it was the big article in the *Times*: 'Cancer hits gay men.' " If she was the cause of his being gay, I asked, does she ever think she might be the cause of his getting cancer? "You can't help thinking it," she sobs lightly. "No matter how I say it, it all comes back to *me* — what did *I* do wrong?" What a burden, I am thinking. "I'm a clown," she says, "that's why I won't go to a therapist, I'm a clown." I try to assure her that she must not blame herself. 'Maybe you helped me," she says, tentatively. But the newly revealed burden lies heavy. "I never said this to anyone before, not even to Roger, did I Roger?" He looks back at her, quietly reassuring — "You've lived with this for quite a while."

Once Roger and Selma accepted the importance of Bruce in their lives, the recurring conflict was over the best mode of caring for Fred. "I have to fight that Jewish mother instinct," Bruce smiles. "I love it, the caring and fussing, sometimes I adopt it myself." But he fears that it leads Fred to atrophy. "So I make the decision that we're going to go ahead and plan things." But Fred resists, holds back, stays home.

"Fred has one goal only," explains their close friend Michael, "and that is to take care of himself. If it means six months or a year indoors, without socializing, it's worth it to him in order to get well."

Bruce's preference for a more active mode of self-caring comes from his experiences with cancer, experiences which, he says, "haven't been frightening." Bruce weighs his words carefully, paces his speech so that each inflection says just what he wants it to say. His mother survived uterine cancer and a hysterectomy. A close friend's grandmother died of lung cancer, but left him with more inspiration than resignation. "I saw her go and I figured, that woman could have said, 'Okay, Doctor, I'll be gone in six months, I'll just sit here and wait.' But she said instead, 'Fuck you,' and she went off fighting with the DAR, building parks — always busy. At the time I didn't think too much of it, but when I visited her in the hospital she was just as bitchy, cranky, energetic as ever."

Fred and Bruce — barely months into a new relationship — found it difficult to reconcile these two modes. But they, and Fred's family, shared an enthusiasm for Dr Laubenstein's work, and an anger about the sensationalistic way the gay community was dealing with KS. Laubenstein impressed Bruce and Fred with her honesty and professionalism. Physically challenged herself, confined to a wheelchair, Laubenstein evokes respect from her colleagues and patients alike. "When Dr Laubenstein doesn't know something, she tells me so," says Fred. He contrasts her caution with the manner of Dr Daniel William, his internist (and not a specialist in KS or AIDS). He has made what Fred and Bruce call "outrageous" statements both to the press and, in private, to his patients. At a gay synagogue forum on the "health crisis" last winter, Fred and Bruce were appalled to hear William concluding that an excess of sexual intimacy with different partners breeds communicable diseases and/or injures the immunological system. But that was not the worst. They recall his saying that "so far we've seen a fifty per cent mortality rate, and in five years we'll see it at one hundred per cent."

"We had just heard Laubenstein on the same panel," Fred says, "saying how little was known about these diseases. And then William stands up and says you're going to die in five years. He had no right to make that statement — they don't have these statistics. How could he do that, when there were people sitting there who were scared about having the disease, or people like myself who had it? Scare works, yes, but he shouldn't stand there and say you shouldn't even kiss strangers."

"Any intelligent man knows that increased exposure increases the possibility of infection." Bruce adds. "But William is trying to scare us all into not having sex. If we go by his answers, we should all stay in our rooms, not ride in the subway, certainly not move into a crowded city, not be around people."

"William wants to put you in a box," Fred elaborated, "that you should meet one person and have sex with that one person for the rest of your life." (Note: five months after this interview, when a draft of this article is read to Fred, he asks me to qualify his harsh recall of Dr William's statements. "He may not have put it just that way," Fred says. "I was only remembering it that way.")

Bruce prefers to look at it another way, as suggested to him by another New York gay internist, Dr Larry Downs. "It would be the ultimate irony," he reports Downs saying to him, "if, out of all this, those of us who are not contributing to the gene pool should contribute medical knowledge about the structure of the human immunity system." Fred assents — "I have the cancer. It upsets me, but please God that something beneficial is going to come out of it. Maybe because I'm sick we will someday find the cure for cancer. That's a better approach to take than blaming people for being sick."

No one chooses to contract AIDS or KS; but as individuals and as a community we can choose our response to it. According to our response, we may reap beneficial results. Describing the aftermath of her breast cancer and mastectomy, Audre Lorde in *The Cancer Journals* concludes: "I would never have chosen this path, but I am very glad to be who I am, here." Her book might give us all an idea of the ways to shape our responses to the appearance of KS and AIDS among us.

Among the beneficial effects of Fred's choices has been the circle of support that has formed around him and the acceptance of his lover, Bruce, into his parents' family. Another is his new friendship with Michael. I will let Michael tell his side of the story, but first note that Fred and Bruce were initially disturbed by the ways a number of good friends reacted to the news of the illness. "They stopped seeing us, even stopped bothering to call." It seemed to confirm Selma's view that most people, faced with illness, prefer to turn away. In the case of KS, there may have been a particular fear, inspired by the *Times* article or other media stories, of contagion. Perhaps it was a deeper and even more irrational fear of illness itself.

About a year after Fred's diagnosis, one old friend finally called — one whose silence had been a particular sore point for Bruce, since he was fond of this friend. When, finally, he called, it was to share something important — he had just been diagnosed as having KS himself.

Michael works as a graphic designer in advertising; his smart Chelsea apartment is just blocks away from Fred's. I wanted to interview him because the experience of close friends is a part of any individual's experience in our modern gay community. To leave it out falsifies the picture.

Michael:

"I was working in Europe when they found out. When I got back, Bruce called, 'I've got to see you right away.' Fred and Bruce's relationship wasn't too strong at that point. For new lovers they'd had to go through a lot very fast. I thought maybe he was having some trouble with Fred. We met, and he told me. My immediate reaction was, 'Fred's going to die.' I may even have asked when. Bruce was upset. We went to dinner and talked more. But even after Bruce explained all he knew, there was no doubt in my mind that Fred was going to die.

"I first heard of Kaposi's from the article in the *Times*. That story frightened me, because if anyone was more promiscuous or around more drugs than me, I don't know who they are. I'd done a lot of poppers. But it also amused me — it was funny that they would localize it in gay people. The day the article appeared I remember walking with friends along Fire Island Boulevard and joking about it. 'How do you get it?' someone asked. 'By touching greeting cards,' someone replied.

"I had been Bruce's friend first. At New Year's 1981 we met and had a mini-affair, but didn't see each other much again until we were in sister houses in the Pines for the '81 season. I grew close to him then, and when he met Fred I started getting to know Fred too. But until Fred went to the hospital I was mainly supportive of Bruce. I could hold him, but I couldn't make it better. It was a difficult time for Bruce — he had to make some very hard choices, including whether or not to stay with Fred through this thing.

"When Fred had his worst time, in the hospital at Thanksgiving, Bruce was away, and I went to visit him there. He had lost half of his hair because of the chemo, and his skin was all broken out. I was frightened, but didn't say a word. Finally, Fred said, 'Michael, why haven't you s
about the fact that I'm going
had to begin confronting son
evasions.

"When he got back home,
reluctant to go out — he's an
patient in terms of taking car
This tended to irritate Bruce.
was at that point getting mor
serious about life. The novel
illness had worn off. He reali
go on much longer than he'd

"So Bruce and I went out
tried to maintain his own life
Fred was resentful of this. Bu
growing closer to both of the
Christmas they gave me a bes
from Tiffany's — and I reali
made two incredible friendsh
through this pain together, w
Bruce. I realized how it allow
honest with them, to feel com
with both of them. I had bee
fall about saying the right thi
never touched Fred a lot — fi
He was months into the sickn
kissed him.

"After the hospital, Fred a
free to talk even about the po
his dying. This was a real joy
could talk to someone about
that was most precious to hin
ly opened up enough that we
ized what was going on — I h
fear of the disease myself. Bu

MICHAEL: "I REALIZED I'D MADE TWO INCREDIBLE FRIENDSHIPS, GOING THROUGH THIS PAIN TOGETHER WITH FRED AND BRUCE."

with Fred eliminated my fear, even the fear I've had a long time, the fear c
could talk about what would happen with Bruce if he died — and even ab
might happen in the relationship if he were to get well.

"At Thanksgiving, Fred was afraid of dying, but now I think he's more
not getting well. That he's going to go on like this forever and ever. And w
about these things! It's been real important to me; he's made it real easy f
There's a part of me that feels guilty that he's given me [illegible]

"We even joke about it more freely now; Fred tends to [illegible]
plans for the future, 'I'll be there. Clod willing.' The other [illegible]
install a new closet unit in the apartment. At one stage [illegible]
Fred stood in it as if he was in a coffin and asked us to [illegible]
for him. We clowned around with that for a while. Or if he's feisty, I say, 'I
you're going to be in chemo again soon, that will calm you down.'

"If he does die, I'll be pissed off. Really angry. But I don't see it happeni
Fred a lot. I can't believe he's going to go away. I love him, really deeply, h
so much from him. If he does die, I'd be scared. What would my responsib
Bruce? I'd see myself as having to be real strong. Bruce would be devastate
Bruce and I will be friends for life now. Nothing we could do to each other
break this. Even though he sometimes resents that Fred and I have become

"I don't think of Fred as having cancer anymore. I don't remember wha
like with hair! He's here now, and during this process he hasn't been dehur
The friendship has become real rich. As to the friends who shut them off, I
whole lot of compassion for them. They missed a whole lot, for themselves
Fred. But I guess they did what they had to do.

"You wouldn't believe the panic around here these days. I have one frie
counts the days since he's had sex, like someone trying to stop smoking wh
proudly counting the days since his last cigarette.

"Often I think to myself — I wish I could cure cancer rather than just m
pretty ads."

And so this small circle bonded together, quarr
at times, bolstering each other at times. When Fred recov
from the PCP he was able to return to work while continuing h
treatments. (His employer has accommodated all his absenteeism;
medical insurance has covered all his bills, running well over $100,000.)

Not long after Easter, when we did these interviews, Fred reached the en
chemo treatments and waited for several months until tests could show ho
his immune system was. The uncertainties were awesome, the tedium hard
was disheartened to learn that he would have to submit to another round, t
a different sort of chemotherapy. But before that could begin, in Septembe
very ill again and returned to the hospital once more, this time with tuberc
another of the diseases that afflicts people with AIDS. He was told this was
news" because "we can cure that," but even this takes time — time waiting
proper medication to arrive, time to be treated, time to assess the results. S
first round of chemo he has grown back his hair and, a source of great prid
moustache. But this summer he refused to take a share on the Island, even
Bruce argued it could be a restful and pleasant change from their Ninth Av
ment. Bruce has gone out to the Pines for several weekends, in the compan
friends.

The TB is now impairing his vision. When I sent them a draft of this artic

was unable to read the page so Bruce read it to him. Imagining this hushed scene tests me as their friend and writer: so close to our brothers, we in the gay press assume an awesome responsibility in writing about their illness.

Fred, Bruce, Michael, Fred's parents and his doctor are constantly in touch and living from day to day. As their stories convey, the operative word here is the verb: *living*, from day to day.

2

I had to tell them: gayness was becoming a very important part of my life.

Fred, Bruce and Michael share a modern male homosexual sense of identity — very 1980s, very urban. This identity was born in the nineteenth century, midwived into existence largely by what gay historians like to call the "medical model." Many of our nineteenth-century ancestors had predilections for same-sex love, for passionate friendship rather than courtship, for fraternity rather than marriage. Some of them formulated a new identity in dialogue with the medical psychology of the age. Some were doctors themselves. The medical profession was largely "supportive" of these developing "homosexuals" — as they came to call themselves — especially over against the "criminal model" by which the state defined us. It was the criminal model that sent Oscar Wilde to two years of hard labour, the medical model which made him of interest to psychologists. But even early on, the medical model treated homosexuals as objects, alien creatures to be studied and classified and labelled. In short, under the medical model homosexuals became pathological. As opposed to the harsh criminal model, this wasn't, at times, so bad.

This ambivalent relationship continued into the twentieth century, with many modern homosexuals using medical concepts to explore, develop and define their identity and culture. The first wave of modern gay liberation swept, from 1897, through Germany under the leadership of Dr Magnus Hirschfeld, himself a homosexual — until the Nazis swept it into the streets and then into the detention camps. Hirschfeld's Scientific Humanitarian Committee engaged many medical concepts to argue for liberalizing the German penal code.

The ambivalence ended when exploratory psychology ossified into dogma, especially among the latter-day Freudians. The medical profession replaced the church in collaborating with the state as oppressors of homosexuals. If originally we had been criminal because we were sinful, we now were criminal because we were sick. Then a second wave of gay liberation emerged in the United States not long after the Nazis were crushed. It viewed the medical profession sometimes with suspicion, more often with outright hostility. The enemy was the medical model. While the Mattachine and other organizations looked to professionals for help with self-definition, they chose empirical researchers such as Alfred Kinsey (a biologist, not a physician) over such medical moralists as Dr Irving Bieber. Nevertheless, Bieber's specious theory that male homosexuality is caused by "close-binding-intimate" mothers and "detached" fathers gained wide acceptance in the straight media, and thus with the public.

Since 1969, the post-Stonewall gay movement has unrelentingly scrutinized the medical model and largely rejected all medical definitions of gay people. In the place of these alien labellings, it has burst forward with acts of self-definition, moving well beyond characterizations related to sexual acts ("we are only what we do in bed") but maintaining that sexual brotherhood of promiscuity as the foundation of our identity. During the 1970s it constructed a remarkably complex community that includes our clubs, arts, press, economic units, recreational sports and political activism. With the rise of neo-conservatism and sexual bigotry in the late '70s, spurred on and symbolized by the Anita Bryant Save Our Children campaign, this newly complex gay identity and community galvanized into a massive defence — and offence — against the moral-medical right. It emerged from the battle with something completely new in gay history: a well-founded pride in its own vigour, breadth, freshness, powers, political legitimacy. The gay community was now on the mainstage of public awareness, arguing its case and developing its possibilities as never before.

And then, 3 July 1981. The *New York Times* article tipped New York's gay populace into a spin which would soon become a darkening vortex. Initial camping in the Pines turned, by the end of the season, to alarm. Back in Manhattan, people began to fear sex itself, and even to feel guilty just for being gay. *I have one friend who counts the days since he's had sex, like someone trying to stop smoking who's proudly counting the days since his last cigarette.* Just how this generalized panic set in can be traced through the media (we have already seen how the original *Times* article cut to the bone for Fred and his circle), but one thing is clear — it could never have set in so quickly and so deeply if within the hearts of gay men there weren't already a persistent, anti-sexual sense of guilt, ready to be tapped.

The *Times*, indeed, did not use the phrase "gay cancer." Nor did author Larry Kramer, whose novel *Faggots* gave us his view of the gay community as a scene ripe for guilt and retribution. ("Don't you know that what you've done," says Uncle Richard whom his nephew has just sucked off, "correction, that what we've just done is considered by ninety-nine and ninety-nine one hundredths percent people as abnormal, immoral, illegal, dirty, shameful, wretched, that's it *wretched*, oh, oh, *Oh*.... Uncle Richard now held his head," says Kramer, "with both his sinner's hands, expecting, no, bringing upon himself the onslaught of doom.") In the fall of 1981, there was a small debate over the degree to which Kramer's "gay homophobia and anti-eroticism" shaped New York's way of responding to the KS outbreak.

THIS PANIC COULD NEVER HAVE SET IN SO QUICKLY AND SO DEEPLY IF WITHIN THE HEARTS OF GAY MEN THERE WEREN'T ALREADY A PERSISTENT, ANTI-SEXUAL SENSE OF GUILT, READY TO BE TAPPED.

Deeply moved by the illness and death of several close friends, Kramer was instrumental in setting up that boardwalk booth in the Pines. It was Kramer who garnered bucks there; who, in his lower Fifth Avenue apartment looking out over Washington Square, organized what would become the Gay Men's Health Crisis group; who, as chair of its Medical Jury Board, recently dispersed $34,786 to four different research projects which he and his Board deemed worthy. Kramer's appeal for funds in the late August *New York Native* provoked a teapot controversy which should have become a serious debate. But Kramer appealed for immediate consensus, not debate. One writer who questioned Kramer's strategy was dismissed as having the "moral posture of an iguana." Finally, even those with doubts about his strategy acceded to it in what seemed the urgency for immediate fundraising — never mind, for now, exactly who the funds were for.

By Christmas, the phrase "gay cancer" was on many lips, along with words such as "epidemic" and "opportunistic diseases." On 21 December, the virulently anti-sexual *Newsweek* slyly introduced a yet more pernicious notion into its headline, "Diseases that Plague Gays." Eventually *New York* magazine would deal a lower blow. "The Gay Plague," *New York* called it, the hard-a assonance itself a chilling attack, as if buboes came with our 501 jeans. We have long battled the straight press for its use of a phrase like "gay murder," but I know of no one who publicly fought the introduction of this new term. Indeed, one member of the Gay Men's Health Crisis (about whom we shall hear more later) publicly praised the *New York* article as a "reasoned, humane accounting of the facts."

Newsweek, and later *New York* and *Time*, predicated a plague effect by which the homos would infect everyone else, perhaps through the interface of the bisexual population. By July 1982, one year after the *Times* article, even the cautious Dr James Curran (who in the *Times* had foreseen no apparent danger to "nonhomosexuals"), was quoted by the national media on the "gay plague." The savagery of the straight press coverage has been unmitigated — in a notably grotesque *Us* magazine article, one dying patient was remembered by his nurse as saying, "Phyllis, if I pull through, I promise to find a girlfriend." Three weeks later, *Us* reports, in the best tradition of moralizing conclusions, he was dead. (No gay man, I rage parenthetically, should ever have to die believing this lie.) The grotesquerie was far less pernicious, however, than the basic linkage, through language and headlines, of gays *as gays* with pathology.

The gay press has shown at best a sad record in dealing with the disease. In a much heralded interview with a KS patient, New York's *Christopher Street* chose a man whose key message was guilt and punishment. He describes a life of parties, discos, "endless functions," "Island fever," and concludes with a litany worthy of Uncle Richard:

I wanted more.
I must pay.
I have paid.

Christopher Street gave Philip Lanzaratta's guilt trip its full front page, and, for a title, the bathetic "Why Me?"

Three men have dominated the gay press's handling of this medical and political turbulence. Nathan Fain is a freelance writer living in New York; Dr Larry Mass is a prolific writer for the *New York Native* (ever with the MD after his name: medical mystification assured); and Dr Daniel William, Fred's internist, is an MD who does not write for the popular press but is ever available for interviews. Far more than Larry Kramer, this trio has shaped the way the gay community understands this "crisis." As we shall see, their editors and publishers have exerted yet more influence over the gay public's perception by the way they market what these men have to say.

It was Nathan Fain who, in defending Kramer, compared a reasonable dissenter's morality to that of an iguana. But Fain's two-part article for the *Advocate* in March 1982 was a cool and sophisticated introduction for the layman to the complex research problems facing medical researchers. Fain is alert to the careerist ego-trips among researchers in such a highly charged field: "It is, says every doctor asked, the most exciting event in their careers: many are mindful of the glory that awaits the hero of the moment, the Jonas Salk of cancer." Consequently, he sketches the infighting within the medical establishment (especially vicious where large sums of money are to be fought over, as in the cancer-cure industry), and a sharp if understated guide to how that power system works.

But David Goodstein, Fain's publisher, drastically altered the impact of Fain's analysis. "Since the *Advocate* ran Nathan Fain's articles on the gay plague about three months ago, Kaposi's Sarcoma has burrowed its way into the consciousness of everyone I know," a New York restauranteur told Arthur Bell recently in the *Village Voice*. Fain himself, however, had never used the word "gay plague," with its moral overtones. That impression was created by Goodstein, who, in a manner of preface to Fain's analysis, editorialized, "The fact is that aspects of the urban gay lifestyle we have created in the last decade are hazardous to our health. The evidence is overwhelming." If Goodstein had even read Fain's piece, he had not understood it. Goodstein's astonishing, homophobic conclusion: "Our lifestyle" — and wasn't it the *Advocate* that popularized this very word in our vocabulary? — "can become an elaborate suicide ritual."

Even for those readers who skipped Goodstein's editorial or Fain's articles, the *Advocate* forged a link in the minds of anyone who saw the cover drawline: "Is our lifestyle hazardous to our health?" If there is, as I suspect, a residue of guilt among gay men, such a drawline — let's call it the Interrogative Draw — nourished its increase for all but the most diligent reader, who discovers that Fain's answer to the question is *no*. The Interrogative Draw has been a favourite in the *Native* as well, where one article asked boldly "Do poppers cause cancer?" and another, on the "epidemic," "Is there a link to handballing?" (Handballing is a new synonym for fisting.) Deep within the technical language of both articles, author Dr Larry Mass answered *no*, but the damage was done. Fain himself complained, in a letter to the *Native*, about the misleading slant of one of these Draws.

"There is no plague, no 'gay cancer,' nor any god leveling a fiery finger on cities of the plain," Fain wrote in Philadelphia's *Gay News* last July. But again, his editor levelled a finger by headlining his page-one article "Special 'gay cancer' report!" In this piece, Fain, who had earlier praised *New York*'s "The Gay Plague," steps from behind his medical reporting to praise the straight press's handling of the issue. "Mainstream publications have told the story with remarkable restraint," he writes, leaving me wondering how carefully he read *New York*, *Time*, and *Newsweek*. "Only the most courageous and responsible news organizations have, so far, addressed the issue."

Dr Mass, like Fain, has covered new developments in medical theories and research. It was Dr Mass, as far as I can determine, who introduced the term "gay cancer" to the media, uncritically except for the inverted commas around the phrase. Unlike Fain, Dr Mass has not explained the politics of the medical establishment — indeed, he has praised them. At an AIDS symposium at New York's Mt Sinai Hospital last July, Dr Mass praised "every physician and researcher in the auditorium" for "extraordinary sensitivity to issue stigma." (Perhaps Fain is just praising his colleagues in journalism, and Dr Mass his in medicine?) I hardly see how he could have done this, given the presence of the panel of Dr Daniel William. Of Dr William, more shortly.

In the cases of Fain and Mass, we can see the limitations of strictly "medical" reporting. Their editors can (and will) use them for whatever moral message they wish, despite the contents. But there is one curious document from Dr Mass that makes me suspect he is supportive of the anti-"lifestyle" use to which his medical writing is being put. In the late August *Native* he interviewed a KS patient who eloquently and passionately pled for extreme caution in keeping medical matters separate from moral matters. This man's argument against the dangers of the "self-hating guilt trap" is close to that which Fred and Bruce have made. But Dr Mass, as the interviewer, seems to be arguing that illness *is* a moral matter. Because of the interview format, and Mass's rhetorical questions, it is difficult to be sure without an elaborate quotation. But my impression, and the interviewee's impression, is clearly that Dr Mass links illness with morality. "Cancer of the cervix is more commonly observed among the lower socioeconomic classes," he notes:

> *Does this mean that women from the lower strata of society are, generally speaking, less moral than those from the higher strata? Are the gay males who are getting these diseases, generally speaking, less moral than those who aren't? Does this mean that gay people, generally speaking, are less moral than nongay people?*

"The answer," Dr Mass concludes, "to these questions, in my opinion, is not a matter for speculation."

The unabashed forger of links between illness and morality, among the doctors, is Dr Daniel William. William came out as a gay physician in 1974, and in a 1978 *Christopher Street* interview detailed his personal moral commitment to a stable monogamous relationship, replete with rings, talk of a marriage ceremony, and in-

GAYS ARE ONCE AGAIN ALLOWING THE MEDICAL PROFESSION TO DEFINE, RESTRICT, PATHOLOGIZE US. WHAT USED TO BE A PSYCHIATRIC PATHOLOGY IS NOW AN INFECTIOUS ONE.

laws. Predisposed well before 3 July 1 to blame various illnesses on promisc ity, Dr William went into full gear las fall and has not stopped since. In December he told *Time* that "promis ous behaviour," as he calls it, "increa the risk of infection." A neutral enou statement — of course it does — but strong moral overtones.

Dr William has played the media d tor throughout this "health crisis." H quoted in the gay and straight press alike, and is forever blaming sex with many partners. In *New York*'s "The Plague," he gave the *Advocate*'s Inte rogative Draw a resounding "yes":

> *The bottom line is that, yes, part of lifestyle is a hazard to our health.*

For the *Native*, he summoned up a ti former-liberal lament that reminds o of Norman Podhoretz and his fellow neo-cons:

> *Deep in my heart I'm a civil libertari and I take great pains to be consisten that viewpoint. But I do think the ti has come for gay physicians and the public health officials to advise the general public about the health haza of sexual activity with many anonym partners.*

In *Us*, he moralizes openly:

> *Promiscuous behaviour can only increase the risk of disease. That's w gay men must turn one-night stands longer relationships.*

In *Gay News*, he makes an elegant comparison between gay men and the heterosex heroin users who get AIDS:

> *They're doing with needles what we're doing with dick.*

And in *Christopher Street* he indulges an ominous whimsicality:

> *Eventually, some restrictive measures may have to be imposed.*

I am certain that Dr William is motivated by care for his patients, but his politics have made him our new Irving Beiber — pushing morality under the guise of medic expertise. Tragically, he goes unchallenged by his colleagues Fain and Mass, and by the organized gay community. The results are easy to measure. A thick brochure from Houston's Kaposi's Sarcoma Committee bears the insidious title, *Towards a Healthier Gay Lifestyle*, and preaches that "gay ghetto mentality" may be "the major contributing factor" to the medical syndrome! Its antidote: eat at least two good meals a day, phone your friends regularly, expand your horizons beyond the "ghetto mentality." A bolder, less insidious result comes from the City Council of Columbia, Missouri, which last June defeated a gay rights ordinance largely becau of the argument by a county health official, (one of those public health officials Dr William wants to "impose restrictive measures") that we are regular transmitters o disease.

Perhaps the most damning analysis of Dr William and his anti-sexual pronounce ments in the guise of medical expertise comes from his co-worker, Dr Donna Mildvan: "Dan William believes that it has to do with the bombardment, the clust ing of a whole range of infectious diseases among these patients which may be exhausting their immunodefensive capacities. But all this — Dan's thinking as well mine — is still speculative." Would that others were this clear on what is "specula tion" and what is not.

Deploying medical threats to control sexual activity is not an invention of that Missouri health official or of Dr William. The threat of venereal disease, even since the development antibiotics, continues to be used by the medical-moralists. The Church, in opposing birth control, safe abortions and lesbianism, maintains its power over women's sexual activity with the threat of pregnancy and even death. The spectre cervical cancer, as Susan Sontag shows in *Illness as Metaphor*, has long been used threat against women's sexual pleasure.

But now Dr William and his followers are adding a potent new means of control They seek to rip apart the very promiscuous fabric that knits the gay male commun together and that, in its democratic anarchism, defies state regulation of our sexuality. Just as disturbingly, gays are once again allowing the medical profession to define, restrict, pathologize us. What used to be a psychiatric pathology is now, as Missouri health official indicated, an infectious one. The American Psychiatric Association may have given us all an instant cure in 1974 when they took "homose uality" off the list of mental diseases, but now the MDs of the land have placed us their agenda, and no one, so far, seems to be resisting them. A particularly sad commentary on the state of things comes from the recent meeting of gay leaders in Dallas to consider a national response to the AIDS situation. Their first recommen tion was to lobby Congress for additional funds for the AIDS researchers: — throw ing more bucks to the good doctors so they can cure us of our ills.

The crisis of 1981-82 is not simply, or even most importantly, a gay men's health crisis. It is a crisis of gay men allowing the medical moralists to reassert their power over us. The gay community today lies prostrate before the physicians. In 1978 we

the Dade County battle but won the war. We mobilized thousands of gays to come out, to open public discussion of gay issues, to defend our cherished institutions, including promiscuity. In 1981-82 we are winning some small battles — having an openly gay physician quoted in *Time* or *Us*, raising funds on the Pines boardwalk or at a big disco event called "Showers" or over cocktails in the elegant Southampton home of artist Larry Rivers — but losing the war. Why? Because we have misunderstood the battlefield.

When a young gay man, in 1977, read in his morning paper of the Dade County battle, he got an image of gays being open and proud. In 1981, that same young man reading the public press will see gays as panicky victims who raise money for doctors to cure what ails them. How many mothers, in 1981, have sent newsclips to their gay sons as a warning? How many, like Selma, have privately blurred the medical models of Bieber and William to blame themselves for their son's illness or death? Here lies the stuff of tragedy.

How was it that New York, that centre of our artistic and intellectual life, tumbled so easily and swiftly into the medicalization trap? We will debate this for years to come, but I propose two explanations now. The first I have mentioned already — deep within ourselves lingered a readiness to find ourselves guilty. We were ripe to embrace a viral infection as a moral punishment. The media nourished this readiness, but did not create it.

Perhaps we still mirror our larger culture in that readiness; we certainly do in what I propose as a second explanation — the gay community, like many other urban communities, simply cannot deal with sickness, dying and death in a humane way. Over the years we have become able to handle death by violence (Harvey Milk, the shooting outside New York's Ramrod bar, weekly gaybashing), but not death by illness. Unlike, say, the rural southern US town I grew up in, where several people of different ages were *always* facing cancer, our community is poorly equipped to deal with the taboos of aging, illness and death. Gay men drink and trick together, but die alone. We respond to illness by distancing ourselves — by not phoning, by yielding to medical mediators or by frenzied, irreflective fundraising. By turning to the doctors and the cocktail parties, rather than to our gay brothers themselves, we yielded our own powers to deal creatively with all aspects of our life, including dying.

Once we see this, we may take our lives and our self-definitions back into our own hands. We have to make illness gay, and dying gay, and death gay, just as we have made sex and baseball and drinking and eating and dressing gay. This is the challenge to us in 1982 — just when the doctors are trying to do it for us. If we address this challenge, I believe, we can begin to brake that darkening vortex that is about to drown us under this reconstituted medical model. There are, as Bill Lewis reports in the accompanying article, welcome signs that this has already begun.

WE HAVE TO MAKE ILLNESS GAY, AND DYING GAY, AND DEATH GAY, JUST AS WE HAVE MADE SEX AND BASEBALL AND DRINKING AND DRESSING GAY. THIS IS THE CHALLENGE TO US IN 1982.

3

I draft the final part of this article in Room 4104 of Duke University Hospital North, at the Carolina bedside of my mother. Two months after my interviews with Fred about living with Kaposi's, she was found to have an advanced, inoperable lung cancer. Three days ago, as I was transcribing the last of those interviews, I was called here. There's now a tumour in her brain, impairing speech but promising no pain. In these months I have felt anger and grief beyond any bounds I could have anticipated. Here at her bed, the I-V catheter dripping out the seconds, I find strength, affirmation, a sequence of moments of intimacy and clarity. She can articulate very little, but her eyes fix on me and speak. Her lower jaw juts out with magnificent fury. I have to guess at what she wants to say, but I'm becoming a skilled guesser.

"You're mad as hell that you didn't have more time?" I try. Um, her grunt affirms.

"You hate your body for trapping your this way?" Um.

"But you know that we're not going to leave you?" Um.

"Are you afraid?" She looks me clearly in the eyes and shakes her head firmly: no. Holding my hand. "Honey," I promise her, "we're going to do our best to see you experience no pain. And we'll stay right beside you all the way."

During these months I've needed more than a little help from my friends. It has come in odd ways. From Fred and Bruce, the honesty of their discussions with me has opened the possibility of honesty with her. We do not need to play our old mother-son games any more. From Roger and Selma, who described their helplessness when, as parents, they were used to being helpful, I feel an empathy. There is nothing I, the strong son, can do now to help the weakened mother. From a gay friend, whose own mother died a year ago after a long and painful cancer, have come practical favours and much-needed fellow-feeling. From the lesbian couple I'm closest to, much help: one of them, who knows my mother, has flown across the continent to be with us now. An ex-lover has explained various aspects of cancer to me patiently; another has run an errand I couldn't handle myself. In all these instances the gay community glows as I experience it.

But do I see this gay community reflected in the press? Today's *Time*, which my stepfather just brought into the room, carries a story on AIDS with this sentence, its implicit threat further sleazed by the callous quotation marks:

> *AIDS has been traced from sexual partner to sexual partner. In one Los Angeles study, nine out of thirteen patients had had sexual contacts with one another. In San Francisco, six pairs of "roommates" have been stricken with Kaposi's Sarcoma.*

So much of what I experience as wonderful in the gay community — from the pleasure of promiscuity to the irreplaceable support of friendship networks — is brutalized and dehumanized by that language. Almost in vain have I turned to the gay press to find better.

The day my mother entered her first coma, her final letter to me arrived in the mail. Enclosed was a clipping from her local newspaper on the National Gay Leadership Conference in Dallas. The headline: "Center Warns Homosexuals about Disease." Nothing else of substance from the two-day conference was reported. If the federal government warns us that we're in trouble because we're gay, and the national media warn us, and the local editors confirm it, well, why shouldn't a loving mother pass on the same warning?

The organized gay community across North America needs to be preparing for the "health crisis" onset when it leaves Manhattan, as it has already begun to do. Surely we must, as a community, continue to improve our educational and referral efforts. As in gay health care over the past decade, our intent must not be to frighten or to moralize, but to inform and to care.

We must launch an all-out campaign, of the scale that we undertook during the Bryant attacks, to fight the equations that gay equals pathology. We can only protest the inaccuracy and inhumanity of the anti-sexual straight press, but we can demand that the gay press give fuller human pictures of support groups and first-person experiences. We must challenge the medical profession whenever it attempts to regain its power to define us, or to cloak a moral programme in medical terms. Our money should follow our priorities. Before contributing to cancer research, we need a much fuller picture of the political terrain among researchers, and the availability of funds from other sources. Better, first, to spend money on our gay brothers who need expensive medical care. Second, to carry on the media campaign. And third, to make sure that money now available is being tapped for this research.

As gay individuals, we must come to see death and dying not as opposed to life, but rather as a part of living. In short, we must make dying gay — *in our own terms.* Morbid? Not at all. The only morbidity lies in turning our backs on our ill or dying friends, or abandoning them to die straight deaths within alien families or institutions. As a community, we must develop caring rituals not just as a support for weakness but as a way to make weakness a source of strength. We may want to demand gay space in hospitals — certainly, the sanity of the co-op care system that put Bruce in the room beside Fred should be extended elsewhere. We will surely want institutional recognition of our friends and lovers on a par with recognition of our families. We must widen our efforts at founding gay hospices and other forms of outpatient care.

The thrust of gay liberation, even if the term does feel nostalgic in 1982, remains that we make our own lives, that we do not sign ourselves over to the panic-mongering journalists and doctors. We did not acquiesce to Dr Bieber or Anita Bryant. The coming months of 1983 will show whether we will acquiesce to the physicians and the press. The choice is ours.□

Author's note: For their gifts to this article I thank Fred and his circle, Bill Lewis, Bert Hansen and its sponsors. For showing me how warmly and magnificently one can live with a terminal cancer, I dedicate it to the memory of Dorothy Lynch Lee, who died on 26 September one mile from where, in North Carolina in 1911, she was born; who taught me to treasure friends and dancing.

Michael Lynch dances at Stages.

SUPPLEMENT TO THE OFFICIAL NEWSLETTER OF THE NCGSTDS Volume 4 #5 May, 1983

THE BODY POLITIC

NOVEMBER 1982

WITH THE MEDIA SPREADING FEAR AND FALSEHOODS, IT'S HIGH TIME WE CLARIFIED WHAT WE KNOW – AND DON'T KNOW – ABOUT THESE NEW DISEASES

AN ARTICLE BY BILL LEWIS

The real gay epidemic: Panic & paranoia

Information & Misinformation

What do you do when faced with this bewildering array of rare and often fatal diseases: Kaposi's sarcoma, Pneumocystis carinii pneumonia, Cryptococcus, Candida, herpes virus, cytomegalovirus, Toxoplasma, tuberculosis? How do you handle the barrage of sensationalized misinformation — and much of it *is* misinformation — from newspapers, magazines, radio and TV?

The "gay plague" has become a story, and our sexual conduct and "lifestyles" are under scrutiny as never before. This time, though, we're running scared, and if reports from New York are to be believed, gay men are forsaking promiscuity and drugs as panic and paranoia spread. According to the New York Gay Men's Health Crisis Newsletter, "the fashion now is not to go out, to stay away from the tubs, discos and sex clubs. It is becoming terribly déclassé to be ripped to the tits." In San Francisco rumours are rampant that men diagnosed as having one of the diseases have been seen subsequently at the local baths, and "JO Night" has become the rage at the Caldron.

If, as *TBP* writer Ken Popert believes, "promiscuity knits together the social fabric of the gay male community," then the diseases, the way they are being publicized — and the way we are reacting to them — have the potential for weakening that fabric by pushing us towards a new era of sexual conservatism. In the face of such a crisis, each of us urgently needs to answer the questions posed above. We need to sift through the avalanche of information and reach an understanding of what is happening to us both medically and politically. With that understanding, we should be able to make clearer decisions about our individual sexual conduct.

The two most common of the new diseases have been the skin cancer called Kaposi's sarcoma (KS) and a pneumonia caused by the parasite Pneumocystis carinii (PCP). In the past two years, four hundred and seventy-one cases of these two diseases, as well as fifty-six cases of other related rare illnesses, have been reported to the Centers for Disease Control in Atlanta (CDC). Almost three quarters of the afflicted individuals have been gay or bisexual men. In Canada, Dr Gordon Jessamine, Chief of the Field Epidemiology Division of Health and Welfare, reports that, by the end of September, fourteen cases had been confirmed: ten in Montreal, one each in Windsor and Vancouver and two in Toronto. There are unconfirmed reports of an additional two cases in Montreal. Of the fourteen confirmed cases, ten have been gay men, and nine are now dead. Nor is the outbreak confined to North America; there are at least a dozen cases in Europe [illegible] in Argentina.

Despite the variety of diseases and symptoms, the common factor seems to be failure of the body's immune defence against particular illnesses — the underlying condition is now known as the acquired immune deficiency syndrome, or AIDS. People suffering from AIDS not only have very low numbers of protective white blood cells, but also are depleted of a special type of immune cell called the T-helper lymphocyte.

As the name implies, these lymphocytes aid other cells of the immune system mount an effective defence against viral and parasitic infections. In their absence normally harmless infections such as herpes virus or cytomegalovirus (CMV) can progress unimpeded to become life threatening. In addition, certain viruses produce a small number of human cancers. These include KS and several other types of cancer now showing up in AIDS patients. It is thought that when these cancer-causing viruses infect some types of body cells, they can endow the cell with the ability to divide continually. Under normal conditions our T-lymphocytes would recognize these infected cells and destroy them. In AIDS patients, however, these T-cells are absent, allowing uncontrolled growth of the cancer.

The types of immune cells circulating in our blood and their interactions both with each other and with foreign organisms are amazingly complex. Even the most sophisticated medical researchers are at a loss when it comes to actually treating the underlying immune failure in AIDS. Experimental therapies with the natural compounds interferon and thymic humoral factor (THF) are being conducted, but it will be some time before results are known. THF has been reported to increase the number of T-helper cells in children suffering from immune deficiency, and researchers hope that the compound will have a similar effect in AIDS patients.

At the present time, however, doctors can really treat only the diseases which show up in AIDS patients, with the hope that eventually the immune system will recover on its own. The infections themselves often progress relentlessly, and despite treatment with various antimicrobial drugs they eventually recur, or another infection overwhelms the patient. Dr F Siegal of New York's Mount Sinai School of Medicine has estimated the long-term mortality of AIDS patients may be as high as sixty-five percent. Other physicians believe that the death rate will be even higher.

Until recently, the cause of the collapse of the immune system's T-cells was baffling, and everything gay me did that straight men didn't was dragged forth as a possible cause. Abundant sex, poppers, fisting, drugs, ingestion of too much sperm, st ing up too late — all have been put forward as an explanation. However, it soon became apparent that for each of these possibilities, abundant exceptions could

found. Some men with AIDS had only four sexual contacts in the year before becoming ill, some had never used poppers, other had never been treated with anti-parasite drugs or used recreational drugs.

Then, early this spring, CDC Atlanta announced that thirty four cases of AIDS had been found in Haitian immigrants to the US and Canada, ending the near monopoly which gay men had had on the disease. The new cases were in relatively young Haitian men who denied any homosexual contact. Some of the patients had been in the US for less than one month, and one man had actually experienced symptoms while still in Haiti waiting to emigrate. Struggling under the repressive dictatorship of "Papa Doc" and now "Baby Doc" Duvalier, the Haitian people have one of the lowest standards of living and health care in Latin America. Poor sanitation, crowded living conditions and malnutrition provide an ideal breeding ground for disease. It is quite possible that AIDS has existed in Haiti for years, unrecognized because of the poor quality of health care. Indeed, some believe that American gay men holidaying in Haiti could have carried back an infectious organism. Although it may be purely coincidental, a gay man from Windsor visited Haiti two months before coming down with swollen lymph glands. He eventually died of PCP. It is probably not coincidental that Montreal, with the largest Haitian immigrant population in Canada, has both all the Haitian AIDS cases *and* three quarters of the country's gay AIDS cases.

As a rule, sexual contacts of AIDS patients haven't developed the disease, at least not in any obvious form. This suggests that if an infectious agent is involved, it is either very difficult to transmit or else causes symptoms only in a very low percentage of cases. There has been, however, one cluster of cases in the Los Angeles area. Investigators there were able to compile data on the sexual partners of thirteen patients with either KS or PCP. Of the thirteen, nine reported sexual contact with other AIDS patients, a remarkably high number considering the estimated two hundred thousand to four hundred thousand gay men in the LA area. CDC Atlanta is continuing to investigate the cluster, and recent information indicates that the nine cases from LA may be directly linked by sexual contact to fifteen additional patients from eight other cities. Although strongly suggestive of an infectious agent, this kind of clustering may instead indicate that these men shared some other important contributing factor which remains unknown.

Further evidence that AIDS is very likely transmissible comes from two other groups of patients. Of the heterosexuals who have come down with the disease, a very large percentage have been users of drugs like heroin which are often self-administered with contaminated intravenous needles. Furthermore, in July, CDC reported that three cases of PCP had been diagnosed in persons with the blood disorder hemophilia A. To prevent bleeding, hemophiliacs require several injections of blood clotting factor per week, and this factor is prepared from the blood of many individual donors. This suggests that an infectious agent was acquired from the donor blood, and is spread in other cases by direct contact with blood, either by injection or by intimate sexual contact.

If AIDS is caused by a transmissible agent present in the patient's blood, it is possible that many gay men in large urban centres have already been exposed to the disease and have now become immune to it — without experiencing symptoms. Until some way is found to identify such an agent, there is no reliable way of knowing how many infected men will go on to manifest the severe symptoms which we now label AIDS.

Does the mystery of AIDS have no precedent in modern medicine? There is, in fact, a striking resemblance to hepatitis B virus infection. Like AIDS, those at greatest risk of coming down with hepatitis B are gay men, intravenous drug users and patients receiving multiple blood transfusions. Hepatitis B is also widespread in those areas of the world with poor sanitation. It is thought that virus particles are introduced into the blood stream either directly by injection or through tiny abrasions often incurred during sex. In urban centres, two-thirds of sexually active gay men show evidence of past infection with hepatitis B. The majority of these men will have experienced only mild symptoms or in many cases no symptoms at all, and, in fact, are usually unaware of having now become immune to further infection with the virus. It is still a serious disease, however, because perhaps one in twenty patients continues to produce the virus in the liver, a state which in a minority of cases leads to progressive liver damage and premature death from cirrhosis or liver cancer. Perhaps not all of us knows someone who has died from hepatitis, but most of us *do* know someone who has been very ill with it over a prolonged period of time. Even knowing how common hepatitis is, gay men have chosen to continue to have a variety of sexual partners — for the most part, the consequences of hepatitis have not been a major deterrent to having sex. I believe this is because gay men recognize that serious damage is relatively rare, and because the viral origin of the disease is known. In contrast, the causative agent of AIDS remains mysterious and the consequences of infection known only in the most serious extreme. True, the new hepatitis B vaccine promises to eradicate any fears we may have about this disease, but there are other common forms of hepatitis for which no vaccine will be available in the near future.

Studying the parallels between hepatitis B and AIDS, I am struck by a key contrast: the media coverage has been vastly different. From 1971 to 1980 the number of cases of hepatitis B reported per capita in Ontario rose more than fifteen-fold. Yet we read no reports of a hepatitis B epidemic. AIDS is deemed newsworthy because it is new and mysterious, but also because it has occurred primarily in gay men. Every year in North America a similar number of Kaposi's sarcoma cases are diagnosed in elderly men of Eastern European Jewish descent. Yet there has not been even a whisper of the "Jewish cancer." Clearly the AID syndrome is being singled out for special attention.

The choice and emphasis of the words "epidemic" and "plague" by mainstream and gay media alike to describe the appearance of fewer than four hundred cases in gay men of a disease which is not readily communicated should make us all very nervous. Compare the actual figures to the way dictionaries define the two words:

> *epidemic: attacking many people in any region at the same time; widely diffused and rapidly spreading.*
>
> *plague: an affliction, calamity, evil, scourge especially a visitation of divine anger or justice, a divine punishment.*

Recent articles in the fundamentalist religious tracts *The Plain Truth* and *Chick Publications* explicitly link homosexuals with the threat of increasing venereal diseases. Because AIDS remains mysterious and untreatable, it is the perfect agent of divine wrath. Increasingly, the so-called "Moral Majority" will become the "Clean Majority," and they will exploit irrational fears of contracting deadly diseases from toilet seats, gay waiters and gay teachers.

On June 7 the city council of Columbia, Missouri defeated, by a five-to-two vote, an amendment that would have added "affectional or sexual orientation" to a city ordinance already prohibiting discrimination on other grounds. The defeat occurred despite strong endorsements from the city's Human Rights Commission and numerous other supporters. The public hearing to discuss the amendment began with the reading of a letter from the Medical Director for the County Health Department, urging rejection of the amendment not on moral grounds but on the basis that its passage would promote a *public health hazard.*

Members of city council and residents of Columbia were undoubtedly receptive to this fear-mongering. After all, last December *Newsweek* told them:

> *What worries epidemiologists is the probability that these diseases will spread even faster in the future... heterosexuals might also be affected, through contact with bisexuals... It's probably only a matter of time.*

New York magazine in an article titled "The Gay Plague" told them:

> *A mysterious immune disorder is spreading like wildfire... and spreading with terrible swiftness to the straight population as well.*

and *Us* magazine said:

> *The new victims (are) young, college-educated gay men earning $25,000 a year. But the worry doesn't stop here. The number of cases among heterosexual men and women grows constantly.*

There is *absolutely no evidence* for the "wildfire spread" of AIDS or the notion that the disease is spreading from gay men *to* heterosexuals. Sexually active gay men are being set up as a dangerous health hazard to the general population, despite all evidence to the contrary. But AIDS will not be used just to stigmatize the sexually active among us. Lesbians and less sexually active gay men are going to have their rights denied and infringed upon — all because four hundred cases of a disease have appeared among twenty million of us.

Risks & Decisions

Most of us know that we would live longer quietly snuggled away in an isolated rural setting. Despite this, many of us choose to live in crowded urban centres, choose to smoke, drink and ingest foods laced with chemicals, choose to identify ourselves as gay in a homophobic society, and choose to make social and sexual contact with other gay men. Each of us has decided that some of these risks are necessary to make our lives fulfilling. In the present crisis precipitated by the AIDS deaths, gay men are being urged to give up multiple sexual partners and a variety of suspect drugs. In an atmosphere of panic fed by the constant referral to the "epidemic," "plague" and "wildfire spread," sex and drugs have become equal to death. If, as is most likely the case, AIDS is caused by a communicable agent such as a virus, we can still attempt to evaluate risks in order to arrive at decisions about our own sexual conduct.

In the first six months of this year, fewer than two hundred new cases of AIDS were reported in American gay men. Although not enough is known to predict the long term outcome of these cases, the disease is serious enough that well over a hundred of these men will probably die within the next couple of years.

That is tragic, but those figures have to be put in the context of the death rate in the community at large. Estimating the size of the gay male community in North America is no easy task, but if we assume that homosexual males constitute five percent of the population and make a further assumption that perhaps one gay man in five is sexually active, then about two million North American gay men risk developing a sexually transmitted disease such as AIDS. If those two million men reflect trends in the North American population at all, we can estimate that, in the same time period that the two hundred AIDS cases were diagnosed, more than five hundred gay men died from lung cancer solely because they chose to smoke cigarettes and another four hundred or so died in traffic accidents because they chose to go outside.

Although the figures are not deemed important enough to warrant official compilation, the number of gay men who are murdered or severely beaten by queerbashers is probably not far from the number of AIDS deaths. Some of us may choose not to smoke in order to prolong our lives, but few among us would remain indoors or remain completely straight-identified out of a fear of death.

When discussing venereal diseases specifically, we are almost never informed of their relative prevalence. VD guides describe one disease after another, leaving the impression that we are just as likely to catch the drip as we are hepatitis. In the first six months of this year, four hundred and seventy thousand cases of gonorrhea were reported in North America, overshadowing seventeen thousand cases of syphillis, ten thousand cases of hepatitis B — and several hundred cases of AIDS. Obviously, the consequences of these sexually transmitted diseases are not the same — we don't die from gonorrhea. Nevertheless, such figures can help us appreciate the relative frequency of AIDS cases.

Some gay publications have suggested that the AIDS cases diagnosed to date represent only "the tip of the iceberg," and that gay men are already walking "time bombs" ready to explode with fatal infections. A few recent medical studies have indicated that perhaps as many as eighty percent of sexually active gay men have fewer T-helper cells than expected, and that their immune cells respond less actively to stimulation by a foreign compound. It is difficult to interpret such studies, for it is not at all clear what significance the changes might have on an individual's immune response to infection. Furthermore, many agents are known to depress immune functions in a transient way, including infections such as herpes and cytomegalovirus (CMV), which are extremely common in gay men. Dr Michael Lange, director of such a continuing study of one hundred New York gay men, told *TBP* that he does not believe the men with low T-cell numbers have mild cases of AIDS. Indeed, some of the men have been followed almost a year and none has developed KS, PCP or other opportunistic diseases.

More significantly, the number of cases of AIDS reported has not risen dramatically over the past year — despite the far greater medical and community awareness of the disease. During the past year the number of cases reported in gay men has risen from about thirty a month to about sixty, but this still represents a relatively modest rate of increase considering the vastly increased awareness on the part of physicians and gay men themselves. Even Dr James Curran of the CDC Atlanta has said that "it is safe to say that the AID syndrome is not readily transmitted, it is not an explosive disease like influenza." Curran believes that the number of cases reported will continue to rise at a steady but slow rate for some time.

CDC Atlanta has assembled a team of twenty full-time and nearly seventy part-time investigators to study the disease. According to one spokesman, "AIDS has become a major undertaking of high priority for the agency. In the last twelve months, more than $2,000,000 has been spent trying to track down a causative agent or contributing factor for the disease." There has been little progress. The results from an extensive study of fifty gay AIDS cases and one hundred and twenty gay male controls, undertaken to identify contributing factors, seemed to rule out both prescribed and recreational drugs as candidates.

From the beginning, gay men and medical researchers alike wanted poppers to be the culprit responsible for AIDS. Amyl and butyl nitrite, as they are known, were used far more frequently by gay men than by straight, became popular only in the mid-Seventies and therefore seemed prime candidates to explain the sudden appearance of the disease in gay men. The chemicals had even been shown in one study to cause mutations in bacteria, a property relevant to the causation of human cancer cells. Desperate for easy solutions, gay men have taken the claim seriously and sales of poppers reportedly are down dramatically in both New York and San Francisco. Even in Toronto, where *no* AIDS cases had been reported until very recently, Jean-Louis DeLanville, manager of Glad Day Books, reports that sales of the chemical have fallen significantly during the past six months.

After analysing the data from their case control study, CDC Atlanta has concluded that the use of poppers is not statistically correlated with the development of AIDS. A significant number of gay male cases and the vast majority of heterosexual cases *never* used poppers. Scientific studies are now underway to measure other effects that periodic inhalation of poppers may have on our bodies. Until the results of these studies are known, gay men may be just as wise to respond to the poppers debate as they respond to the similar, ongoing debate about marijuana.

The only finding that the CDC case control study did confirm was that men with AIDS had more frequent sexual contact with different partners than did most gay men. The AIDS patients reported having an average of sixty-seven different partners in the year before developing symptoms, while the control sample reported about half that number. There was a tremendous range in both samples, however, and among the AIDS cases the number of sexual partners in the previous year varied from only four to more than six hundred. This suggests that, while increasing numbers of sexual contacts is a factor in increasing risk, the correlation is not absolute. As with any sexually transmitted disease, having only a moderate number of sexual partners is no guarantee that AIDS will be avoided.

Attempts to isolate an infectious agent have so far been unsuccessful. Blood and urine samples, throat and rectal swabs taken from AIDS patients have not yielded any microorganism not also found in control samples. There has been speculation that the virus CMV, which is extremely common in sexually active men, could be responsible for both the immunosuppression and perhaps KS as well. CDC investigators have isolated CMV from a number of AIDS patients. However, sophisticated analyses of the DNA from the various virus isolates indicated that no new type of CMV was present in the AIDS cases. Indeed, the types of CMV were the same as those found commonly in the population at large. Increasingly, researchers are discarding the idea that CMV is the primary agent responsible for AIDS.

Viruses often are capable of infecting only certain cells from specific animal species. If the AIDS infectious agent can grow only in human T-cells, then the task of isolating and studying it becomes exceedingly difficult. To help investigators, the US National Cancer Institute announced in August that 2.2 million dollars was being set aside immediately to fund research projects studying AIDS. Because the disease provides a natural, conveniently studied example of a direct connection between cancer and immunology, it has attrac the attention of many large medical research labs in these two fields. Com tition among these researchers for scientific recognition, and the grant money that flows as a result, is fierce, and may result in an understanding o the AIDS disease process within a few years. It may even be possible to prep a vaccine, but this won't happen soor and probably not in this decade.

In the meantime, the gay male com munity will have to come to terms wit disease we know so little about.

IN THE SAME PERIOD THAT 200 AIDS CASES WERE DIAGNOSED, MORE THAN 400 GAY MEN DIED IN TRAFFIC ACCIDENTS BECAUSE THEY CHOSE TO GO OUTSIDE.

While the chances of developing AIDS remain extremely small, gay men should b aware of the general symptoms. Most often it has been diagnosed after prolonged period of profound tiredne persistent fever, or unexplained weight loss. Some of the patients have had early symptoms of swollen lymph glands (especially around the neck and armpits). KS patients often develop purplish or dis coloured new growths on top of or beneath the skin, PCP patients have a heavy, pe sistent, dry cough not caused by smoking cigarettes or by the common flu or cold.

If you have any of these symptoms for more than a month, go to a physician anc tell her/him that you are concerned about AIDS. Many doctors will not be familiar with the disease, and it is important that you choose one that you have confidence i It is difficult to diagnose, but most large Canadian cities will have research labs capable of conducting the tests. In Toronto, the staff of Hassle Free Clinic have be well briefed on AIDS, and procedures have been set up for diagnosis and referral.

In New York, San Francisco, Los Angeles and Houston, gay organizations have been formed to provide information and referrals concerning AIDS. The Gay Men' Health Crisis, a New York group, has been in operation for more than a year and ha been particularly successful in raising money through benefit dances and donations The group's thirty-four-page newsletter, issued in July, is one of the first attempts t distribute comprehensive information to the gay community. The newsletter provides a great deal of useful information. Unfortunately, it also contains several contradictory statements. Compare the newsletter's opening position: "We of GMHC have no wish to scare or coerce anyone. We take no stand on the issue of sexual behavior" to the advice given several pages later: "Be more selective about sexual partners... make a lifestyle switch. Find yourself some steady fuck-buddies."

The New York group has also emphasized financial support for AIDS research, and has given out nearly $50,000 to established medical laboratories. I believe this money has been wasted. As those recent million-dollar grants from US government agencies indicate, there will be no shortage of funds to support AIDS research. The money raised by gay organizations should instead go back into the community for patient support programmes and for campaigns to counteract the panic and paranoia fostered by media treatment of the disease. AIDS is also not the only health care concern for our community — that same $50,000 could have provided hepatitis B vaccine for four hundred gay men who couldn't afford it. That at least would hav saved gay lives.

In late September, the San Francisco City Board of Supervisors granted $345,000 to fund gay male and lesbian health needs. Almost $50,000 of this went to the fledgling Kaposi's Sarcoma Research and Education Foundation. This money will help provide information, referral and follow-up to gay men worried about AIDS. Ed Power, staff member of the Foundation, told *TBP*, "We can't expect to get the amount of money needed for medical research from individuals within the community. Instead, we must pressure government agencies and private foundation set up for this purpose." The KS Foundation has provided information to the city's gay community, and arranged for adequate diagnosis and treatment — particularly i the individual lacks health insurance. During August, their phone line received more than three hundred inquiries. Of the one hundred medical referrals made, twenty-two gay men were diagnosed as having a serious disease (not all were AIDS cases).

Sooner or later, every city with a large gay population will have AIDS cases, accompanied by overblown media treatment, rumours and paranoia. It will be important to establish information centres which gay men can quickly turn to for reassurance.

For most of us, the challenge will be to remain calm, though it will be difficult to remain completely immune to the present atmosphere of fear and ignorance. After returning home from a recent trip to San Francisco, my lower legs developed large reddish-purple blotches. Despite everything I knew, my first reaction was horror and panic. "I've got it. I've got KS."

Fortunately, it was not long before I discovered that, during my absence, my apartment had been colonized by some very hungry fleas.□

Author's note: While writing this article, I relied on Bert Hansen for many ideas and much encouragement.

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