AIDS—A Call for the Wisdom of Solomon, the Grace of Christ

By Douglas R. Hegstad

"And behold, a leper came to him and knelt before him saying, 'Lord, if you will, you can make me clean.' And he stretched out his hand and touched him, saying, 'I will; be clean.'... This was to fulfill what was spoken by the prophet Isaiah, 'He took our infirmities and bore our diseases.'... 'Take heart, my son; your sins are forgiven'" (Matthew 8:2, 3, 17; 9:2, RSV).

"And behold, a married bisexual man came coughing, 'Doctor, might I have AIDS?' And he masked and gloved him and sent him to the laboratory saying, 'You may; tell your wife and have no more sex.' . . .This was to fulfill what was spoken by the Centers for Disease Control and to protect his family... And upon finding protozoa in the sputum, the doctor said, 'Watch out, young man; there is no hope for you; your sins have caught up with you'" (Matthew 8:2, 3, 17; 9:2). (Corrupted)

Trends in the AIDS epidemic, with projections of more than 250,000 cases nationwide by 1991, suggest that all Americans, but particularly health workers, will increasingly face issues related to this epidemic. The deep-rooted emphasis of the Seventh-day Adventist church on health, placing disproportionate numbers of Adventists in health-care professions, assures that its members too are confronting this disease. The initial reaction has been fear of acquiring the disease through patient contact. Increasing experience, however, may redirect this fear to complex social, ethical, and legal issues.

Adventists who find homosexuality and intravenous drug abuse morally anathema will confront additional challenges in caring for the 90 percent of victims whose disease was acquired through one of these two means. Like the priest on the road to Jericho, they may wish to avoid difficult issues by walking on the far side of the road. It is likely, however, that Adventist health workers will soon find their injured neighbor in a narrow hallway. They will have to face him and the issues he represents head on. And they may wonder how Christ might have acted.

I am a clinical teacher of internal medicine and a full-time staff physician at Riverside General Hospital, a 350-bed facility serving Riverside County and its underserved and underinsured populations. I am also a Seventh-day Adventist and a faculty member of the Loma Linda University School of Medicine. Riverside County extends westward from the California-Arizona border on the Colorado River, from which it takes its name. The county's experience with the AIDS epidemic lagged two to three years behind its westward neighbor. Los Angeles County reported its first cases of AIDS in 1981. In 1983 Riverside County saw four cases; in 1984, there were 19; and in 1985, 42.

That I would need to learn about this condition and its ramifications became clear early one morning in October 1985. As I walked into the hospital lobby, the operator instructed me to go straight to the intensive-care satellite to see Linda. A vivacious Adventist nurse, Linda, newly gradu-

---

Douglas R. Hegstad, assistant professor of medicine at Loma Linda University, has, for the past three years, won the university's awards for being the outstanding clinical teacher (1985, 1986) and house staff member (1987) in internal medicine.

ated from Loma Linda University, was working the night shift and caring for Jim, a young man dying with *pneumocystis carinii pneumonia*, the opportunistic disease that most commonly heralds the presence of AIDS. Her usual energy appeared lost in a face white with worry. "I stuck myself with a dirty needle," she blurted out. Many questions ensued: "Will I become infected? Should I postpone my wedding? How long until I know?"

At that time, the retrovirus now known as Human Immunodeficiency Virus (HIV), had already been identified as the infectious agent causing this illness. A reasonably priced and sensitive test for infection was already at anonymous testing centers throughout California. Three patients with *pneumocystis carinii pneumonia* were in our hospital. They were young. Our staff, ranging from laundry and housekeeping workers to bedside nurses and staff physicians, was worried. Linda's plight evoked serious questions.

Certainly, I had to consider the risks to healthcare workers. Information since that time suggests the chance of a needle stick from an infected person leading to infection is less than 1 percent, but may be as high as 3 percent.[1] Ten persons caring for patients with AIDS-related illnesses have become infected, presumably from their skin touching blood, body secretions, or excretions.[2] As of May 1987 in the two years since Linda stuck herself, these modes of infection, however, are extremely rare. Risk to health professionals comes less from those with a full-blown, obvious AIDS disease, than from people

Dentists in New York, Chicago Refuse to Treat AIDS Patients

The Chicago Dental Society is considering setting up a clinic for AIDS patients because so many dentists refuse to treat them, society officials have said.

The society will survey members who accept referrals from the group in hopes of finding dentists who will treat AIDS patients, the officials said.

The society knows of just three dentists in the area, all at one clinic, who are willing to accept new AIDS referrals, said Del Stauffer, executive director for the 4,200-member group.

The three were found after an informal search earlier this year that was conducted after the society received requests for such information from people who were unable to find dental care, said the society's president, Bernard Grothaus.

"We started calling various clinics, dental schools and hospitals and found three who said they were able to take on new AIDS patients." Mr. Stauffer said. He added that a society committee had begun to investigate the possibility of setting up a special clinic in which volunteer dentists would treat patients with AIDS.

Many Referrals From Others

Marc Prill, one of the three dentists listed by the society, said he has received many referrals from other dentists in the two months the group has been giving out his name.

"This is going to be a problem down the line," Mr. Prill said. "If everybody would take care of their own patients, it wouldn't be a problem."

Mr. Grothaus said that dentists might feel unable to provide a sterile office environment for AIDS patients.

Last month, researchers reported that a New York City dentist had contracted the virus, apparently from a patient, in the first known case of such transmission.

Robert S. Klein, of the Montefiore Medical Center in New York who directed a survey of 1,231 dentists and hygienists from areas with relatively high AIDS incidence, said this was the only case found. Mr. Klein said that the dentist in question rarely wore gloves, stuck himself with dental instruments about 10 times a year and worked with cuts on his hands.

Guidelines from the Federal Centers for Disease Control in Atlanta call for dental workers to wear gloves, surgical masks, protective eyewear, and laboratory coats or uniforms when they run the risk of exposure to the patient's blood or saliva.

Ethics of Dropping a Patient

Mr. Stauffer says dentists can ethically drop patients if they give them 30 days' notice and try to help them find new dentists.

But the American Civil Liberties Union and state officals say dentists can lose their licenses or face discrimination lawsuits for "abandoning" patients who admit testing positive for exposure to the virus.

An A.C.L.U. lawyer, Benjamin Wolf, said his agency was representing a patient who was suing a dentist for violating Illinois law prohibiting discrimination against the handicapped.

In New York City, the Human Rights Commission has reported many complaints from AIDS patients who say they were rejected for dental treatment.

Reprinted from *The New York Times*, July 21, 1987.

who are not sick from the virus but are AIDS carrriers. The ratio of healthy persons infected by the AIDS virus (who are therefore potentially capable of transmitting infection) to those with obvious AIDS may be as high as 100 to 1. Caring for persons suffering the severest and most pathetic form of AIDS is no riskier than taking care of housewives admitted for appendectomies who may have acquired the AIDS virus from their husbands. In one recent study at a Baltimore hospital, six of 37—or 16 percent of trauma victims between the ages of 25 and 34—who otherwise appeared normal, were found to have laboratory evidence of carrying the AIDS virus.[3] Some population groups in certain areas have been identified as having a 50 percent prevalence of AIDS virus infection. The point of these statistics is that the pool of AIDS carriers with no obvious symptoms presents greater risks to health providers (though still low) than do patients suffering from the ravages of AIDS.

I also had to consider whether I should recommend that Riverside General protect its health-care workers by requiring testing of all patients admitted to the hospital. I learned that although in certain settings testing may be of value, imperfections in the test and confidentiality issues have limited the potential benefit of this approach. Certainly, risks to health-care providers are low, low enough to be negligible when compared to the risks of driving to work through traffic, of smoking, or of drowning at the beach. I read the report of the University of California task force on AIDS, which concluded that there is no ethical, legal, or medical basis for refusal to care for patients with AIDS.[4]

I turned from the physical risks to health-care providers to other causes of their fears. In examining my own reticence to care for AIDS patients I came to realize that my fears related to the difficult situations in which I found myself. Caring for a person with a noncurable, progressively debilitating disease leading to death is always difficult. When that person is also young, often in his early or mid-twenties, the problem becomes worse.

With many patients acquiring infections through a homosexual life-style or intravenous drug use, the discovery of this disease often adds a social stigma. The disease may flag a homosexual life-style or intravenous drug use that parents or wives had not suspected. Friends may reasonably fear acquiring infection and direct their intimacies elsewhere, further isolating the patient. Mental confusion due to the severity of illness, and sometimes directly related to infection of the central nervous system, often makes it difficult for patients to direct their own care.

A homosexual partner, frequently sharing responsibilities and emotions equal to those of a spouse, often lacks legal authority to speak for the patient. The partner is not the "next-of-kin." When a parent and the homosexual partner have conflicting guidance for the doctor on major issues, such as whether to offer intensive supports or burial plans, physicians may find themselves mediating between strangers who are racked by guilt and anger, and have sharply conflicting values. Another difficulty for us as health-care professionals is whether we should get involved with support groups. Should we become part of a *gay* support group?

If a person acquires disease through homosexual relations or blood-contaminated needles, does that patient have a lower spiritual value than someone with appendicitis?

Also, how should the doctor respond to the man who confides his bisexual lifestyle? Should the wife be told? Should the man be tested for infection? If he is infected, must the doctor tell the wife? Or what of the pregnant mother who, though healthy, discovers she is infected with the AIDS virus? Should the Christian doctor counsel abortion, knowing the high probability that the disease will be transmitted to the fetus?

Health-care providers who, like me, are Adventist Christians have further moral and religious questions. What about the intravenous drug abuser who is not yet infected and will not or cannot stop using drugs? Should the doctor supply that person with clean needles? Would this be

abandoning the person to his sins? If yes, should overweight patients and smokers also be abandoned to the consequences of their sins? If a person acquires disease through homosexual relations or blood-contaminated needles, does that patient have a lower spiritual value than someone with appendicitis?

What then did I recommend at Riverside General? We instituted some common-sense physical precautions. We decided against mandatory testing of patients before admitting them to the hospital. Most importantly, we reaffirmed that the first and minimum requirement is to continue to provide excellent medical care both to patients who suffer from AIDS and those many more who are carriers.

My colleagues and I at Riverside General, many of whom are Adventists, have come to realize what I hope all Adventist health workers and administrators are discovering: the gravest threat of this epidemic does not come from needle sticks like Linda's; AIDS' greatest danger rises from its threat to our Christian commitment to serve the neediest of "these my brethren."

NOTES AND REFERENCES

1. Eugene McCray, "The Cooperative Needle-stick Surveillance Group," *New England Journal of Medicine*, Vol. 314, No. 17 (April 24, 1986), p. 1131.

2. *Morbidity and Mortality Weekly Review*, Vol. 36, No. 19 (May 22, 1987), p. 1.

3. James L. Baker, "Unsuspected Human Immunodeficiency Virus in Critically Ill Emergency Patients," *Journal of the American Medical Association*, Vol. 257, No. 19 (May 15, 1987), pp. 2609-2611.

4. John Conte, "Infection-control Guidelines for Patients With the Acquired Immunodeficiency Syndrome (AIDS)," *New England Journal of Medicine*, Vol. 309, No. 12 (September 22, 1983), pp. 740-744.

Appendix A

Lessons From a Previous Epidemic—Syphilis

Parallels are instructive between the response of community leaders and health providers to AIDS and their response to a previous epidemic 400 years ago.

In the late 15th century a new disease swept across Europe and for about 60 years was extraordinarily malignant in its acute phase, frequently leading to death.[1] First recognized among mercenaries of Charles VIII who had captured Naples in February of 1495, the disease later known as syphilis quickly spread among his troops.[2] By late spring, the occupation was in disarray, as ill soldiers returned to their homes across Europe. The disease struck France, Germany, and Switzerland in 1495; Holland and Greece in 1496; England and Scotland in 1497; Hungary and Russia in 1499.[3] The age of discovery led to the efficient dissemination of the epidemic throughout the world in less than 100 years.

Though it would be 400 years before the etiologic agent was discovered, the mode of transmission was quickly identified. Within months laws were passed[4] that if universally heeded might have eliminated the disease within a few generations. On April 21, 1497, the town council of Aberdeen, Scotland, ordered that "for protection from the disease which had come out of France and strange parts, all light women desist for the vice and sin of venery and work for their support, on pain, else, of being branded with a hot iron on their cheek and banished from the town." In October of 1497 the Scottish privy council passed an edict ordering all inhabitants of Edinburgh afflicted with syphilis into banishment to the Island of Inchkeith near Leith.

In 1918, 13 years after the discovery of the spirochete by Schaudinn and Hoffmann and the discovery of arsenicals as treatment for the disease, John Stokes observed, "Think of syphilis as the wages of sin, as well-earned disgrace, as filth, as the badge of immorality, as a necessary defense against the loathesomeness of promiscuity, and our advantage [in fighting the disease] slips from us. The disease continues to spread wholesale disaster and degeneration while we wrangle over issues that were old when history began, and are progressing with desperate slowness to a solution probably many centuries distant." He continued, "History affords little support to the lingering belief that if syphilis is done away with, licentiousness will overrun the world." On the

other hand, "In the five centuries in which it has had free play over the civilized world, the most optimistic cannot maintain that it has materially bettered conditions or acted as a check on loose morals, though its relationship to sexual intercourse has been known."[5]

Writing in 1937, just prior to the penicillin era, William Baker addressed "The ten million in this country who have the disease" and "the other 115 million or more who at some time or other may be exposed."[6] With Chain and Florey's purification of penicillin in 1939, 12 years after Fleming's discovery, the era of syphilis as an indolent killer capable of destroying the nervous system, eroding the aorta, and passing from mother to child came to an end.

NOTES AND REFERENCES

1. Bernard D. Davis, et al. *Microbiology*, Second Edition (New York: Harper & Row, 1973), pp. 59, 60.
2. William Allen Pusey, *The History and Epidemiology of Syphilis* (Springfield, IL: Charles C. Thomas Pub., 1933), p. 4.
3. Pusey, p. 6.
4. Pusey, p. 7.
5. John H. Stokes, *The Third Great Plague* (Philadelphia: W. B. Saunders, 1918), pp. 18, 19.
6. William S. Becker, *Ten Million Americans Have It* (Philadelphia: Lippincott, 1937), p. 18.

Appendix B

A Layman's Glossary to AIDS Terms

AIDS—Acquired Immunodeficiency Syndrome. The Centers for Disease Control definition must satisfy the following criteria:

1. The presence of an opportunistic infection or malignancy.
2. Absence of known causes of immunodeficiency, such as immunosuppressive therapy.

AIDS, the worst or ultimate consequence of infection by HIV, has now been reported in more than 30,000 Americans. In certain communities it is the leading cause of death among young men. Based on a U.S. HIV-infected population estimated at one to two million, the Public Health Service projects another 250,000 or more cases will be reported by 1991. The percentage of HIV-infected individuals eventually progressing to AIDS is unknown but may be in the range of 20-30 percent.

ARC—AIDS-related complex. A clinical syndrome generally recognized in risk groups characterized by chronic fatigue, weight loss, febrile episodes, lymphadenopathy, oral thrush (a common fungal infection), often diarrhea. Considered a less severe or earlier form of HIV disease than AIDS.

AZT—Azidothymidine. The only Food and Drug Administration (FDA) approved drug that enhances an HIV-damaged immune system. In one recently published study*, patients with AIDS confirmed by recent *pneumocystis carinii pneumonia* infection were randomly assigned to receive either AZT or a placebo. At 24 weeks, survival in the AZT-treated group was 98 percent; in the placebo-treated group, 78 percent. Problems: it does not cure AIDS. It has significant toxicity. It must be taken every four hours 24 hours a day. It costs about $1,000 per month.

HIV—Human Immunodeficiency Virus. Formerly known as human T-cell lymphotropic virus Type III (HTLV-III) or lymphadenopathy-associated virus (LAV).

The virus probably originated in central Africa sometime in the past few decades, entering the United States in the mid-1970s. Spread via sexual intercourse and blood-to-blood contamination, it now most frequently occurs during the sharing of needles by users of illicit drugs. Other modes of transmission are rare (breast milk to child, for example). Not spread by casual contact.

Discovered in 1983, the genetic information of this virus is carried in RNA. Upon entering specific cells, reverse transcriptase, a special enzyme, mediates the production of a DNA complement to the viral RNA strand. At cell division, this DNA is integrated into host DNA. Subsequent "stimulation" of the cell leads to transcription of viral genetic material to RNA and subsequent protein synthesis. Ultimately, viral RNA and proteins are assembled at the cell surface and new virions are produced.

Opportunistic Infection—Any of a plethora of microorganisms not usually capable of producing significant disease that may produce overwhelming or life-threatening illness in the presence of weakened function of the immune system.

Risk Groups—Homosexual men, intravenous drug users, hemophiliacs, and recipients of blood transfusion. Ninety percent of persons having AIDS have been homosexual men, intravenous drug users, or both. Hemophiliacs and recipients of blood account for most remaining cases. Nearly 50 percent of randomly tested homosexual males in San Francisco show serologic (antibodies) evidence of infection, as do nearly 60 percent of New York intravenous drug users.

*Margaret A. Fischl, *et al*, "The Efficacy of Azidothymidine (AZT) in the Treatment of Patients with AIDS and AIDS-Related Complex." *New England Journal of Medicine*, Vol. 317 (July 23, 1987), pp. 185-191.