New Directions

Volume 15 | Issue 3 Article 3

7-1-1988

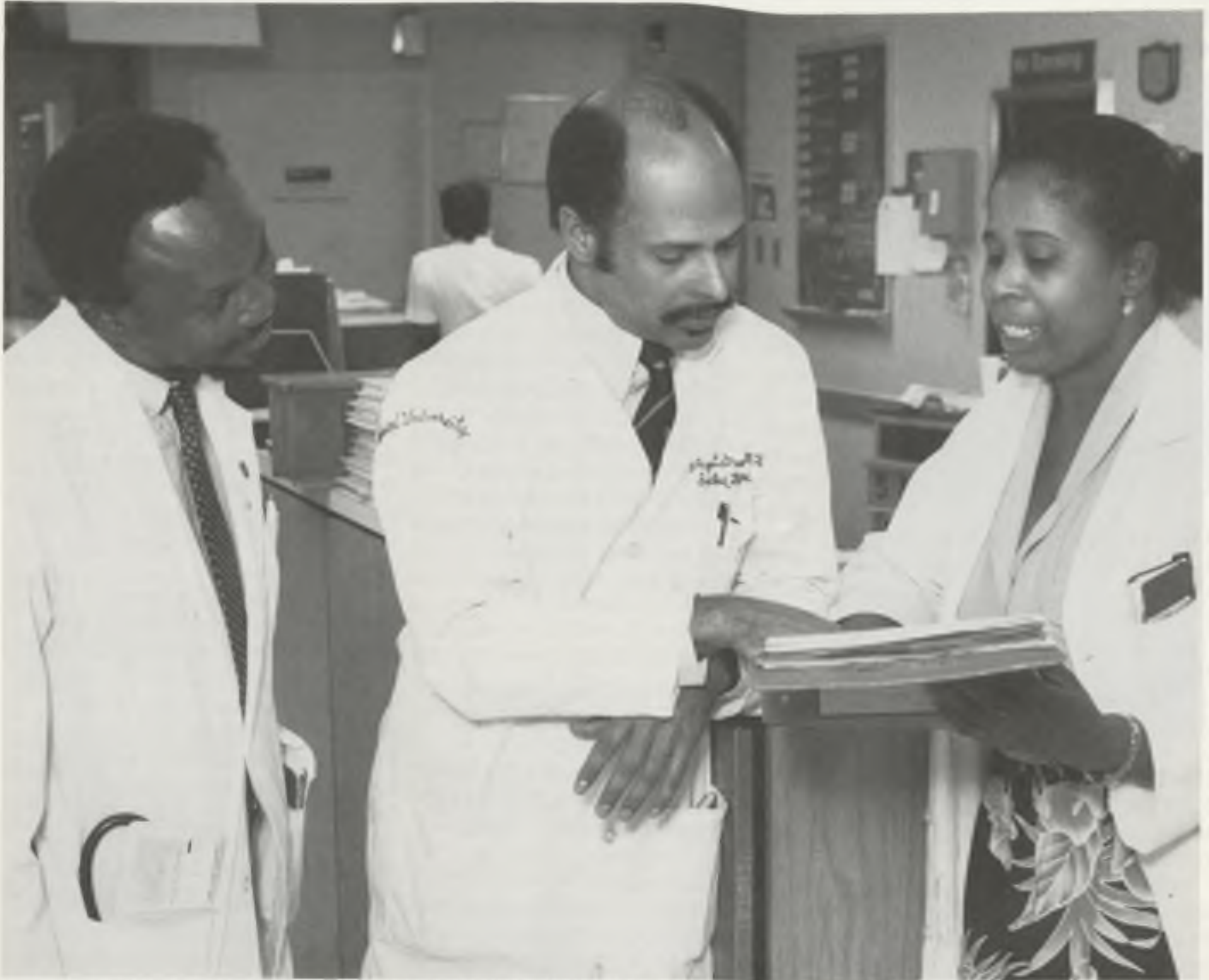
On the AIDS Battlefront: Wayne Greaves; Other Voices; A Roundup of Responses

Harriet Jackson Scarupa

Follow this and additional works at: https://dh.howard.edu/newdirections

Recommended Citation
Scarupa, Harriet Jackson (1988) "On the AIDS Battlefront: Wayne Greaves; Other Voices; A Roundup of Responses," *New Directions*: Vol. 15: Iss. 3, Article 3.
Available at: https://dh.howard.edu/newdirections/vol15/iss3/3

This Article is brought to you for free and open access by Digital Howard @ Howard University. It has been accepted for inclusion in New Directions by an authorized editor of Digital Howard @ Howard University. For more information, please contact digitalservices@howard.edu.



Greaves with infectious diseases fellows Lateef Olopoenia (left) and Margaret Kadree.

On the AIDS Battlefront

Published by Digital Howard @ Howard University, 1988

Wayne Greaves

By Harriet Jackson Scarupa

Wayne Greaves, chief of the division of infectious diseases at Howard University Hospital, is making rounds with two senior medical students, Michael Simpson and Karen Garvey. Near the end of the rounds, the trio stops outside a door with a shocking pink placard posted beside it. In large black letters, the placard reads: "Blood/Body Fluid Precautions." Under that: "Visitors — Report to Nurses' Station Before Entering Room." Under that is a list of specific guidelines that must be followed when attending to the patient inside.

The reason for the placard is that the patient has tested positive for the human immunodeficiency virus (HIV), more commonly called "the AIDS virus," which causes the deadly acquired immune deficiency syndrome.

At the nurses' station, Greaves reads the latest entries about the patient in a thick bound black notebook labeled "Doctors' Progress Notes." He then prods Simpson, who has been following the patient throughout a four-week rotation in infectious diseases, to describe the patient's initial symptoms, subsequent treatment and current condition.

Wearily, using a kind of medical shorthand, Simpson sketches in some particulars: "a 36-year-old man with a history of intravenous (IV) drug abuse . . . in the hospital for six weeks now . . . when admitted, was almost passing out, had a bad cough, temperature of 104°, constant diarrhea, an altered mental state, fungus in blood, possible pneumonia . . . Patient has refused a bronchoscopy" [A bronchoscopy is a procedure in which a tube is inserted in the lung, a piece of tissue scraped off and examined under a microscope.]

"We [in the infectious diseases division] were consulted because of persistent staph [a bacterial infection]. . . . Patient was given multiple antibiotics and seems to be doing well. His lungs have cleared; he's able to talk, follow simple commands, eat more. He should be ready for discharge soon."

"How do you know his lungs have cleared up?" Greaves asks. Simpson refers to a statement made by the attending physician. "That's not enough," Greaves counters. "*You* need to look at the chest X-rays. You can't go on what other people say. You have to see for yourself."

After a few other pointed reminders, Greaves goes in to see the patient. First, he dons a pair of latex gloves. Simpson and Garvey do the same, but they put on face masks as well. They watch as Greaves sits next to the patient's bed, all his attention directed at the tall, thin, lethargic man stretched out before him, the track marks on his arms and legs spelling out his history of addiction.

In an easy conversational style, the physician asks the patient how he's feeling and how his appetite is. "A little better," the patient manages to get out, responding to both questions at once. "But it hurts my legs to move." Greaves examines the patient's spindly legs, their muscles showing signs of atrophy, takes note, too, of the flaky white fungus covering the patient's feet. When he finishes the examination, he exchanges some small talk with the patient, says goodbye, discards the gloves and carefully washes his hands. He then returns to the nurses' station where he takes out the "Doctors' Progress Notes" and jots down a brief assessment of the patient's condition.

"We can't officially say he has AIDS yet," says Greaves as the trio heads for the next stop on rounds: checking a woman with a festering diabetic ulcer on her foot. "You have to think of infection with HIV as a sequence. There are some very specific criteria [as designated by the Centers for Disease Control (CDC)] for saying a person has AIDS. It's not enough that someone has tested positive for antibody to the virus. If the patient would allow us to take a biopsy and if the biopsy were to show the presence of an opportunistic infection [associated with AIDS] then we would make the diagnosis of AIDS. But he has refused."

What Greaves *can* say is that the patient already has shown some of the conditions that are prevalent in AIDS patients: fungal infections; weight loss; difficulty and pain in walking; inability to concentrate; general debilitation. "Even though his lungs are getting better, he seems to be deteriorating," observes Greaves, who is two years older than the patient but looks far younger. "AIDS patients look old, wasted, weak. We are seeing more and more neurological impairment in patients with this virus and with it, the development of what is called HIV dementia."

The deterioration one sees in AIDS patients reflects the attack HIV makes on certain white blood cells — the T helper cells — that form a key part of the body's immune system. The attack causes the body to become susceptible to a wide range of opportunistic infections, so called because they take advantage of damage to the immune system. Eventually it is one of these opportunistic infections that leads to death. The most common of these, *pneumocystis carinii* pneumonia, was considered extremely rare before the advent of AIDS.

Epidemiologists and infectious diseases experts are increasingly coming to the harrowing view that anyone who harbors HIV, even if now healthy-looking, will likely eventually go on to develop AIDS. And for *that*, as just about anyone and everyone must know by now, there is no cure in sight.

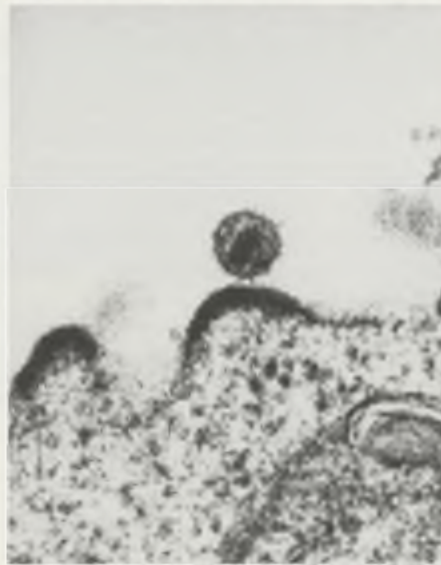
Not surprisingly, then, many of those who are firsthand witnesses to the relentless progress of this killer disease and all its medical, ethical, psychological, sociological, economic, legal and political ramifications speak of being "on the front lines," "on a battlefront," "in a war zone."

Overview of the Battlefront

On this battlefront, Wayne Greaves has cut a particularly compelling figure. Consider:
☐ As chief of the division of infectious diseases at Howard University Hospital, his responsibilities include serving as a consultant to other physicians whose patients have developed persistent infections in connection with the AIDS virus, as we have seen in our opening scene. He treats AIDS patients directly as well.

He also has been the moving force behind the establishment of a special AIDS team at Howard University Hospital that should be in place by the end of the summer. Composed of a physician, health educator and nurse, the team will focus exclusively on meeting the needs of patients who are infected with the AIDS virus. The team will monitor and provide care for them in the hospital (except where a private physician would prefer to be the sole care giver) and will develop and maintain an AIDS clinic.
☐ As an associate professor of medicine at Howard's College of Medicine, he helps train medical students through teaching rounds, as well as through more formal lectures on infectious diseases. Most of his teaching, though, is directed at infectious diseases fellows and at residents. In this, his purpose is not only to convey to these young physicians the most up-to-date information on the medical management of AIDS and its associated conditions, but also to help them approach those with the virus with sensitivity and compassion.
☐ As a researcher, he is a member of a joint Howard University Hospital-D.C. General Hospital team that is studying infants born to women infected with the AIDS virus. By following these babies from birth to up to three years of age, the study seeks to determine how many of them become infected with the virus and what factors, if any, can predict whether that will or will not occur.

He also served as a co-investigator of a study on the incidence of the AIDS virus in female "street" prostitutes in the D.C. area. That study has since been abandoned, largely because of the negative fallout from too much publicity, too soon, he says. Yet even the study's preliminary findings pinpoint the need for further research on "the role of drug abuse, sexual promiscuity and use of condoms" in the transmission of the deadly disease, the investigators report. [Half of the 26 women tested were found to be infected with the AIDS virus. All of these were IV drug abusers and almost none required their customers to use condoms.]
☐ As a charter member of the AIDS Research Review Committee of the National Institute of Allergy and Infectious Diseases of the National Institutes of Health, he serves research in a broader, particularly influential capacity. The committee scrutinizes proposals for AIDS research from institutions across the country and decides which should be funded.
☐ As the hospital epidemiologist at Howard University Hospital and chairman of its infection control committee, he oversees the development and updating of hospital-wide policies for handling patients with the AIDS virus in order to minimize the risk of transmission of the virus from these patients to hospital employees and other patients.



Howard University Hospital, in fact, sees nowhere near the number of AIDS patients many urban hospitals see. In some hospitals in New York City, for instance, those infected with the AIDS virus account for as much as one-third of the patient load, Greaves points out, while in Washington, three other hospitals — George Washington, Washington Hospital Center and D.C. General—surpass Howard in the number of AIDS admissions.

Still, in the past year or so, the hospital has witnessed a significant jump in the number of its patients who have tested positive for the AIDS virus as well as those with full-blown AIDS. "In 1984, when I first came to Howard University Hospital, the hospital had nine patients with AIDS," Greaves remarks. "This year, we've had 26 and the year is not half over." (He was speaking in April.)

The Howard figures mirror the national multiplication of AIDS cases. As of May 9, the number of AIDS cases reported to the CDC totalled 61,596. In the first six months of 1981, the year AIDS was first identified, there were 89 reported cases.

Of those infected with the AIDS virus, the two largest groups the hospital sees remain homosexual and bisexual men who have contracted the virus through sex with an infected partner and intravenous drug abusers who have contracted it through exposure to infected blood when sharing hypodermic needles and syringes. The balance consists of infants born to infected mothers; heterosexual sexual partners of those infected with the virus; and transfusion recipients who contracted the virus from infected blood before stringent screening was instituted. A few appear to have had no known risk factor for AIDS, or at least none they wanted to reveal.

Another salient, perhaps over-obvious fact about these patients: almost all are Black. It's a fact that can serve as a natural transition to taking a closer look at Wayne Greaves' most visible role on the AIDS battlefront. And that has been raising the alarm about the disproportionate impact of AIDS on the Black community and the absolute necessity of getting the message of how AIDS is transmitted and how it can be prevented to *every* segment of this community.

It is a crusade he has embraced with the fervor of one who has seen firsthand that such education is — literally — a life and death matter.

It is a crusade that has brought him respect, admiration and even a measure of celebrity.

It is also a crusade that has brought him a measure of condemnation — at least from some quarters.

Raising the Alarm

On October 22, 1985 at a breakfast news conference organized by Howard's university relations department, Wayne Greaves stepped before a podium in the Armour J. Blackburn University Center to share some alarming statistics. They had been issued by the CDC, but up until that time few seemed to be paying much attention to what the statistics meant in relation to Black people.

Speaking grimly, almost harshly, the musicality of his Barbadian accent seemingly muted by the import of his words, Greaves laid out the facts. Nation-

Published by Digital Howard @ Howard University, 1988

wide, he reported, 25 percent of the 14,288 persons found to have AIDS up until that time were Black — even though Blacks accounted for only 12 percent of the U.S. population. The disproportion was even worse in cases of childhood AIDS: 56 percent of the nation's children hit by the deadly disease up until that time were Black.

And he called for a national effort to counteract the misconception held by far too many in the Black community that AIDS is "a white man's disease."

Greaves' presentation attracted the largest media turnout in the four-year history of the university relations department's breakfast news conferences. In the question and answer period, some reporters were skeptical, as they are engrained to be. They were skeptical, specifically, about Greaves' assertion that Blacks were disproportionately afflicted by AIDS.

A case in point: Margaret Engel, in an article in *The Washington Post* the following day, quoted Harold Jaffe, director of AIDS epidemiology at CDC, to seemingly refute Greaves. Jaffe's view, as she reported it, was that it was invalid to compare the percentage of Blacks with AIDS with Blacks in the general population because those in risk groups — not the general population — contract AIDS. And, he told her, "No one knows the racial distribution of drug users and gay men."

Today, Jaffe seems to regard the whole matter differently. When asked in an interview for this article if AIDS had hit Blacks disproportionately, he answered: "The numbers, in a sense, speak for themselves. That's what the numbers say. So you can't really debate that part of it. The real question was how the Black community would respond [to the import of the numbers].

"I think for a period of time people within the Black community, in a sense, didn't want to hear about it. It was as if they were saying, 'Look, we've got all these other problems to deal with. We've got poverty. We've got unemployment. We've got teenage pregnancy. We've got all kinds of other health problems. Don't give us AIDS as well!'

"But I think that kind of attitude has gradually changed and I think people like Wayne have helped change it. So the attitude now is, 'Yes, we have all these problems *and* we also have AIDS and unless we recognize the AIDS problem and deal with it, we're not going to get anywhere."

Today, ironically perhaps, Jaffe lauds Greaves for being "one of the first leaders in public health to point out the impact of AIDS on the Black community. That, to me, has been a very important — and difficult — role and I think we [at CDC] are all very grateful to him for taking it on."

One reason it's been so difficult is that some in the Black community acted as if they not only wanted to block out Greaves' message, but to shoot the messenger as well.

> "I think Wayne was one of the first leaders in public health who pointed out the impact of AIDS on the Black community. . . . That, to me, has been a very important — and difficult — role to take on."
> — *Harold Jaffe, chief of the epidemiology branch of the AIDS program for the Centers for Disease Control*

After that nationally publicized Howard press conference, Greaves recalls, "Somebody called me from Detroit and somebody else from New York suggesting that I'd been 'brainwashed by my white Jewish professors' [at McGill and Vanderbilt where he had studied] and that I was essentially being a disgrace to the Black community. They felt it [Greaves' testimony on the impact of AIDS on Blacks] was a fabrication by whites to get us. 'Another racist ploy' was the way it was put."

Greaves seldom hears such views today. He is heartened to see that more Black organizations, including such influential ones as the National Medical Association, the National Council of Negro Women and the Southern Christian Leadership Conference, have been involved in AIDS education efforts.

He also has found himself much in demand as a speaker on the issue, as a source of "good quotes" for newspaper and magazine articles on the subject and as an occasional writer on the subject himself (e.g. his chapter, "The Black Community," in *AIDS and the Law: A Guide for the Public*, a 1987 Yale University Press book.)

He has been asked, as well, to serve on such groups as the Mayor's Task Force on AIDS, the D.C. School Board AIDS Task Force and the advisory board to the Whitman-Walker Clinic, a private D.C. facility that provides services and support to those with AIDS.

Indeed, the severity of the problem posed by AIDS in the Black community has become more and more difficult to ignore. As of May 9, the CDC reported that 15,955 Black Americans were afflicted with the disease. Another fact: Black Americans now make up 26 percent of the nation's overall AIDS cases and more than 50 percent of the women and children stricken with the disease. And still another: the CDC estimates that for every person with AIDS, there are 50-100 carriers of the AIDS virus who have no obvious symptoms.

When Greaves shares such stark facts, when he talks about the magnitude of the AIDS epidemic, when he dwells on the hysteria that epidemic has aroused — all of which he did during a series of interviews in his small office at Howard University Hospital last spring — he sometimes sounds battle-fatigued. Once, after reeling off yet another devastating fact about this devastating disease, he paused to proffer what sounded like an apology to his nearly shell-shocked interviewer: "I know this sounds like doom and gloom."

Yet there seem to be "doom and gloom" reminders everywhere, even in that small office. They're in the CDC's AIDS weekly surveillance reports on his desk; in the illustration of a skeletal AIDS patient on the cover of a magazine atop his bookcase; in the beeper which interrupts his conversation, prompting him to pick up the phone to respond to a request that he check on the HIV status of a former patient or advise a nurse about the best room assignment for a new HIV-positive admission; in the poster on the bulletin board outside his door . . .

Distributed by the D.C. Office of Public Health, the poster depicts a group of Black men and women of different ages and apparent walks of life. Above the group are the words: "Every two hours a black American dies of AIDS. Don't be next in line."

The Initial Misconception

As for why AIDS has been able to make such inroads in the Black community,

Greaves readily lists a number of possible reasons. "When the disease first occurred we weren't apprised of the problem as a problem that seriously affected Blacks," he observes. "It was portrayed by the media as a gay white male disease. So Blacks assumed it didn't affect them. Period. And when we realized that it did, there was still some reticence to address the problem and so the disease was able to make inroads before we caught ourselves.

"The second problem has to do with the taboo associated with homosexuality in the Black community. I think far more Blacks than whites perceive homosexuality as a sin and thus Black homosexual and bisexual men are more likely to be outcasts. As a result, people didn't want to reveal their sexual identity or preference and they continued their [sexual] activities underground, if you will, but meantime they were spreading the disease.

"Another reason could be that there is a high prevalence of IV drug abuse among urban Blacks and most of the cases of AIDS have been in large urban areas. The fact that many of these addicts will share needles has put them at even greater risk for infection. Also, a number of Black women who were infected were IV drug abusers or the sexual partners of IV drug abusers and they have passed the virus onto their infants at birth. So it's a vicious cycle.

"Then there's the question of access to health care. We know that historically Blacks tend to postpone health-seeking behavior until a problem is quite severe. This is true for hypertension; this is true for cancer of the cervix; and I think AIDS is no exception. If you don't have access to health care you're also not likely to receive good health education so you're more likely to continue behavior patterns that place you at risk.

"Condoms, for example, have been shown to be very effective in decreasing the risk of transmission of many sexually transmitted diseases and there is data to suggest it can minimize the transmission of the AIDS virus. But it has taken a long time for this to be accepted by many Black men who want to be macho and by many Black women who either don't like it if their partner uses condoms or are afraid to confront their partner and insist he use one. So there are a number of subtle problems that need to be addressed."

Time and again, Greaves emphasizes that the only "cure" for the AIDS epidemic right now in the Black community — or any community — is education and behavior change. "It is still amazing to me that in 1988 we still have people who come to the hospital who don't know heterosexuals can get this disease," he exclaims. "Education doesn't have to be elaborate," he adds. But it does have to be accurate.

"We're not saying use condoms and do anything you want," he warns. "That's down the line in a series of steps to minimize risk. I think everyone should be offered the chance to practice abstinence, but I don't think it's realistic for most people. So you have to offer people alternatives.

When Greaves "went public" with statistics showing the disproportionate impact of AIDS on Blacks, some accused him of being a "disgrace" to the Black community, others of collaborating in a "racist ploy."

"The next best thing would be to suggest that people be mutually monogamous and faithful to each other. If that doesn't work, then you have to let people know that condoms — *latex* condoms — will offer significant protection. But condoms aren't foolproof, not even in preventing pregnancy. So there's no reason to think that condoms are going to be totally protective against this virus. That's why people must be educated correctly so they won't be foolhardy, thinking all they have to do is use condoms and they're 100 percent safe.

Even with the best educational efforts, Greaves believes, it will take some time before the Black AIDS rate goes down. That's because, he says, "The biggest risk factor for AIDS in the Black community today is IV drug abuse and we have not come up with a way to truly stamp that out." When he talks about what must be done about this, urgency pulses through his voice:

"We need to provide greater access for people to get into drug treatment programs. The waiting period is too long. If people want to kick the habit, particularly in urban areas, they have to wait months before they can get into drug treatment programs. That's unacceptable. Drug abusers don't have that kind of patience or tolerance."

For those drug abusers who are unable or unwilling to "kick the habit," he says, "It's important to let them know there are ways to minimize the chance to pass the infection by cleaning their needles with a solution that will kill the virus. In D.C., for instance, we've begun the distribution of free bleach for that purpose." As for allowing addicts to exchange their used needles for new ones, as some countries in Europe have done, he says he neither strongly supports nor strongly opposes the idea.

He adds, "The big thing is this: If we don't stop the spread of this infection it will just be a matter of time before it really gets into the heterosexual community, as it has in Africa." [He does not, however, endorse Masters' and Johnson's controversial book with its thesis that "the AIDS virus is now running rampant in the heterosexual community." "The book," he says, "is lacking in scientific data."]

"Right now in the U.S.," Greaves says, "we're talking about some 4 percent of AIDS cases being among people who are not gay or not drug abusers and so on. But a woman could sleep with a man who was an IV drug abuser two years ago. She may be unaware of his past and he may have no obvious scars on his arms that would clue her in. But he may be a carrier [for HIV] and she could become infected. She may then go with somebody else and the infection could be passed on and on. *The point is* [one of Greaves' favorite prefatory remarks] there is no limit to how this virus can spread within the heterosexual community." Irritation creeps into his voice when he says, "And I think people are fooling themselves if they keep adopting this 'they' and 'me' approach to this disease."

Irritation and impatience, in fact, often seem natural states with Wayne Greaves.

He is irritated by the "respectable" Black professional who smugly considers himself or herself immune from AIDS and looks down on those afflicted with it, figuring "they brought it upon themselves." He is perhaps even more irritated by those who seem fixated on the idea that "AIDS resulted from germ warfare as an attempt to annihilate Black people as a race," he says, citing a typical expression of that fixation.

The "Genocide" Charge

"Charging 'genocide' is the easy way out," he contends. "I prefer to look at it the way Dr. Samuel I. Okware, head of Uganda's National AIDS Prevention Committee, looks at it [in a draft of *Blaming Others: Racial and Ethnic Aspects of AIDS*, scheduled for publication by Panos Institute, London]. "He says, 'Look, there's a snake in the house. What are you going to do? Aren't you going to try to kill the snake? Are you going to sit and ask where did it come from and how did it get here?,'" which is what some Blacks would prefer to do. That's not going to help save anybody's life.

"Instead, we need to be telling people how they can protect themselves from this disease. So, you're right, I don't have a lot of patience with people who are trying to convince me AIDS is genocide or this or that or the other. It serves no useful purpose."

That's not all Greaves is impatient about. He's impatient with health professionals who express what he considers irrational fears about "catching" AIDS. "I mean *we* should be in the position to give accurate and responsible information about how this disease is spread to those who are seeking it. Too many people are reluctant to deal with the basic fact that AIDS is a *sexually transmitted* disease for the most part. Americans, in general, despite all the pornography that exists, despite all the sexual overtones that we see on TV, are basically very uptight about sexuality and sexual issues. And so the whole question of how this disease is [primarily] spread is one that's distasteful for some people to address."

At a recent presentation on AIDS to a group of Howard dentistry students, Greaves tried to give a realistic assessment of the risk the disease presents for health care workers. [Two students in the front row appeared disinterested in his efforts in this regard, as well as to his repeated warning that anyone who is sexually active today is potentially at risk. The two students played chess the whole time.]

"There have been only four properly documented cases of health care workers who seem to have gotten AIDS on the job," said Greaves, citing a study done by the CDC. "Of more than 1,100 people who have had needle-stick injuries or mucous membrane [mouth or eye splash] exposure to AIDS' patients' blood or other body fluids, so far none has developed AIDS. So, the risk for infection is low. But the risk is not zero. There's a need to take precautions, even though sometimes it's not pleasant to follow the guidelines." [Among those guidelines: wearing gloves and sometimes masks, protective eyewear and gowns when there is a danger of being exposed to infected blood and other body fluids; being especially careful about washing hands; disposing of needles in a puncture-resistant container; wiping up any blood or other body fluid spills immediately with a 10 percent bleach solution.]

"Because the disease is fatal," he reiterated, "there's a need to be prudent, but not paranoid."

> "I don't have a lot of patience with people who are trying to convince me AIDS is genocide or this or that or the other. It serves no useful purpose."
>
> — *Wayne Greaves*

Paranoia, often coupled with prejudice, has caused some physicians, physicians-in-training and other health professionals to refuse to treat AIDS patients. The threat this presents to the very foundation of medicine prompted the executive council of the Association of American Medical Colleges (AAMC) last February to adopt a formal statement to address the issue. It read, in part:

"Medical students, residents, and faculty have a fundamental responsibiity to provide care to all patients assigned to them, regardless of diagnosis. A failure to accept this responsibility violates a basic tenet of the medical profession — to place the patient's interest and welfare first."

Greaves applauds the AAMC statement, adding that he thinks there's still a need for Howard to develop a clear-cut policy on the issue as well. "I've had at least three reports of medical students refusing to treat AIDS patients," he says. When asked if he thinks such students should be kicked out of medical school, he answers, "I think that should be a last resort. But clearly, they should be counseled intensively by someone at the next highest level. In the case of a medical student that means counseling by a resident; in the case of a resident, by the attending physician; in the case of a faculty member, by his department chairman and/or dean or by a bioethicist.

"There are some physicians who are just as paranoid and negative about AIDS patients as the students are. If we don't set a good example as attending physicians, it's going to be difficult to convince our students."

Fears and Frustrations

What about himself? He has no fears whatsoever about treating AIDS patients? "I have my own fears," he admits. "There are times that I've thought, 'Gee, I wonder if I remembered to wear gloves when I saw that patient' or 'I wonder if there was a little nick on my finger and I forgot to wash my hands and I might be exposed.' I think these are natural reactions to working with a disease like this and I think that with most of us who are on the front lines, periodically, even if only transiently, these kinds of thoughts cross our minds."

If the fears faced by those on the "front lines" are transitory, the frustrations are not.

There's the frustration of knowing that no matter what you do, your patient will die. "Overall, the reward of being in infectious diseases is that we can treat most infections successfully and the patients are grateful," Greaves says. "They come to you with malaria, you make the diagnosis, and you treat them, and they're better. They come to you with pneumonia, again, you make the diagnosis, and you treat them, and they're better. AIDS is different."

The satisfactions in working with AIDS patients are small in scale: arresting a bout of *pneumocystis carinii* or *cytomegalovirus* infection (which can cause blindness) or esophageal *candidiasis* (a fungal infection) one more time; seeing some improvement of the immune response, at least for a little while, after placing a patient on AZT, which, at this writing, is the only drug approved by the Food and Drug Administration for treatment of AIDS; helping the person who learns he is infected with the virus to work out such feelings as despair, guilt, anger, shame, revenge so he can go about the business of making the best of whatever time he has left.

When pressed, Greaves acknowledges that having to witness the end stages of AIDS—when patients are reduced to barely recognizable skeletons — is "depressing." But he quickly adds, "It's quite similar to what you see in cancer patients. There is some difference. But I think most of the difference lies in the stigmatization. People like to be able to say, 'He did this to himself' or 'She did this to herself' and there's almost a kind of withdrawal, sometimes with some harshness, from those who are dying from this disease."

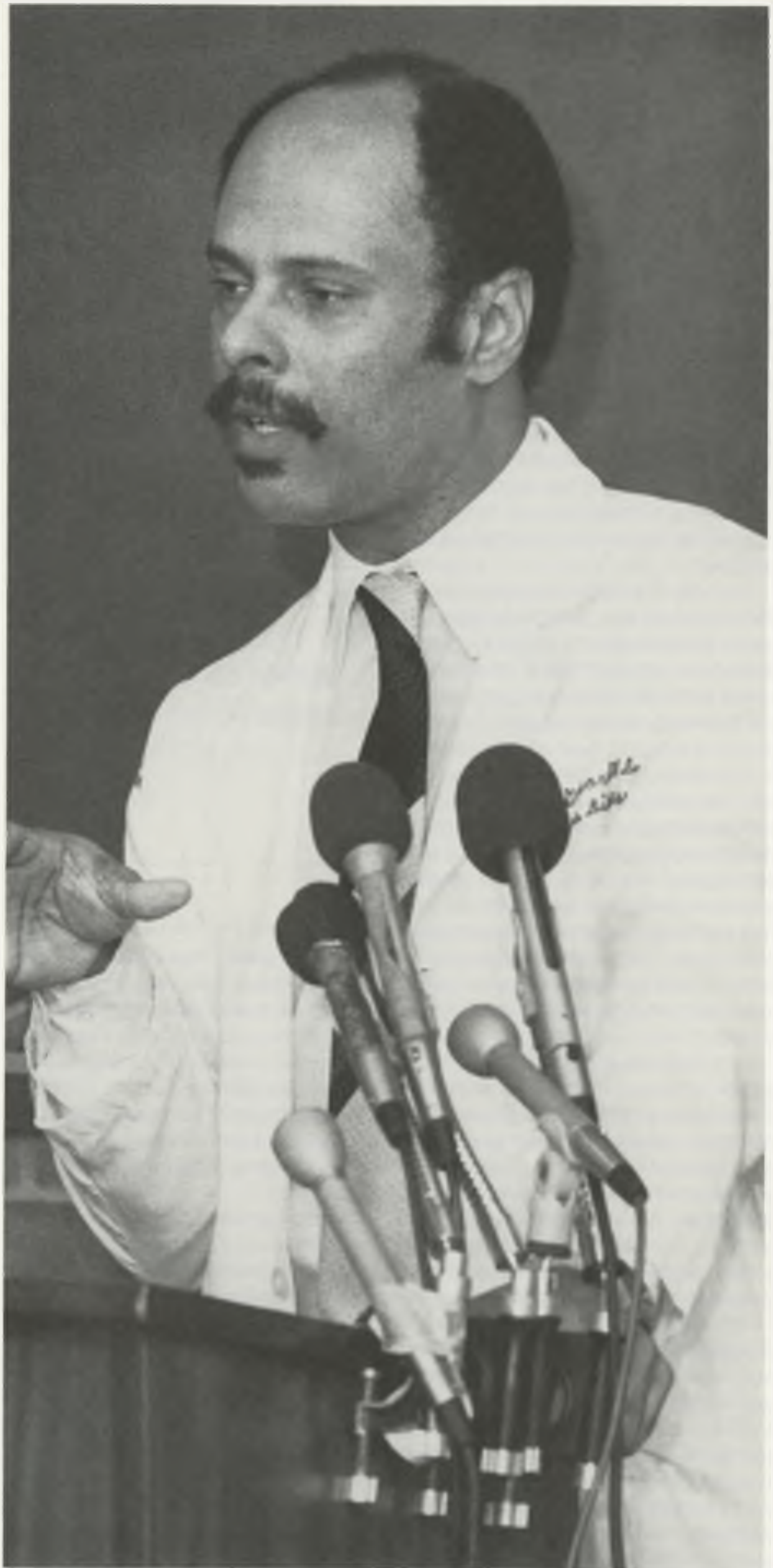
As for how he personally copes with the inevitable death of AIDS patients, Greaves says, "Perhaps because of my religious upbringing and also because I've had to face death in my family, I've always viewed death as an inevitable part of living. Having to deal with death, to me, is not the worst part of it. The worst part is the suffering that people endure before death.

"My frustrations are more related to the difficulty I've experienced in getting other people—both in the health professions and in other professions—to do the things that need to be done for these patients: getting a lung biopsy done promptly when we need a lung biopsy to make a diagnosis; trying to get Medicaid for someone, that's always a big hassle; getting counseling from ministers . . . There were times in the past when there would be a person with AIDS who was dying and wanted to speak with a minister and there were very few who were willing to come forth. Those who were willing were mostly gay and mostly white. Now the Black clergy has begun to take the role."

Those health professionals who don't believe in giving AIDS patients optimal care because such patients "are going to die anyway" earn Greaves' thinly disguised contempt. "If I'm going to live for six months more because of what you do, I think you should do it even if you know I'm going to die," he says, assuming the voice of an AIDS patient talking to just such a health professional. "There's nothing to say that you couldn't be hit by a truck on the street and die tomorrow." Speaking for himself now, he adds, "So I think it is highly unethical to withhold treatment from a patient we know has a fatal disease just because he has a fatal disease."

Such an attitude has earned Greaves high marks from some of his colleagues.

Remarks Winifred King, who this past academic year was president of the Howard University Hospital House Staff Association: "Dr. Greaves is still very much ori-



ented to the patient and what's best for the patient regardless of the inconvenience it may cause to himself or others. If I were so unfortunate as to be ill, I would certainly trust him to be the kind of person who would put my health first. And that's not something that you can say about every doctor."

As a teacher, he also seems to have earned high marks. Says Robert Delapenha, who spent two years as a fellow in infectious diseases under Greaves' supervision: "He likes to teach and he teaches by giving little case histories, asking you to come up with a diagnosis and from that he gets into the topic. I've learned a lot from him in terms of the clinical management of infectious disease patients."

"He can be demanding at times," Delapenha admits. "He describes himself as being very 'picky.' I might call it 'meticulous.' But, then, I think I'm like that, too, so it doesn't bother me."

At Howard, Greaves has more than enough opportunities to help nurture other "picky" (or is that "meticulous?") young physicians.

Destination Howard

Wayne Greaves came to Howard in 1984 via the CDC, where he was a clinical research investigator in the division of veneral disease control and before that, an epidemic intelligence service officer; via Vanderbilt University School of Medicine, where he was a fellow in infectious diseases; via Montreal General Hospital, where he was a resident in clinical pharmacology, an assistant resident in internal medicine and an intern in medicine; via McGill University, where he received his M.D. and B.Sc. (with honors) in psychology; and via St. Lucy, an inland parish at the northern end of Barbados, where his childhood observations of the way medicine was practiced spurred him to aim for a career in the field.

"Medical care was not readily available to many of the poorer people who needed it," recalls Greaves, whose own family lived in relative comfort. "People would go to the hospital emergency room and would spend the whole day waiting there to be seen by a doctor who would see them five minutes and say maybe ten words. The British system particularly offended me in terms of the way physicians interacted with patients: from a pedestal." By the time Greaves was 13, he knew he wanted to be a doctor—but not that kind of doctor.

His gravitation to infectious diseases, he traces to his "long-standing interest in microbiology." Pragmatically, he also was attracted to the field because infectious disease specialists weren't likely to be on night call, something that appeals to him especially now as a husband and father. (He and his schoolteacher wife have two children, 7 and 8.) He also knew there was funding available for research in infectious diseases and he was drawn to the intellectual challenge of research. In the case of AIDS, of course, not only is research funding available, it is becoming abundant.

> Many of those who are firsthand witnesses to the relentless progress of this killer disease and all its ramifications speak of being "on the front lines," "on a battlefront," "in a war zone."

Despite the magnitude of the AIDS epidemic, the demands it is increasingly placing on just about every aspect of society and Greaves' own high visibility on the AIDS battlefront, he has some misgivings about being labeled "an AIDS specialist."

As a physician, researcher, teacher and hospital administrator, AIDS is not his sole focus. Nor is it the sole focus of the hospital unit he heads. Of the three other physicians in the division of infectious diseases, one, Winston Frederick, treats AIDS patients and does AIDS research. The other two, Margaret Grigsby and Vinod Mody, are specialists in tropical diseases. As if speaking for the division as a whole, Greaves observes, "Even with all the attention now on AIDS, we have to be constantly mindful that we don't only train people who are AIDS experts because there are still other infectious diseases that are killing people."

At the same time, he is the first to recognize that AIDS is special, special in a kind of terrible/intriguing way. "This disease defies most of our thinking and our concepts of infection," he says. "So it is an intellectual challenge. It is a clinical challenge, an ethical challenge and, really, a personal challenge. It is particularly disturbing to see people younger than yourself die and you stand with them trying to help them, but realizing that ultimately you're helpless and that all you can do is attempt in some small way to comfort them and give them what hope you can."

What keeps him going? "I think I feel a sense of advocacy, not just for those with AIDS, but for Blacks in general," he answers. "As Black academicians, I feel we can't just walk around with our heads in the air and scoff at those who are not as fortunate as we are or aren't in our social circles, or whatever. Particularly at Howard, we have a responsibility to speak out. I think we're listened to.

"I mean, since I've been here I *really* feel I've been listened to—not everywhere, but many places."

He has. □

Other Voices

Here, some others at Howard University Hospital who have been firsthand witnesses to the AIDS epidemic talk about what it's like for them—as professionals, as people.

Garvey

King

Delapenha

The Medical Student

Karen Garvey chose infectious diseases as one of her electives during her fourth year at the College of Medicine because she "wanted to get a handle on how to treat patients with infections," she says, and also "wanted to learn more about antibiotic therapy." Part of this rotation involved following AIDS patients, but she had encountered them in other rotations as well.

The first AIDS patient I had was an early morning admission. The intern who was in the room with me, who drew his blood and everything, said, "We have to take precautions." I said, "AIDS patient?" She said, "Yeah." I was frightened. I think I had a preconceived notion of what an AIDS patient would be like, but after spending a lot of time with the patient and talking with him on a personal level, we built up this rapport.

He had come in with one of the opportunistic infections, pneumocystis carinii, *and I followed him through the course of his hospitalization. I happened to run into him on the elevator some time later. He looked a lot thinner, weaker. He was walking on his own, but you could tell in a few months' time he was going to deteriorate . . . I don't know if he's still living.*

The scariest thing about this AIDS crisis is that you don't know. There are a lot of people who may have risk factors and you don't know. That's why I make it a habit, with most patients, to wear gloves.

When I applied to medical school, AIDS wasn't publicized. It's different now. I think AIDS is in the back of everyone's mind. It's scary. I'm scared. But I have to just go on with what I want to do. I can't get hung up on it. I know there are AIDS patients and I know I will have a fair number of AIDS patients, but I just hope they're not bitter and want to pass on the virus to anyone who's treating them. [With that, she laughs, but there's not much mirth in her laugh.]

The Resident

Winifred King was a third-year resident in emergency medicine and president of the Howard University Hospital Staff Association, composed of some 300 residents and interns, during the past academic year. The concern of the house staff about treating patients who carry the AIDS virus prompted her to organize (with Wayne Greaves' help) a special program on AIDS and the health care worker for hospital employees last March. At the program, in her introductory remarks, she amended her choice of words. There wasn't "concern," among house staff, she said; there was "panic."

Really, in medicine as residents you're exposed to diseases every day. We're kind of happy-go-lucky about it. If patients have cancer, we know we're not going to get it from them. Most of us have had the hepatitis vaccine, so hepatitis isn't the big concern for us that it had been in the past. So, really, AIDS is the first thing that people are confronted with that could potentially kill them and I think that's where all the panic comes from.

It's in the emergency room that I've really seen this panic. The employee health department [of the hospital] is closed after four [p.m.], so any employee who is injured in any way or exposed to any kind of secretion from a patient is directed to come to the emergency room. I've seen people running down to the emergency room screaming "I've been stuck. I've been stuck. What do I do?"

I've seen the panic, then, from the bottom up, and that's why I thought it was important to bring these fears and anxieties out on the table, as well as for us to hear a clear-cut definition of the hospital's policy in the event that health care workers are exposed to the virus. [Those employees who have gotten needle-stick injuries or been exposed to potentially infectious blood or other body fluids are tested for the presence of HIV at regular intervals. To date, no hospital worker has tested positive for the virus as a result of such accidents.]

I think the emergency room and perhaps in anesthesiology and surgery are the hot areas right now for being exposed to AIDS patients. And our policy has been to treat every patient as though he or she is a potential AIDS patient so that you don't find out much later that you were exposed to someone who was positive for the virus.

The Fellow

Robert Delapenha has just finished up a two-year stint as a fellow in infectious diseases. His special interest in treating AIDS patients, he says, stems from the fact that "These patients are in need of care and there are very few physicians who want to take care of them."

As a fellow, he consulted on infectious diseases cases, helped organize the infectious diseases division's weekly case conferences and did clinical research on AIDS. That research, which was done under the supervision of Winston Frederick, involves putting patients on AZT and monitoring their progress on the drug.

What we're finding out is that on AZT some patients show an improvement in their neurological functioning. Patients who could not walk are now walking. More than half have an increase in appetite, significant weight gain. Maybe a similar number have an increase in energy and a feeling of well-being.

For the time being, AZT is all we have [for the treatment of AIDS itself]. But I don't think it is the answer because it's got a lot of toxicity. It's just a stopgap measure. It does not cure the disease by any means. It basically gives the patient some improvement in his symptoms. But I think if that's all we can do right now, we should do it for as many patients as we can.

I don't focus on the fact that these people are going to die. I guess I get some satisfaction out of seeing them improve, gain weight, look better, feel better, walk better. That is heartening.

The Nurse

Leslie Thomas is a licensed practical nurse (LPN) who has helped care for patients infected with the AIDS virus in various stages of the disease. Sometimes this has meant doing just about everything for these

Thomas

Rozario

Palmer

patients, from "checking their vitals" to bathing them, feeding them and combing their hair.

AIDS patients require a lot more work and attention than most other patients. For one, when they have full-blown AIDS, you have to check on them so frequently. Then, if they're on blood and body fluid precautions, you have to wear the gloves and the gown, or if they're on respiratory precautions, you also have to wear the mask.

Some patients have resented nurses coming in their room with gloves, masks and gowns. I'd ask them, "Didn't the doctor speak to you about why you've been put on isolation?" And a lot of times, they'll say, "No," when I know the doctor has spoken to them. They really do know what's going on as far as this disease, but sometimes they don't want to accept it.

It seems like lately the patients are getting younger and I'm wondering what kind of life they've had and expect to have when at 28 or 29 they're in the hospital with this disease. It's depressing. It's depressing. It really is. I hope I don't get to the stage where it will be too depressing to care for these patients. I could see where that could possibly happen, but I haven't gotten to that stage yet.

If we can make their lives a little more comfortable that's better than nothing. I guess we just do what we can and say a little prayer now and then and that's about all we can do.

Maria Rozario is an epidemiology nurse assigned to the hospital's infection control department where her responsibilities include monitoring AIDS patients and ensuring that infection control guidelines are followed. As a former visiting nurse, she also has provided home care to AIDS patients, an experience she found "very, very sad, very heartrending."

One of her prime concerns is that AIDS patients get appropriate counseling about their diagnosis. But she is also concerned with shoring up the emotional health of the nurses and other health care workers who care for these patients.

I think we as nurses need to come to grips with what the AIDS scare is. It is a reality. It is here. We have chosen our profession. It is a committed profession and if we're going to be in it and stay in it and do the best possible job, we have to learn to support each other. Once we can learn to do that I think we'll be able to provide better care and counseling and support to the patients that we're trying to take care of.

Because caring for AIDS patients can be very threatening. You think, "That could be me. That could be my sister, my cousin, who knows." It's very, very draining. To have a lot of patients with an AIDS diagnosis is extremely draining. I mean, there is very little positive feedback. And everybody has to have some sort of positive feedback in order to function well.

The Social Worker

Raquel Palmer is an associate director of the hospital's department of social services. When a physician determines that a patient cannot emotionally handle the diagnosis that he or she has AIDS or has tested positive for the AIDS virus, Palmer is often called in to counsel the patient and sometimes the patient's family as well. Part of that counseling also involves helping such patients accept their responsibility to not spread the virus to others.

She also is involved with such practical matters as helping AIDS patients get welfare and Social Security benefits and Medicaid if there is a need and finding them a place to live when they can no longer function on their own and no family members or friends are willing or able to take them in.

AIDS has a way of triggering the most intricate unresolved conflicts that could exist within a person and within a family's relationship to that person. They get triggered because there's the thought of deterioration of functioning, there's the thought of rejection, there's the thought of death and how people process death, this tremendous final separation.

If there were problems with separation and individualization, they definitely come to the surface. If you have been a homosexual who has been in the closet, at this point you've got to deal with it in one way or another. If you have been a bisexual who is married and has a family — and that happens — you're going to have to deal with it. If you've always thought others in your family have treated you poorly, now you're in the position to say, "You're going to have to take care of me."

Most of the referrals I get are about patients whose emotional problems about the illness are very crippling. An example [certain details have been changed to protect the patient's privacy]: After one young man found out he was [HIV] positive, he had some suicidal ideation. He started drinking heavily, which was defeating what the physicians were trying to do: build up his immune system. He couldn't go to work he was so depressed and was in danger of losing his job. His lover became very angry and abusive and rejecting. He lost his apartment and had to move in with relatives in an already overcrowded apartment. He was in a mess.

When he came to me, we really dealt with his depression, his suicidal ideation, very intensely. With such a patient, you say, "There is hope. You may have thoughts of killing yourself, but there is hope. You don't have to be totally dysfunctional. At this stage of the game, you can see 'I can function. I can do.'" So that was my approach.

His suicidal feelings disappeared very quickly. He needed someone who could really understand what he was going through, understand his tremendous feelings about his own homosexuality. He hated to be a homosexual to begin with, hated it, and when he learned he had this virus, he said, "This is my punishment."

The diagnosis forced him to deal not just with the disease, but with the whole thing about the self. He came to the conclusion, "I cannot be other than a homosexual, because this is what I am, this is my orientation." When he came to that resolution of himself, within himself, then he could move on. He told his mother who, fortunately, turned out to be very supportive. He stopped drinking, went back to work, began to produce on the job. He left his lover who had been giving him such a terrible time and found a new apartment. Last time I talked with him, he was functioning quite well. □

A Roundup of Responses

Recognizing that "AIDS is a leading public health problem in the nation that has reached epidemic proportions," Howard's Board of Trustees on April 24 approved a formal policy statement in regard to the disease. Some excerpts:

"It is the policy of Howard University that no person shall be discriminated against based on acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC) or any positive human immunodeficiency virus (HIV) antibody test. . . .

"The University will attempt to address AIDS issues in a caring, compassionate, responsible manner and will strive to ensure the confidentiality and dignity of persons with AIDS, ARC or a positive antibody test. The primary response of the University to AIDS will be one of education. The most important goals for the University will be those of increasing awareness and providing education to prevent further spread of the disease."

To this end, the statement calls for the creation of a university-wide AIDS task force, to be chaired by the vice president for health affairs, which will meet on a regular basis to keep abreast of any new developments concerning AIDS, recommend educational programs and coordinate the dissemination of information about the disease within the university community and review and make recommendations to the university president on specific situations and issues that may arise.

According to general counsel Daniel Bernstine, whose office was instrumental in drafting the statement, the AIDS policy came about "partly as a response to the need for the university to be in compliance with local and federal law but it also is just an attempt by the university to be sensitive to the AIDS crisis and what that means in a university environment."

That Howard respond forthrightly to the AIDS crisis is, of course, congruent with the university's threefold mission of education, research and community service. Among other actions at the university in response to the crisis:

☐ The University Health Center has sponsored a wide range of activities aimed at informing students about what AIDS is, what its modes of transmission are and how it can be prevented. AIDS educators have made presentations in dormitories, before fraternities and sororities, as part of the formal freshmen orientation program, and in miscellaneous seminars and workshops.

"Our emphasis is basically education and prevention," explains Carolyn Goode, the health educator who coordinates most of these activities. "It's a matter of making information available to students so they can make responsible choices."

☐ The Office of Satellite Communications (OSC), through a $450,550 grant from the Centers for Disease Control to Howard and the Hospital Satellite Network, presented a two-hour live national video conference on March 15 entitled "The Frightening Dilemma: AIDS and the Black Community."

Originating from Howard's Cramton Auditorium, the teleconference was transmitted to the 96 Black College Satellite Network member schools, 1,400 hospitals, approximately 75 Black churches and an impressive number of cable stations, other college and university sites and even to the major D.C. shelter for the homeless, according to OSC director Mabel Phifer. A study guide and poster produced in connection with the event, likewise, were widely distributed.

The teleconference featured a panel of AIDS experts sharing the facts — as opposed to the fiction — of the disease. It also featured often-poignant accounts from three men who have been diagnosed with AIDS and some hard questions for the experts from some in the Cramton audience, as well as from others who were watching the program at colleges, hospitals and churches around the country. The rationale for the program was aptly summed up by moderator Jim Vance, a D.C. TV news anchor, in his closing remarks: "One thing for sure, in the case of AIDS what we don't know not only will hurt us, it will kill us."

In the more strictly academic arena, the advent of AIDS has had its greatest impact on the curricula and policies of the colleges in the division of health affairs. But there have been responses in other colleges and schools as well.

☐ Medical students now learn about AIDS in microbiology and infectious diseases courses, for instance, and AIDS-related issues are covered in courses on patient care, physical diagnosis, and medical ethics, among others. In the clinical years, medical students may have actual contact with patients who are infected with the AIDS virus. As preparation for this, the students are introduced to the necessary guidelines they must follow to limit their own risk for infection. Nursing, allied health and dentistry students, likewise, learn the appropriate precautions.

Consider what this has meant for the College of Dentistry, as described by John Boyd, the college's associate dean for clinical affairs, and chairman of its department of clinical dentistry:

"AIDS has had an extreme impact on the college in the provision of services and to our budget because of having to provide barrier techniques as prescribed by the CDC and as accepted by the American Dental Association in their guidelines for treating patients with infectious diseases.

"The basic philosophy behind these techniques is that since you don't know and you can't determine ahead of time who is infected with the AIDS virus and who is not, we treat all patients and we teach our students to treat all patients as if all patients have been infected. Therefore, you have to protect not just yourself but you have to break the chain of infection from patient to patient by practicing barrier techniques: wearing gloves, masks and protective glasses or goggles. These are now worn routinely throughout our school."

☐ In the College of Pharmacy and Pharmacal Sciences, third year undergraduate students have been involved in monitoring drug therapy for hospital patients with AIDS or suspected AIDS, explains Soon Park, an associate professor at the college who is assigned to the hospital's infectious

Published by Digital Howard @ Howard University, 1988

diseases and surgery divisions.

She explains what that means: "My students and I recommend a proper agent and a proper dosage and make sure that the drug is administered properly, meaning that if it is taken orally or intravenously or intramuscularly, we ensure that it is properly done. Also, we watch for any adverse effects of this drug therapy because often these patients are so immunocompromised, in that their immune system is so low, they can hardly tolerate these toxic agents. So, from a pharmaceutical point of view, these patients present special challenges."

☐ The School of Divinity has featured lectures on AIDS in both individual classes and large assemblies and last fall co-hosted with the Council of Churches a community conference on AIDS and the church, notes School of Divinity Dean Lawrence Jones. "AIDS is a very active concern for us because it has implications for pastoral care, for congregations that have persons with AIDS as well as for overcoming the fear of AIDS," he says.

☐ The School of Social Work has held workshops on AIDS and has invited people with AIDS to come in to speak to students as a way to help these future social workers develop greater sensitivity to those afflicted with the disease, reports that school's dean, Richard English.

☐ Two faculty members in the College of Liberal Arts (Richard Seltzer in the political science department and Aisha Gilliam in the physical education and recreation department) and a School of Communications researcher (Carolyn Stroman who directs the school's Center for Communications Research) have collaborated on a study on public attitudes about AIDS based on a telephone survey of 489 D.C. residents. A report based on that research, "Public Perceptions of AIDS in the District of Columbia: Knowledge and Attitudes," was published last year by the Institute for Urban Affairs and Research. From the report's abstract:

"Although most respondents knew that AIDS is spread by intimate sexual contact, fewer respondents identified the sharing of needles or blood transfusions as sources of transmitting AIDS. In addition, many respondents falsely believed that AIDS is spread by casual contact. We also found a significant minority of respondents favored imposing severe restrictions on AIDS victims; for example, quarantining people with AIDS.

"People who had incorrect knowledge of AIDS and supported repressive actions towards AIDS victims were more likely to be less educated, Black, and to have a greater personal concern for getting AIDS. Many of these racial differences disappeared after controlling for education and personal concern for AIDS. People who were most at risk for AIDS (youth and the less educated) did not exhibit more knowledge of AIDS than did those who were less at risk. Educational outreach on AIDS needs to be intensifed and tailored to specific communities."

☐ Studying the impact of AIDS from still another angle has been the intent of two faculty members in the School of Business and Public Administration's finance and insurance department, James Chastain and Martin Weiss. Their research involves assessing the impact on the insurance industry of a 1986 D.C. law which bars insurers from testing life or health insurance applicants for the AIDS virus.

The law was conceived as a way to prevent insurers from discriminating against those they believed were at high risk for AIDS (mainly gay men). But when it was passed many predicted it would prompt life insurance companies to simply stop issuing policies in D.C.

In a much-quoted paper, "AIDS, Life Insurance and The District of Columbia Law," Weiss reported that that prediction has, indeed, come to pass. "Approximately four months after the passage of the AIDS law," the paper states, "eight of ten of the nation's fifty leading companies had already, independently, decided to refuse offering individual insurance to all residents of the nation's capital. . . .

"Thus, each company, apparently at the highest management level, came to the conclusion that it would be fiscal suicide to follow the District law in its present form. . . . What we have here is a fear so pervasive that no amount of resources, knowledge or experience appears to be adequate to meet the current challenge of AIDS except for the implementation of a basic risk management technique — avoidance."

The only way out of the present stalemate, the paper states, is for representatives of the insurance industry and representatives of the D.C. government to "engage in negotiations intent on finding positive solutions to mutual problems. . . . A first step in such negotiations, we suggest, would be to modify the severe penalties imposed by each party on the other."

Chastain has prepared a paper, "Insurability of Persons Exposed to AIDS," which he was scheduled to present this July in London at a research roundtable of the International Insurance Society.

Thus, from insurance to religion, dentistry to new student orientation, AIDS has triggered a response in academia. That this roundup of AIDS-related activities and actions at the university is not comprehensive is but another measure of the impact the killer disease is having throughout society.

Remarks Carolyn Goode of the University Health Center, "Lots of things are being done at the university on AIDS. Different people are doing different things and that's good. Sometimes our approaches are overlapping, but that's o.k. because that means we're able to reach a greater number of people." ☐