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Acquired Immune Deficiency Syndrome [AIDS], 1988-1994.

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SHERMAN N. BAKER
CHAIRMAN OF THE BOARD

April 22, 1994

407-655-
1276

Rabbi Alexander M. Schindler
Union of American Hebrew Congregations
838 Fifth Avenue
New York, NY 10021-7064

Dear Alex:

Rather than lose the pleasure of the company of two of our favorite people, you may have the pleasure of picking up the next tab whenever and wherever we dine--or eat. Hopefully, this will be sooner than later.

I appreciate your sending the copy of your speech on AIDS. I am bringing it with me to give to Steve and Michele next week.

Regarding the Union's Committee on HIV/AIDS, it was gratifying to read the description of the depth of the programs that are being provided. Rest assured that as soon as I complete the project of raising two million dollars for the Groopman Laboratories, I will be anxious to work with the Committee and to contribute financially to its work.

I am enclosing for your information, a copy of the presentation that I have developed. Hopefully, I will be able to raise the total needed by the end of May. (The first two individuals I have approached have committed $100,000 each.)

If you consider it appropriate, I may ask you to provide assurance of the integrity of my involvement to some individuals whom you know, such as Mary and Max Fisher. Equally important, would be suggestions regarding men or women who may be receptive to giving to this critical project, possibly those with families or loved ones who currently are HIV positive or have developed AIDS.

However, if this is not the case, exposure to the manner in which Steve and Michele are handling his problem can be a source of hope and positive action for some who do not believe it is possible to live normal lives for extended periods with the disease. I found his letter to be extremely exciting, particularly his description of his approach using both a holistic and also almost a spiritual approach (along with normal medical treatment).

Please confirm your date at the Cape so that we can make plans. Hopefully, you will steal a couple of extra days and stay with us. As in the past, I have extra shoes for dress or for tennis--still size 12.

Love to Rhea.

Fondly,

Sherman N. Baker

SHERMAN N. BAKER

April, 1994

Dear:

I am enclosing an overview describing the progress being achieved by Dr. Jerome Groopman, Director of the Laboratory for Aids Research at the Deaconess Hospital. Please read it before continuing with this letter.

I hope that you are as impressed and affected as am I by the fact that as a result of the research being done by Dr. Groopman and his associates, a major breakthrough in the containment and cure for AIDS is possible within the next twelve to twenty four months--one that could save millions of lives.

Over a year ago, Lois and I contributed over $500,000 to this program. These were the funds needed to enable Dr. Groopman to expand space and facilities in his laboratory. Today, this facility is second in size only to the National Institute of Health (NIH) in Washington, D.C., and is recognized as one of the three or four foremost institutions in its field throughout the world.

At this time, it is urgent that an additional two million dollars is provided to enable Dr. Groopman to maximize the potential described. I assure you that this is a realistic sum, not a starting point. Quoting Jerry, this is "the supplementary amount that is needed and all that can be spent during this critical period". It is a need that should and must be filled quickly by a few individuals who understand the urgency and the importance of this program.

To start the project, Lois and I are contributing an additional $500,000 (25% of the total needed). We have made the commitment also to work with a few other lay people to raise the remaining $1,500,000. (This will be done without administrative or professional costs.) The need is great, the potential incredible, and the dollars required minimal when compared with worldwide fund raising on behalf of AIDS. It can and should be provided quickly by a few responsible, knowledgeable, and caring individuals.

My interest is not completely unselfish. I have a 48 year old son who has AIDS--a result of involvement in drugs 10 to 15 years ago. He discovered he was HIV positive after his marriage as a result of a blood test in 1987, part of an application for life insurance. A short time later, in 1988, he developed AIDS. Miraculously, he is in better health today than he was almost seven years ago. He lives a complete life, working full time and participating in all normal activities. Further, he provides encouragement and assistance to others with AIDS and other problems. Dr. Groopman has treated him successfully for several years. For this, Lois and I are deeply grateful.

However, let there be no misunderstanding, my son will receive the same care by Dr. Groopman regardless of my involvement. Nothing could influence his efforts, his integrity, nor his dedication to all of his patients. Unfortunately, his help is not available to millions of others infected all over the world.

Together we have the rare opportunity to participate in what can be the most important program in our lifetime--the turning point in the fight against AIDS. To achieve this, we need commitment of the funds required to permit Dr. Groopman to maximize the potential described in the overview. The $2,000,000 ($1,500,000 balance) covers two years of active research. If you so desire, your contribution can be spread over three tax years--1994, 1995, and 1996.

I hope that you will join us by becoming a major contributor and then an active participant in this effort. I will call you within a few days for a personal meeting. (There are no professionals involved in raising these funds.) If you desire to discuss this at once, please call me at my home 617-266-9666 (wife Lois) or at my office 800-795-0795, extension 2111 (Debbie).

Kindest regards,

The Laboratory for AIDS Research

New England Deaconess Hospital
Harvard Medical School

Director: Jerome E. Groopman, M.D.

OVERVIEW

The Laboratory for AIDS Research

New England Deaconess Hospital
Harvard Medical School

Director: Jerome E. Groopman, M.D.

The AIDS epidemic stands at the forefront of the world's health crises. Since the early 1980's, 12 million people worldwide have been infected with the HIV virus, and 210,000 in the United States alone have succumbed to this devastating illness.

Despite the progress that's been made over the past decade in the treatment of the AIDS virus (through the drugs AZT, DDI and DDC), a cure is still elusive. However, recent, new technologies are providing hope that major breakthroughs may be forthcoming in the next 1-2 years.

Since the mid-1980's, Dr. Jerome E. Groopman and his colleagues in the Laboratory for AIDS Research at Deaconess Hospital have been working to unlock the mystery of this disease at its most basic, scientific level. **The laboratory's 57 physician-investigators comprise a group that in size is second only to the National Institutes of Health (NIH) in Washington, D.C., and in stature is considered among the top two or three in the country.**

PURSUING THERAPIES TOWARDS A CURE

AIDS is caused by the Human Immunodeficiency Virus (HIV), which affects T-lymphocytes (T-cells), the body's white blood cells, important components of the immune system. Because HIV attacks these cells, people with the virus become immunosuppressed, making them susceptible to different types of infection. What makes HIV a particularly vexing virus to control is its tendency to mutate when it encounters a drug or the body's own immune response.

While much AIDS research has focused on extending applications of drugs like AZT, Dr. Groopman's research aims to render the virus benign. Dr. Groopman's team has made significant progress in a highly innovative approach whereby new, artificial HIV-resistant genes are implanted into blood cells to replace those infected with HIV. Simply stated, a genetically altered, "protected" immune system might be created in people with HIV through altering their T-cells.

The past technological limitations in pursuing this goal have been the lack of good delivery vehicles for artificial genes. The Laboratory for AIDS Research has recently constructed a new delivery vehicle termed adenoassociated virus (AAV) which appears to be highly efficient at delivering artificial genes to resting cells. **The next six to nine months of work will involve exploring the most potent configurations of blocking genes with respect to their ability to inhibit HIV.** This approach holds great promise as an innovative treatment for people with AIDS. It is hoped that within two years gene therapy can be moved from the laboratory to patients. If successful, gene therapy would protect the immune system from the destructive effects of HIV.

DRUG THERAPIES

In the absence of a cure for AIDS, new drugs are being sought to combat HIV. Yet one of the most frustrating issues in drug development for HIV involves the development of resistance of the virus to drugs. This is clearly seen with AZT, DDI, DDC, etc. When a patient is treated for months to years with such drugs, the virus often mutates and escapes from the inhibitory effects of the treatment.

HIV carries with it an enzyme, termed protease, which functions as a "scissor." The protease "scissor" cuts the viral proteins in an essential way to form an infectious particle. If this cutting function is blocked, then the assembly of infectious viruses is impaired.

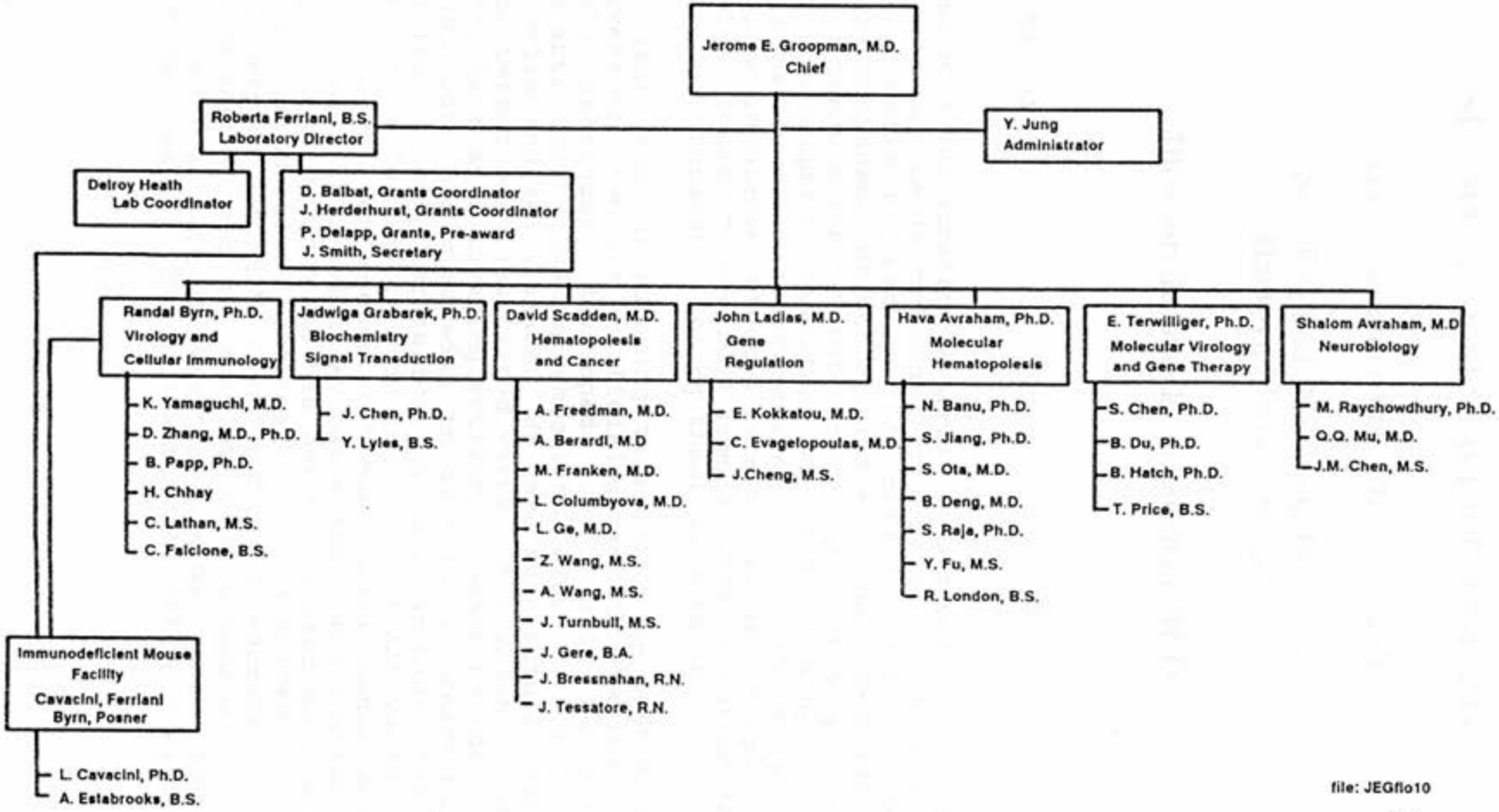
Dr. Groopman's team has helped develop a number of different (protease "scissor") blockers, which are a promising new family of potent and effective anti-HIV drugs. Trials on human AIDS patients of the first generation of protease inhibitors have begun at Deaconess Hospital this month. It is hoped that by preventing infectious viruses from being made, the immune system may be stabilized or able to partly recover.

CURRENT FUNDING NEEDS

The Laboratory for AIDS Research operates on an annual budget of approximately $3.4 million, all of which must be secured through either federal granting sources (like the NIH) or private sources (foundations, corporations and individuals).

To move ahead even more rapidly with both the gene therapy and protease inhibitor research, Dr. Groopman is seeking $2 million in additional operating support over the next two years for the AIDS Research Laboratory. The progress of the laboratory's current efforts would be significantly accelerated by creating research teams working in parallel on complementary strategies in molecular and cell biology of AIDS. **These funds would provide the necessary laboratory equipment and staff to succeed in identifying more potent treatments for HIV patients which ultimately could restore the immune system, resulting in a long and high quality of life.**

New England Deaconess Hospital
The Laboratory for AIDS Research



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SUMMARY OF RESEARCH PROGRAMS

The Laboratory for AIDS Research

New England Deaconess Hospital
Harvard Medical School

Director: Jerome E. Groopman, M.D.

I. GENE THERAPY

We have pursued the strategy of developing specific blocking genes to HIV which may be introduced into bone marrow stem cells Bone marrow stem cells ultimately give rise to helper T cells and monocyte-macrophages. Helper T cells and monocyte-macrophages are the primary targets for HIV infection. By creating populations of T cells and macrophages resistant to the effects of HIV, a major clinical benefit could occur manifest as a stable or improving immune system in people infected with the virus. Simply stated, a genetically altered, "protected" immune system might be created in people with HIV through altering their stem cells.

The past limitations in pursuing this goal have been the lack of good delivery vehicles for artificial genes. The delivery vehicles ("vectors") previously developed were unable to efficiently introduce artificial blocking genes into resting cells such as stem cells, T cells and macrophages. We have successfully exploited a new vector termed adenoassociated virus (AAV) which appears to be highly efficient at delivering artificial genes to resting cells. Our initial work has succeeded in genetically rearranging AAV, retaining its capacity for delivering genes at high efficiency to resting blood cells, and introducing into the AAV vector a series of artificial "marker" genes. These marker genes are easily detected in cells into which AAV has entered and provide a format to verify that this approach has merit. Stated more simply, we need to prove to ourselves that the AAV vector system is applicable to the delivery of anti-HIV genes to T cells, macrophages and stem cells before embarking on the complex and more demanding scientific work of creating the different blocking genes to HIV and incorporating them into the engineered AAV delivery system.

We have had considerable success in genetically re-engineering the AAV delivery system and have recently proven that it is indeed appropriate for our goal of introducing anti-HIV genes. We have been able to introduce marker genes into resting cells such as T cells and monocyte-macrophages with a very high degree of efficiency. Given this initial success over the past five months, we are now designing a variety of blocking genes to HIV and then will engineer them into the AAV delivery system. The next 6-9 months of work will involve determining the most potent configurations of the blocking genes with regard to their ability to confer resistance to HIV. We also need to determine how best to switch these genes on when they enter stem cells, T cells and monocyte-macrophages. The HIV gene therapy program is off to a excellent start and holds great promise as an innovative and highly beneficial approach to the treatment of the immune system of people with HIV disease.

II. PROTEASE INHIBITORS

HIV carries with it an enzyme, termed protease, which essentially functions as a "scissor." The protease cuts the viral proteins into the correct configuration so that the virus can assemble into an infectious particle. If this cutting function is blocked, then the assembly of the virus is impaired and viral particles are formed which are not infectious. Using high performance computers, the three dimensional structure of the viral protease (scissor) was studied and candidate blockers were chemically designed. We have been working with several different computer groups, and have synthesized a number of different protease inhibitors which appear very potent. A clinical study of the first generation of protease inhibitors will begin at the Deaconess Hospital within the next two to three months.

One of the most frustrating and limiting issues in drug development for HIV involves the development of resistance of the virus to drugs. This is clearly seen with AZT, ddI, ddC, etc. When a patient is treated for months with such drugs, the virus has the capacity to mutate and escape from the inhibitory effects of the treatment. Anticipating resistance may occur with protease inhibitors, we have set up systems in our laboratory to try to force the virus to become resistant. To date, it has been very difficult for the virus to mutate to become resistant to the protease inhibitors we are studying. This portends well for this new family of drugs compared to AZT, ddI, etc. Nonetheless, recently we have created in the laboratory viruses with mutations that make them less sensitive to the inhibitory effects of the first generation of protease inhibitors. We can now study these mutated viruses and develop second generation protease inhibitors.

Thereby, we should be clinically prepared to treat HIV infected people who may ultimately become resistant to the effects of the first generation protease inhibitors. It is our impression that the virus will take a much longer time to mutate to become resistant to protease inhibitors compared to its 12-24 month time to become resistant to AZT. We believe this work to be of great importance in the strategy to more effectively block HIV. We are aiming to "keep ahead" of the virus so that we are armed with backup drugs should the virus mutate and escape from the effects of this new class of therapeutics, the protease inhibitors.

It should be pointed out that treatment with protease inhibitors could have important benefits with regard to transmission of HIV. Because the viral particles made in the T cell or macrophage in the presence of protease inhibitors are not infectious, one might imagine that this treatment could reduce the efficiency of transmission of HIV by sexual routes or from mother-to-fetus during the birth process. The importance of continued research on optimizing drugs against the HIV protease is clear given both the great need for new drugs beyond AZT, ddI, ddC, etc. for people with HIV disease as well as the potential public health impact of such novel compounds.

III. IMMUNE RECONSTITUTION

As is clear from our AAV project, we have a major program studying the biology of human stem cells. Stem cells are primitive cells which are capable of maturing into any of our blood cells, including red blood cells, neutrophils, macrophages, platelets, B lymphocytes, and T lymphocytes. The hormones or "growth factors" which direct a stem cell to mature into a red cell or a neutrophil have been relatively well characterized. Very little is known about the hormones which direct a stem cell to mature into a T cell. We believe that understanding which hormones direct stem cells to mature into T cells could be clinically exploited to accelerate reconstitution of the immune system in people with HIV disease who have markedly reduced T cell numbers. To that end, we have created systems in our laboratory to isolate primitive stem cells and then introduce them into artificial environments in the laboratory where T cells can develop. These systems have required considerable conceptual and technical leaps. We recently have successfully created an environment using fresh human thymus and have observed primitive stem cells mature in the thymic environment into T cells. We now need to discover which hormones and growth factors produced by the thymus direct the stem cells to develop into T cells. We are investigating the different thymus cells using advanced molecular technology to identify such hormones. We

hope to uncover the full repertoire of hormones that ultimately could be given to HIV-infected people to foster T cell development.

This approach has been highly successful in the past in other clinical diseases. Patients with certain forms of anemia (low red cell count) can now be treated with erythropoietin, a hormone which specifically directs the bone marrow to produce red blood cells. Similarly, G-CSF is a hormone which specifically fosters the development of neutrophils (phagocytic white cells which ingest bacteria). Given the success of these hormones in other contexts, the establishment of the thymus system in which human T cells can mature from primitive stem cells serves as a first step along a research path to discover new hormones which can be used as drugs in the strategy of T cell reconstitution.

IV. HIV AND THE BRAIN

One of the most devastating outcomes of HIV disease involves neurological degeneration. The mechanisms whereby HIV can impair brain cell function are not well understood. We are approaching this issue by studying the toxic effects of HIV proteins on brain cells in the context of regulatory genes which are important in the growth and function of different brain cell populations. A neurobiologist has recently joined the Mapplethorpe Laboratory. He has considerable expertise in characterizing such genes. His initial efforts in this project have been very fruitful. We have identified new genes of the protein tyrosine kinase, protein tyrosine phosphatase, and communication channel families in brain. These three families of genes are all important in transmitting signals among brain cells. In our studies on HIV, we have found that the virus specifically blocks the function of certain protein tyrosine kinases and may thereby interfere with the capacity of the brain cells to communicate with each other. More intensive research in this complex area is required in order to devise clinical strategies to prevent these toxic effects of the virus on the brain.

V. GENE THERAPY FOR LYMPHOMA

As people live longer with HIV disease, their risk for developing certain cancers increases due to the profound immune suppression as well as the presence of cofactors which promote cancer (such as Epstein-Barr virus). Lymphoma is a cancer of B lymphocytes and in people with HIV disease acts in an aggressive way. Nearly all B cell lymphomas of the brain and about 50% of the non-brain lymphomas in people with AIDS are related to the Epstein-Barr

virus. We are developing a new strategy to treat lymphoma in people of AIDS based on capacity of the Epstein-Barr virus to specifically enter B cells. We are genetically re-engineering the Epstein-Barr virus so as to utilize its envelope structure which allows it to enter B cells. We have enclosed within this genetically rearranged envelope a "suicide gene." The suicide gene is activated only when a specific drug is given to the patient. The approach will be to preferentially deliver a suicide gene to the lymphoma B cells and then switch it on, thereby destroying the lymphoma cells.

This suicide gene approach has been used very recently in cancer therapy but not yet for people with AIDS. Patients with certain brain tumors have had the suicide gene preferentially delivered to their brain tumor. Shrinkage of the brain tumor occurred when the suicide gene was switched on through the administration of an appropriate activating drug. We believe that B-cell lymphoma is emerging as one of the major causes of death in people with AIDS and that more definitive and creative strategies need to be pursued against lymphoma. Given the success that has occurred in other brain tumors, we believe that lymphoma of the brain in people with AIDS can be effectively addressed by targeting the suicide gene with an Epstein-Barr virus delivery system.

I realize that as a person with AIDS, I am not typical. I enjoy the love and support of my entire family. I have learned to be active in my healing. I am under the care of the most dedicated and compassionate physician, foremost in his field. I've come to believe that I can live compatibly with AIDS. I don't have to eliminate it and it doesn't have to eliminate me. Today I am stronger than I was seven years ago, both physically, emotionally, and spiritually. My immune system is stronger with a T-cell count almost double what it was five years ago. When people ask how I'm doing I tell them I'm the healthiest person I know, other than a touch of AIDS.

Steve Baker

It May of 1987, ten months after my marriage, a life insurance company denied me coverage, and I was informed of the reason: A blood test had shown that I was HIV positive. I immediately went to the NIH Center at the University of Miami and two months later I entered the first protocol testing AZT for HIV+ asymptomatic patients. Unfortunately, my body could not accept the AZT at any dose. Five months later, after reaching dangerously low levels of anemia requiring blood transfusions on two occasions, I was dropped from the study and the only possibility for help that the medical establishment had to offer.

My wife Michele and I had recently learned about creative visualization. Forced to find an alternative to conventional medicine, we pursued the study of healing through imaging, based on the concept that our minds are strong enough to tell our bodies what to do. I began to believe that I could treat my condition as a chronic disease, not a terminal one. I stopped reading the gloom and doom reports in newspapers and began creating my own reality.

Michele and I read, travelled, and gathered information from every available source of alternative therapy, making significant changes in our diets and lifestyle. I was introduced to Chinese healthcare, and began taking herbs, receiving acupuncture and massage. I became committed to being actively involved in my own healing on a daily basis.

Then in 1989 I contracted Kaposes Sarcoma, a form of cancer, changing my status from HIV+ to AIDS. It was my Chinese Healthcare practitioner who strongly suggested I seek further conventional medical care. Again, the fear-mongers were saying there was nothing out there in the way of help. But I had been introduced to Dr. Jerome Groopman that year and had flown up to Boston from Florida to see him several times. He had been following my case closely and had put me on antibiotics and several preventative medications, to guard against the development of opportunistic infections and the many problems common to HIV. There was a feeling connected with my meetings with Jerry. It's called trust. Michele and I knew exactly where to go for help, because he had let us know from the start what he would do to facilitate my health: "whatever it takes" were his exact words. I entered Dr. Groopman's protocol, the first phase one study for the new antiviral DDI. The results were not what we hoped for, and within a short period of time, Jerry began prescribing antiviral drug combination therapy at extremely low dosage. Today this is considered the best possible form of treatment, and I have continued with it successfully for five years. Not only have the KS lesions not progressed, they have gone into remission.

To this day I continue with all aspects of alternative healing. I have added the study of Tai Chi and Chi Gong and practice these disciplines daily. My wife and I have been on a journey that has taken us as far as the deserts of Arizona where last year I spent eight days and nights in ceremony with a Navajo medicine man. Jerry has always been extremely supportive of the active role I take in my treatment. We work as a team.

AmFAR

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March 15, 1994

Rabbi Alexander M. Schindler
President
Union of American Hebrew Congregations
638 Fifth Avenue
New York, New York 10021

Dear Rabbi Schindler:

On behalf of the American Foundation for AIDS Research (AmFAR), I would like to thank you for your contribution to the journal produced for the December 7, 1993 benefit event sponsored by *Playboy*. The event was a tremendous success and the journal was an important publication for the guests.

I am pleased to enclose a copy of the journal for you. Again, many thanks for your participation.

Sincerely,

Claire Lieberwitz

Claire Lieberwitz
National Director
Special Events & Earned Income

COPY

Per S.W.

January 23, 1991
8 Shevat 5751

Rabbi Janet Marder
Pacific Southwest Council - UAHC
6300 Wilshire Blvd. Suite 1475
Los Angeles, CA 90048

Dear Janet:

On my return from California, I found your memo of January 7 awaiting me. Many thanks for the excellent update on our AIDS program and the Outreach to gay and lesbian Jews. I am grateful for your very thoughtful and detailed report.

You supervise these two critical areas of concern with great intelligence. I am beholden to you and thank you for all of your efforts in our behalf.

With fondest regards, I am

Sincerely,

Alexander M. Schindler

cc: Ellen Nadell (see attached) 1/23
to: AG 1/7 FOR

MEMORANDUM

From Rabbi Janet R. Marder

Date January 7, 1991

To Rabbi Alexander M. Schindler

Copies

Subject

(5) Thanks Ellen for all the great suggestions

I'd like to update you on two matters. First, I enclose a copy of the liturgy from our region's second Jewish community service in support of people with AIDS. You'll note that this year the sermon was delivered by Erv and Agnes Herman. I believe it was the first time that Erv has spoken publically about the fact that his son is HIV positive and his son's lover has AIDS. Though the crowd was somewhat smaller this year (minus the drawing power of your name), it was once again a moving and unifying event.

I'd also like to let you know about my latest effort to help congregations fulfill the 1989 resolution on homosexuality.

The enclosed letter, which was sent to board members of Temple Beth Hillel in North Hollywood, CA. describes the rationale for our latest project: a four-week dialogue group designed to bring gay and straight Jews together. After debating the proposal for an hour, the Beth Hillel board voted unanimously to endorse it.

The group has just concluded its four-week run, and we are now gathering evaluations from the participants. On balance, it seems to have been an extremely valuable experience. Rabbi Jim Kaufman is delighted that his board members were able to take part in this pilot project, and we are now planning to run several other groups in Los Angeles. After that, I hope to export the idea elsewhere. The detailed "curriculum" employed in the group will be available to any other regional director who wishes to undertake this project.

By the way, the group was facilitated by two very competent therapists (one gay, one straight). They accepted a fee considerably reduced from their normal scale ($200 each for the entire four weeks). I persuaded the rabbis of Beth Hillel and Beth Chayim Chadashim to cover half of this expense from their discretionary funds, and the PSW Council covered the other half. I'm therefore seeking reimbursement of the $200 we spent on this project. (See enclosed memo to Bob Koppel)

Meanwhile, our congregations in Santa Barbara and San Diego (Emanu-El) upon hearing about this project, have initiated their own outreach to gay and lesbian Jews in the community, and are meeting regularly for study and dialogue. Most of the regional biennial conventions featured (or will feature) seminars on this topic, and at least in our area, it has been addressed in many rabbinic sermons as well.

All in all, I have the sense that the 1989 resolution is having an impact on our movement. I will keep you abreast of all new developments in this area. My best wishes for health and fulfillment in 1991.

JRM/mg - dictated but not read

איחוד קהילות מתקדמת באמריקה

Union of American Hebrew Congregations

6300 WILSHIRE BLVD., SUITE 1475, LOS ANGELES, CA. 90048 (213) 653-9962

VOLUNTEER INTEREST FORM

One goal of this service is to involve more members of the Jewish community in volunteer work on behalf of people with AIDS. Please indicate below which areas of involvement interest you:

_____Speaking about AIDS at synagogues, Jewish schools, community centers and camps (training provided by NECHAMA, an agency of Jewish Family Service)

_____Joining members of University Synagogue, Leo Baeck Temple and Temple Isaiah in preparing and/or serving brunch to outpatients in the AIDS Clinic of County-USC Medical Center. Volunteers are especially needed for the first Thursday of the month, or for any Tuesday. Those who cannot travel to the hospital may help prepare sandwiches at the synagogue.

_____Joining with other Jewish community volunteers to serve Sunday brunch once a month to inpatients and staff on the AIDS ward of Sherman Oaks Community Hospital. (You need not participate every month)

_____Assisting members of Beth Chayim Chadashim with their bi-monthly potluck dinners for people with AIDS and their loved ones (dinners are held at the temple, 6000 W.Pico Blvd. Los Angeles 90035)

_____Serving as a driver for Project Angel Food, a food delivery service for homebound people with AIDS throughout Los Angeles. Project Angel also needs volunteers to work in the kitchen or the office, located at 1550 N.Hayworth Ave., Suite #1. Los Angeles 90046.

_____Volunteering with AIDS Project Los Angeles in one of the areas below--

___Buddy Program (providing emotional support to clients)

___Citizens Network (legislative advocacy)

___Dental Treatment Center (needed are dentists, dental assistants, dental hygienists and administrative assistants)

___Fundraising

___Hospital visitation

___Informational hotline

___Insurance Counseling

___Facilitating support groups (volunteers must be licensed psychiatrists, psychologists, LCSW's and MFCC's or clinicians)

___Necessities of Life Program (a food bank providing a wide selection of food, toiletriest, cleaning and medical supplies to clients at no cost. Volunteers may help with processing orders, delivering to the homebound, collecting groceries at local supermarkets, stocking and facility upkeep)

___Office (clerical) service

___Phone Buddy Program (provides ongoing phone contact with clients)

___Public Benefits counseling (explaining to clients the procedures for obtaining Social Security, SSI, Medi-Cal, etc.)

(over)

איחוד
ליהדות
מתקדמת
באמריקה

Union of American Hebrew Congregations

SERVING REFORM JUDAISM IN NORTH AMERICA

PATRON OF HEBREW UNION COLLEGE-JEWISH INSTITUTE OF RELIGION
6300 WILSHIRE BOULEVARD, SUITE 1475, LOS ANGELES, CA. 90048 (213) 653-9962 FAX (213) 653-9236

PACIFIC SOUTHWEST COUNCIL

Rabbi Lennard R. Thal
Director

Rabbi Janet Ross Marder
Associate Director

October 10, 1990

"We have yet to shed the destructive anti-gay and anti-lesbian prejudices and sterotypes that preclude a genuine embrace of the heart. Our union of congregations must be a place where loneliness and suffering and exile end, where gay and lesbian Jews know they are accepted on terns of visibility, not invisibility; that we place no limits on their communal and spiritual aspirations."
Resolution passed by the UAHC
General Assembly, New Orleans, 1989

Dear Board Member,

The resolution on gay and lesbian Jews presented a difficult challenge for many of the delegates at the last UAHC Biennial--difficult because it calls us not only to action but to attitudinal change. The authors of this resolution recognized that congregations will become more welcoming of gay and lesbian Jews only when individual congregants became more knowledgeable, accepting, and above all, comfortable with gay people.

Resolutions alone, of course, cannot change our beliefs and feelings about a subject as personal as homosexuality. Something more is required to bring about "a genuine embrace of the heart." Accordingly, the Pacific Southwest Council of the UAHC has decided to embark on an experiment in social change--and we'd like to invite you to take part in it. In fact, we'd like the Board members of Temple Beth Hillel to be our pilot group for this important and exciting new project.

We believe that in order for heterosexuals and homosexuals to shed their destructive stereotypes about each other (and there are stereotypes on both sides), there must be extensive, open, personal contact between these two groups. Reading articles and hearing sermons may bring about change on an intellectual level, but they cannot alter deeply-held, visceral emotions and associations. They cannot produce comfort, trust and a sense of kinship. We're convinced that this kind of profound attitudinal change occurs only when gay and straight people come to know one another, understand one another's concerns, and develop honest friendships.

Thus we've decided to launch a series of parlor meetings to give homosexual and heterosexual Jews the opportunity to converse on an unusually personal level. Using the model developed by Interfaith Circles, which has successfully brought thousands of Jews and Christians together for honest, respectful conversation, we've planned a four-session dialogue series.

The group will be small--10 to 12 participants in all--to allow for greater intimacy and depth of dialogue. Half of the participants will

come from Beth Chayim Chadashim (a synagogue with special outreach to lesbian and gay Jews) and half from the board of Beth Hillel. We've chosen to invite board members because, quite frankly, you are the leaders and opinion-shapers in your congregation. The group will be guided by one male and one female facilitator, both therapists with special expertise in group work and issues of sexual orientation. While this is not a therapy group, we feel that having leaders sensitive to group development and process will help create an open, safe environment for discussion.

The sessions will be two hours long and will meet in the homes of participants--an important step in establishing a friendly, informal tone and "demystifying" one another's lives. Here's an outline of the kind of topics we plan to cover:

1. What was it like to grow up Jewish and straight, gay, lesbian, or bisexual? What messages were we given about sexual orientation when we were youngsters?

2. How does our sexual orientation affect our religious feelings and religious involvement?

3. What aspects of gay or straight behavior are disturbing to us?

4. What is a family? How do I define family for myself; what kinds of families make me uncomfortable?

5. Are there right and wrong ways of having sex? How do we decide?

6. How much do we identify with traditional Jewish ideals such as monogamy, marriage and the mitzva of becoming parents?

7. How much do we really want to be integrated within the same synagogue? Are separate synagogues for gay and straight Jews desirable or not? What can we do to make our own synagogues more accessible and welcoming to one another?

Our main agenda, however, will simply be to get to know one another in a relaxed atmosphere and, along the way, to discover how we're the same and how we differ.

We hope that you're as intrigued by this idea as we are, and that you'll be eager to participate. Knowing of Beth Hillel's status in this community as a pioneer in making the synagogue accessible to the disabled, another marginal group, we have high hopes for your involvement. However, only five or six of you will be able to participate in this first series. To help you decide if this group might be right for you, we are sharing our criteria for participation:

1. Participants must commit to attending all four meetings. The dates are:

2. Participants should have had limited contact with gay/lesbian or bisexual Jews and be interested in learning more about them.

3. Participants should be prepared to speak honestly about their own feelings and to listen carefully and respectfully to those of other group members.

4. We are particularly interested in welcoming group members who are aware of their own discomfort with homosexuality and are interested in working on the issue.

One final note: This is not a one-sided effort to teach heterosexuals about homosexuals and to propagandize for gay rights. We truly believe that there is educating to be done on both sides, and that the more we learn about one another, the stronger our Jewish community will be.

We hope very much that this board will vote to endorse Beth Hillel's participation in this pilot project. If you are interested in taking part in the dialogue group, please contact us, either in writing or by phone, by November 8 so we can discuss your participation.

Thank you for taking the time to read this proposal, and for giving it your thoughtful consideration.

B'shalom,

Rabbi Janet R. Marder
Associate Director

Fran Chalin
Social Action Intern

MEMORANDUM

From Rabbi Alexander Schindler

Date 12/22/89

To Robert Koppel

Copies Rabbi Lennard Thal, Rabbi Janet Marder

Subject Fulfillment of Biennial Resolution on Homosexuality

COPY

You will recall the resolution on the subject of homosexuality and the mandate of the Biennial that we engage in nationwide program to "raise consciousness" on this sensitive issue.

I have asked Janet Marder to assume responsibility for this effort, and she will do so. She will undoubtedly have some administrative expenses connected with that - telephone calls, some mailings, etc. To that end, it would be well if we were to establish a separate line in the Los Angeles Council budget for this purpose.

Most of her work will probably be done through the region so no major sums will be involved, but it is just as well that we keep all the lines clean and not burden the regular budget of the region with these expenditures.

If you have any questions, please let me know.

Union of American Hebrew Congregations
838 FIFTH AVENUE, NEW YORK, N.Y. 10021 (212) 249-0100

MEMORANDUM

From Rabbi Janet R. Marder

Date December

To Robert Koppel

Copies

Subject

I am seeking reimbursement of certain expenses incurred by the PSW Council in accordance with the enclosed memo dated 12/22/89. I am not sure how to code these expenses properly, and would appreciate your getting this request to the appropriate person in the appropriate form.

The expenses are as follows:

1. $15.00 - for previewing a film (invoice enclosed)

2. $200.00 - for paying two therapists ($100 each) to lead a four-week dialogue group. Their names are Dr. Mason Sommers and Marcia Weitzman, M.A. In a separate memo to Rabbi Schindler I have described the dialogue group.

The PSW Council has absorbed the costs of mailings and telephone calls for this project. Thanks very much for your assistance in this matter.

Union of American Hebrew Congregations

6300 WILSHIRE BLVD., SUITE 1475, LOS ANGELES, CA. 90048 (213) 653-9962

RABBI ALEXANDER M. SCHINDLER • UNION OF AMERICAN HEBREW CONGREGATIONS
PRESIDENT 838 FIFTH AVENUE NEW YORK, NY 10021-7064 (212)249-0100

January 6, 1994
23 Tevet 5754

Executive Director
Center for Disease Control & Prevention
1600 Clifton, Road, E-25
Atlanta, GA 30333

Dear Executive Director:

On behalf of the Union of American Hebrew Congregations (UAHC), which represents over 1.5 million Reform Jews in 850 congregations across the country, I would like to express our support for the AIDS Prevention commercials sponsored by the Center for Disease Control.

The UAHC has historically been committed to education that seeks to prevent the spread of AIDS. We recognize that AIDS is one of the principal health crises in the 1990s, affecting millions of young men and women from all walks of life. We further recognize that public education is an essential element in combatting this crisis. According to a UAHC 1985 Biennial resolution "public education is an essential element in dealing with the AIDS crisis; only this can enable us to provide the human support that is part of our tradition as a caring community. Fear is generated by ignorance; education is the only solution."

Our support of this educational effort stems not only from our humanitarian concerns, but specifically from our Jewish tradition. Judaism advocates the ideal of pekuach nefesh (the saving of lives). It is the responsibility of each Jew to do whatever he/she can to preserve and sanctify life. We feel that these commercials do just that by informing young people about viable ways to prevent the transmission of this deadly disease.

I commend the Center for Disease Control's forthright efforts to educate our community on the facts about the transmission and prevention of AIDS.

Sincerely,

Alexander M. Schindler

Rec

[illegible]

tur traces from this town, rby Ocosingo and most of lets and roadblocks they any of them vowed that turn to fight another day.

t forces moved aggres- control of the area. But

on Page A7, Column 1

clear weapons requires nations that sign it to agree to a regular system of inspections to track its nuclear fuel to make sure that it is not diverted to a weapons program.

In interviews today, International Atomic Energy Agency officials said they had not been notified of any agreement with United States and would have no comment. But they voiced fears that permitting a one-time inspection would set a bad precedent, perhaps encouraging other countries to seek to limit inspections.

Nonetheless, several arms-control

Continued on Page A2, Column 3

P. Carter Smith for The New York Times

Houston, former President George Bush now attends to the Christmas gift at a discount appliance store. Page A10.

ays Will Be Just an Option

t when the designers of der compact sedan tried the doo-dads that buyers und themselves scratch- s over that murky little with a designation only tive or a Pentagon ana- coct.

ot to the ash receiver, we st people don't even use

this thing,'" said Stephen Bartoli, the 33-year-old nonsmoker who is the product planning manager for the new cars, called the Chrysler Cirrus and the Dodge Stratus. Instead, they added a cup holder for a mug of coffee or an oversized drink.

But nonsmokers need not worry. They will still be able to plug in telephones and radar detectors, using an outlet instead of the lighter. And the

Continued on Page D20, Column 1

The association has asked the Federal Government to reconsider the directive, and the state officials interviewed said lawsuits to challenge it were likely.

Timing of Announcement

In an interview today, Mr. Hanley said the Clinton Administration had "decided to make a political statement by distorting what was intended to be an optional clause" in the new Federal law.

He said the Administration had not consulted state officials before issuing the directive on Dec. 28 and had not given the states time to adjust their laws.

At least one state, Utah, has rejected the Federal mandate to pay for Medicaid abortions in case of rape or incest.

"We don't intend to implement that mandate until it is clarified to our satisfaction that it was intended to operate in the way described by the Clinton Administration," said Rod L. Betit,

Continued on Page A12, Column 1

NY Times 1/5/94

In U.S. Ads for TV, Condoms That Dare Speak Their Name

By KAREN DE WITT

Special to The New York Times

WASHINGTON, Jan. 4 — One television spot shows an animated condom that leaps from a chest of drawers just as a couple, whose sex is unclear, are about to make love. Like a tiny superhero, the condom scurries across the room past a surprised cat and dives under the covers with the pair.

"It would be nice if latex condoms were automatic," an announcer says. "But since they're not, using them should be."

In other announcements, a man or a woman tells an unidentified companion beyond the camera: "I want you — but there is time for us to be lovers. We will wait until that time comes."

The announcements are part of an effort by the Clinton Administration to persuade young people to use condoms to protect themselves from AIDS and other sexually transmitted diseases. Clinton officials say that by using the

Continued on Page A12, Column 1

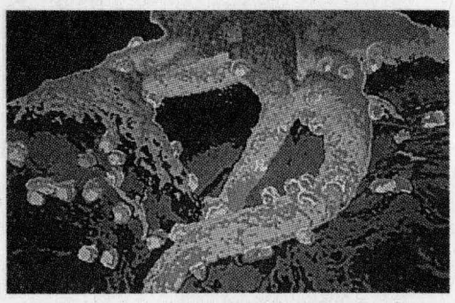
Intentional tourist
An interesting trip around the world with the essays of Pico Iyer. Page 53.

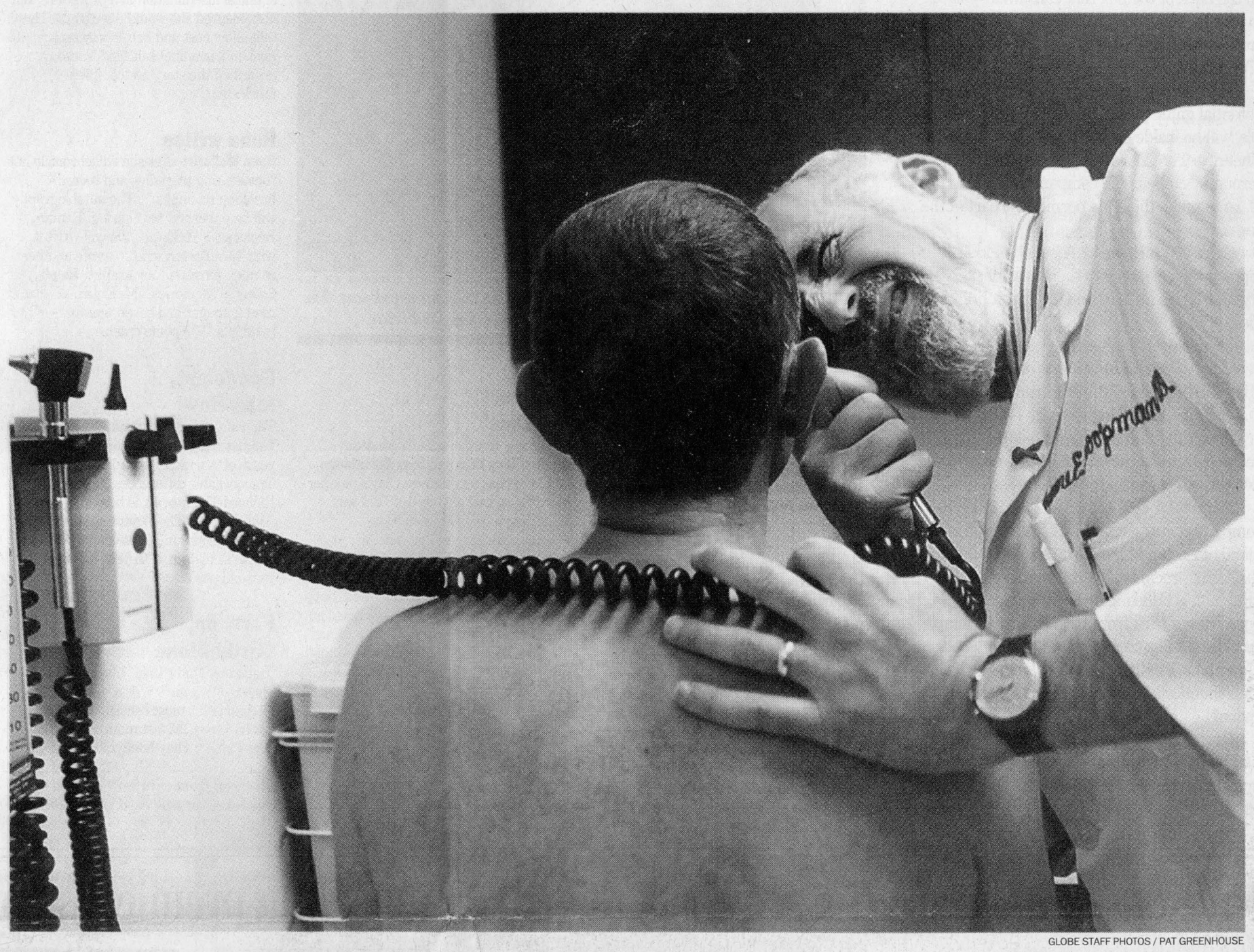
Living|Arts

THE BOSTON GLOBE • THURSDAY, JUNE 24, 1993

Jerome Groopman, AIDS warrior

In a sealed lab, a Boston doctor and his army of researchers battle to unlock the secrets of the deadly virus





Dr. Jerome Groopman examines a patient with AIDS (right); an HIV-infected cell (above) takes on a malevolent beauty.

GLOBE STAFF PHOTOS / PAT GREENHOUSE

By Barbara Carton
GLOBE STAFF

Here, in an unmarked brick building just off Kenmore Square, is a laboratory where researchers handle HIV, the deadly virus that causes AIDS, so concentrated that it can be 1,000 times as potent as that found in the blood of AIDS patients.

There are no windows.

The rooms are kept at a constant negative air pressure, so that any virus escaping into the air will be immediately filtered out at .22 microns before the air flows into the busy streets.

The floor of the lab curves into the walls, eliminating any seams where the virus might hide.

A small radio is usually kept tuned to sports talk, or WMJX. It cannot be removed – not unless it is first decontaminated, then burned to ashes. No janitors enter or exit. Even notes taken inside have to be faxed out.

This unnatural world is the biological theater of war in which Dr. Jerome Groopman, an internationally known AIDS researcher, has assembled his armaments to do battle against one of the 20th century's great scourges.

He is one of thousands of AIDS researchers, slaving, like the others, in the relative anonymity of a scientific netherworld, praying for answers.

Groopman is 41, but his hair is nearly white. It has been 13 years since he saw his first AIDS patient, and in the intervening time, he has watched many die. Anguished patients still call him at home, often several times a night.

As a doctor, Groopman has the medical tools to ease the diarrhea, night sweats, swollen glands, fatigue. He can treat the thrush, the purplish-red lesions, and manage a hundred other complications.

But HIV, the human immunodeficiency virus, is a crafty opponent, cunning and elusive. Despite years of his – and others' – work, it continues to evade attempts at a vaccine, or a cure. In Groopman's battle against the disease, his adversary – lurking in plastic test tubes that contain the thickish yellow slurry of concentrated HIV – is still winning.

"It's horrific," he says simply, of the infectious disease epidemic that consumes his life.

"I probably have seen more death than most people outside of those in Cambodia, or concentration camps, or Nagasaki."

Groopman has examined his enemy intimately, in detail. Its physical structure is imprinted on his mind: the fatty membrane studded with protein spikes, the p24 viral core, the snake of RNA.

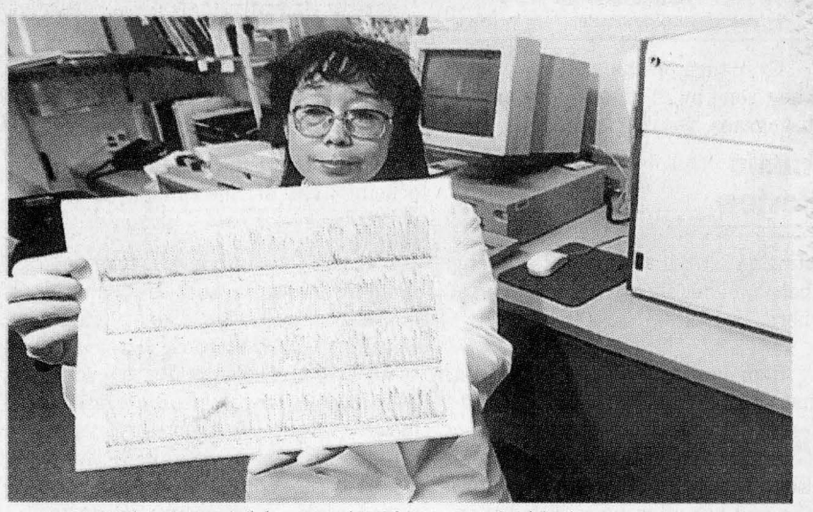
He knows the deepest crevices of the body, where it hides, silently, in the dark, often for years . . . waiting . . . waiting. He understands that it hunts like a smart bomb, wired with 9,213 bits of genetic information, programmed to destroy.

But knowledge about his labile, ever-changing enemy doesn't, so far, allow him to overpower it.

"There is a tremendous spectrum of strains," he says, "and a tremendous capacity to mutate and slither away."

Over the years, he has built a bigger and bigger research laboratory, aimed at stalking the virus and unraveling its vicious mysteries.

But he also has a human laboratory, in which patients' wracked bodies are the vials and their blood the experimental solution. At any given time, he may have a dozen clinical studies under way, aimed at testing new treatments for complications of AIDS, such as Kaposi's sarcoma, or cancer of the lymph nodes, as well as advanced AIDS and early HIV infection.



Researcher Shuxian Jiang with data from the $100,000 DNA sequencer (right).

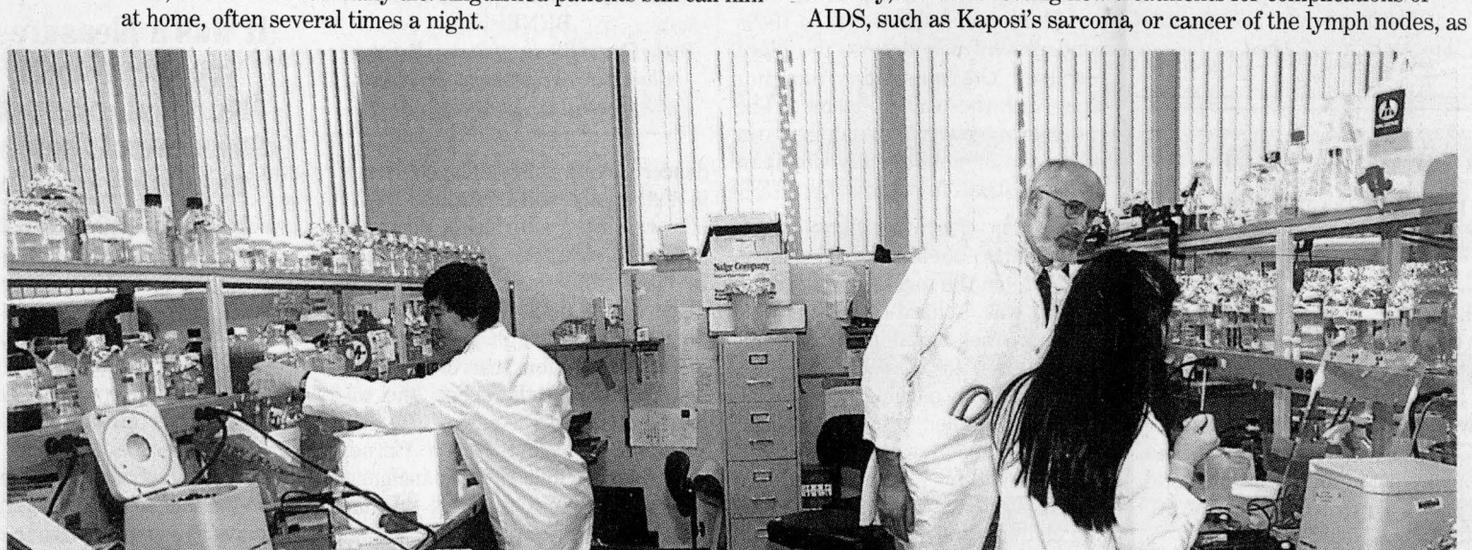
He also knows the epidemic continues to gallop along.

The World Health Organization is reporting that 14 million people have been infected with the virus since the start of the epidemic, most through heterosexual intercourse. By the year 2000, the total number worldwide is expected to rise to a staggering 40 million, including growing numbers of women and children.

Already, more than 2 million infected adults have gone on to the final stage of the disease, AIDS, and most of them are now dead. In some countries, as many as 80 percent of hospital beds are occupied by AIDS patients, and there is a growing debate over how to manage, and pay for, their care. Even in Boston, on some wards, the figures have hit 20 percent or more.

"This," says Groopman, "is a race against time."

• • •



Groopman (center) confers with researchers in an outer room of the lab.

The first cases

Groopman – who is chief of hematology/oncology at Deaconess Hospital and the Recanati associate professor at Harvard Medical School – does not remember the name of his first AIDS patient.

There have been so many.

Maybe it was Michael?

It was 1980.

He was blond, Groopman remembers, a homeless gay teenager living on the streets, and he suffered from a constellation of perplexing symptoms.

For starters, he had a rare pneumonia he shouldn't have had – *Pneumocystis carinii,* generally seen only in cancer patients, or the severely malnourished, or in those taking immune-suppressant drugs for, say, an organ transplant.

"There was a lot of discussion and questioning and hypothesis," Groopman recalls.

Of course, no one called it AIDS at the time. No papers had been published. You could only describe the symptoms: the pneumonia or swelling of the lymph nodes.

And when other patients began turning up, there evolved a whole spectrum of possible explanations, everything from rock 'n'

AIDS, Page 58

Racing against time to unlock AIDS' secrets

■ AIDS
Continued from Page 53

roll to swine virus to secret military experiments gone awry.

It wasn't until 1981 that the first papers began to come out, including descriptions by Groopman and his colleagues of what they had seen.

This virus killed so exquisitely.

It ravaged the heart, the brain, the skin, the liver, the lungs.

It was blood thirsty, parasitic, driven to destroy tissue and organs in its path.

It could be slowed.

But it could not be stopped.

Since then, Groopman has been working to halt AIDS' inexorable march.

Groopman spends much of his time here, at his laboratory headquarters, where 53 researchers work amid the constant whoosh of overhead air being carefully filtered. His is not one of the nation's largest research machines, but it is substantial.

He lopes through the corridors, a long man in a short white coat, pointing out specialized weaponry for probing the defenses of the virus.

Here is his $100,000 automated gene sequencer, which can map out a new gene in three weeks instead of the usual year or two.

Over there is a waist-high freezer containing 14,000 specimens taken from AIDS patients, their serum and plasma preserved in suspended animation at minus 80 degrees centigrade.

"In a way," he says, "it's strange to think that many of them are now dead."

Along that wall are the two ultra-centrifuges, spinning to create a force 100,000 times that of gravity, their rotors worth $10,000 or more, carved of single blocks of the purest titanium.

And behind double-locked doors is the special containment area, where researchers work with the concentrated HIV.

All it takes is one exposure . . .

Everything that touches the virus – the tissue plates, the plasticware, the gloves – is decontaminated in a steam autoclave at 260 degrees, then incinerated.

When one of Groopman's seven principal investigators – Randal Byrn, 40, a PhD in immunology and microbiology – accidentally spilled a plate of live HIV on the floor, he followed emergency procedures, stripping off his blue surgical gown and shoes, leaving them behind.

Byrn's belongings were tossed into the autoclave, then burned. He was unharmed, but he went home that evening in a pair of borrowed shoes.

The worst incident happened several years ago. A medical student tried to stuff too many pipettes into a container, snapping one off about ½ inch from the live virus, slashing her finger in the process.

Right away – plunge the finger in 70 percent alcohol for 10 minutes.

Hurry.

Bleed it.

Squeeze the virus *out*.

She was OK . . . that time.

• • •

Foot soldiers in the lab

On this recent morning, Groopman has come to the lab for an update from his troops.

He is not interested in the plate of breakfast bagels and cream cheese that someone has put on the laboratory conference table.

Instead, he is focused on the microfiche slides flashed against one wall, with titles like "Chimeric-Receptor CD8 Cells, Cytotoxicity Against CEM and CE./IIIB Cells Comparison of T3, T3/F3 and T3/F15 Effectiveness."

One by one, Groopman's researchers stand before him in their white lab coats and Adidas or Nikes and explain their latest probings into the deepest workings of the virus.

As is true for any army, they are trained to different tactical capabilities.

You have the gene jocks and the membrane guys. Each is assigned to tackle the virus from a different angle: genetic, developmental, structural, cellular.

They are predominantly young and foreign – from Israel, Pakistan, Italy, Bangladesh, Cambodia, Korea, Germany, England, Hungary, Poland, Greece, India, China, Britain, Japan.

In the distinct minority are Americans. They represent only about one-fifth of the laboratory's fighting force, and most are at the less skilled end of the hierarchy, working the technician's jobs.

This is partly because competition for jobs in science is global. Furthermore, new-minted American PhDs often emerge from the university so swamped with debt that they can't afford to take a research salary of $18,000 to $25,000. Even MD/PhDs working on their second postdoc can expect to make only about $27,000 starting out.

Nationality aside, biology researchers are a breed apart, eager to roll up their sleeves, get down in there, into the middle of the warfare, engage in hand-to-hand combat with the enemy.

Stalking HIV is not like astrophysics. It is not something you can do in your head or only on a computer.

You've got to know how the equipment works. You've got to fix the equipment, build the equipment. Like everyone who has ever fought in a war, you have to be able to handle the moments of terror and failure, as well as the long stretches in which nothing seems to happen.

You have to not mind spending your days like Anita Estabrooks, 35, a research assistant, peering through plastic safety glasses, repeatedly punching the thumb button on her black plastic pipette, filling 96-well trays – 12 columns this way, eight that.

Punch: add the antibodies. Punch: add the virus. Incubate. Punch: add the cells.

You've got to love the acrid smells of the lab, the bottles of orange Cellgro, the feeling of coming in early and setting up experiments, of being the first one to look at the data.

"And you need to be highly self-critical," says Groopman, "because as opposed to how people usually conceive of research, a lot of good ideas don't work, and there are frustrations of incredible magnitude."

And this is precise, fine, meticulous, small-picture stuff – an engineer's war, really. There is an intensity and isolation that's required.

It's easy, working at the bench, to shut out everything except that single cell, that individual *tat* gene, the cold of the microscope pressing against the eye socket as your white-lit circle of vision comes into focus.

There it is.

You can't see the virus.

But you can see the infected cells.

They look so beautiful, so translucent – a cluster of the tiniest pearls. Malevolently beautiful.

"The first time I worked with the virus I felt overly relaxed," Estabrooks says. "And that bothered me afterwards. I was more concerned about radiation, but everybody was like, 'No – you can withstand a lot of radiation, but you can only withstand one exposure to HIV.' "

And to be a part of this war, you have to be willing to work as part of a complementary team, because a massive modern assault like that on HIV requires numerical strength.

In the 19th century, the great discoveries in medicine and other fields were made by individual researchers.

Robert Koch, the father of bacteriology, made some of his initial discoveries working in the family kitchen in Germany with his wife. And Col. Drake found oil in western Pennsylvania because he saw it bubbling out of the ground.

But in oil, as in modern science, there are no more solo flyers, no more easy discoveries. You've got to be willing to collaborate and to dig thousands of feet down.

It is easy, spending your days in a windowless laboratory, to forget about the urgency.

Many bench researchers only come into contact with HIV-infected patients on television or at walkathons. If an experiment fails, you do it again. You can do it over 100 times, if you have to.

It is not as easy for Groopman to forget.

He often finds himself at the bedside of the dying, or admitting yet another sick patient to the hospital for the last time.

He sees the hemorrhages and the loss of ability to think. *Pneumocystis carinii* is an everyday occurrence. He hears the rales from tubercular lungs, runs his fingers over the shrunken and wasted flesh.

As a general in the war against HIV, he directs clinical studies to test new treatments. And he maintains a caseload of 100 patients, most of whom are infected with HIV or suffering from AIDS.

• • •

Caring for patients

On a recent morning, he welcomes a stream of patients, one after the other, into his tiny examining room near the Deaconess.

He greets them in his white laboratory coat, a stethoscope stuffed into the right pocket.

"Good to see you," he says, calling them by name.

They drop their bicycle helmets and Jansport knapsacks near his desk, and when he asks about their health, their responses are matter-of-fact: "Great – no diarrhea whatsoever," and "I'm taking AZT, ddI and what's that other blue stuff? Acyclovir."

They lift their jeans and show him bruises, worried that the dark blotches might be the harbingers of Kaposi's. They let Groopman peer into their eyes to search for retinal damage.

They speak nervously about T-cell counts, anxious that theirs have dipped to, say, 410 – "but, as you know, my boyfriend had 360 two years ago, and now they're up to 800."

He listens when they say:

■ "Well, I had five friends die last summer, so that kind of put me in the hole."

■ "As I told you early on, my goal is to be that one exceptional patient that outlives everyone."

■ "Over the winter I would keep thinking, 'Oh, I think I'll call so-and-so.' But then I'd remember they're all dead."

Groopman asks one woman, a young veterinarian, what she plans to do, career-wise, in life.

For a second, she can't answer.

He reaches out and grasps her hand.

He continues to hold it . . .

Later, another of Groopman's patients pauses briefly in the hospital waiting room. "I love him," he

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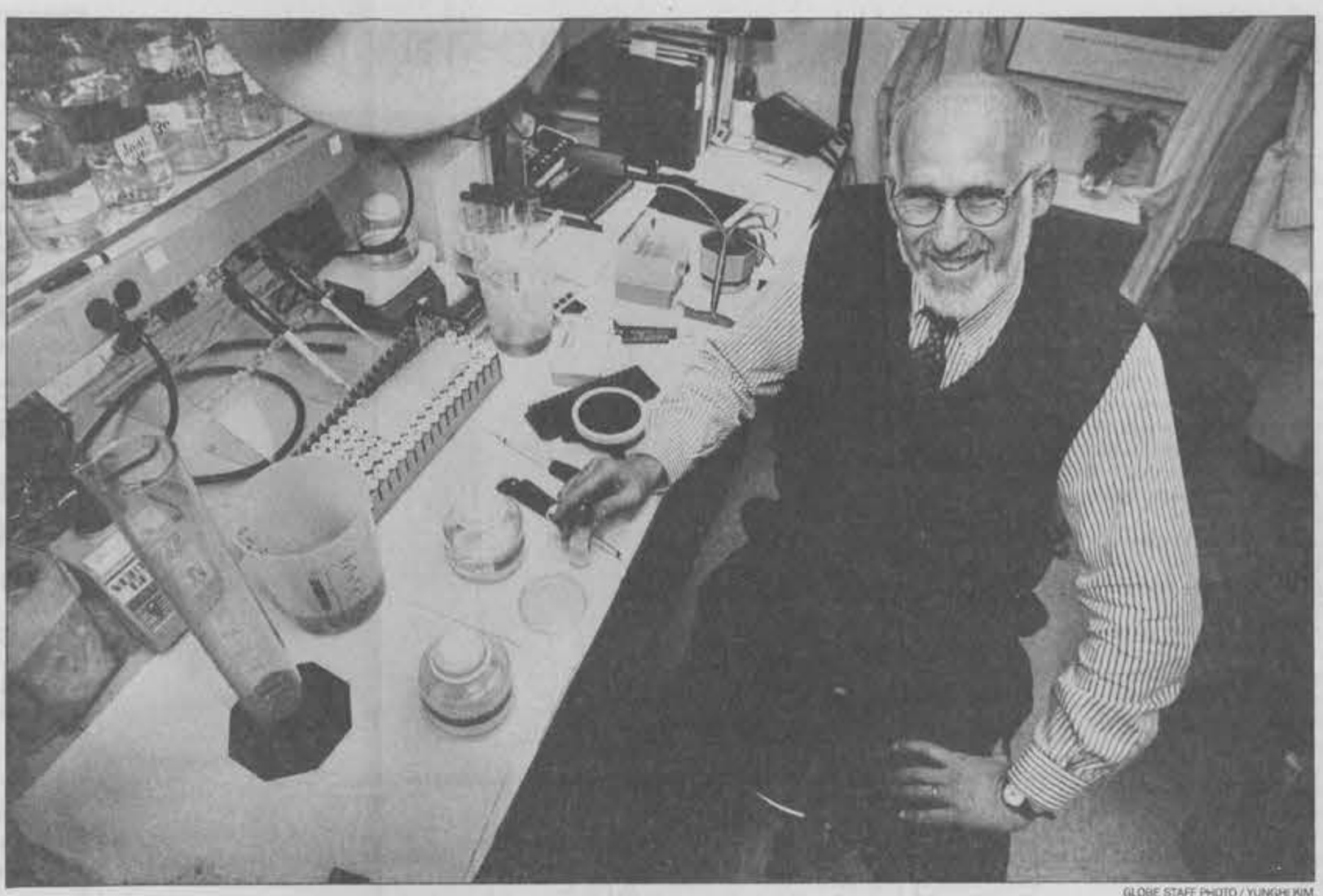
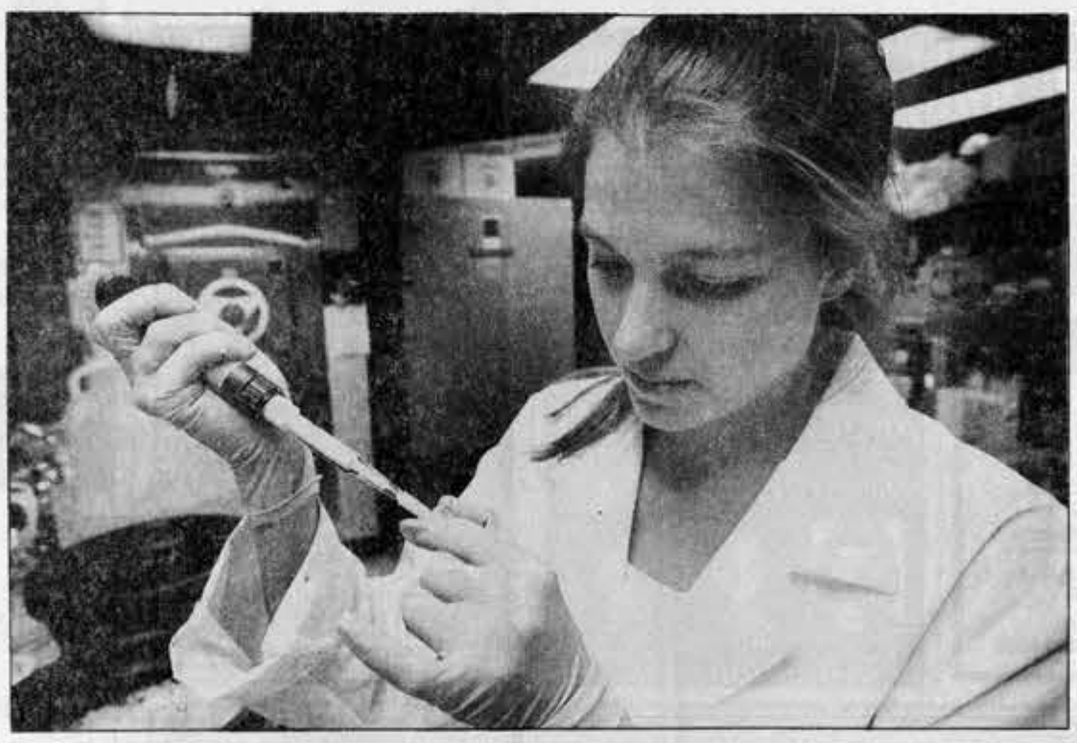


GLOBE STAFF PHOTO / YUNGHI KIM

Groopman in his lab: "A lot of good ideas don't work, and there are frustrations of incredible magnitude."

Researcher John Ladias examines human cells through a microscope.



Jennifer Watters uses a pipette as she works in Groopman's lab.

'Disease is a humbling event. You see people with tremendous fame or wealth or political power or achievement, and there are times when all of these material attributes don't change things. It teaches you what's substantial in life, like family relationships and friends.'

DR. JEROME GROOPMAN

GLOBE STAFF PHOTOS BY PAT GREENHOUSE

Jerome Groopman, AIDS warrior, leads the fight against the disease

Continued from preceding page

says, simply. "I feel very, very lucky to have him."

Groopman once considered becoming a rabbi.

But he chose medicine because he thought he'd have the "most real" life that way.

And he picked hematology/oncology as a specialty because he knew that if you had a blood disease or cancer, you needed a doctor who could take primary responsibility.

Also, hematology was so elegant, because such a tremendous amount of science was known.

In the academic-medicine establishment, the classic way to get ahead is to select a rare disease – some metabolic abnormality – and study it, biomedically, publish obscure papers on it and make a reputation as an expert in X.

That way, you have your little niche, you work up the ladder and off you go.

So, in 1979, after medical school at Columbia, an internship and residency at Massachusetts General Hospital and further training elsewhere, Groopman went off to UCLA as a research fellow to study a rare disease, human T-cell leukemia, which occurred mostly in Japan and the Caribbean.

It was while at UCLA that Groopman saw his first case of AIDS.

And, curiously, it seemed to be the exact reverse of human T-cell leukemia. Instead of infecting patients' T-cells and causing them to multiply and become leukemic, and live forever, the AIDS virus just killed them.

Death comes in many forms.

AIDS is about as bad as it gets.

The urgency and pressure Groopman says he feels from caring for patients who know what may be in store for them is incredible.

Many have already buried 10 friends, or 15, and have seen the vomiting and the fungal infections and the bodies covered with tumors lying in sweat-drenched sheets and the blindness.

You can't compare AIDS to the Holocaust, of course. But on some level, Groopman feels the connection. There is that sense of sudden disappearance of an entire community.

The Bayside, Queens, neighborhood where Groopman grew up was full of Holocaust survivors – even the family doctor had numbers from Auschwitz tattooed into his arm – and he heard all the stories.

"I think about this a lot, actually," he says. "About what it must have taken to sustain the energy and the commitment to persist in a situation that was logistically much more horrendous than this, but there is that sense among people who have HIV that they are fighting for their lives, and that sense of 'Why us?' "

There are also financial pressures.

Like all AIDS researchers, Groopman complains that he is spending more of his time scrambling to write more and more grants, each of which is smaller and smaller.

And he worries endlessly about replenishing his $2 million budget, which is supported by federal dollars, foundation donations, selected contracts with pharmaceutical and biotech firms like the $100,000 one with Genentech, and private gifts.

"It's not that you're becoming personally rich," he says. "It's that everything that touches the virus has to be disposed of, because it's contaminated. And then you have the equipment – the gene sequencer costs $100,000 alone, plus thousands of dollars a month to operate."

And there's intense competition – the subject no one wants to talk about.

Big science has always been about being first, being best and keeping one's advances secret until publication. At stake are money, fame and the peer recognition that helps determine how much grant money flows your way. An extreme example is the acrimonious dispute between American Robert Gallo and French researcher Luc Montagnier over who discovered HIV.

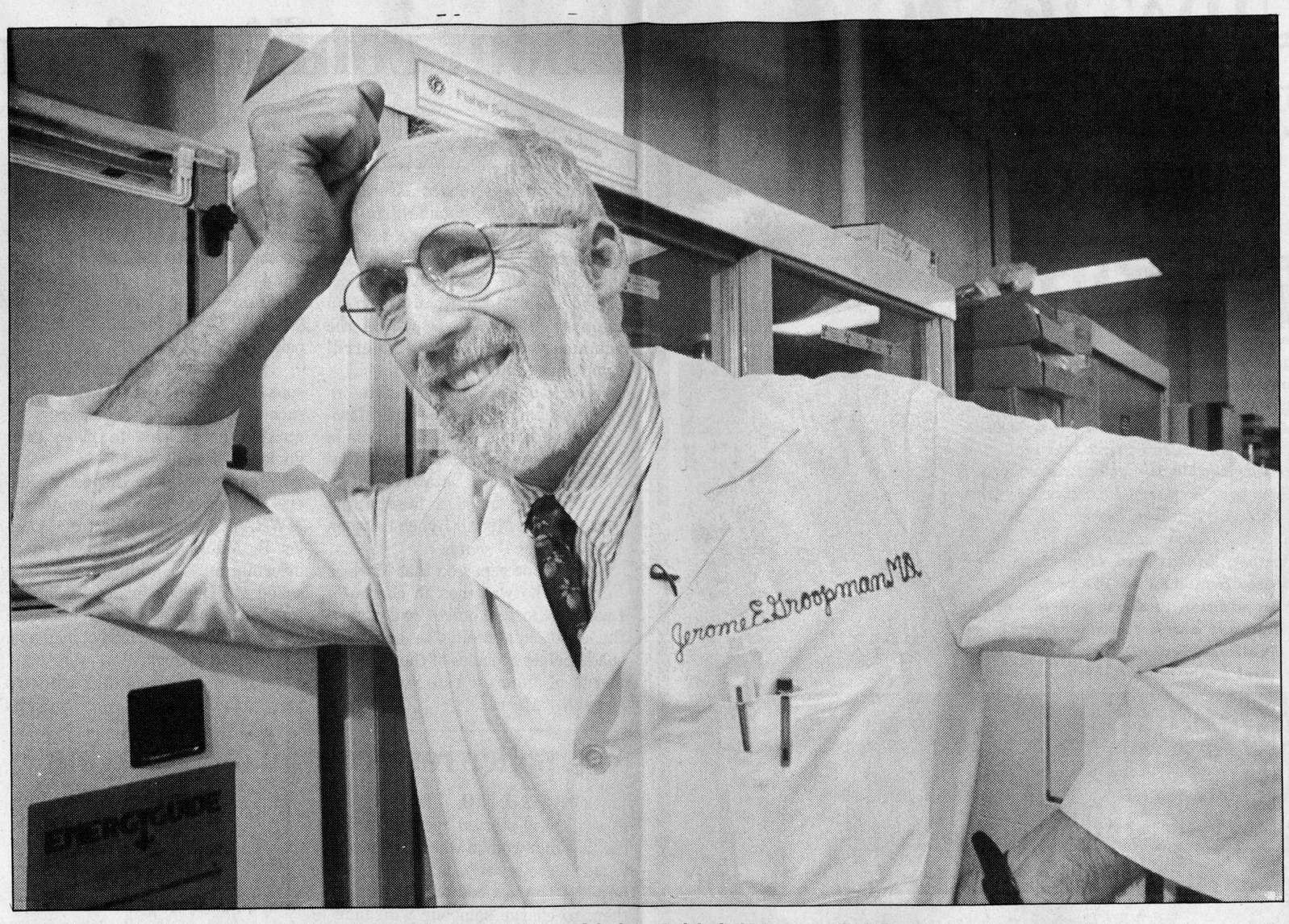
In the United States alone, there are probably 100 cities where competitive AIDS research is being done, including San Francisco; Bethesda, Md.; Baltimore; Boston, and Durham, N.C. And there are legions of researchers, virologists, epidemiologists, pharmacologists, molecular biologists and oncologists – all rushing, like Groopman and his team, to answer any of thousands of scientific questions about the virus.

Yet in the face of an infectious-disease epidemic like this, there is also an emerging, competing ethos that demands sharing knowledge.

A lot of networking and collaboration take place, such as the $1.2 million grant recently submitted to the National Institutes of Health on behalf of a consortium of seven Boston hospitals, including the Deaconess. Even 15 major pharmaceutical companies from the United States, Germany, Italy, Britain and Switzerland recently made the highly unusual announcement that in order to speed research, they would conduct joint studies of experimental medicines.

The frustrations, too, are shared. There are so many different ideas about how the virus causes AIDS that one British researcher has likened the confusion to a group of blind men who encounter an elephant and attempt to identify it by pressing and poking at various body parts. Everyone has a tiny piece. So much is known, but so much is still obscure, and there are days when all familiar markers are lost.

As Science magazine recently put it, "The more we learn, the less certain we are."



Groopman: "People would want a vaccine that's significantly protective, and I don't see it. I don't think it's very likely."

Secretary Youngsun Jung assists Groopman in his lab.

• • •

Getting away from it

Swimming helps ease the pressure.

On any given day, you can probably find Groopman at lunchtime, pulling his gray Saab into the parking lot at Harvard's Blodgett pool for his 25-minute swim.

It's partly to soothe an old back injury; he once spent six months sleeping on a bed of ice, and kept a stretcher in his laboratory so he could lie down.

But there is, as he says, "a big Zen component" – something about losing yourself in the warm blue water, the smells of chlorine, the humid air and the crimson flags strung over the ends of the pool.

Swimming also helps focus whatever has been percolating in the back of Groopman's mind – say, how to construct experiments to understand the process by which an innocent cell is invaded by the freeloading virus, with its halo of spikes.

It is so crafty.

So utterly evil.

Its life cycle consists of more than a dozen parasitic steps: *Attachment ... Reverse Transcription ... RNAseH Degradation ... Migration To Nucleus* ... If any one of these can be interrupted ...

Then, there is Groopman's family.

His wife, endocrinologist Pamela Hartzband, works several floors above him at the Deaconess.

"She has a wonderful effect," says Larry Kessler, executive director of AIDS Action Committee, New England's largest AIDS service organization, "and I think she is probably able to lift him up from time to time."

Groopman also pitches in to drive his sons' early morning car pool several days a week, and tries to break away for their Little League games – priorities, he says, that are partly the result of being immersed in so much death.

"We are not masters of the universe," he explains. "This is not like 'Bonfire of the Vanities.' And disease is a humbling event. You see people with tremendous fame or wealth or political power or achievement, and there are times when all of these material attributes don't change things. It teaches you what's substantial in life, like family relationships and friends."

He also finds some relaxation in studying foreign languages. Groopman and Hartzband often speak French at home and once trudged merrily through 40 Pimsleur tapes in Russian, astonishing the store clerk, who said that no one *ever* finishes 40 language tapes.

Groopman speaks Yiddish, too, and studies Hebrew for two hours every Sunday with a private tutor.

The process of discovery is never the way the public conceives of it, with billowing test tubes of colored gasses, the heavens opening up and the pop of exploding champagne corks.

For many of these things, the light turns on only slowly. Even the discovery of DNA's structure didn't come in a vacuum; it is only an incremental advance over the other models that were proposed.

Newspapers talk of "cures," but Groopman knows that up to now there have been no cures for viral diseases.

"In order to have a cure in the classic sense," he says, "you'd have to figure out how to purge this virus out of the brain, the bone marrow, the spleen, everything. *Everything.* And that is not, right now, medically approachable."

He sighs.

Newspapers talk of 'cures,' but Groopman knows that up to now there have been no cures for viral diseases.

Preventative vaccines against the virus are also very difficult.

"People would want a vaccine that's significantly protective," he says, "and I don't see it. I don't see it, probably, even at the 30 percent level. I don't think it's very likely."

In the end, the best odds are on prevention to block transmission, and on a chronic treatment that would manage the disease the way insulin manages diabetes.

For example, gene therapy might control the virus by rendering cells resistant to it. "That could start to amount to something within two years," Groopman says.

"We are mobilizing a tremendous amount of technology to try to achieve that."

Groopman is also optimistic that the next five years will bring new medications to ease patients' suffering and extend their lives by up to 15 years.

As he speaks, the deaths continue to climb.

In some cities in Africa, one of every three adults is infected.

Parts of India are doomed.

The statistics are staggering.

In the United States, a new government report states, among other things, that last year, 30 percent of AIDS cases in American women were attributable to heterosexual contact, an increase of 40 percent over 1990 ...

People always ask Groopman how he copes.

Hanging on his office wall is a painting of a rainbow. It is linked in his mind to God's promise to Noah, that after the devastation will come a rainbow of hope, and that all flesh will be sustained on Earth.

Groopman also keeps an old photograph near his desk. It is of family – his great-grandfather, aunts, cousins. They were Jews, from the eastern Hungarian town of Mamarosh, and most were exterminated in the Holocaust.

"These people were Hassidim," Groopman says, carefully turning the photograph over in his hands. "And their philosophy was sort of to maintain the faith, but to never rest easy, and to always question the cause of so much evil and suffering."

ACTIVITY REPORT

TRANSMISSION OK

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CONNECTION TEL	9888561
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START TIME	10/15 13:23
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Am Fax

October 12, 1993
27 Tishri 5754

Dr. Mathilde Krim, Chair
AmFAR
733 Third Avenue
New York, NY 10017-3204

Dear Dr. Krim:

In response to your request, I am delighted to provide some comments which might be included in the AmFAR commemorative event journal.

At the UAHC Biennial convention in 1985, I broached the topic of AIDS and I believe my comments are still valid. A copy is enclosed herewith and you may, of course, edit my words as you see fit. I hope this will fit the bill. As requested, I also enclose a glossy photo.

I am honored to have been invited to serve on the AmFAR Board and look forward to a meaningful and fruitful association in behalf of the worthiest of causes.

With warm good wishes, I am

Sincerely,

Alexander M. Schindler

Encl.

Also on the social action front, I want to introduce a resolution on the AIDS crisis. It is a resolution that summons our national leadership to deal with this illness as a top health priority, and to put a final end to that mindless discrimination to which the victims of this dread malady are subject. It is my intention, also, to appoint a national panel of experts who will be prepared to counsel our Temples and their schools on how to deal with this issue in an informed and compassionate way, consistent with the demands of public health.

The AIDS epidemic has spawned a secondary scourge as deadly as the primary affliction: a wave of hysteria whose symptoms include ostracism, prejudice, and violence. AIDS victims, already serving a death sentence, are victimized a second time: they are tormented, thrown out of jobs, often spurned by family and friends; they have been denied admission to hospitals and refused desperately needed medical services; and organizations and even families offering refuge to patients have been subjected to bomb threats and to vandalism.

It all reminds me of the bubonic plague when — so Barbara Tuchman instructs us — parents left their own children to die in the gutter for fear that they themselves would be infected. In the 14th Century, Jews were made scapegoat for the horrors of the plague. Today, homosexuality and not AIDS itself, receives the pointed finger. This shared victimization gives proof of our common humanity — and of the seamlessness of human hatred.

Finally, I would like you to strengthen the Resolution on South Africa which has been placed before us by the Social Action Commission. Its members have never lacked in courage or political foresight, but in this instance, events have passed them by. What seemed a forward-looking resolution last May, is almost irrelevant today. The black majority of South Africa has taken the bit into its own teeth. They will no longer settle for a slight loosening of their chains; they want them removed completely and they are prepared to pay the price. All we can really do is to make certain that this price will not be too heavy in human blood.

And so I would like to have our resolution strengthened in several ways: by calling on the South Afrian government to release Nelson Mandela and the other political prisoners and to negotiate with the responsible and recognized leaders of the black and colored communities, and by calling on our own government to increase its pressures on South Africa by the setting of deadlines for compliance and by lowering the level of our diplomatic ties to that country; I also urge that the "disinvestment clause" of the resolution be expanded to allow the UAHC to join a selective boycott of firms engaged in business with South Africa and not yet in compliance with the provisions of the Sullivan Act.

Our country's voice must be heard clearly on this moral issue. Too many of those who have jumped on the bandwagon of anti-apartheid sentiment, including the President of the United States, are only half way aboard and are still dragging their feet in the dust. Me thinks that their aim is more to kick up the dust than to be aboard the wagon. As the Yiddish saying goes: "If their words were a bridge, I wouldn't cross."

And our own resolution must mince no words. Apartheid is an abomination. Apartheid is institutional racism. Apartheid is a first cousin to the Nuremberg laws. Apartheid means the stunting of millions of lives. These are the political realities that must form the terms of political debate about South Africa. And any attempt to subordinate the question of racism to other political concerns is but an attempt to prop up an ungodly system of human expolitation. Racism cannot be countenanced in this world of ours, for any reason whatsoever, and never by Jews.

Now what I have said in these past several paragraphs should forestall the fear that our present programmatic emphasis on the deepening of spiritual commitment in any way represents a flight from the world. In fact the very opposite motive impels us towards God and Torah: to discover those inner resources we require to grapple with the torments of

AMERICAN FOUNDATION FOR AIDS RESEARCH

TO: Pabh. Schindler FROM: MATHILDE KRIM, Ph.D.

DATE: October 11, 1993 PAGES: 3 (Including this page)

The original of this letter and the article Dr. Krim mentions in it will arrive tomorrow by Federal Express.

Thank you.

If there is any problem with this transmission, please contact Harry Brown or Duncan Arp at 212.988.7655.

Thank you.

AmFAR

733 THIRD AVENUE
NEW YORK, NY [illegible]
TEL [illegible]
FAX [illegible]

October 11, 1993

Rabbi Alexander M. Schindler
President,
UNION OF AMERICAN HEBREW CONGREGATIONS
838 Fifth Avenue
New York, NY 10021

Dear Rabbi Schindler:

I take the liberty of turning to you for assistance with a small matter, but one of importance to AmFAR.

AmFAR is working on the preparation of a commemorative event journal that will contain much more copy of substance than is customary for such publications. In addition to containing text on the epidemic of HIV/AIDS, a history of AmFAR and a description of its programs and activities, it will also include short essays by prominent people from the worlds of science and medicine, religion, government, business, entertainment and others. These statements will each be a few paragraphs long, or some 200 words altogether.

I write to ask you to please be one of those who will contribute such a statement.

The journal will be issued by The Playboy Foundation (a Foundation that has undertaken very commendable public services) on the occasion of the company's 40th Anniversary celebration, of which AmFAR will be the beneficiary.

To make your task easier, I enclose copies of letters and essays written for such a book, published last year, on a similar occasion. I suggest that you consider commenting on the uniqueness of the challenge posed by the AIDS epidemic from your stand-point, i.e. as a spiritual leader and educator, as well as a father.

We would be grateful if you would also express your thoughts on the subject of the role the voluntary sector can play in the fight against the epidemic.

I very much hope that you will see it possible to provide us with such a text by October 22 and, if you do, also with a black and white photograph of yourself for use in the same journal.

We apologize for the short notice and stand ready to assist you in any way. (You could, for example, call me and tell me in a few words what you would like to say. We will put your thoughts in writing and will submit this text for your approval.)

I thank you very much for your consideration. Either Dr. Mervyn Silverman, President of AmFAR; Jane Silver, our Director of Public Policy, or myself will call you within the week to find out whether you are willing to help us with a short essay.

Sincerely yours,

Mathilde Krim, Ph.D.
Founding Co-Chair and
Chairman of the Board

MK/hb
enc.

If you want to reach me by phone, my home number is 212.879.4131 and my office number is 212.988.7655.

months. It is not at all clear whether that incudes all U.S. college students or American seminary students. They will not be testing anyone making aliyah or Israelis returning from other countries. Therefore, there is no epidemiological defense, as established by other countries regarding all foreign entries.

You should also know that on more than one occasion the World Health Organization has noted that testing leads to vast possible discrimination and compromise of confidentiality. There is a constant danger of a false positive or false negative. Would someone who was falsely tested be denied entrance to Israel regardless of his/her behavior?

You write that "if infected walk the street the probability of contracting AIDS increases. As you well know, this has nothing to do with the behavior from which HIV exposure could be provided. And in terms of the American regulation and its nature, there are already one and a half million HIV carriers here. We do not know how many carriers exist in Israel and the Israeli regulation allows for no preparation for counselling, before or after the HIV antibodies test. And, who would get the information and how would the information be used?

In addition to our opposition to the nature of testing, the Central Conference of American Rabbis is also on record pertaining to testing. We have also learned that in Illinois, where testing was required before marriage licensing, it was repealed overwhelmingly after seventeen months of failing financially and epidemiologically to provide any protection.

Also enclosed herewith is our brochure: AIDS: A Glossary of Jewish Values, which I am certain will be of interest to you.

With kindest greetings, I am

Sincerely,

Alexander M. Schindler

Rec. '85-6.7

May 12, 1993
21 Iyar 5753

Mr. Edward M. Petsonk
3408 Oneida Avenue
Altoona, PA 16602

Dear Mr. Petsonk:

Please pardon this delayed response to your letter of April 26. I have been travelling in behalf of the Union of American Hebrew Congregations (UAHC).

The UAHC is a religious and educational organization dedicated to the principles of Reform Judaism. Central to Reform Judaism is the belief in one God, the universal God of all people and the source of values that invest human life with meaning and make it sacred.

We are deeply involved in all manner of educational activity concerning AIDS. We seek to educate our young people, as well as their elders. Our commitment to the great ideals of the prophets is a critical aspect of our work in Religious Action and we strive to create within Reform Judaism an ethical, caring, religiously motivated community. We are concerned about civil and human rights, even as we today have people delving into bio-medical ethics for there are many aspects of this type of research and endeavor which concern us as individuals and as Jews. I might also add that physicians are members of our Bio-Medical as well as AIDS committees.

For your perusal, I enclose herewith resolutions passed by the UAHC Board and/or Biennial which deal with AIDS. The Biennial General Assembly is the highest policy making body of our Union, with proportionate representation from every member-congregation. Nonetheless, each congregation and, of course, congregant, is autonomous and need not abide by every resolution passed by a Biennial. But it is these resolutions which give us the right to speak to the issue of AIDS and HIV testing.

The Israeli regulation regarding the testing for HIV Antibodies is inherently compromised because it only tests foreign workers or visitors with a stay beyond three

Temple Israel
2324 Emerson Avenue South • Minneapolis • Minnesota • 55405 • (612) 377-8680

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To RABBI SCHINDLER	From RABBI EDELHEIT
Co. UAHC	Co. TEMPLE ISRAEL
Dept.	Phone # (612) 377-8680
Fax # 212-570-0895	Fax # (612) 377-6630

May 6, 1993
15 Iyar 5753

Rabbi Alexander Schindler
UAHC
838 Fifth Avenue
New York, NY

Dear Alex:

In response to Mr. Edward Petsonk my suggestion is the following:

The Israeli regulation regarding the testing for HIV Antibodies is inherently compromised because it only tests foreign workers or visitors with a stay beyond three months. It is not at all clear whether that includes all U.S. college students or American seminary students. They will not be testing anyone making aliyah or Israelis returning from yiridah. Therefore, there is no epidemiological defense, as other countries have established, regarding all foreign entries.

Secondly, the World Health Organization has noted, on more than one occasion, that testing leads to a vast possible discrimination and compromise of confidentiality. There is a constant danger of a false positive or false negative. Would someone, who was falsely tested, be denied entrance to Israel, regardless of his behavior? The writer of this letter somehow misunderstands. In the third paragraph of his letter he states, "Infected walk the street the probability of contracting AIDS increases." Of course, walking the street or sitting on the street, or rolling in the street, has nothing to do with the nature of the behavior from which HIV exposure could be provided. It goes on to note, "Carriers of the disease to come unhindered into this country." Regarding the nature of the American regulation, there are already one and a half million HIV carriers here. We don't know how many carriers already exist in Israel. Further, the Israeli regulation allows for no preparation for counselling, before or after the HIV antibodies test. Who would get the information and how would the information be used?

The UAHC is on record as being opposed to the nature of testing. See our own resolutions passed in 1987. The CCAR has also made such a stipulation. We found that in Illinois, where testing was required before marriage licensing, it was repealed overwhelmingly after seventeen months of failing financially and epidemiologically to provide any protection. Ultimately, I would ask the writer of the letter, what is his view of the purpose of the test? Who is he trying to protect?

I include a fax of our own AIDS: A Glossary of Jewish Values. I am sure you can get a copy and send it to him. This is the basis on which any argument ultimately must end. I hope this helps. Sorry it took a couple of days to get to you.

Most sincerely,

Joseph /se

Rabbi Joseph A. Edelheit

JAE/se

SHITUF BETSA'AR

Contracting AIDS is not a judgment of character regarding the person with AIDS nor an assessment of his/her family and friends. It is a disease in which a degree of cause/effect predictability MAY exist. However, this awareness does not change the fact that, as Jews, we do not define AIDS as a punishment levied against a "sinner" by an angry diety whose vindictive justice cancels out all compassionate and merciful action.

Unfortunately, many people do not accept these opinions and the person with AIDS—family and friends—*is/are* often isolated, avoided and evaluated as pitiful, inadequate, misled or evil. Jews, in response to the mitzvah of SHITUF BETSA'AR (empathy), must be sensitive to these dynamics and act in such a way as to nurture, in the person with AIDS, family and friends, feelings of self-worth and dignity.

TIKUN OLAM

TIKUN OLAM reflects a Jewish mystical perspective on creation. This interpretation suggests that, when time began, Adonai filled all space with divine right. Indeed, God was everywhere. Subsequently Adonai experienced self-imposed contraction or withdrawal in order to leave space in which creation could take place. This ongoing process, bathed in divine light, resulted in our world being created. However, according to the mystics, the negative effect is that the divine light becomes fragmented and the sparks are scattered throughout the universe. Thus the lifelong challenge of each individual is to gather the sparks together (TIKUN OLAM) so that Adonai's divine light can be united.

To the extent that TIKUN OLAM implies repairing an imperfect world, the AIDS epidemic provides every Jew with a demanding agenda:

1. Financial support for medical research.

2. Initiation of, commitment to and participation in AIDS education programs for young people and adults.

3. Advocating the legal, economic, occupational and social rights of persons with AIDS and those diagnosed as "carrying" the AIDS virus.

4. Organizing a wide range of programs for one's synagogue including: family counseling, bikur cholim (visiting the sick), chavurot, religious school and youth group education projects and specially sensitized minyan (worship) support groups for families and loved ones mourning the death of a person with AIDS.

5. Support of and participation in blood bank projects.

AIDS:

A Glossary of Jewish Values

◇

This collection of mini-essays, designed for individual study and group discussion, has been prepared as an educational resource by the UAHC Department of Education for the UAHC Committee on Aids.

BIKUR CHOLIM

Implied in the mitzvah of BIKUR CHOLIM (visiting the sick) is the value of active caring in contrast to well-expressed intention.

BIKUR CHOLIM demonstrates to the patients that illness has not cut them off from the world.

Although they might feel, and indeed be imprisoned by the limitations of their own bodies, medical apparatus and the "doctor's orders," BIKUR CHOLIM can provide a sustaining sense of connectedness.

AIDS imposes multiple levels of isolation. Social judgments, ever-increasing physical helplessness, (generally) a lack of hope—and a lack of self-control—combine to create an environment in which BIKUR CHOLIM may be the most significant act of intervention from which the person with AIDS can derive benefit.

Accurate information about the AIDS virus and an awareness of its impact on an individual are important aspects of one's involvement in the mitzvah of BIKUR CHOLIM.

For the person with AIDS, family members, friends and the caring visitor, BIKUR CHOLIM is an extension of Judaism, a declaration of a Jew's privilege to imitate the image of Adonai.

Adonai is Tsur Yisrael—the Rock of Israel—thus, the mitzvah of visiting the person with AIDS can generate similar feelings of stability and safety.

As with all mitzvot, BIKUR CHOLIM is not a one-time "good deed." The true reward for performing any mitzvah is the opportunity to do another. For the person with AIDS, the ability to rely on BIKUR CHOLIM, as an ongoing example of Jewish activism, can result in a "healing" sense of belonging to a unique family, Am Kedushah (the Jewish people)—a people who really care.

CHESED VE'EMET

The biblical concept of CHESED VE'EMET (compassion and truth) has special significance in relation to the death of a person with AIDS.

CHESED VE'EMET reflects the concern in Judaism that Jews respond to an individual's death with lovingkindness and integrity, expectations not unlike those mandated for a Jew's lifetime dealings with others.

Death—resulting from AIDS—often promotes denial, misrepresentation and cruelty. Rather than experience kindness and honest confrontation, the person dying of AIDS, as well as his/her loved ones and friends, are often ignored, judged as flawed individuals and forced to construct fantasies or mysteries about their relationship with AIDS.

The mitzvah of CHESED VE'EMET requires that we reject even the slightest expression of prejudice and/or naive judgment regarding AIDS or the person who has died of AIDS. Jews must demand that sophisticated AIDS education, combined with an aggressive campaign for human dignity, inspire all of society with a perspective on AIDS which reflects compassion and truth.

CHESED VE'EMET calls on the Jewish community to provide meaningful settings and liturgies in which the family and friends of a person who has died of AIDS can express their grief and receive ongoing comfort.

Of greatest significance, however, is each Jew's relationship with the person dying of AIDS. The mitzvah of CHESED VE'EMET calls on Jews to reach out to the individual and discover ways in which to support his/her confrontation with death, a quiet but dependable presence, an offer to facilitate a wish or special need, careful listening, and other behaviors designed to communicate respect for an important life and a brave struggle to survive.

KOL YISRAEL AREVIM ZEH BAZEH

As members of the Jewish People, we are taught that "Each Jew is responsible for every Jew," and that this mitzvah should condition our concerns for Jews in particular and all humanity in general. The AIDS epidemic tests this valued rabbinic principle in unparalleled ways.

1) As we make love with another person, educated behavior is an absolute requirement. The casual, temporary relationship could seduce one or both individuals into unsafe acts. Loving demands RESPONSIBLE sex in which people are treated as the end rather than the means to the end. (The use of condoms and total rejection of medically unsupervised use of narcotics are some of these RESPONSIBLE behaviors.)

2) Each individual is RESPONSIBLE for knowing up-to-date facts about AIDS and its treatment. This information can be the basis for constructive and meaningful relationships among individuals involved with a person with AIDS.

3) Each of us is RESPONSIBLE for providing others with assertive perspectives on safe lovemaking. It is a mitzvah to say "NO!" when encouraged to become involved in high risk sexual behavior. Holding, hugging, caressing, kissing—indeed, enjoying each other's company—must be reaffirmed as serious, satisfying and romantic expressions of passionate feelings.

PIKUACH NEFESH

In our Jewish way of life, PIKUACH NEFESH is an ultimate value. This Hebrew concept asserts that any behavior devoted to saving a life is unparalleled. Only being forced to commit murder, adultery or idolatry can modify a person's dedication to life. Lifesaving is a mitzvah (responsibility) that is so *important* it must be pursued relentlessly—even if other religious mandates must be set aside. PIKUACH NEFESH is the Jewish priority which captures the drama of the "le chayim" when one completes the Shabbat kiddush; highlights the description of Torah as a Tree of Life; and reminds all students of Judaism that Adonai is the living God.

The AIDS epidemic challenges the concept of PIKUACH NEFESH. It has brought death and dying into the lives of individuals, families and communities to such a degree that lifesaving seems an impossibility. Nevertheless, adopting a more educated style of personal sexual activity, supporting a variety of efforts to provide people with honest and realistic information on AIDS, treating every person with AIDS as a life-equal-to-all-life and participating in projects designed to further AIDS research are assertions of PIKUACH NEFESH which can make a difference in the quality of life.

Perhaps the most significant relationship between the concept of PIKUACH NEFESH and AIDS is best expressed by the word "relevancy." Because a Jew must strive to save life, praise life, cherish life and nurture life, threats to life—such as the AIDS epidemic—should be treated as an enemy, and the fight to control AIDS as a major battle.

The Jewish concern about AIDS is more than a response to the media or a reaction prompted by personal fear. It is a logical advertisement of Judaism's valuing of every human person and the quality of life which makes the individual unique.

MEMORANDUM

Fax/ 3 Pages

May 3, 1993

From: Edith J. Miller

To: Dr. Robert M. Rankin

Please note the enclosed from Mr. Edward Petsonk of Altoona, PA. Your counsel as to a response from Alex will be helpful and much appreciated.

Thanks and warm regards.

Union of American Hebrew Congregations
SERVING REFORM JUDAISM IN NORTH AMERICA
838 FIFTH AVENUE, NEW YORK, NY 10021-7064 (212) 249-0100

3408 Oneida Ave.
Altoona, Pa. 16602
April 26, 1993

Rabbi Alexander M. Schindler, President
Union of American Hebrew Congregations
838 - 5th Ave.
New York, N.Y. 10021

Dear Rabbi:

I am in receipt of the current publication Tikvah, of the Committee on AIDS. It isn't possible, I suppose, that the entire UAHC Board of Trustees would simultaneously take leave of its senses. The last page of Tikvah presents a "Resolution on HIV Antibody Testing" adopted by the UAHC trustees, condemning both the U.S. and Israeli government positions with respect to HIV testing.

As a member of Temple Beth Israel in Altoona, Pa. I question the authority of the UAHC to take any position on the medical aspects of AIDS and further, to obligate any Temple or member regarding such matters. This is not a subject for religious interpretation, and therefore outside the mandate of the UAHC.

It has been pretty well established that this disease is spread only through body fluid contact between people; there is no known cure, and once activated, AIDS is invariably fatal. Also the spread is of epidemic proportions, and the authorities have been unable to stem the tide. It follows that if more infected walk the street the probability of contracting AIDS increases.It would therefore be a crime and disgrace if our government were to permit carriers of the disease to come unhindered into this country. Since HIV antibodies are not visible or identifiable except by medical testing, it is unthinkable that people so infected be permitted to travel about the country, constantly spreading the disease. Some may not even be aware that they have the problem.

The issue of Tikvah is substantially devoted to Rabbi Herman's son. He and his family, as well as the hundreds of thousands worldwide who are affected, have the sympathy of everyone. No one questions the need for compassion and for scientific and social research in this matter. In these aspects, the propriety of adopting resolutions and taking appropriate action may well be the prerogative of the UAHC.

There are additional considerations. What right does the UAHC have to commit me as a Jew to a new ideology without my consent? This concept was not present when I accepted Reform. How does this expose me to ridicule in the general community?

The UAHC does its work at the pleasure of its constituents, but somehow the shoe seems to be on the other foot.

In closing, I would recommend that the "Resolution on HIV Antibody Testing" be immediately rescinded and possibly be rewritten to express the concern of the UAHC only in the areas in which that body has jurisdiction and knowhow, and which do not fly in the face of common sense, or run counter to the wishes of its constituents.

I would appreciate a prompt reply.

Sincerely,

Edward M. Petsonk

MEMORANDUM

May 3, 1993

FROM: Edith J. Miller

TO: Rabbi Eric Yoffie

Please review the enclosed letter which was sent to Alex and suggest a response to Mr. Petsonk - - if you think I should, I can ask Mike Rankin to assist us in this connection.

Eric Ed Mike

510 273-7879

Union of American Hebrew Congregations
SERVING REFORM JUDAISM IN NORTH AMERICA
838 FIFTH AVENUE, NEW YORK, NY 10021-7064 (212) 249-0100

RABBI ALEXANDER M. SCHINDLER • UNION OF AMERICAN HEBREW CONGREGATIONS
PRESIDENT 838 FIFTH AVENUE NEW YORK, NY 10021-7064 (212)249-0100

B

October 26, 1992
29 Tishri 5753

Rabbi Herbert Bronstein
North Shore Congregation Israel
1185 Sheridan Road
Glencoe, IL 60022

Dear Herb:

I am taking the opportunity to thank you for sharing with Alex your Rosh Hashanah morning sermon on AIDS. I know he will be interested in reading this sermon which will await his return from the Jewish Agency sessions in Israel.

Since this sermon will be in a mountain of mail that awaits Alex on his return, I want to be sure that you knew that it had been received and will, of course, be read with interest.

With warmest regards and every good wish, I am

Sincerely,

Edith J. Miller
Assistant to the President

north shore congregation israel

HERBERT BRONSTEIN
Rabbi

Rabbi Alexander Schindler
U.A.H.C.
838 Fifth Avenue
New York, NY 10021

October 21, 1992
24 Tishrei 5753

Dear Alex,

The enclosed sermon with reference to Aids, "Helping Our Children to Stay Alive", is one that I had been meditating on for a long time and then spoke on the subject the morning of Rosh Hashanah. It had a tremendous affect in the congregation and people were concerned that it get out to a "wider" audience. I feel very strongly about the way most people are going about dealing with the issues without dealing with questions of mentality and at least it should be grist for the mill at discussion and conscience raising. This point of view should be part of our "resource materials" to educate our children and adults on the joys of healthy sexuality and the risks of "unsafe sex". The latter requires some definition.

All personal good wishes.

H Bronstein

Rabbi Herbert Bronstein
RHB:sf

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Aids;
Helping Our Children
To Stay Alive

by

Rabbi Herbert Bronstein

North Shore Congregation Israel
Glencoe, Illinois

The old Rosh Hashanah prayer, "Inscribe us in the Book of Life, O God who delights in life" is weighted, in our time, with a new and heavy significance, especially for our young people today.

Each year, I ask the members of the confirmation class what they worry about the most. Almost every year they have, without exception, answered "grades"! But this past year was different. In response to my question this past year one of the Confirmands blurted out: "what are we worried about! Staying alive!" Others in the class quickly agreed.

The last time I heard that kind of an answer from a High School student was during the Viet Nam war. Or I might have expected, certainly, such an answer from students in places in our cities where teenagers, children also, are regularly shot dead. And, indeed, whereas in 1940 teachers listed as major disturbances in schools and impediments to learning: making noise, messing around, running in halls and the like; in 1990 the following made the top list: drugs, alcohol abuse, pregnancy, rape, robbery and assault.

But when our Confirmand said "staying alive", he was not worried about any of these. Rather, as some of you may have already surmised, he was worried about HIV infection, about Aids. Yes, to the ordinary worries of our children, that is, grades, social life, and in this generation, parental divorce, has been added worry about "staying alive". And for good reason. HIV infection which first moved across geographical boundaries, then ethnic and gender boundaries, now moves easily back and forth between social classes. Earlier this year, and subsequently at the Republican Convention, many of us heard the courageous revelation by Mary Fisher, the daughter of the noted Jewish philanthropist and national communal leader Max Fisher that she had contracted an HIV infection from her former husband and went public to dramatize that the social gentry were also not immune. More to our point, earlier in the year we heard a teenage woman who had only one sexual liaison and was infected. She has subsequently died. The first 100,000 cases of Aids in the United States

was reported in August of 1989. By January 17th 1992, the Aids epidemic had reached 206,392 cases, the second 100,000 coming four times as quickly as the first; and the 300,000 mark is expected much sooner. Over fifty percent of teenagers in this country reportedly have sexual relations; and in that generally under-reported group, there has been an increase in Aids cases just this past year of forty percent. One in seven young persons nationwide are contracting one or another sexually transmitted disease, increasingly HIV infection. And Aids is now the sixth leading cause of death in this country of persons fifteen to twenty-one years of age.

Surely our children have very good reason to be worried about staying alive.

It does not take much imagination in reading the now regular obituaries to picture and to feel the pain and to lament the loss of so many creative people whose lives have been snuffed out; and to wonder who will be next. It is heartbreaking to listen to a Mary Fisher; but even more so, to weep, as I have, with families or commiserate with colleagues whose families have lost young people to this disease. Or to look into the eyes of parents and their children who confront on their threshold, every day, the shadow of the Angel of Death.

As we pray for life for ourselves, on these High Holy Days, is it not incumbent upon us to ask the question: how can we help our children to stay alive?

You will agree at the outset that we must resort to every means possible. Considering the fact (we do not like it, you know that I certainly do not like it) that in a culture in which casual sex and multiple sexual liaisons is widely considered normal, even normative, in such conditions the inculcation of protected sex, a better job of teaching our children the physiology of sex, along with far more funds for research into prevention and treatment of Aids, all are necessary. We also need more knowledge and less denial among ourselves about Aids and its rapid spread into our circles. And we must learn compassionately to break through the isolation

and neglect to which Aids patients are subjected, sometimes, tragically, even by their own families.

But, we must go beyond this. For none of it is adequate to insure that our young people will stay alive. And so I have to add what is (disastrously for our children) very rarely spoken: ***To keep our children alive, we must go beyond the technical, mechanical approaches and deal with what is in great part a problem of the mentality of our time. A problem, therefore, of values and behavior that will require, ultimately, not a mechanical solution alone but a spiritual solution, a change in mentality.***

And I am not dealing with outdated and impractical moralisms.

You see, our particular culture is so materially and so technically oriented that whenever we have any kind of problem, no matter its source or nature, our culturally conditioned reflex, even in confronting conditions of a life and death nature such as Aids is to seek a technical solution and to stop there as if we were fixing a broken lamp or tinkering with an engine problem.

Just as the monstrous surge of violence, the other great threat to all of our lives in this country, is a problem of the mentality country, a mentality of violence, so the increase of Aids is linked with a problematic aspect of our current culture. So far, the most energetic programs for Aids prevention are depending on what has been communicated to our teenagers as the veritable symbol of the battle against Aids, a technical device which we know as the condom.

But it is not enough. We know that even the best grade condom, even when used properly, (which is certainly not all of the time) are at the very best roughly 84 to 87 percent successful, which in terms of sheer numbers translates itself into a lot of infection and potential death. The use of condoms is certainly far more safe, but to declare, as if it were a mathematical formula, that "condoms equal safe sex" is inaccurate, even mendacious and potentially lethal to our children.

And so I have to bring a perspective of moderation to the hero status of Magic Johnson and his "Safe Sex" campaign. Especially since the Olympics, Magic Johnson with his beautiful smile has been well nigh canonized as "National Hero". We all feel very sorry for him. He is most likely going to die after a dreadful illness. He has been very effective raising consciousness about the need for more government support in the battle against Aids. But I wonder about how careless we are and even destructive to our children in assigning hero status in this country, particularly for black young people with whom presumably, Magic Johnson would be most concerned. He is not a very good example. Magic Johnson walked out of college, fathered a child out of wedlock, was sexually promiscuous. Ironically, he discovered his infection only because he had taken a blood test to get a policy to insure a no-interest loan that the Lakers were giving to him to circumvent the salary cap the League places on each team.

His message at first revealed more of hedonism than heroism. Among other similar statements he said: "I confess that after I arrived in Los Angeles in 1979, I did my best to 'accommodate' as many women as I could, most of them through unprotected sex". In his public statements he expressed little or no concern for the many women he may have infected and, as one sports writer pointed out, who will suffer without his connections, without his means and support. And at the beginning, what came across was only and solely the message of "Safe Sex", words which he used over and over again which translated into the acceptance of promiscuous sex as long as it is "safe".

Now, I am fully aware that recently he has nuanced his message. But especially because of the publicity, the first impressions were the most lasting. And everyone involved missed the boat on what could have been a tremendous opportunity to help keep children in America alive. He could have said: "My values were messed up. Young men and women we have to change our behavior! We ought to start thinking of other people in ways

other than as sex objects. We have to think of the results in the lives of other people and our responsibility for those results". Even as recently as the new video with Arsenio Hall his message still is "if I can get it, brother, anybody can get it". But that is simply not true. People with self discipline, people with self respect, people with respect for other human beings, a sense of responsibility toward others; particularly one's future wife, husband or child, is not as likely to get HIV infection as he was. The Magic Johnson syndrome will one day be seen, if we ever get out of this mess, far more clearly as helping to complicate as much as to solve the problem.

The condom is necessary, I say, when we are struggling against an epidemic. But it is not the answer to keeping our children alive. The Aids problem is the problem of a mentality in a culture which has, for many long years in behalf of commercial gain, promulgated promiscuity and glamorized casual sex. A recent survey of television programming alone shows that depictions of extra-martial sex is given a thirteen to one preference over sexual relationships within marriage.

Our Confirmands have told me quite articulately, with a lot of self awareness, of the constant stimulus to sexual acting out all around them; the "pressure," to use their word, that they are put under by all of those constant images of sex in the media, expectations and provocations to sexual behavior that they see all the time around them continuously in advertising of everything from perfume, cosmetics to clothes at the very stage of life at which they are most susceptible to pressure to adapt and conform to what they see around them. And, the communication they are getting around them is "you are expected to do this".

In discussing exactly this problem, a Wall Street Journal (Feb. 20, 1992) feature article reports the view of many experts that we ought to caution young men nowadays about how to handle sexually aggressive teenage women.

These are the questions we have to ask ourselves: Do our sons have to define their masculinity by "scoring" or our daughters, in order to show

that they are normal engage in sexual relationships or prove their feminine attractions, and therefore, (another sign of the times) their self-esteem, in bed? Have we ever asked ourselves why no society has ever had the level of teenage sexual behavior outside of a consecrated relationship that we have? And why it is that without anywhere near the kind of technical devices that we have to prevent pregnancy no society without these technical devices, anywhere, has ever, anytime, come near the off-the-chart rates of teenage pregnancy outside of marriage that we have: One million roughly, a year and still increasing. Or why our thinking has become so privatistic, that many are even incapable of even beginning to consider the affect of their sexual behavior on other people. We have to keep reminding our young people that every time they have a sexual relationship with someone, they are, as far as disease is concerned, having sex with every person that person has ever had sex with; and, that the popular saying "my body is my body and whatever I want to do with it is okay" is not true in the most down to earth physical way, because what you do with your body can affect thousands of other people when it comes to sex.

So if we stay on the technical level alone and distribute condoms alone without discussing issues of morality, of social responsibility, of self image along with the perspective of the values of other times and other societies, we are communicating something like the following: Since everyone is "doing it", and since we accept it as normal, even normative to engage in random sexual encounters, just like you see on television and in the magazines, the films and the soaps, well just be careful, use condoms! And then we put the words "Safe Sex" on a banner as if it were some kind of an inspiring motto of a noble cause. And, what we are doing is deepening the problem, cheapening and betraying them.

And so now, at this late date, yes, focal efforts of Arsenio Hall, Arthur Ashe and many others are being directed at abstinence as the only real safe sex and on the virtue and value of a sexual relationship within a committed monogamous relationship. And should we in our community do

anything less? Stopping at the technical level, the level of the condom without going on to the issues of values, is a betrayal of our young people by a weak, confused and gutless adult generation which is denying our children what every new generation in any civilized society has the right to expect from their elders, an outright authoritative system of values, principles by which to live and now, principles by which our children can stay alive. And that is what parents are for. Adults must grapple with their own values. As one teacher put it the same Wall Street journal report: "How can I teach about a long term committed monogamous relationship to a child whose mother has had three live in boyfriends in quick succession?"

We have to learn to tell our children that to be a decent human being and to find personal fulfillment lies in sharing with others not only pleasures but also challenges and responsibilities.

We have to learn again to tell our children of the kind of love that discovers its highest joys not in self gratification alone but also in sacrifice for another human being.

Where will our young people hear these things? In the mind-rotting laugh track situation comedies that most of television is today? From a Madonna video? From whom will they hear it? I believe that such issues and questions have to be raised in schools. I certainly think that our young people should hear such things from workers in our Jewish social service agencies and, above all, from their parents. I will never forget how I was greeted, with what relief, when in response to a question about premarital sex I answered a group of our young people at an "Ask the Rabbi" session that despite what they see on television and they hear around them, there are still a lot of young men and women who sit in my study, flesh and blood people, and tell me that they still believe that is important not to have intimate relations before they find the person with whom they are going to enter into a sacred commitment; and that I am beginning to think that, after all, earlier marriages supported, if necessary, might now not only be

"normal", but might even be a far better for the institution of marriage itself.

And I saw in their faces an expression as if I had lifted some burden of pressure off their shoulders. And (most significant) afterwards some of them, as we walked away from the group, told me that I was the first person, parent, teacher, anyone, who had ever talked on such a level about such things with them.

At the present time, we have to combine our technical knowledge, the material protection, with a discussion of the mentality which is so much a part of the Aids epidemic. But the problem is that those who want to discuss values, principles, and mentality are attacking the distribution of condoms and the teaching of physiology. And many who want to hand out condoms only and talk about physiology only, oppose a discussion of values, responsibilities, ideals, principles, mentality. What a self-destructive polarization in our society, lethal for our children. It is exactly that polarization, for example, which has so far impeded the implementation of the sex education Aids Prevention Program for a million children in the New York Public School System alone.

And in concluding I ask: Who is responsible for the increase in Aids? Is it, as in the gay-bashing we heard at a recent political convention, only homosexuals? Is it only the I.V. drug users? Should not responsibility also be assigned to the likes of a Wilt Chamberlain (another idol of our star-crazed society) and others like him, who boasted on television that he has had sex not with hundreds but thousands of women and was proud of it? Just as I believe the purveyors of violence in all the media, from kiddy cartoons to cop killing, rap music to slick block bluster violence movies, must be held collaterally responsible for the surge of violence in our society, so it is also the purveyors of promiscuous sex for cash, (and I am not talking about prostitutes) the producers, the writers, the advertisers who glamorize random sex to sell everything and anything and subject our young people to this over-kill of sexual stimulation who must be held partially responsible for the increase in Aids. And, friends, are we not also

responsible when we refuse to communicate to our own children, not only the physiological knowledge, but also an ideal of committed, monogamous sacred relationship. And if we do not communicate this by precept, by teaching, and yes, by example, we too are responsible. We are not helping our children to stay alive.

And only when we begin to renew a moral consciousness, at least in our own circles, where it has also been deteriorating, can we and our children begin to feel more secure about living out their days, secure about our grandchildren as happy and healthy people.

This year we have special reason to pray: "Remember our children unto life, O God who delightest in life". Help us, O God, to live out this prayer so as to make possible its fulfillment.

Amen.

RABBI ALEXANDER M. SCHINDLER • UNION OF AMERICAN HEBREW CONGREGATIONS
PRESIDENT 838 FIFTH AVENUE NEW YORK, NY 10021-7064 (212)249-0100

April 23, 1992
20 Nisan 5752

Agnes G. Herman
1537 El Paseo Drive
Lake San Marcos, CA 92069

Dear Aggie:

I will try to get some lines for you in the next few weeks, possibly even days, depending on how my weekend goes. I am unusually pressed this time of the year. I have never had so many engagements in my life.

As a consequence, what with some twelve other speeches to write, I will probably draw on some things that I said before on the subject of AIDS, but there is nothing wrong with plagiarizing myself, I suppose.

Be well. I too regret that we don't have a chance to say more than an occasional "hello." But when I join NAORRR some four or five years hence - if I survive that is - I will relax with you and Erv - provided, of course, your tennis game has improved!

Warm good wishes to Erv as well, in which Rhea joins me.

Sincerely,

Alexander M. Schindler

NOTES FOR EDITORIAL TO BE SENT TO AGNES HERMAN

AIDS is a dreadful disease; an entire generation of young people going to waste, their abilities and their possibilities, what they were and what they might have been . . . all going, gone. It is a calamity, a disaster, a terrible disease for civilization and for life.

True enough, humankind has been laid waste by many a plague: the black death, tuberculosis, leprosy. Still, AIDS is the most dreadful epidemic of them all, for it has stirred demons in the depth of our collective soul, and of a kind we had long thought extinct.

It has spawned a secondary scourge as deadly in its own way as the primary affliction: a wave of hysteria whose symptoms include prejudice, ostracism, and violence. AIDS sufferers, already threatened by death, are victimized a second time: they are tormented, thrown out of jobs, too often spurned by family and friends.

Unfortunately, large segments of the Jewish community continue to deny the existence of AIDS in our midst, and Jewish families who do suffer from AIDS continue to hide from their community. Clearly, this illness has revealed a deficiency in our own community's immune system: that we are not so immune to prejudice, that we are not so immune to the general human propensity for blinding our eyes to hurtful truth, that we are

not so immune to the very process of stigmatization by which we as Jews have been shunned and persecuted and massacred.

This is precisely why the AIDS Commission was established and why this publication is widely distributed to various segments of our religious community. It is our purpose to sensitize our constituents, to spur them to speak out against the hatred attached to the AIDS crisis, against the scapegoating of those who are suffering most acutely.

We must begin this process by refining our sense of compassion. But we must go beyond compassion and come to identify ourselves with those who suffer AIDS. We must remember that we <u>all</u> are family, that people with AIDS and their friends and their relatives and their lovers are our sons, our sisters, our neighbors, our fellow Jews.

Alexander M. Schindler

Agnes G. Herman

1537 El Paseo Dr., Lake San Marcos, CA 92069
(619) 744-6878

April 20, 1992

Rabbi Alexander Schindler, President
UAHC
838 Fifth Avenue
New York, NY 10021

Dear Alex,

It was good to see you and Rhea at Temple Israel last month. In recent years we seem to cross paths periodically, never with an opportunity to say more than "Hello". Join us at NAORRR, and we'll show you the meaning of relaxation! But I am not writing to recruit you, YET!.

I am writing as the Editor of TIKVAH, the AIDS Committee Newsletter. Mike Rankin, Committee Chair, and I agree that a Commentary/Editorial from you would be motivation and support for our Congregations, members and rabbis alike, to increase their efforts (and, for some, to begin theirs) on behalf of people with AIDS.

Our AIDS Committee works toward this end and many of our Congregations do cooperate. On the other hand, too many act as if their members are immune or as if AIDS education is not the responsibility of a Temple.

Please help us, Alex, to spread the word. I am talking about three hundred (300) words. My deadline for the Summer issue is June 15. It will be a personal pleasure to receive your affirmative response.

For your information, I am seeking a commentary from Mel Meriams, as well. Mike and I feel that the support of both of our leaders will be wonderfully meaningful to TIKVAH readers.

Erwin joins me in sending warm regards to you and Rhea.

Cordially,

MEMORANDUM

COPY

April 24, 1991

FROM: Rabbi Alexander M. Schindler

TO: Rabbi Alan D. Bregman, Rabbi Howard Bogot

I believe the enclosed letter is self explanatory. Will you please make certain that any further editions of this manual be corrected. We simply cannot give misinformation to our youngsters.

TELECOPIER COVER LETTER
FAX

OFFICE FOR CHURCH IN SOCIETY
UNITED CHURCH OF CHRIST
110 Maryland Avenue, NE
Washington, DC 20002

Telephone: (202) 543-1517

Fax # (24 hours): (202) 543-5994

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PLEASE DELIVER THE FOLLOWING PAGES TO:

NAME Mr MILLER

COMPANY Union of American Hebrew Congregations

FAX TELEPHONE # 212-570-0825

FROM:

Name KT South Account AWIU

Total number of pages 3 including this cover page.

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IF YOU DO NOT RECEIVE ALL THE PAGES AS SHOWN ABOVE, PLEASE CONTACT OUR OFFICE AS QUICKLY AS POSSIBLE.

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SIGN-ON Letter for Heads of Religious Organizations. The following letter will be sent to the Congress. If your religious organization can agree to this letter please call Rev.Ken South, Office of Church in Society, United Church of Christ (202) 543-1517 by Friday, July 6th by 12:00 Noon. Please also send the signature of your "CEO" via Fax: (202) 543-5994. Thank You.

July 10, 1990

An Open Letter to the Congress of the United States:

We, the spiritual leaders of several of America's largest religious bodies, are united in our deep concerned that the Congress is stalling the passage of the conference report on the American's with Disabilities Act (ADA). We understand the delay is over the controversy surrounding the "AIDS/food handler" amendment, sponsored by Representative Jim Chapman.

We urge you to vote against any "motion to re-commit" on the basis of the Chapman amendment and help thereby preserve the integrity of the ADA, the trust of the American people, and ensure the civil liberties of all disabled Americans, especially those with AIDS.

The ADA marks a turning point in America by accepting that irrational discrimination against disabled citizens must be stopped. The religious community has been extremely active in advocacy of the ADA because it saw that America was willing to correct injustices brought about by fears and prejudices concerning the disabled by legislating civil protections in employment, transportation, public accommodations and telecommunications. With the passage of the ADA we are saying as a nation that it is not only unfair, unjust and unethical to discriminate against someone solely on the basis of their particular disability, it is now, finally, illegal.

All of this progress however, will be tainted, if not reversed, if the Congress votes to re-commit the conference committee report on the ADA and thereby include the Chapman amendment.

The core of this amendment, plays to the undocumented fears of the American public that AIDS can somehow be transmitted by food. This cuts at the very core of the spirit and intent of the ADA to eliminate such myths and fears. The proponents of this amendment have clearly acknowledged that their premise is false, and yet they want to codify such fiction. We find this totally unacceptable and contrary to all that we stand for as institutions based on the sovereignty of a loving God and the dignity we deserve from each other as humans beings.

As leaders ourselves, we admit that we feel a special responsibility of trust has been placed upon us to lead our various religious associations seeking the truth in all we say and do. The same is true of the members of Congress. The American people endow the federal government with a public trust to lead in good faith and truth. We look to Congress not just to lead, but to lead justly. We believe the acceptance of this amendment will betray this sacred trust.

THOSE WHO SIGNED THE October 12, 1989 Letter on ADA to the House of Representatives and invited to sign this Heads of Religous Organizations letter.

Thank you for your consideration of this important issue.

Sincerely,

Dr. Daniel E. Weiss
General Secretary
American Baptist Churches, USA

James A. Hamilton
General Secretary
National Council of Churches

Dr. John O. Humbert
General Minister and President
Christian Church (Disciples of Christ)

The Reverend Jame E. Andrews
Stated Clerk of the General Assembly
Presbyterian Church (U.S.A.)

Dr. Donald E. Miller
General Secretary
Church of the Brethren

Rabbi Irwin M. Blank
Past President
Synagogue Council of America

Dr. Claire Randall
President
Church Women United

Rabbi Alexander Schindler
President
Union of American Hebrew Congregations

The Most Reverend Edmond L. Browning
Presiding Bishop
The Episcopal Church

Dr. William F. Schultz
President
Unitarian Universalist Association

The Reverend Dr. Herbert W. Chilstrom
Bishop
Evangelical Lutheran Church in America

Dr. Avery D. Post
President
United Church of Christ

Edward F. Snyder
Executive Secretary
Friends Committee on National Legislation

Bishop Robert C. Morgan
President
General Board of Church and Society
The United Methodist Church

HOMOSEXUALITY AND THE RABBINATE

Papers Delivered at the 100th Convention of the
Central Conference of American Rabbis
June 1989

Selig Salkowitz, Introduction
Yoel H. Kahn, The *Kedusha* of Homosexual Relationships
Leonard S. Kravitz, Address

HOMOSEXUALITY AND THE RABBINATE

INTRODUCTION

SELIG SALKOWITZ

Some weeks ago I was discussing this presentation with a rabbinic friend, and I was telling him about the process that the Committee on Homosexuality and the Rabbinate had gone through. It was often a painful process during these past three years. I told him of the many draft resolutions we had attempted, and of the one we presented to the CCAR Executive Board last year — one which, at first, had the unanimous agreement of the committee, and then, on second consideration, parts of which were found unacceptable by a number of our members. After lengthy discussion it was sent back to committee by the Executive Board. The Executive Board was appreciative of the committee's attempts, but determined that the report presented more problems than solutions.

My friend reminded me of a story — supposedly true — about Thomas A. Edison and his attempts to invent the storage battery. Edison, we are told, went through more than 50,000 experiments before he produced a functional storage battery. He was asked how he had overcome those thousands of failures and found the courage and will to continue. He replied that he did not consider all those unsuccessful attempts failures, but rather successes. "Each one taught me," he is reported as saying, "what *didn't* work, and I proceeded from there."

I believe that this is a thoughtful description of the work of our committee over these past three years. In my cover letter which you received with the background papers prepared by four of our colleagues at the invitation of the committee (papers that are scholarly and thought-encouraging), I described some of the process that the committee had gone through — from its initial creation in response to a resolution submitted by two of our colleagues, through the unanimous decision that a resolution and vote was *not* the solution to the task presented to us, and finally to a process of study and consciousness raising.

That decision was reached after we had studied the many disciplines relating to our subject. We read in the fields of medicine, psychology, law, and biology. We considered current policy decisions by Jewish and Christian groups. We reviewed traditional and contemporary Jewish scholarship and interpretation.

The initial process of argument and defense developed into mutual understanding and respect for differing approaches and conclusions and for the sincerity of those who hold them. But no unanimity or even overwhelming consensus could be attained.

Permit me to share with you the significant areas of unresolvable disagreement among the committee members. These will help you to understand our considered judgment that this is not a time for parliamentary resolutions but

for sensitive and considered study. It is a time for discussion of the sources and their implications for the Reform movement as a Jewish religious community in the United States, and for its influence on Reform Jewry.

A primary area of disagreement is the *nature* of homosexuality. Is it a genetic condition over which the individual has no control, or is it a learned expression of sexuality and therefore a matter of personal choice? The literature, other than the traditional Jewish sources, is divided. Scholarship and integrity demand our awareness to this fact. Selective quotations can support either position, but that is not helpful in attempting to arrive at an objective conclusion. Some see homosexuality and heterosexuality as equal alternative life styles; others hold that heterosexuality is the ideal and homosexuality is not.

A second area of unresolved disagreement concerned the manner in which to interpret the halachic material available to us. Some hold that over time the Halacha has been accepted and rejected, modified, loosely and strictly interpreted by Reform scholars and this Conference, and therefore should not be a significant resource in our deliberations and decisions. Others hold that our interpretation of Halacha has indeed been modified — it has been both loosely and strictly understood — but that was in matters in which there were disagreeing positions held by different rabbinic sources and authorities. In our case there is *no* disagreement in the rabbinic positions anywhere in the tradition. Therefore, it is argued, the weight of tradition is stronger and needs to be considered in that context.

A third, very painful, area of disagreement was the *effect* a resolution could have on our gay and lesbian colleagues. A supportive resolution might encourage colleagues who have concealed their homosexuality to express it more openly, relying on the support of the Conference.

Committee members argued that the freedom of homosexuals to express themselves and their sexuality as openly as heterosexual colleagues would ease the pain of isolation and secretive love relationships, and the fear of discovery. Others held that our Conference — no matter how supportive a resolution it passed — could not ensure the positive response of congregation and community and the certainty that positions would not be lost and careers endangered. Others held that such a position was paternalistic and inappropriate. Still others maintained that such a concern was appropriate and collegial.

There was further discussion of the effect of *any* statement on congregational selection committees. Would it have them asking questions they do not now ask? What would be the effect on those choosing not to discuss their sexual lives? What might it do to the entire interviewing process?

Perhaps you can now appreciate better the difficult and necessary wrestling that went on within the committee.

A position on homosexuality would need to address the matter of the sanctity of homosexual marriages. Some argued that such a relationship could not be considered *kiddushin*, while others held that there was no reason it could not be. We could not even seek the asylum of civil law, since civil law does not address itself to the sanctity of marriage, only its legality. To the best of our knowledge, no state legalizes homosexual marriages. If rabbis officiate at them as religious ceremonies, would this be in conflict with the law?

We struggled with the question of the reaction of *Kelal Yisrael* — what would the effects be? How would *amcha* — the Reform community — respond? Would a supportive resolution be seen as a further wedge between Reform and non-Reform Judaism? Again, some held that this should not be an issue. Others maintained that we should be concerned about the total Jewish community and not become a schism outside the mainstream of American Jewry. The effect on MaRaM and the Israeli Reform community were similarly debated.

Good colleagues, after three years of arduous, intensive, and sincere study and debate, your committee recognizes that what is needed is *not* a resolution which at best would be a pyrrhic victory to whatever group might narrowly achieve a parliamentary majority. We would serve ourselves, our movement, and the Jewish community best by entering into, and encouraging among our congregational bodies, programs of study and heightened awareness of the available sources, resources, and disciplines. Some congregations have begun the process with positive results. It should be our goal to seek understanding, not coercion; reason, not emotion; unity within diversity.

To begin the implementation of this process, this morning you will hear two presentations. Each speaker has been asked to address two questions: (1) Since Judaism teaches, and Reform Judaism has affirmed, that monogamous heterosexual marriage is the ideal relationship for sanctification and sexual expression, is it Judaically possible to grant spiritual value to monogamous homosexual relationships? (2) How do you react to the claim that sexual orientation is not chosen; and how does your conclusion affect your position on question one?

We know each speaker will interpret them from differing approaches to tradition. That is the purpose. We will then adjourn into smaller groups to discuss the general theses and to consider some real scenarios which will require your thought and your willingness to respond to them in your rabbinate. Recorders will take notes of the points raised. The committee plans to meet following this convention and before the Seattle convention and to take your responses into account. It is hoped that together with the other institutions of Reform Judaism we will develop a program of education in its broadest sense which will elicit your support and cooperation.

Our speakers are Yoel H. Kahn, Rabbi of Shaar Zahav Congregation in San Francisco, and Leonard S. Kravitz, Professor of Midrash and Homiletics at the New York School of our seminary.

May I be permitted two personal comments. First, I sincerely hope that the process suggested by the committee will be encouraged and implemented. I hope that the members of our Conference will allow adequate time for the process to develop and that no resolutions be presented for a few years. I believe that members of the Conference need, as the committee needed, time for thought, introspection, and interaction in CCAR *Kallot*, UAHC regional meetings, and congregational programs. Second, I publicly thank and praise the members of our committee. You have worked diligently, thoughtfully, and unsparingly on a sensitive and provocative subject. You have been open, considerate, and accepting during the give and take of the discussion. You have supported and encouraged me, and joined together to reach this day.

THE *KEDUSHA* OF HOMOSEXUAL RELATIONSHIPS

YOEL H. KAHN

I am deeply honored by this opportunity to address our Conference and am appreciative of the special efforts some of you made in order to be here this morning. Today is a most appropriate date for our consideration of Judaism and homosexuality. This convention commemorates the 100th anniversary of the founding of our Conference. This year — in fact, yesterday — also marked the 20th anniversary of the modern gay and lesbian liberation movement in this country. Tens and hundreds of thousands marched in cities throughout the country in Freedom Day parades. The congregation I serve, and other members of the World Congress of Gay and Lesbian Jewish Organizations, observed this weekend as Shabbat Freedom.

My linkage of these two anniversaries may seem inappropriate. But the proximity of their observance can remind us of the common heritage of liberal Judaism and the contemporary struggle for gay and lesbian rights. The pioneering Jewish model of a minority battling for — and securing — civil rights, and then going on to full social and political integration as a distinct community within the general culture has been an inspiration to many others. Today, gay and lesbian people seek recognition of their humanity and equality, in both the civic and religious realms. To that end, in 1983 the CCAR Committee on Justice and Peace called for our "individual and collective involvement in achieving political, social and religious freedom [for all], regardless of sexual orientation."[1] As we consider the pleas of the gay and lesbian Jews among us, let us remember those of the Jewish people as a whole in years gone by.[2]

The status of the homosexual in the Jewish community in general, and the rabbinate in particular, is the topic of my paper which you have already received.[3] I will limit my remarks this morning, at the request of our committee's chair, to what is essentially a prior question: Can we affirm the place of the homosexual Jew in the synagogue and among the Jewish people? Specifically, if the goal of Jewish life is to live in *kedusha*, can we sanctify and bless homosexual relationships without compromising the integrity of our tradition? If we wish to bless these relationships, can we reconcile this new stand with the historical Jewish teaching in favor of heterosexual, procreative marriage as the normative and ideal form of Jewish family life? This morning, we will examine this question in relation to God, Torah, and Israel.

God

I begin with the most fundamental, yet unanswerable, question: What does God want of us? As a liberal Jew, I am usually reluctant to assert that I know precisely what "God wants." For me to begin by stating that "God calls us to affirm the sanctity of homosexual relationships" (a statement I believe to be true) would be to assert a privileged claim as little open to dispute as the counter-assertion by Rabbi David Bleich that these relationships today remain "*to-eiva*."[4] How would one respond to such an argument?

Thus, although our assertion of what God wants properly begins our debate, in fact it cannot. Our conclusions about God's expectations of us in a particular matter develop against the background of our unfolding, wider understanding of what God summons us to do — rooted in what we know about God and God's nature. In the foreground is all that we have learned from the scientific disciplines, from universal ethics, from Jewish tradition, and from our own prayerful conscience. It is when they touch, where the background of what we have already learned of God's expectations of us and God's nature meets foreground of knowledge, prayer, and conscientious reflection about a subject that we may discern God's will.

My teacher Eugene Borowitz writes that he does not hear a clear message from God about homosexuality, as he has in other areas.[5] I differ with Rabbi Borowitz. I believe that we can hear and affirm what God expects of us in this matter. My understanding of what God wants emerges from the background of God's justice and compassion, and is shaped in the foreground by religious interpretation of the insights of modern science. It is this foreground that has changed in recent years and leads me to dissent from the teachings of our received tradition.

The overwhelming consensus of modern science — in every discipline — is that homosexual relations are as "natural" to us as heterosexuality is. Now, to call something "natural" is a descriptive act; what occurs in nature is not inherently good or bad. Assigning of meaning is a religious act. I, along, with many others, have come to recognize sexual orientation as a primary, deep part of the human personality, inseparably bound up with the self. Science does not know what creates homosexual attraction in some people, heterosexual attraction in others; yet today we recognize that some people can only be fulfilled in relationships with people of the same sex. What do we say to them? What does God expect of them and of us?

I do not believe that God creates in vain. Deep, heartfelt yearning for companionship and intimacy is not an abomination before God. God does not want us to send the gays and lesbians among us into exile — either cut off from the Jewish community or into internal exile, living a lie for a lifetime. I believe that the time has come; I believe that God summons us to affirm the proper and rightful place of the homosexual Jew — and her or his family — in the synagogue and among the Jewish people.

I cannot prove my claim that homosexuality and the homosexual are an organic part of the divine plan unfolding in nature. I am making a religious faith statement that, like all such statements, requires a leap of faith before its assent, but one that is not inconsistent with all that we have learned of the meaning of faith in Judaism. My leap of faith, though, begins on solid ground.[6] The premises on which it rests meet the scientific criteria for a probable hypothesis of most simply and elegantly explaining the facts; and it is consistent with what we learn from our extra-Judaic sources of scientific knowledge. These are the publicly verifiable warrants for my private religious intuition: God does not create in vain. And if God does not create in vain but with purpose, we thwart God's purpose when we turn away from the homosexual Jews who turn to us. I believe, therefore, that God does not want us to discriminate against homosexuals; that lesbian and gay people are cre-

ated and live *betselem Elohim*. And I do believe that homosexual relationships contribute to, and do not diminish, God's *kedusha*. Our responsibility as Jews is to find a route to the expression of full covenantal fulfillment and responsibility for the homosexual Jew.

The Jew meets God in Torah, and it is to a consideration of *kedusha* in the light of Torah that we now turn.

Torah

When we confront the text honestly, we face a twofold challenge: first, we must dissent from an explicit biblical injunction that has been in force until modern times. Now, dissenting from Leviticus has not been an obstacle for us before; Reform Judaism has long abandoned the biblical and rabbinic proscriptions in the area of ritual purity in marriage.[7] Robert Kirschner, in his paper which you received, argues convincingly that the biblical and rabbinic injunctions forbidding male homosexual acts are no longer applicable to the situation of homosexuals today.[8] It is important for us to realize that the biblical authors proscribed particular sexual acts, the motivation for which they could only understand as sinful.

We begin from an entirely different perspective than our ancestors did. If we grant that homosexual acts are not inherently sinful, then can a homosexual relationship be sanctified? When two Jews, graduates of our schools, alumni of our camps and youth movements, members of our synagogues, promise to establish a Jewish home, pledge to live together in faithfulness and integrity, and ask for God's blessing and our own on their union, is this *toeiva* or is it *kedusha*?

Do we look at this committed and loving couple from an I-It perspective, which sees a particular act and condemns it, or with I-Thou understanding, which affirms the propriety of sexual intimacy in the context of holistic and enduring relationship? Let me be clear: I do not propose merely that we politely overlook the historical Jewish teaching condemning homosexual behavior, but that we explicitly affirm its opposite: the movement from *toeiva* to *kedusha*. This transformation in our Jewish standard, from a specific act to the evaluation of the context in which acts occur, seems to me entirely consistent with Reform Jewish thought and practice.

Many are prepared to affirm that for some Jews, homosexuality is the proper expression of the human need for intimacy and fulfillment. Still, I know that some are reluctant to endorse *kiddushin* for same sex couples because these relationships apparently disregard the historical and continuing Jewish preference for what Eugene Borowitz and others have called "the procreative family."[9] How can we grant Jewish sanctity, they ask, to a form of family which by its essence precludes procreation, a primary purpose of *kiddushin?*

My reply has three parts. First, we cannot hold homosexual families to a higher standard than we do heterosexual ones. We do not require proof of fertility or even an intention to become parents before we are willing to marry a heterosexual couple. Is the homosexual couple who uses adoption,

artificial insemination, or other means to fulfill the Jewish responsibility to parent so different from the heterosexual family who does the same?

Second, does *kiddushin* require procreation? While Judaism has always had a preference for procreative marriage, our tradition has also validated the possibility that some unions will not produce children. Halacha states that a woman who does not bear children after ten years can be divorced by her husband.[10] But the evidence that this law was reluctantly or negligibly enforced is precisely the type of historical example Reform responsa often cite to support the explicit expansion of a value we find implicit in our historical tradition. The Jewish tradition has never insisted that the sole purpose of sexual expression is procreation, as evidenced by the numerous rabbinic discussions on the mitzvah of sexual intimacy and pleasure.[11]

Third, the situation of the gay and lesbian Jews among us points out the need for new categories in our thinking. Reform Judaism is committed to affirming the responsibility of the individual. Can we not teach that a heterosexual relationship is the proper form of *kedusha* for many and a homosexual relationship may be a proper form for others? Can we not create a plurality of expressions of covenantal responsibility and fulfillment, and teach that different Jews will properly fulfill their Jewish communal and religious responsibilities in different ways?[12]

Finally, I would like to introduce into this discussion of Torah a text different from those that have shaped our debate so far. Mine is a classic Jewish text, the record of a uniquely Jewish form of revelation — the text of our history. The history of our people, writ large, has been a continuing source of revelation. For our own generation, the recollection of events that we witnessed has assumed the force of Torah, and makes demands upon us as a people and as individual Jews. But our history is not only writ large; history is also written in the small, daily events of our lives. I come then today bearing not only the scrolls of our sacred texts, halachic and aggadic, but also another scroll — the scroll of our people's history. And it, too, makes claims upon me.

When I arrived to assume my pulpit in San Francisco four years ago, deep down I still believed that gay and lesbian relationships and families, were, somehow, not as real, not as stable, not as committed as heterosexual marriages. I could tell many stories of what I have learned since. There are the two women who have lived together for many years without familial or communal support, who have endured long distances and job transfers because employers thought them both single, and admitting their homosexuality would have endangered their livelihoods; women who have cared for each other without benefit of insurance coverage or health benefits or any legal protection. They came to me one Friday night and simply asked: "Rabbi, this is our 25th anniversary, will you say a blessing?"

Mine is a synagogue living with AIDS. I have been humbled by the unquestioning devotion of the man who, for more than two years, went to work each morning, calling intermittently throughout the day to check in on his partner, and spent each night comforting, talking, preparing meals, and waking in the middle of the night to carry his loved one to the bathroom. Who would have imagined, when they first chatted 12 years earlier, that their

life together would take this path? The loving caregiver stayed at his partner's side throughout the period of his illness and until his death.

These many lives have taught me about the possibility of enduring loyalty, the meaning of commitment, and the discovery of reservoirs of strength in the face of unimaginable pain and suffering. If the Covenant people are summoned to be God-like, then these Jews live their lives *betselem Elohim* and these relationships are surely of true covenantal worth. *Kiddushin* is, in Eugene Borowitz's words, "Judaism's preferred condition in which to work out one's destiny. ... Because it is a unique fusion of love and demand, of understanding and judgment, of personal giving and receiving, nothing else can teach us so well the meaning of covenant." If "[i]t is the situation where we are most thoroughly challenged to be a Jew and where ... we may personally exemplify what it means to be allied with God in holiness," then the Torah scroll of lived history records the *kedusha* of these relationships.[13]

Israel

I would like to conclude with a word about *kiddushin* and the Jewish people. I have been repeatedly asked: If we elevate homosexual families to an equal status with heterosexual families, will we not undermine the already precarious place of the traditional family? I do not believe that encouraging commitment, stability, and openness undermines the institution of family — it enhances it. At present, many gay and lesbian Jews are estranged from the synagogue, the Jewish community, and their families of origin because of continued fear, stigma, and oppression. Welcoming gay and lesbian families into the synagogue will strengthen all our families, by bringing the exiles home and by reuniting children, parents, and siblings who have been forced to keep their partners and innermost lives hidden. *Kelal Yisrael* is strengthened when we affirm that there can be more than one way to participate in the Covenant.

I speak to you today on behalf of many Jews — members of our people, members of our congregations, members of our Conference — who are unable to speak themselves. They each seek, as best they are able, to establish a home that will be a *mikdash me-at*. The gay and lesbian Jews amongst us seek to live their lives in loyalty to the Covenant and as members of the Covenant people and its community. Turning to us, they offer themselves, their lives, and their sacred commitments as stones with which to build the *sanctuary of the House of Israel*.

NOTES

[1] "Statement of Purpose and Function, Report of the Committee on Justice and Peace," *Yearbook* XCIII (New York: CCAR, 1983).

[2] This comparison was first suggested by Sanford Ragins in "An Echo of the Pleas of Our Ancestors," *CCAR Journal* 20:3 (1973). Throughout European history "the fate of Jews and gay people has been almost identical" (John Boswell, *Christianity, Social Tolerance and Homosexuality* [Chicago: University of Chicago, 1980], p. 15). Although often unmentioned or ignored in Holocaust commemorations and studies, homosexuals in Nazi Germany were beaten in the streets, sent to camps, enslaved, and killed.

[3] Yoel H. Kahn, "Judaism and Homosexuality," in *Homosexuality, the Rabbinate, and Liberal Judaism: Papers Prepared for the Ad-Hoc Committee on Homosexuality and the Rabbinate* (New York: CCAR, 1989).

[4] J. David Bleich, *Judaism and Healing: Halakhic Perspectives* (New York: Ktav, 1981), p. 69.

[5] Eugene B. Borowitz, "On Homosexuality and the Rabbinate, a Covenantal Response," in *Homosexuality, the Rabbinate, and Liberal Judaism*, p. 2.

[6] See Milton Steinberg, "The Common Sense of Religious Faith," *Anatomy of Faith* (New York: Harcourt, Brace, 1960), pp. 80ff.

[7] E.g., *nidda* and *shefichat zera.*

[8] Robert Kirschner, "Halakhah and Homosexuality: A Reappraisal" *Judaism* 37:4 (Fall 1988), reprinted in *Homosexuality, the Rabbinate, and Liberal Judaism*, p. 2.

[9] Borowitz, *op. cit.*, p. 9

[10] Yevamot 64a; *Shulchan Aruch*, EH 154:6.

[11] See David Feldman, *Marital Relations, Birth Control and Abortion in Jewish Law* (New York: Schocken, 1968), chaps. 2, 4, 5 *passim*, esp. pp. 65-71, 103-105.

[12] Consider the Centenary Perspective's statement on *aliya:* "We encourage *aliyah* for those who wish to find maximum personal fulfillment in the cause of Zion." Eugene Borowitz, *Reform Judaism Today* (New York: Behrman House, 1978), p. xxiii.

[13] Eugene Borowitz, *Liberal Judaism* (New York: UAHC, 1984), pp. 448-449. This section ("Accepting the Single Jew") begins, "It will not do, however, to give the impression that one must be married to be a good Jew."

ADDRESS

LEONARD S. KRAVITZ

To speak of "homosexual marriages," to seek to apply the term *kiddushin* to same sex relationships is — to say the least and to use the most neutral terms — to stand at a cultural interface. It is more, of course: a matter of pain for some and a matter of profound discomfort for others. For some, *kiddushin*, as word and symbol, is a stamp of acceptance for behaviors which to others cannot be accepted. For each side of the interface, *kiddushin* is that which touches and hurts. That interface itself stands at the center of the arena in which we as Liberal or Reform Jews live and decide, an arena with the general culture on the one side and Jewish tradition on the other.

In truth, it is not the general culture as it is, but the general culture as we perceive it, as members of a particular cohort of college-educated middle class people. For that cohort sexual activity of whatever kind, at least among consenting adults, is a private matter. Being private, the only authority figures who may speak to it are those who deal with private concerns — the psychologist, the psychiatrist, and the sex therapist. If one of these worthies were to declare that a particular behavior is psychologically unhealthy, or psychiatrically problematical, or sexually dysfunctional (all internal private matters), then, perhaps, that behavior would be proscribed. If, on the other hand, a particular behavior were to be declared to be not unhealthy, then for some, it might be viewed as acceptable. Hence, when the American Psychiatric Association declared that homosexuality *per se* was no longer a pathology,[1] for many such behavior became licit and indeed acceptable.

Jewish tradition, on the other side of the arena, is not that which we follow blindly. We are, after all, Liberal or Reform. Yet we are Jews, and the Torah as a Book and a Tradition is our heritage, giving us our attitudes, our values, and our sense of self. By our study of it and our reflection on it, we have given the Torah a vote in our decision making, an *a priori* commitment in the way we live our lives. As Liberal Jews, we use the literature of the Jewish past as a means of guidance for the Jewish present and future.[2] Those who feel that they follow the tradition would hold that the term *kiddushin* could hardly be applied to behaviors proscribed by Torah texts.[3] Indeed, the notion of *homosexual marriage* is touched upon by the Midrash. We read that

> Rabbi Huna stated in the name of Rabbi Joseph: The generation of the flood was not blotted out from the world until they wrote wedding contracts (*gemomsiyot*) for males and animals.[4]

As might have been expected, there is no discussion of homosexual marriage in traditional sources. There have been two discussions in Reform Jewish sources. Our teacher Solomon Freehof has written that

> Homosexuality is deemed in Jewish Tradition to be a sin — not only in law, but in Jewish life practice ... [and] it is hardly worth mentioning that to officiate at a so-called "marriage" of two homosexuals and to describe their mode of life as "Kiddushin" (i.e., sacred in Judaism) is a contravention of all that is respected in Jewish life.[5]

Our colleague Walter Jacob, who, as chairman of the Responsa Committee has served as Dr. Freehof's successor as decisor in the Reform movement, has written that

> ... we cannot accommodate the relationship of two homosexuals as a "marriage" within the context of Judaism, for none of the elements of *qiddushin* normally associated with marriage can be invoked for this relationship. A rabbi cannot, therefore, participate in the "marriage" of two homosexuals.[6]

For those for whom texts are decisive, the Midrash and the responsa of Freehof and Jacob have said all that need be said.

For those for whom their perception of the general culture is decisive, to raise the issue of *kiddushin* for homosexuals is to follow the trajectory of change that has occurred with regard to the view of homosexuality itself within some sectors of the liberal Jewish community. By incremental steps, each containing its own logic, homosexuality and all that could be associated with it, became acceptable. The Jewish past viewed homosexuality as a sin and hence proscribed it. Some in the Jewish present would make changes. At first, homosexuality ceased being a sin; it became a disease. As a disease, there could be no penalties or disabilities. How could you punish a disease? If it were a matter of *ones* and not *ratson*, of compulsion and not volition, how could there be discrimination against those compelled to be homosexuals?[7] Then it became a matter of life style, to be "understood" but not accepted[8]; then as something to be accepted but as some kind of disability; then to be accepted as something given in nature, equivalent in its own terms as heterosexuality is accepted in its own terms.[9] Following the logic of such develop-

ment, the UAHC has passed a resolution calling upon full civil rights for homosexuals in the civic sphere, and some members of the CCAR made proposals to the CCAR for full acceptance of homosexuals even in leadership roles in the Jewish religious sphere.[10] Beyond that, the HUC-JIR has decided that homosexuality *per se* is no longer grounds for non-acceptance into the rabbinic program. That decision has been described by Eugene Borowitz as "passive acceptance."[11] With all these changes, some would argue: Why should there not be marriage forms for homosexual couples, and, indeed, why should not the traditional term *kiddushin* be applied?

In truth, both sides of the interface make selections; both are not totally consistent. Those who, from their perception of the general culture and the modern world, argue the case of the homosexual, would not, I think, argue that the other sexual behaviors described and proscribed in Leviticus 18 and 20 (such as incest, bestiality, and adultery) are now acceptable. I would hope that as Liberal Jews and as rabbis, we are not *wertfrei* in the sexual realm! On the other side, those of us who hold a more traditional view would hardly go along with the draconian punishments described in the Torah text or indeed any punishment. We, too, hold in many ways that illicit sexual behavior is a private matter, we would hope amenable to persuasion, but nothing more.

Gufa! The question stands: Why not? Why am I opposed to marriage ceremonies for homosexual couples? I should think it fair to give my own assumptions of this discussion. Whether or not homosexuality is natural is to me irrelevant. All behaviors, including all sexual behaviors, are natural in that they statistically occur in nature. People — alas, or perhaps hurray — do everything. That which is natural is not necessarily that which should be done. Indeed, I would hold that all of human culture is the attempt to transcend that which is natural. What is natural is not necessarily Jewish.[12] Indeed, it might be argued that that which is natural is that which is universal, touching all persons as persons. As a Jew, I am involved with the particular. As a Liberal Jew, I am also involved with the universal as it casts light upon the Jewish particular, but the particular makes me what I am as a Jew and as a rabbi. As a modern Jew and as a Reform rabbi, I listen to the universal, but as a Jew and as a rabbi I listen to what others might call "the voice of Sinai" and I would call "the voice of the Jewish past." My world is formed by the books that have created the Jewish ethos; my time is spent reading and teaching those books; my associations are with other Jews who read those books and attempt — in their way, as I attempt in mine — to live by them. Thus the Jewish past and the Jewish present speak to me.

My view of homosexuality is in part formed by Jewish books, the Jewish past; it is formed in part by other Jews, both within and without our movement, the Jewish present. As I read the record of that past, homosexuality is not acceptable behavior; as for the present: as I interact with other Jews, I hear the message that it is not acceptable behavior. Now, it is often argued that there are other things, such as women rabbis and patrilineality, that are not acceptable to some in the Jewish present. For them I can use the Jewish past to give analogues so as to argue for change. I can say, "You don't like women rabbis? What do you do with women prophets like Miriam and Deborah? You don't like patrilineality? What do you do with Menasseh and

Ephraim with whom you bless your sons? They were the sons of Yosef haTzaddik and Osnat bat Potiphera Kohen On! What do you do with the sons of Mosheh Rabbenu and Tziporah bat Yitro Kohen Midyan?" (Translate that into Yiddish, you begin to cry: both Yosef haTzaddik and Mosheh Rabbenu *hat gehayrat mit a galach's atochter*!) With homosexuality, I can give no analogues; indeed, the past provides counter arguments!

But what if homosexuality were something given, something so grounded in personality that it could not be changed? Would that make a difference? We are at another interface: of nature and nurture, of genetics and environment, of determinism and free will. Here I make another assumption, based on my reading of history and my understanding of psychology,[13] that homosexuality is not as locked-in behavior as some would hold. There have been some cultures, e.g., Classic Greece, where such behaviors have been more prevalent and other cultures where they have not.[14] There are situations, such as in prisons, where those who are generally heterosexual may act in a homosexual manner. As I read the past and the present, admittedly in a particular way, I have come to the conclusion that homosexuality in terms of homosexual acts manifests a kind of bell curve phenomenon: at the one end are those who never under any circumstance would act in a homosexual manner; and at the other end there are those who under all circumstances would; and there is the vast majority of people who, depending on circumstances, might.

For me, circumstances are the issue. If the relationship between two homosexuals is granted the status of *kiddushin*, a public matter, we are changing the circumstances, so that those who previously might not have acted in a homosexual manner, now might. Since, as a consequence of my reading of the Jewish past, I do not accept such behavior, I therefore would wish that those who are not involved with homosexual behavior continue not to be involved.

If I have a difficulty in adjudicating the claims of nature and nurture, of compulsion as opposed to volition with regard to sexual behavior, I am in good company. Maimonides, it will be remembered, observed in the *Guide* that

> one whose testicles have a hot and humid temperament ... in whom the seminal vessels abundantly generate semen ... it is unlikely that such a man, even if he subject his soul to the most severe training, should be chaste.[15]

Nonetheless, in the *Code*, Maimonides spoke of the need of self-control,[16] indicated sanctions,[17] and gave the refraining from an illicit sexual liaison as the very model of repentance. (You remember the case: the same woman, same town, same desire. If you don't, that is true repentance ...[18])

Kiddushin is a public act. It is a declaration that a particular sexual behavior is Jewishly acceptable. At a time when there is no unanimity in the general culture that homosexual behavior is acceptable; when there have been important voices in the Reform Jewish community[19] saying that it is not; when there are many voices in the general Jewish community saying that it is not[20] — it would be a mistake for the Central Conference to create any form of sanctification for homosexual relationships or to apply the term *kiddushin* to such relationships.

NOTES

[1] I do not enter into the question of the political nature of the decision nor the absolute number of psychiatrists who voted for this position against the total number of psychiatrists.

[2] All four papers in *Homosexuality, the Rabbinate, and Liberal Judaism: Papers Prepared for the Ad-Hoc Committee on Homosexuality and the Rabbinate* (New York: CCAR, 1989) implicitly or explicitly make the claim that they follow some aspect of the Jewish past.

[3] Leviticus 18:23, 20:13. What might be asked of all participants in the discussion is which of the other sexual behaviors proscribed in the two chapters of Leviticus they would be willing to see allowed and which proscribed.

[4] B.R. 26:9, Lev. R. 23:9, MHG Noah 6:11.

[5] Solomon Freehof, "Judaism and Homosexuality," CCAR *Yearbook*, vol. 83, 1973, pp. 115-119, reprinted in *American Reform Responsa*, Collected Responsa of the Central Conference of American Rabbis (New York, 1983), pp. 51, 52. This responsum is also quoted in the most complete listing by Yoel H. Kahn.

[6] Walter Jacob, "Responsum on Marriage," quoted in Yoel H. Kahn, "Judaism and Homosexuality," in *Homosexuality, the Rabbinate, and Liberal Judaism*, p. 20.

[7] One can think of the evolution of the thinking of Hershel Matt in this regard (cf. citations given by Kahn, p. 7 of his paper).

[8] Cf. the view of the Rabbinical Assembly which Kahn gives (p. 14 of his paper).

[9] Note Kahn's summary of the views of John Boswell, *Homosexuality, Christianity, and Social Tolerance* (p. 15 of his paper).

[10] Yoel H. Kahn, "Judaism and Homosexuality," in *Homosexuality, the Rabbinate, and Liberal Judaism*, p. 10. We are beholden to Rabbi Kahn for his most comprehensive presentation of relevant material. We should note that this suggestion flies in the face of the Responsum "Homosexuals in Leadership Positions," CCAR *Yearbook*, vol. 91 (1981), pp. 67-69, reprinted in Walter Jacob, editor, *American Reform Responsa* (New York: CCAR, 1983), pp. 52-54.

[11] "Addendum: A correction to 'On Homosexuality and the Rabbinate'" by Eugene Borowitz, in *Homosexuality, the Rabbinate, and Liberal Judaism.*

[12] Cf. the discussion of circumcision in the Midrash, B.R. 11:7 and B.R. 46:2.

[13] My reading of the statement of Mortimer Ostoff as expressed in a letter to *Conservative Judaism* 40:1, pp. 103-106, cited in Kahn, p. 25, and in my private conversation with him.

[14] There is the claim by Lamm that "the very scarcity of Halakhic (i.e. Jewish legal) deliberations on homosexuality, and the quite explicit insistence of the various halakhic authorities, provide sufficient evidence of the relative absence of this practice among Jews from ancient times down to the present," quoted in Kahn, p. 1. On the other hand, the discussion by Saadia's *Beliefs and Opinions*, Ideal Human Conduct, Chapter Six, suggests that, at least in one period, homosexuality was enough of a problem that a philosopher devoted part of his discussion to it.

[15] *Guide* I:34, p. 77.

[16] *Hilchot De-ot* 3:2, 3; 4:19.

[17] *Hilchot Ishut* I: 4, 5.

[18] *Hilchot Teshuva* II:1.

[19] Not only the aforementioned statements of Freehof and Jacob, but also the statements in the position papers of Eugene Borowitz and Peter S. Knobel in *Homosexuality, the Rabbinate, and Liberal Judaism.*

[20] Cf. the summary given by Kahn, pp. 1-5 in his paper.

AIDS National Interfaith Network

November 27, 1989

Rabbi Alexander Schindler
Union of American Hebrew Congregations
838 Fifth Avenue
New York, NY 10021

Dear Rabbi Alexander Schindler:

The press has been alerted to ANIN's upcoming consultation of national religious leaders to be held December 4, 1989 in Atlanta. We ask that you be available for interviews and to make public statements concerning the religious response to AIDS and the work of the AIDS National Interfaith Network (ANIN).

Ogilvy and Mather Public Relations has notified over 300 religion editors and secular news agencies, both print and broadcast media, of this event. The American Jewish Committee has sent a media advisory to close to 300 Jewish and Catholic contacts. The National Council of Churches Office of Communications has assisted in notifying the other Christian presses. We anticipate a good response on December 4 and also hope to gain exposure prior to the consultation.

The press has been instructed to contact me at ANIN's New York office if they are interested in contacting any of you directly for interviews or statements. Please let me know immediately if you do not wish to be contacted by the press for this purpose. You can call me at 212-870-2100.

I have enclosed some materials about ANIN to help familiarize you with our work or to refresh your memory. The background paper for the consultation and the "Consultation Statement Document" will highlight some of the issues raised by the religious communities' response to AIDS.

I hope that each of you will consent to speaking on behalf of those infected with HIV and on behalf of all of us affected by the social dimensions of this disease. You may also wish to write a letter to the

Ok — no objection to providing calls to come to office

Called 11/29 OK

New Address Effective August 1, 1989:

475 Riverside Drive, 10th Floor
New York, New York 10115
(212) 870-2100

t 17th Floor New York, NY 10001 (212) 239-8700

editor of your local newspaper or submit an "op-ed" piece using the enclosed materials as reference.

Please do not hesitate to contact me if I can be of further help.

Sincerely,

Susan Harlow

The Rev. Susan Harlow
Communications Coordinator

AIDS
NATIONAL
INTERFAITH
NETWORK

ANIN PROGRAM INITIATIVES

The aim of ANIN is to provide strong national leadership in AIDS/HIV ministry and to encourage and enhance local and regional interfaith ministries of education, service provision and public policy advocacy. Efforts underway include the following:

1. Religious leadership training and referral:

   ANIN maintains a computerized listing of close to 10,000 individuals engaged in AIDS ministry across the country affiliated with congregations/synagogues, AIDS service providers, hospitals, hospices, prisons, colleges and universities, and counseling services. ANIN also relates to two hundred and fifty community-based AIDS interfaith ministries and national AIDS ministries. Utilizing this nation-wide network of individuals and organizations, referral services are available to persons with AIDS/HIV and their families and friends for spiritual, emotional, educational, and non-medical assistance.

   ANIN is committed to insuring that quality pastoral care is available for all persons with AIDS/HIV and their loved ones. In cooperation with the Association for Clinical Pastoral Education, ANIN is developing regional AIDS Pastoral Education and Resource Centers in Chicago, New York, and San Francisco. These centers will provide intensive AIDS pastoral care training for clergy and lay persons, as well as resources for community-based AIDS ministries. Funding for this project is currently being sought.

2. Families and Friends AIDS Network:

   In May 1988, the Families and Friends AIDS Network (FFAN) was established by a national steering committee sponsored by ANIN. Through organizing skills-building conferences in key regions and urban areas, ANIN provides FFAN leadership training for the formation and sustenance of local support groups. Such groups combat isolation, fear, stigmatization, and misinformation, and enable healing among families and friends through the sharing of feelings and experiences and mutual care giving. FFAN is a vital component of ANIN's national, regional, and local organizing among people of faith. Working with national secular organizations, ANIN is establishing a national families and friends referral and education network to provide support for interpersonal needs, resources for congregational education, and public policy advocacy.

3. AIDS awareness/AIDS prevention education:

As increasing numbers of religiously-affiliated persons are affected by AIDS/HIV, there is a growing desire on the part of many religious leaders for better information and preventive action. ANIN, relating to local congregations and synagogues, national, regional, and local ANIN organizational members, national and regional religious judicatories, and lay organizations, facilitates effective, culturally-sensitive AIDS/HIV prevention education within a context of sexuality and comprehensive drug education. Drawing upon the experience of community-based interfaith AIDS service providers, ANIN will soon publish the first interfaith planning guide for AIDS ministries designed specifically for congregational use.

4. National religious leadership conference:

ANIN recognizes the critical importance of moral and spiritual leadership in directing community opinion and response. In December 1989, ANIN, the Carter Presidential Center, and Atlanta Interfaith AIDS Network will co-sponsor a consultation with national religious leaders entitled, "AIDS - The Moral Imperative: A Call to National Leadership." Selected national appointed and elected religious leaders are being invited to discuss a unified religious community response to the challenges posed by AIDS. The consultation will provide the first opportunity for these leaders to join with community-based AIDS ministers and secular AIDS experts in committing themselves to public advocacy for effective and humane responses to the AIDS/HIV pandemic.

5. Racial/ethnic community involvement:

With the rapid spread of the HIV epidemic in racial/ethnic communities, ANIN is taking direct action to assist clergy and lay leaders in these affected communities. Advisory committees are currently being established to address the nature and form of effective new initiatives for resourcing racial/ethnic community responses to AIDS. These committees will draw from leadership within the African American, Hispanic, Asian/Pacific Islander and Native American communities involved in religious and secular AIDS organizations.

6. Public Affairs and Governmental Relations Project:

Decisions made by the federal government greatly effect people with AIDS/HIV, their loved ones and care givers. In June 1989, ANIN established its Public Affairs and Governmental Relations Project and hired a Washington, D.C.

based public policy advocate. The advocate works with Congress and regulatory agencies to represent ANIN concerns.

ANIN works to assist in the development of humane and adequate leadership in two coalitional forums in Washington, D.C., the Washington Interreligious Staff Council (WISC) and National Organizations Responding to AIDS (NORA). Along with representing ANIN at these forums, the public policy advocate evaluates legislative proposals, develops strategies for ANIN advocacy, works directly with policy makers, delivers testimony and works with the media to influence public opinion on AIDS. The advocate also works with national and regional ANIN organizations to share information, to provide training and to help formulate pilot programs for state and local government advocacy efforts.

7. Resource development:

Through its quarterly newsletter Interaction, ANIN shares news of events, provides AIDS-related theological reflection, legislative information, models of congregational response and other topics relevant to the interfaith community's involvement with AIDS, as well as illuminates human dimensions of the AIDS crisis. ANIN is also developing a pamphlet series containing helpful information, guidance, referral and spiritual support for persons with AIDS/HIV, their families and friends. These resources, encompassing interfaith perspectives, will be distributed through local chaplaincy services, congregations, and AIDS service providers and reflect racial/ethnic diversity.

THE ATLANTA DECLARATION

"An Interfaith Call to Hope"

We come together as members of different faiths. Our traditions teach us different ways to embrace God. We represent humanity's wide range of ways to be human. Across our diversity, however, AIDS magnifies the fact that we are also one, bound together in relatedness.

Our religious vision proclaims that living with AIDS is a condition in which we must all participate actively. We seek hope amidst the moral and biological tragedies of this epidemic in order to pass on hope for generations to come.

The tragedy of the Human Immunodeficiency Virus epidemic has confronted each of us personally, each of our religious institutions, as well as the whole society with the need for a new understanding of the interconnectedness between physical disease and social responsibility. It calls for creative action among all our institutions -- medical, social, economic, political and religious -- for the purpose of providing systemic attention to the epidemic. The religious community in particular is faced with these extended responsibilities:

A. To embody and proclaim hope, life, and healing in the midst of suffering;

B. To assure that all whose lives are affected by the epidemic will have access to compassion, non-judgmental care, respect, support and assistance;

C. To provide accurate and comprehensive

information for the public regarding HIV transmission, related behavior patterns, and means of prevention;

D. To affect public attitudes and policies so that adequate care and appropriate preventative measures will be available for all people in need;

E. To generate a prophetic vision of society in which the "general welfare" becomes the abiding obligation of public, private and voluntary sectors of society.

Fulfilling these responsibilities will require of us new commitments as individuals, as religious bodies, and as a nation.

As Individuals:

Because we are friends and neighbors of persons with AIDS, we commit ourselves to personal ministries of care for those infected with and those affected by HIV;

Because we are members and leaders of religious institutions, we commit ourselves to the work of insuring that our institutions renew their calling to ministries of health and healing;

Because we are citizens of this nation, we commit ourselves to establishing public policies through which all citizens contribute to the care of all persons with AIDS and to the health and well-being of the nation as a whole.

As religious bodies:

Because the presence of HIV calls us to mutual cooperation, we commit ourselves to work within interfaith coalitions wherever and whenever feasible;

Because the needs in local communities are so great, we commit ourselves to promote and support local interfaith coalitions for education, provision of care, community service, public policy advocacy, and specialized training for professionals and laity in care and counseling;

Because our constituents and the public need accurate and comprehensive education, we commit ourselves to produce and promote culturally and linguistically appropriate HIV related educational materials -- audio, video, and printed -- in a context that promotes individual self-esteem, teaches the fundamental goodness of human sexuality, and supports the integrity of responsible and caring intimate relationships.

As citizens:

Because the President's Commission on HIV has issued a comprehensive, balanced, and informed report based upon the expertise of hundreds of America's best scientists, we call for immediate implementation of its recommendations.

Because HIV is a threat to the life and health of all people in the nation, we call upon President Bush to demonstrate moral and political leadership in assuring adequate care for all who are afflicted and responsible federal action to the ends of:

- protecting against HIV related discrimination

of all forms,

- o expanding of drug-treatment programs to include all who choose them,
- o placing highest priority on AIDS/HIV education and care programs within the Black and Hispanic communities
- o for all HIV infected persons:
  -eliminating of segregation and isolation in prisons as well as provision of humane and professional medical care,
  -assuring decent, appropriate and affordable housing for the homeless,
  -establishing comprehensive health care,
- o insuring expeditious approval by the Federal Drug Administration of AIDS/HIV treatments, expeditious experimental drug trials, easier access to promising AIDS/HIV treatments, and wider availability of new drugs to persons with AIDS/HIV,
- o expanding the availability of residential health care facilities, hospices and affordable home care for persons with AIDS/HIV,
- o encouraging the prudent use of HIV anti-body testing with the strictest of safeguards whether anonymous or confidential as used for medical evaluation,

epidemiological or prevention modalities,

- o advocating for the continuation of comprehensive prevention programs for drug users including the distribution of AIDS prevention information and materials including bleach for the sterilization of hypodermic needles,
- o supporting research to establish the effectiveness of needle exchange programs as an additional method of the prevention of infection among IV drug users.

As a people dedicated to a future of hope:

Because barriers among us based on race, class, gender and sexual orientation that continue to generate fear, persecution and violence are intensified by the HIV pandemic, we call upon all sectors of our society to adopt as highest priority the elimination of racism, classism, sexism, and homophobia.

Because America's businesses and industries must address the presence of AIDS, we call upon its leaders to endorse and implement the "Ten Principles for the Workplace," and we commit our institutions to adopting these principles,

Because the presence of AIDS/HIV creates special needs among different people, we call for all sectors of society to contribute to support for infected infants and children in need of foster care and adoption services; to support HIV infected women who suffer discrimination from many sources; for families who need community care.

Because economic disparity and the poverty it engenders is a major contributing factor in the AIDS epidemic, and a barrier to the accessibility to prevention and treatment, we call upon all sectors of society to seek ways of eliminating poverty in a commitment to a future of hope and security.

Finally, we commit ourselves to call for accountability on the part of this nation's public officials and corporate leaders. It is a time for envisioning a new society, one committed to the health and welfare of all people, and united in anticipation for that time when we will know that to care for today's afflicted is the only way to insure hope for tomorrow.

A CALL FOR COMMUNITIES OF HOPE
-- Background Paper --
"AIDS -- The Moral Imperative: A Call to National Leadership"
Consultation of Religious Leaders
December 4, 1989
The Carter Center of Emory University
Atlanta, Georgia

Introduction

Religious people in every civilization have attended to the sick and infirm. Like the earliest Christians who roamed the countryside teaching and healing, or medieval monks and nuns who cared for the ill whomever they might be, religious people draw upon our faith tradition to be of service. By so doing, we discover the truth of the Torah's teachings that pikuach nefesh -- the saving of life -- is the greatest good deed, that bikhor cholim -- visiting the sick -- brings us close to God as God drew close to Abraham.

Throughout the history of this nation, and particularly in the 19th century, religious bodies established hospitals, primarily for those unable to afford private medical care. Many of these hospitals have become primary care institutions in their communities. Religious bodies have also been active in establishing nursing homes, children's homes, settlement homes, hospices, foster care services, family education and counseling services, and facilities for food and shelter.

Our traditions, however, are by no means guarantors of righteous action. Scripture and dogma can wall off the recognition of our shared humanity and suffering, leading us to

choose blind faith rather than to cope with moral ambiguity. Our calling must be renewed in every generation.

Civilizations in today's world are threatened by the pandemic of HIV -- the human immunodeficiency virus. At a time in history when illness is assumed to be the exclusive province of the medical profession, societies are called upon to confront a disease for which no cure yet exists, and the treatment of which requires far more attention than medical science alone can offer. Religious people are called once again to their historic vocation of care.

AIDS Facts

These questions take on meaning when examined in light of the facts about AIDS. It is estimated that the human immunodeficiency virus (HIV) has already infected 1.5 million Americans. Over half will have progressed to the end stage of HIV infection, AIDS (acquired immune deficiency syndrome), within ten years of infection. By then, most of the rest will have begun to suffer some degree of progressive immunological damage. As of October 1989, 50,000 Americans had already died from AIDS. Federal health officials project that by the end of 1992, 365,000 Americans will have developed AIDS and 263,000 will have died. 80,000 new cases of AIDS will develop in that year alone.

In the earliest years of the epidemic, which was first reported in 1981, HIV infection seemed to be an acute stage of terminal illness, since only AIDS, the most acute stage of HIV infection, was recognized. Now that the much wider range of HIV

infection is understood, the anti-viral properties of AZT have been discovered, and effective treatment strategies for the opportunistic infections resulting from immune deficiencies have developed, HIV has come to be understood as a much longer-term and chronic phenomenon.

Over time, as our understanding of HIV infection has developed, the social complexities that surround it have increased. Unable to rely upon the rapid development of a vaccine to prevent further spread of infection, public health must rely upon education leading to behavior change to slow the epidemic's spread. This is a problematic strategy because of its necessary reliance upon public discussions about sexuality and intravenous drug abuse.

Because of its link to intravenous drug abuse, the epidemic's demographics are expanding to include an increasing number of African-Americans, Hispanics and other people disproportionately represented among the poor. Once thought to be a disease primarily affecting gay men, HIV infection is rapidly becoming a disease affecting young black and Hispanic heterosexual men, women and their children. From its initial concentration within isolated urban settings, HIV has spread to every state and into suburban and rural communities.

Finally, however, HIV is not confined to any population groups. It is at large in our society, and around the world. We all live with AIDS, a fact that reminds us daily of the social consequences that attend our personal life-styles and behavior.

Problems of Care

The epidemic of AIDS has evolved beyond a medical challenge. It has generated an epidemic of fear, and has challenged the capacities of our institutions of care.

Medical research and technological advances have mastered the mysteries of acute trauma and bacterial infection. But in so doing, the very nature of morbidity -- how we die -- has been altered. The AIDS epidemic emerges at a time when society faces the resultant widespread dilemmas of chronic care.

Chronic care needs are vastly different from the needs of those suffering acute illness; yet a new paradigm -- a new concept of care which more adequately accounts for the needs of the chronically ill -- has not developed. The mental, physical, emotional, and spiritual health of the chronically ill interact in complex interweavings that affect one's very sense of meaning in the world because of the involvement of personal issues of control, autonomy, dependence, fear of abandonment, and -- especially -- loss.

The result is the inherently impersonal nature of most forms of institutionally-based chronic care. Rather than feeling like respected members of the human family, many individuals, often in concert with personal physicians, quietly choose to curtail treatments and end their lives rather than to endure further pain and hardship from chronic disease. For anyone suffering irreversible, degenerative illness, the standard rationalizations

which offset present discomfort for the sake of future benefit come to naught, for means and ends come resoundingly together.

The alternative to institutionally-bound chronic care -- home care -- has already begun to emerge as the hospice movement in the years just prior to the epidemic. Confronted with the increasing ability of medical technology to prolong what some percieve as meaningless life, more and more people looked to hospice as an alternative.

The nature of hospice -- care for the terminally ill in the home or home-like settings through the efforts of family, friends and trained support volunteers coordinated by interdisciplinary professional teams -- remains at risk today because society fails to recognize the differing needs of the chronically ill, and to adequately fund such needs. Medicare requirements more suited for calculating surgical hours or recovery days than for encouraging strategies for caring and support force hospices to become more like the institutions for which they were originally an alternative.

Out of anguish over AIDS, gay and lesbian communities adapted the most important qualities of hospice and created teams of friends and volunteers to enable persons with AIDS to receive the broad range of chronic care services capable of being delivered in the home, at a fraction of the cost of institutionally based delivery. Yet these isolated, stigmatized communities caring for their own amidst the devastating intensities of the epidemic has already begun to burn-out. In

response, church-based efforts have expanded upon such efforts by organizing caring communities with mainstream congregations for people with AIDS. Congregational support and the involvement of larger numbers of people within each team have successfully addressed the critical issue of burn-out.

Such strategies begin the process of raising awareness about alternatives for all who suffer chronic illness, not only people with AIDS, and illustrate the way in which AIDS is transformative for the whole culture. Justice demands that successful aspects of new programs be applied to the frail elderly, the neurologically impaired, anyone who requires chronic care. With our struggle against AIDS as a catalyst, our religious institutions can begin to construct a new ethos of caring which speaks deeply to moral and spiritual needs of life in our complex society. A new ethos of caretaking could help redefine the nature of daily life, redressing the imbalance between our private and public selves, involving each other in regenerating the caring and communal values so badly needed today.

Political and Economic Realities

Two immediate economic issues both are the cost of medication and the availability of health insurance. The extraordinary cost of AZT -- $8,000 a year for full-time users -- makes it the most expensive prescription drug in history. Since AZT is used not only as treatment for AIDS-related afflictions but also as a means of postponing the onset of AIDS for HIV-infected persons, the limits of its availability due to cost is

particularly tragic. Recently, the manufacturer has modified its policy to allow AZT a wider, less expensive market, but it is surely in the interest of the nation to insure that the drug is universally available on the basis of need, both as treatment and as a means for delaying the onset of symptomatic AIDS.

Health insurers have responded to persons with AIDS as to other high-risk individuals -- by imposing high deductibles, limiting benefit coverage, setting premiums at high levels and in some cases refusing to sell policies at all. Related to the availability of insurance is the specter of widespread discrimination through testing requirements and rejection of whole groups based on life-style, geography and occupation. As with the availability of medication, the universal availability of health insurance is a benefit not only to those affected but to all people. Segregation of HIV and non-HIV risk groups is neither possible nor desirable. Lack of access to medication and insurance is segregation on the basis of economic means, and can lead only to the unequal distribution of those political and social institutions that exist to unite us as one people. We see more clearly than ever before how our nation structures its economic resources to enhance it political and social well-being. This is an issue not only of justice but also of survival. The constitutional responsibility of the federal government to provide for the general welfare requires a thoughtful and comprehensive approach to both the economic and political consequences of AIDS.

Historically, federal definitions of and provision for the general welfare have been sketchy in this country as compared with most other industrialized nations of the world. The American tradition has been one of reliance on the dynamics of a market economy and the compassion of eleemosynary organizations to provide basic necessities for everyday existence. As a result, the private sector has generated prosperity for some, and access to adequate food, shelter, employment and health care for many, while a significant proportion of Americans remain in poverty. According to the Federal Census Bureau, the poverty rate in 1988 had risen to 13.1 percent, as contrasted to an 11.4 percent figure in 1978. Moreover, the decreasing number of higher-paying industrial jobs, coupled with rapidly rising costs for housing and health care, means that an increasing percentage of income, particularly among middle- and low-income populations, must be spent for these basic necessities. As a result, a wide range of people are now experiencing a relative decline in the quality of their economic life.

These economic realities impact our response to AIDS. The economic costs of HIV, illustrated by health insurance limitations, access to treatment and medicine, and personal care requirements, threaten the most vulnerable with lives of isolation and hopelessness. The failure of America's primary health and health-related institutions to respond to the HIV pandemic is a moral question for our entire society.

The general welfare may also be interpreted to include protection from discrimination. In recent years there has been a proliferation of legislation and court cases dealing with specific types of discrimination against specific groups: racial and ethnic, elderly, handicapped, gender and sexual orientation. Yet, despite new legislation and legal guidelines, increasingly subtle forms of discrimination continue to be practiced in organizations and communities across the land. The question of resolving cases of possible discrimination against persons with AIDS is particularly acute, since the life expectancy of the person discriminated against and waiting for a "day in court" may be short.

A salient indicator of the general welfare is length of life expectancy. Since 1984, the gap in life expectancy between blacks and whites has grown, after decades of having narrowed. The disparity, according to the National Center for Health Statistics, is not found in the leading causes of death -- cancer, heart disease and stroke -- but rather in the increase among blacks of death by drug-related factors, diseases of infants, accidents, alcoholism, and AIDS. These deaths constitute a pattern of poverty-induced self-destructive behavior in a despairing population. During this period, black poverty has also increased in both amount and severity.

These statistics signal the tragic significance of a trend that has been widely noted: the growing economic, racial and social divisions in our nation. The import of such divisions

ultimately affects the nation's political capacities. Can a democratic system survive great disparities in the degree of freedom and justice among different populations? The prominence of HIV infection as a factor in the black mortality rate, and the relationship between mortality, poverty, race and hopelessness, signifies the malaise of a society in which the distribution of wealth and power negatively affects significant portions of the population.

Revisioning

Our legal language has enshrined a vision of wholeness into the very vocabulary we use to constitute ourselves -- equality. Yet that word has not grown to encompass in meaning the recent rise in black poverty and the other economic, racial and social divisions in our nation. At the heart of our struggles to become a kinder and gentler nation, the reason that rhetoric has resounded so deeply in the American soul, is the need to envision a new ethos of mutual care-taking. The relationship between government, medicine, religious communities, secular communities, business and labor must be re-worked in relationship to our needs. To do so, however, we must see clearly what is truly needed.

A key to answering these questions must be provided by our nation's voluntary sector. Voluntary organizations have shown their capacity to respond positively to HIV-associated needs through such means as AIDS prevention and sexuality education; counseling with persons with AIDS, their families and friends;

care and support for persons with AIDS who need shelter and living assistance. But the resources of the voluntary sector -- volunteer, financial contributions and organizational capacities -- are no match for the need. Thus, the voluntary sector is called to an advocacy role, calling the federal government to its constitutional responsibility of providing for the general welfare.

The educational role of the voluntary sector is expanding. Without abandoning a focus on HIV transmission and its prevention, the voluntary sector is called to develop effective means for education of the public regarding the nature of AIDS and consequent implications for an expanded understanding of mutual care as a way of life for all people.

The educational role includes both factual and conceptual teaching, through formal and experiential methods, to the end of increasing both wisdom and insight regarding how we live as a society in the face of existential realities beyond our control. It is education that targets not only the discreet constituencies of our particular institutions, but also extends more broadly to the general public. This public dimension requires a new degree of coordination among component organizations in the voluntary sector, both religious and secular.

The voluntary sector is called to a new dimension of community leadership. Both public and private institutions are shaped and augmented by innovative voluntary institutions. The need for innovation occasioned by the presence of HIV in our

midst is apparent at two levels: vision and insight from the wellspring of our religious heritages; and the practical organization of new forms of care. Increasingly, for example, mediation is being used to assist HIV positive persons to resolve complaints about discrimination in housing, health care, and employment. In a U.S. Department of Health and Human Services study of social service programs, mediation is reported to be by far the most successful means of resolving AIDS related disputes. Mediation often results in voluntary compliance, eliminating the need for formal legal action. As a result, both the time of resolution and personal stress associated with litigation are greatly reduced.

Mediation is a procedure that is well suited for the voluntary sector in general and religious bodies in particular. The historic religious concern for fairness and justice is one that can be translated into concrete community action through mediation.

A new care paradigm should begin with public and private financial assistance to religious and community-based groups to help them mobilize congregational and community volunteers. Federal dollars should mandate that hospitals, out-patient facilities and health agencies provide home health education and training. Employers should explore continued ways to create flexible work times and places. Health-care institutions, fearing the epidemic's unplanned impact upon their fiscal and institutional stability, should welcome truly home-based care

strategies. Churches and synagogues, with their struggles to respond forcefully to issues of spiritual meaning in today's world, should embrace a comprehensive restructuring of our vision -- a re-vision -- of what it means to care for our health, communal as well as individual, environmental as well as personal.

Conclusion

For those affected by AIDS, the national AIDS quilt has been a true re-membering of those who have died from AIDs. For inner-city, poverty-stricken African-Americans, and others similarly cut off from a shared vision of American life, renewed commitment and respect in the fashioning of AIDS-related strategies for such communities could have a powerful effect. Inner-city-based facilities coordinating home care programs, AIDS education and humane drug treatment and care strategies, if supported by real social commitments to ending the cycles of despair, would powerfully reorient relationships. The oft-times destructive nature of institutionally-based services upon the poor could be replaced by strategies requiring and funding the education and involvement of family, friends, and neighbors. Home-building experiments in Los Angeles' inner-city jointly undertaken by a wealthy church and synagogue suggest the ways in which some of the strengthening of our nation's infrastructure might occur. The support provided by caring professionals in inner-city based programs could help transform residents's self-image by overcoming the paternalism inherent in institutionally-based care

models. For the middle class assisting inner-city efforts, such programs offer the basis for strengthening religious and civic values.

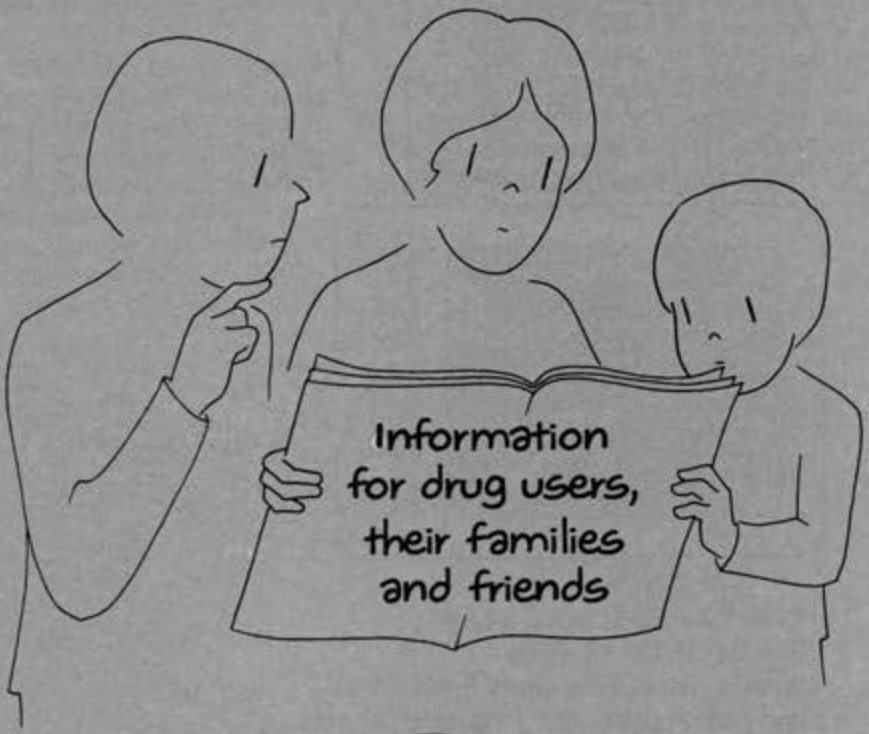
We are members of different faiths. Our traditions teach us different ways to embrace God. We represent humanity's wide range of ways to be human. Across our diversity, AIDS magnifies the fact that we are also one, bound together in relatedness. Great care must be taken to hear each other, so different are our traditions's melodies. Some of us are bound by covenant, others by faith, some by mighty bodies of worship, other by a simple stance before creation. But while the integrity of faith depends upon the establishment of boundaries beyond which members do not go, the fact of our interdependent nature cuts across the necessary chasms of particular story, ritual and law. America looks to its religious bodies for innovative response and new directions. Our religious vision proclaims that living with AIDS is a project in which we must we must all engage. We must find hope amidst the moral and biological tragedies of this epidemic in order to pass on hope for generations to come.

This background paper has been co-authored by Theodore H. Erickson, Secretary for Special Mission Emphases, United Church Board for Homeland Ministries, and David Schulman, a Los Angeles

deputy city attorney who heads the city attorney's AIDS Discrimination Unit.

This paper will be distributed in final edited form on December 4th to all participants.

About AIDS and SHOOTING DRUGS

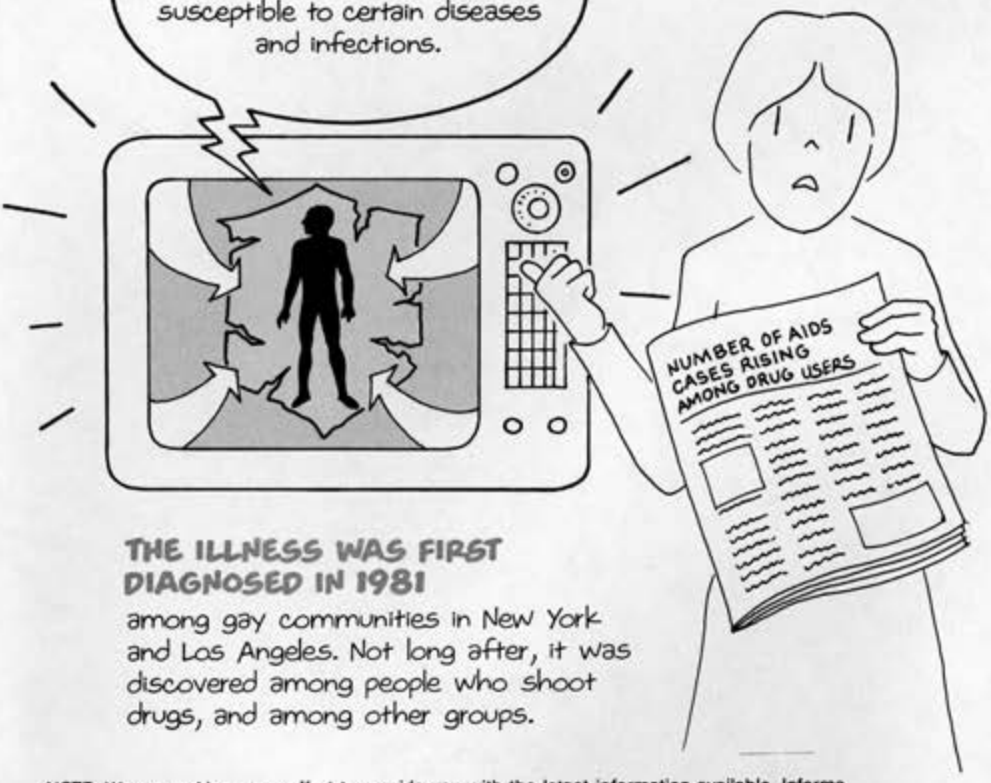


CHICAGO DEPARTMENT OF HEALTH

What is **AIDS**?

It's the **Acquired Immune Deficiency Syndrome** -- the name given to a serious illness that impairs the body's ability to fight infection.

WITHOUT FULL RESISTANCE, a person with AIDS is susceptible to certain diseases and infections.



THE ILLNESS WAS FIRST DIAGNOSED IN 1981 among gay communities in New York and Los Angeles. Not long after, it was discovered among people who shoot drugs, and among other groups.

NOTE: We are making every effort to provide you with the latest information available. Information in this booklet was current as of February, 1987. However, research on AIDS continues daily. Reading this booklet is not a substitute for keeping up to date on AIDS information or making sure that AIDS information is based on scientific research -- not on fear or rumors.

A SCRIPTOGRAPHIC BOOKLET by CHANNING L. BETE CO., INC., South Deerfield, MA 01373 U.S.A.

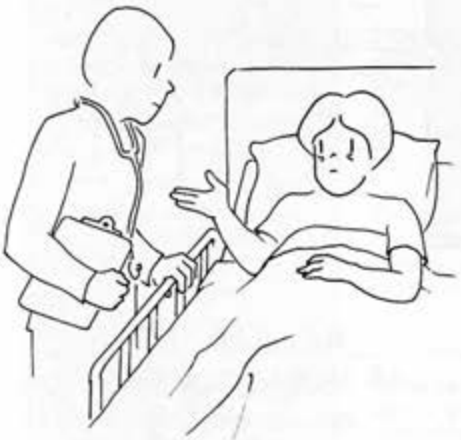
Tel. 1-413-665-7611 1987 Edition 14787H-2-87

WHY should I KNOW MORE about AIDS ?

Because AIDS is:

A SERIOUS HEALTH PROBLEM FOR THOSE WHO GET IT

The fatality rate for AIDS victims is high. At present, there is no known cure for AIDS, although the U.S. Public Health Service and many major medical and public-health institutions are working hard to find treatments, as well as a cure.



SURROUNDED BY MORE FICTION THAN FACT

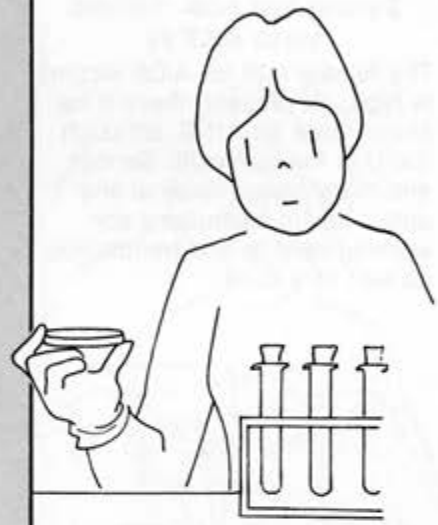
Perhaps no other illness of our time has been so dominated by both ignorance and misinformation. For many people, the fear surrounding AIDS has been far more threatening than the illness itself.

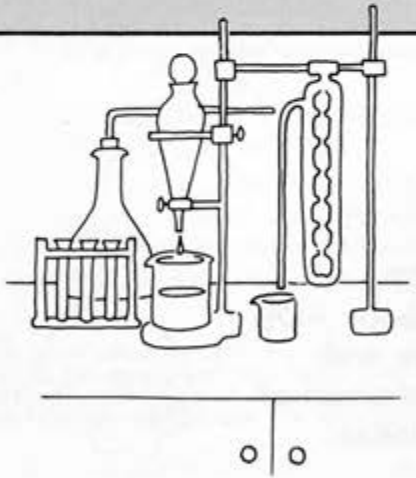
KNOWING THE FACTS

-- <u>not</u> the fiction -- about AIDS will help stop AIDS fear and, possibly, reduce your chances of getting or giving the illness.

Recent discoveries have led to great progress in the fight against AIDS:

- Researchers have isolated and identified the cause – a virus called HIV. (Other names for the virus include HTLV-III, HTLV-III/LAV and the AIDS virus.) HIV changes the genetic structure of the cell it attacks.
- HIV is especially harmful to certain cells, leaving the immune system weakened.
- Using a newly developed process, researchers can now grow HIV in the lab, so that they can study it more closely.

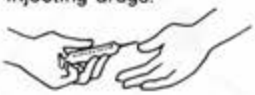




RESEARCH IS NOW FOCUSED on developing treatments and a vaccine for **AIDS.**

In the meantime, a change in behavior is your best protection.

Nearly all AIDS cases have occurred among people with these characteristics:

PATIENT CHARACTERISTICS	DESCRIPTION	POSSIBLE WAY TRANSMITTED
GAY AND BISEXUAL MEN -- about 66% of all cases	This group includes sexually active homosexual or bisexual men, especially those with multiple sex partners.	Anal intercourse or any sexual activity involving exposure to semen and/or blood.
HETEROSEXUAL INTRAVENOUS DRUG USERS -- about 17% of all cases*	These people share – or have shared – hypodermic needles to inject themselves with heroin, cocaine, or other substances.	Sharing "works" when injecting drugs. 
GAY AND BISEXUAL MEN WHO ABUSE INTRAVENOUS DRUGS -- about 8% of all cases*	This group includes sexually active homosexual and bisexual men who also abuse drugs by injection.	Sexual activity, or sharing of needles or other drug use equipment.
HETEROSEXUAL SEX PARTNERS OF THE ABOVE -- about 4% of all cases	These people have been sexual partners of AIDS patients or other persons at risk of getting AIDS.	Any sexual activity involving exposure to semen and/or blood.
HEMOPHILIACS AND PEOPLE WHO HAVE HAD BLOOD TRANSFUSIONS -- about 3% of all cases	These people have used a special clotting substance produced from donated human plasma, or they've been given transfusions for medical reasons.	Donated blood and blood products infected with HIV. 

* In certain parts of the country – especially the Northeast – the percentage of AIDS cases that involve IV drug users is much higher.

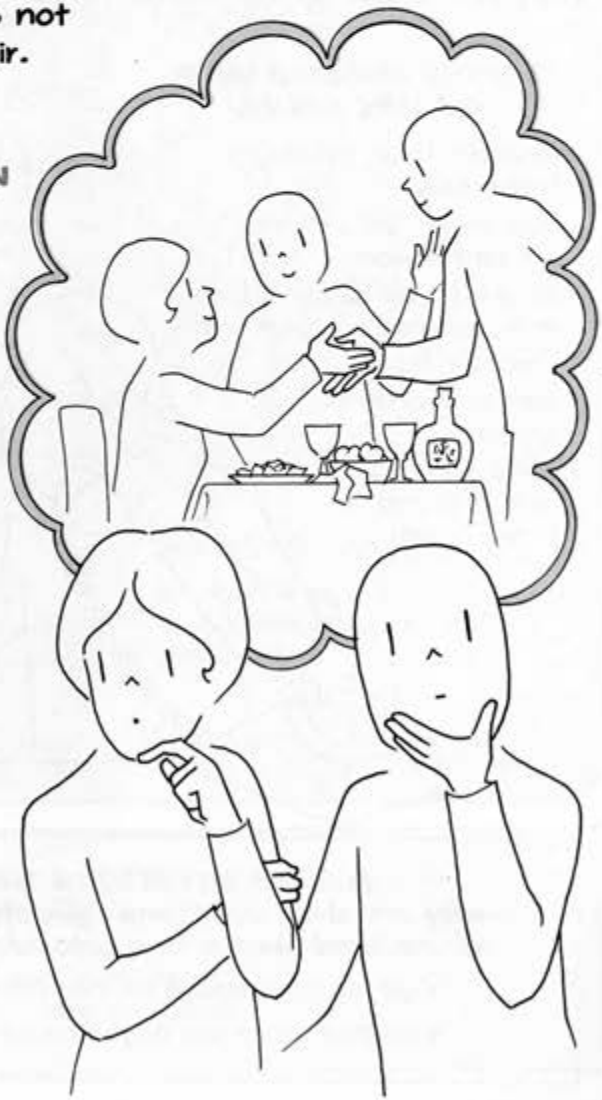
Most often, the virus is transmitted through sexual contact or by sharing "works."

PEOPLE INFECTED WITH HIV MAY LOOK HEALTHY!

- Your sex partner or needle-sharing partner doesn't have to look sick to transmit the virus.
- A pregnant woman may carry HIV and pass it on to her baby even though the mother herself doesn't show any signs of illness.
- A person infected with the virus that causes AIDS can infect others without even knowing it!

Is AIDS highly **CONTAGIOUS**?

Current scientific research indicates that AIDS is not transmitted through casual contact, and that it's not spread through the air.



NO CASE OF AIDS IS KNOWN TO HAVE BEEN CAUSED BY:

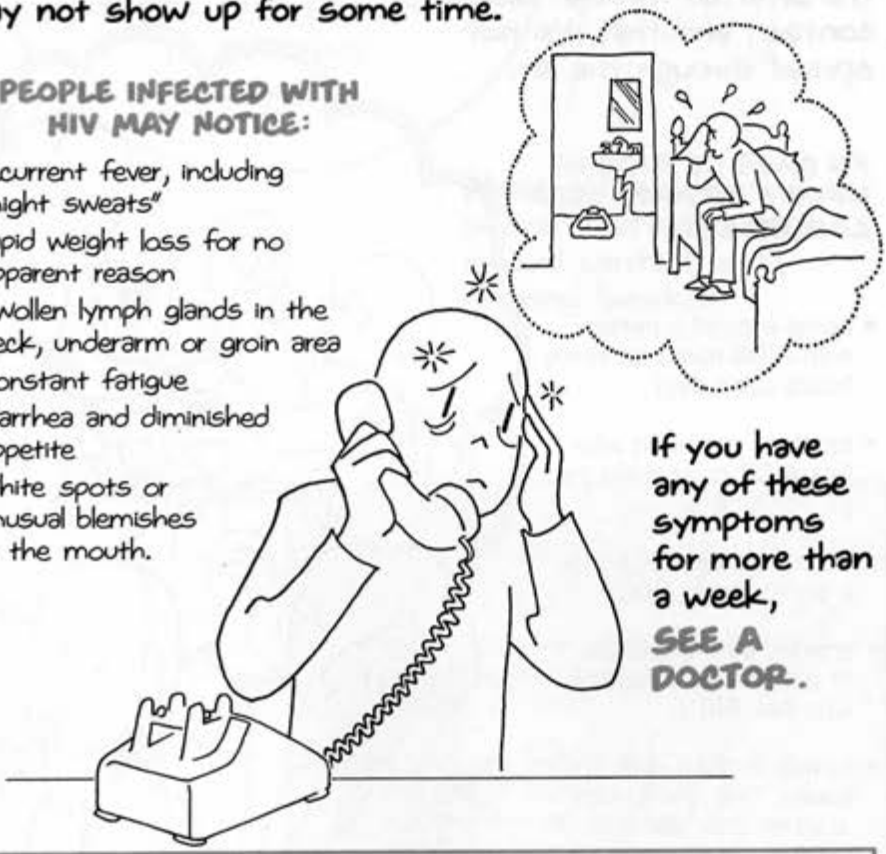
- being around a person with AIDS (even for many hours each day)
- touching a person who has AIDS or shaking the person's hand
- eating food prepared by a person with AIDS
- sharing eating utensils or plates with a person who has AIDS
- having contact with towels, bed linens, etc., used by a person with AIDS
- caring for a person with AIDS, while using the proper procedures
- donating blood.

THE SYMPTOMS OF INFECTION

with HIV aren't always clear, and they can be confused with problems associated with drug use and withdrawal. Also, since the incubation period of AIDS may range from a few months to 5 years or more, symptoms may not show up for some time.

PEOPLE INFECTED WITH HIV MAY NOTICE:

- recurrent fever, including "night sweats"
- rapid weight loss for no apparent reason
- swollen lymph glands in the neck, underarm or groin area
- constant fatigue
- diarrhea and diminished appetite
- white spots or unusual blemishes in the mouth.



If you have any of these symptoms for more than a week, **SEE A DOCTOR.**

A BABY INFECTED IN THE WOMB

may not show symptoms right after birth. Mothers who suspect they've been exposed to HIV should:

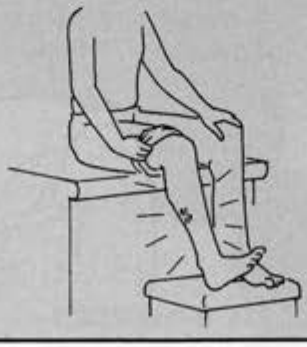
- get regular checkups for their babies
- tell their doctor why they're concerned about AIDS.

IN PEOPLE WHO DEVELOP AIDS,

the immune system becomes severely weakened, turning normally mild, harmless, and rare diseases into potentially fatal conditions. The two most common illnesses of this type are:

PNEUMOCYSTIS CARINII PNEUMONIA

– a parasitic infection of the lungs that's highly uncommon among healthy individuals, but occasionally found among cancer and transplant patients who must take certain kinds of drugs.



KAPOSI'S SARCOMA

– a form of cancer that causes pink, brown or purplish skin blotches.

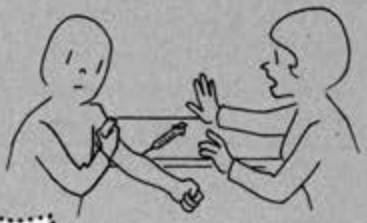
Scientific research shows that HIV may also attack the nervous system, causing damage to the brain and spinal cord. Signs of damage may include memory loss, indifference, inability to make decisions, partial paralysis, loss of coordination, and other problems in controlling the body.

What can I do to PREVENT AIDS?

Based on current research, these prevention tips may help reduce your risk of getting or giving AIDS:

DON'T SHOOT DRUGS

of any kind. There are programs to help you stop.



DON'T SHARE YOUR "WORKS"

with anyone or use anyone's set, if you can't stop shooting drugs. (If you must share a set, experts believe that you should clean it thoroughly to remove any residue, and soak it for 1/2 hour in 1 cup of water with 2 tablespoons of household bleach added. Rinse well in running water.)

IMPROVE YOUR HEALTH

by eating well, getting enough sleep and seeking prompt treatment for any infections.

LIMIT THE NUMBER OF YOUR SEXUAL PARTNERS,

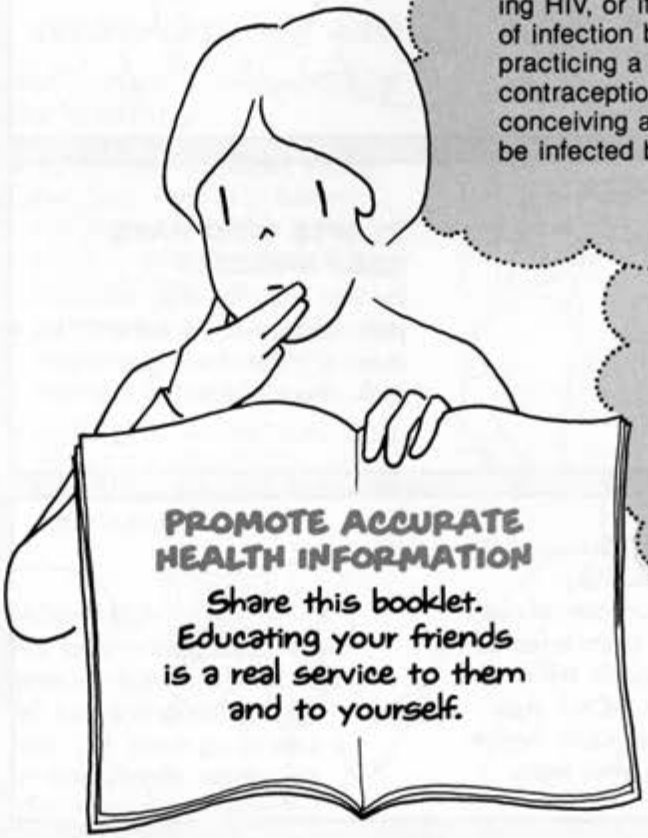
and avoid having sex or exchanging body fluids with any partner who might be infected. Use of a rubber with a spermicide* may help reduce your risk of getting or giving AIDS.

CONSIDER POSTPONING PREGNANCY

if you think you may be carrying HIV, or if you're at risk of infection by the virus. By practicing a reliable form of contraception you may avoid conceiving a child who could be infected by HIV.

REMEMBER:

if you have ever shot drugs or had sexual contact with a drug user, you may be carrying HIV.



PROMOTE ACCURATE HEALTH INFORMATION

Share this booklet. Educating your friends is a real service to them and to yourself.

*Never use petroleum jelly or a petroleum-based product with a condom (it may cause the condom to break down).

WHAT ELSE SHOULD I KNOW about infection with HIV ?

MANY DRUG USERS HAVE BEEN INFECTED with HIV. Some of them will develop AIDS. Some will develop less serious illnesses, but most will remain well.

PEOPLE WHO HAVE BEEN INFECTED by HIV may be able to pass the virus to others even if they don't get sick themselves.

THOUGH THERE IS NO TEST FOR AIDS, there is a test that can show if a person has ever been infected by HIV (the test can't tell if a person will develop AIDS). Ask your physician or a public health clinic about taking this test.

Is there a **CURE FOR AIDS**?

There's still no known cure for AIDS, although a concentrated research effort continues in hope of finding one.

TREATMENTS FOR AIDS

and secondary illnesses include the following:

- **AZT** (azidothymidine), which has been helpful in halting the spread of HIV in some patients with Pneumocystis carinii pneumonia.
- **INTERFERON**, which has helped some patients fight Kaposi's sarcoma.
- **SURGERY, RADIATION AND DRUG TREATMENTS**, which have helped patients overcome other conditions.

HOWEVER --
No treatment, including transplants and the use of experimental drugs, has yet been successful in completely restoring the immune system.

THERE IS HOPE FOR THE FUTURE!

There is every reason to believe that the extensive research effort headed by the government will lead to preventive measures and a cure for AIDS.

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still considers AIDS a top-priority health concern. More than $853 million has been budgeted since 1981 for work related to AIDS.

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has awarded research grants to scientists and medical doctors throughout the U.S., in an all-out effort to solve the AIDS puzzle.

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has sent workers into local communities to gather as much information as possible about AIDS. CDC laboratories also test blood and tissue of AIDS patients and those exposed to HIV.

THE ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION (ADAMHA)

is funding research to find the risk factors for AIDS among drug abusers, and is studying the mental-health aspects of AIDS.

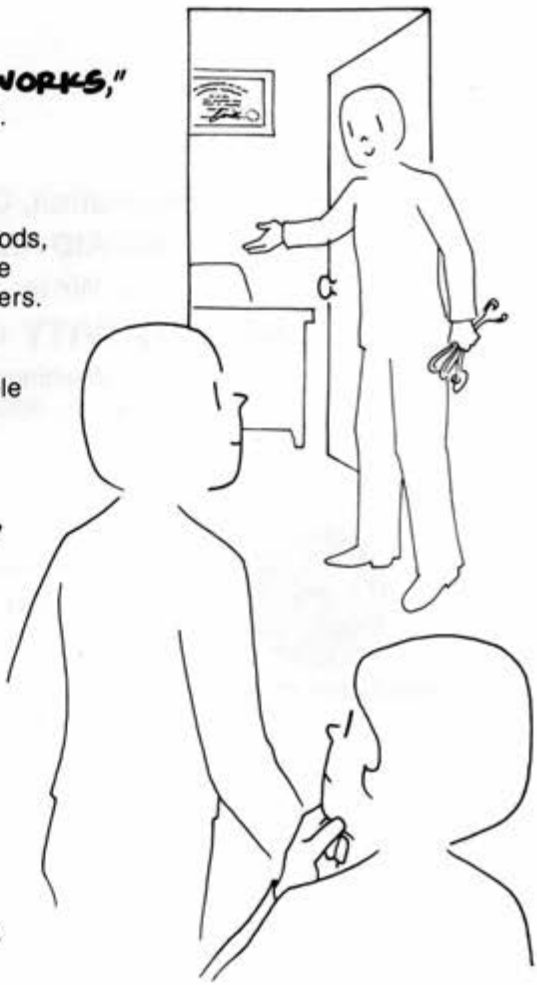
THE FOOD AND DRUG ADMINISTRATION (FDA)

is cooperating with research efforts and working to promote the safety of the nation's blood supply.

Soo--

HELP STOP THE SPREAD OF AIDS!

- ✓ **DON'T USE DRUGS.**
- ✓ **DON'T SHARE YOUR "WORKS,"** if you can't stop using drugs.
- ✓ **TAKE PREVENTIVE MEASURES** by using contraceptive methods, rubbers, etc., and limiting the number of your sexual partners.
- ✓ **KNOW ABOUT AIDS,** so you can recognize possible symptoms and be aware of who is at risk.
- ✓ **SEEK MEDICAL ATTENTION PROMPTLY** if you notice any symptoms or if you have reason to think you're infected.
- ✓ **HELP OTHERS LEARN ABOUT AIDS** by talking to your friends and encouraging educational programs.
- ✓ **SUPPORT AIDS RESEARCH EFFORTS** and local treatment centers.



AIDS CAN BE CONTROLLED!

For More Information, Call Toll Free:

1-800-AID-AIDS

or Write:

AIDS ACTIVITY OFFICE

50 W. Washington
Chicago, IL 60602

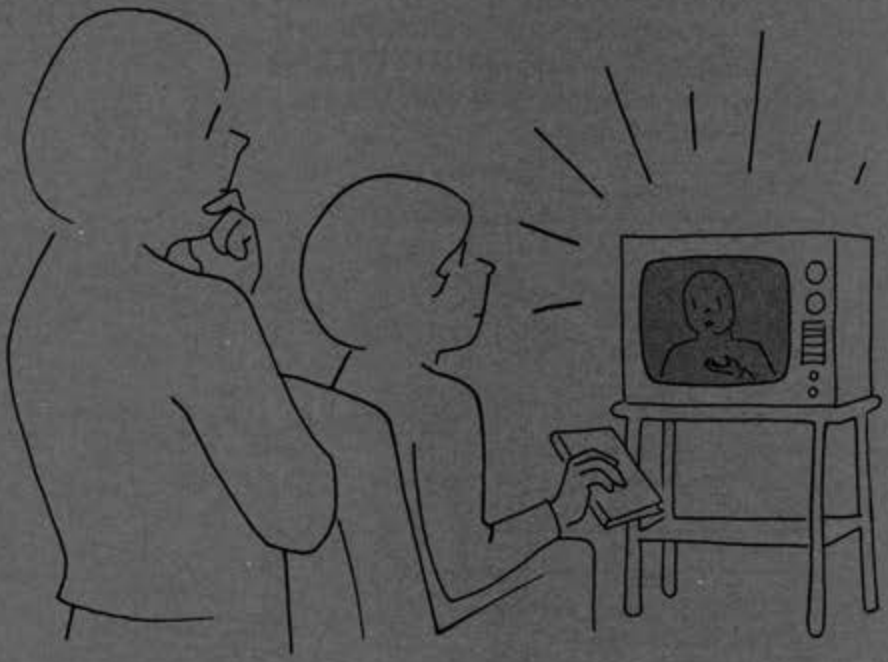
DEPARTMENT OF HEALTH

CENTRAL INFORMATION NUMBER:
744-8500

LITHO IN U.S.A.

What **EVERYONE** should know

ABOUT AIDS

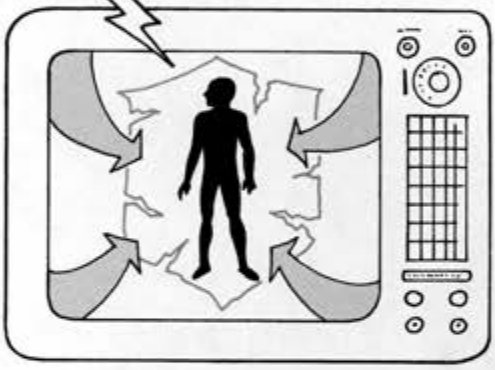


CHICAGO DEPARTMENT OF HEALTH

What is AIDS ?

It's the **Acquired Immune Deficiency Syndrome** -- the name given to a serious illness that impairs the body's ability to fight infection.

WITHOUT FULL RESISTANCE, a person with AIDS is susceptible to certain diseases and infections.



THE ILLNESS WAS FIRST DIAGNOSED IN 1981 among gay communities in New York and Los Angeles. The number of cases has been increasing since then.

NOTE: We are making every effort to provide you with the latest information available. Information in this booklet was current as of February, 1987. However, research on AIDS continues daily. Reading this booklet is not a substitute for keeping up to date on AIDS information or making sure that AIDS information is based on scientific research – not on fear or rumors.

A SCRIPTOGRAPHIC BOOKLET by CHANNING L. BETE CO., INC., South Deerfield, MA 01373 U.S.A.

Tel. 1-413-665-7611 1987 Edition 14274R-2-87

WHY should I KNOW ABOUT AIDS ?

Because your knowledge is the key to separating the **FACTS FROM THE FICTION** surrounding this illness.

You can help stop the **EPIDEMIC OF FEAR!**

The MYTHS and MISCONCEPTIONS about AIDS have caused needless panic and concern. There's absolutely no reason to become burdened by feelings of fear.

BY LEARNING ABOUT AIDS, you can help dispel any myths you may hear.

What CAUSES AIDS?

Recent discoveries have led to great progress in the fight against AIDS.

- Researchers have isolated and identified the cause -- a virus called HIV. (Other names for the virus include HTLV-III, HTLV-III/LAV and the AIDS virus.) HIV changes the genetic structure of the cell it attacks.
- Using a newly developed process, researchers can now produce HIV in the lab, so that they can study it more closely.
- Researchers have also developed a test to detect antibodies to HIV in the blood. The test, which is being used to screen donated blood, shows if a person has ever been infected by the virus. It does <u>not</u> indicate that a person has or will get AIDS.*

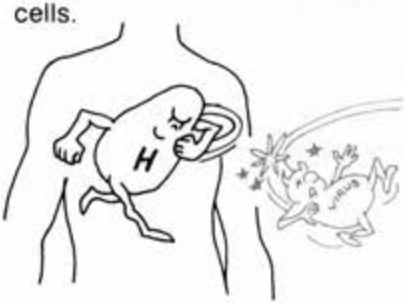
* *People who suspect they've been exposed to HIV should consult a physician -- rather than donate blood in order to be tested.*

HOW A HEALTHY IMMUNE SYSTEM WORKS

Human blood contains different types of white blood cells that play different roles in protecting against disease. Among a type of white blood cells called lymphocytes are the B cells and T cells.

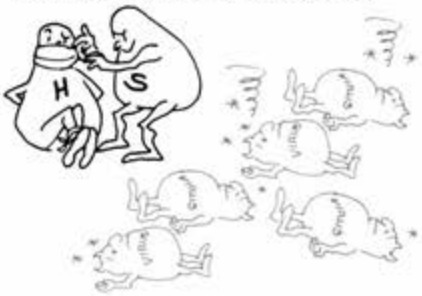
"HELPER" CELLS

Some T cells help the B cells produce antibodies that fight disease-causing organisms. These T cells are called helper cells.



"SUPPRESSOR" CELLS

Other T cells, known as suppressor cells, work to stop or suppress this fight against invading germs, once the infection has been overcome.

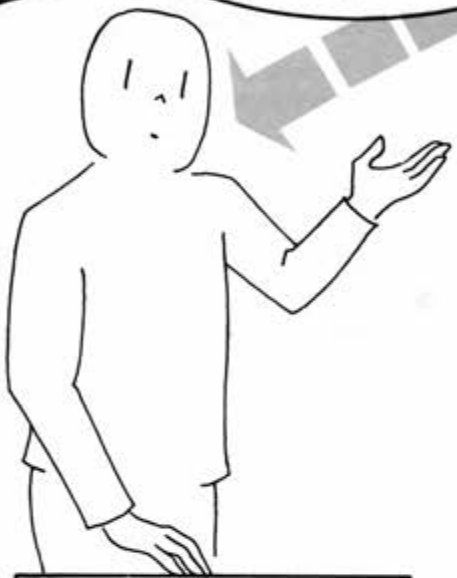


IN A HEALTHY PERSON,

helper cells outnumber suppressor cells by a 2 to 1 ratio.

IN A PERSON WITH AIDS,

suppressor cells outnumber helper cells, leaving the immune system weak or ineffective in the fight against disease.



HIV can be transmitted by sexual contact, sharing an infected hypodermic needle or, less often, through blood or blood products. Also, an infected mother may transmit the virus to her baby before, during or after birth (possibly through breast-feeding).

IS AIDS HIGHLY CONTAGIOUS?

Current scientific research indicates that AIDS is not transmitted through casual contact, even when people live in the same household, and that it's not spread through the air.

WHO GETS AIDS?

The majority of all adult and adolescent AIDS cases have occurred among people in the following categories:

HOMOSEXUAL AND BISEXUAL MEN

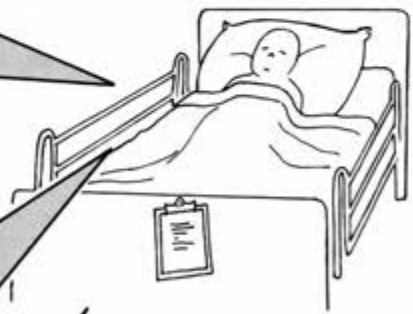
– about 66% of reported AIDS cases – who risk contracting AIDS through sexual activity. Especially at risk are those with many sexual partners.

HETEROSEXUAL INTRAVENOUS DRUG ABUSERS

– about 17% of the reported cases – who may have been exposed to AIDS by sharing contaminated needles.

HOMOSEXUAL AND BISEXUAL MEN WHO ABUSE INTRAVENOUS DRUGS

– about 8% of the reported cases – who risk contracting AIDS through both sexual activity and drug use.



HEMOPHILIACS AND PEOPLE WHO HAVE HAD BLOOD TRANSFUSIONS

– about 3% of the reported cases – who apparently contracted AIDS through the use of donated blood or blood products.

HETEROSEXUALS

– about 4% of the reported cases – who have been sexual partners of persons infected with HIV or other persons in the risk groups.

A small number of adult/adolescent cases don't fit into these groups. Other cases have occurred among children who have been given donated blood or blood products, or who have contracted AIDS from an infected mother (see p. 6).

EFFECTS ON THE BODY

DURING THE INCUBATION PERIOD,

which may range from a few months to five years or longer, there may be no signs that a person is infected with HIV.

AS THE INFECTION PROGRESSES,

symptoms become apparent. People infected with HIV may notice severe, prolonged and persistent:

- recurrent fever, including "night sweats"
- rapid weight loss for no apparent reason
- swollen lymph glands in the neck, underarm or groin area
- constant fatigue
- diarrhea and diminished appetite
- white spots or unusual blemishes in the mouth.

SOME PEOPLE INFECTED WITH HIV

go on to develop AIDS. Their immune system becomes severely weakened, turning normally mild, harmless, and rare diseases into potentially fatal conditions. The two most common illnesses of this type are:

KAPOSI'S SARCOMA

– a form of cancer that causes pink, brown or purplish skin blotches.

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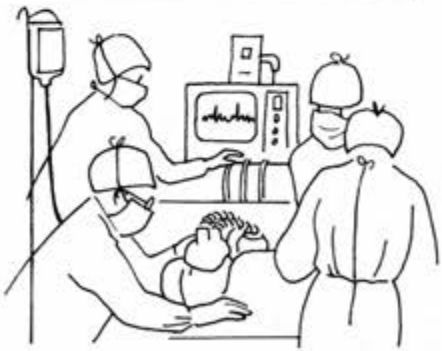

New evidence shows that HIV may also attack the nervous system, causing damage to the brain and spinal cord. Signs of damage may include memory loss, indifference, inability to make decisions, partial paralysis, loss of coordination, and other problems in controlling the body.

Some steps being taken to

PREVENT THE SPREAD OF HIV AND AIDS

HOSPITALS

are taking precautions to protect patients as well as employees.

SPECIAL HANDLING, LABELING AND ISOLATION PROCEDURES

are being used for blood and tissue samples of AIDS patients, and also for any patient-care equipment that may be contaminated. Based on current research, there's no reason to fear being in a hospital where AIDS patients are being treated.

TRANSFUSIONS

The chances of acquiring AIDS through a blood transfusion have been extremely small – less than 1 in 100,000. With the blood test for the HIV antibody, even this risk has been largely eliminated.

BLOOD BANKS

are taking steps to avoid accepting blood from people who have been infected with or exposed to HIV or other infectious diseases.

At the same time, blood-collecting agencies are publicly urging the following people not to donate blood:

- persons in the groups at risk of AIDS listed on page 7
- any man who has had sexual contact with another man (even if only once) since 1977.

The blood test for the HIV antibody should make the screening process more certain.

EVEN IF YOU DON'T FIT INTO A CATEGORY LISTED ON PAGE 7,

it is recommended that you avoid having sex with:

- multiple and anonymous partners
- partners at risk of AIDS
- partners who have sex with people at risk.

Remember, in general, the fewer sex partners you have, the better your chances of avoiding infection.

Is there a CURE FOR AIDS ?

There's still no known cure for AIDS, although a concentrated research effort continues in hope of finding one.

TREATMENTS FOR AIDS

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is funding research to find the risk factors for AIDS among drug abusers, and it's studying the mental-health aspects of AIDS.

Some QUESTIONS and ANSWERS

Can I get AIDS by **DONATING BLOOD**?

Not a chance! Only sterile equipment is used by blood banks and blood collection centers. Needles are discarded after one use, leaving no chance of passing AIDS from donor to donor.

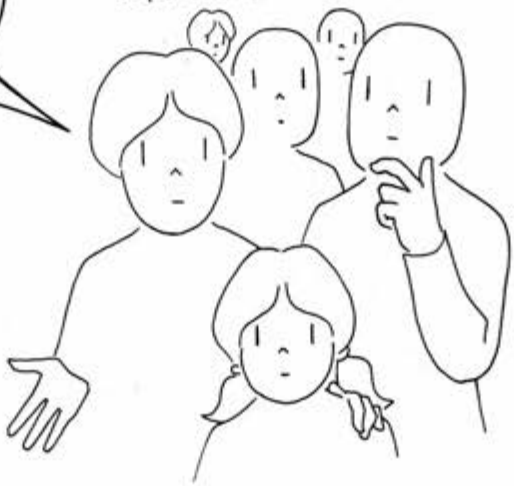
Should I avoid places where **PEOPLE WHO MIGHT HAVE AIDS** are likely to be found?

Since current research indicates that AIDS is not spread through casual social contact, health officials don't recommend avoiding any public or private place, including schools, as a preventive measure.

Furthermore, the CDC has issued guidelines to help determine, on a case-by-case basis, whether school-age children with AIDS should attend school. For more specific information, contact your child's school or your state or local health department.

What if someone with AIDS is **INJURED** and **BLEEDS**?

It's recommended that school and health-care personnel practice antiseptic techniques, in accordance with CDC guidelines. This includes cleaning up any spilled blood with a disinfectant and, of course, cleaning the wound appropriately.




Soo--
SEPARATE THE FACTS FROM THE FICTION ABOUT AIDS!
Do your part in the fight against AIDS.
✓ KNOW THE FACTS about AIDS -- keep up with new information and what's being done to stop AIDS.
✓ SUPPORT EFFORTS to find a cure.
And, put your knowledge and understanding to work by
DISPELLING THE MYTHS AND FEARS ABOUT AIDS TODAY!

For More Information, Call Toll Free:

1-800-AID-AIDS

or Write:

AIDS ACTIVITY OFFICE

50 W. Washington
Chicago, IL 60602

DEPARTMENT OF HEALTH

CENTRAL INFORMATION NUMBER:
744-8500

LITHO IN U.S.A.

Union of American Hebrew Congregations

PATRON OF HEBREW UNION COLLEGE-JEWISH INSTITUTE OF RELIGION
100 WEST MONROE STREET, CHICAGO, ILLINOIS 60603 (312) ST 2-1477

GREAT LAKES REGION
Rabbi Alan D. Bregman
Director

Gerard W. Kaye
Director of Camping & Youth Activities
Olin-Sang-Ruby Union Institute

PACKET INFORMATION

1. CONFRONTING THE AIDS CRISIS UAHC RESOLUTION
2. WHAT EVERYONE SHOULD KNOW ABOUT AIDS. CHICAGO DEPARTMENT OF HEALTH
3. ABOUT AIDS AND SHOOTING DRUGS. CHICAGO DEPARTMENT OF HEALTH.
4. "AIDS: A JEWISH VIEW" Dr. Fred Rosner
5. "JEWISH REACTION TO EPIDEMICS (AIDS)" Rabbi Walter Jacob, CONTEMPORARY AMERICAN REFORM RESPONSA, CCAR
6. "TERMINOLOGY AND INFORMATION" PREPARED FOR THE CHICAGO BOARD OF RABBIS. RABBI JOSEPH EDELHEIT.
7. CASE STUDY. PREPARED FOR CHICAGO BOARD OF RABBIS. REV. CARL MEIROSE AND RABBI JOSEPH EDELHEIT.
8. "AIDS RESOURCES IN THE CHICAGO AREA." ASSEMBLED BY NORMAN SANDFIELD.
9. "MIND GAMES" GREGG LEVOY
10. " THE HIGH ROAD" DAVID KIRP
11. AIDS EDUCATOR SAN FRANCISCO AIDS FOUNDATION
12. SUGGESTED GUIDELINES FOR COUNSELLING UAHC
13. ARTICLE FOR TEMPLE BULLETIN
14. AIDS RABBI KIRSCHNER
15. RECOMMENDATIONS FOR CHILDREN & EMPLOYEES

The HIGH ROAD

When a child with AIDS comes to school, it doesn't have to be a crisis

Article by David L. Kirp
Photos by Val Mazzenga

The pleasant-looking men and women who gathered outside Chicago's Pilsen Community Academy in March of 1987 looked like Jehovah's Witnesses in their go-to-meeting clothes, but the message they brought was not the Word. "The blood of your own children will be on your hands," they shouted, "if you allow this child with AIDS in your school."

Those words, uttered by strangers eventually unmasked as camp followers of political extremist Lyndon LaRouche, words that would scare anyone, were particularly chilling to the people living in the Pilsen neighborhood of Chicago. This old-line Latino community knew very little about AIDS, but from years of fighting, it did know the Board of Education, which had ordered that this child be enrolled, and what they knew made them uneasy. Was this unnamed youngster with the deadly disease just the latest and worst thing that downtown was dumping on Pilsen's doorstep?

This was not the first time a child with AIDS had enrolled in Chicago-area schools, nor would it be the last. Two months earlier, in January of 1987, the affluent suburb of Wilmette had allowed an elementary school child with AIDS to remain in attendance. And in May another Chicago school, Nettelhorst Elementary, would confront the situation.

Although there was no precedent in the state of Illinois, Wilmette handled the situation so flawlessly that the whole event looked from the outside as if it might have been stage-managed. Only those who really knew the story appreciated how, for all the meticulous preparation, it was good fortune, together with parents who were willing to learn the facts and a family that was its own best advertisement, that had carried the day.

The Village of Wilmette, on Lake Michigan some 15 miles north of Chicago's Loop, looks like an upscale version of a Norman Rockwell painting. The people of Wilmette also seem to have walked straight off of a Rockwell canvas. Everyone makes at least a comfortable living, and almost everyone is white. Though the population of 28,221 is roughly divided equally among Protestants, Catholics and Jews, most of the people who live in this pleasant place have taken on the protective coloration of the WASP. Even the children look like ads for Laura Ashley and Brooks Brothers, and a local joke has it that when the high school was deciding its colors, gray flannel was the top choice.

There is old money in town, and new money, too; houses in the Indian Hill Estates area go for a half-million dollars and up. Politics in Wilmette is determinedly more liberal than in the other so-called "power suburbs" north of Chicago.

The true pride of Wilmette is its public education. There are four schools in Wilmette Elementary District 39 and one junior high school (the high school, New Trier Township, which serves several communities, is managed by a separate board), all lavishly supported with tax dollars and carefully watched over by parents. In Chicago many parents—including many non-Catholics—scrimp to send their youngsters to the parochial schools; in Wilmette, approximately one-third Catholic, one of the two parochial schools was forced to close for lack of enrollment.

Enrollment has been declining in Wilmette's public schools, too, as escalating housing prices have put the town out of reach for many young families. Since 1970 the number of students has dropped from 4,900 to 2,400, and fewer than one adult in five now has a child in the Wilmette schools. Those demographics have forced the school district to make hard choices about which schools it should close.

These kinds of questions can elicit the passions of parents, even in a place as seemingly placid as Wilmette. It is not merely a matter of how long a bike ride Johnny has every day but a more important matter of identity, for individual schools in Wilmette take on the character of their neighborhoods. The Jews, the German Catholics, the old-line families

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and the *nouveaux riches*—each group has its own school.

The school superintendent and the seven-member school board that, between them, make these determinations—the people who also decided to keep a child with AIDS in school—are habitually attentive to the shifting political currents of Wilmette. Supt. of Schools William Gussner, who came to Wilmette in 1983, thrives in tight spots. In his previous job as assistant superintendent of a prosperous bedroom community outside St. Louis he helped develop and then sell a city-suburb racial integration plan to hostile white neighboring towns. Gussner prides himself on paying meticulous attention to detail. What he describes as his "personalized" style of running the schools, an out-and-about style, means that not much escapes his attention.

Though the citizens of Wilmette would shrink from the notion that a political machine runs the schools, the way school board members are picked would have been the envy of Mayor Richard J. Daley. A caucus of some 80 people, representing the local organizations, the garden clubs and the Junior League and the PTAs, screens candidates and assembles a slate. The election is a formality, since no one has beaten the slate in recent memory. Wilmette has adopted a sanitized version of ward politics, with the slate studiously balanced to take into account the geographic and ethnic divisions in the community, although, as one might expect, no one discusses this.

Bill and Fran McCardle (their names and certain details have been changed) had moved into one of Wilmette's old Colonials in 1983, when Bill's company transferred him to Chicago. The McCardles hadn't gotten involved much in school affairs; they were not "PTA types," recalls Paul Nilsen, principal of Central School, which the two youngest of the four McCardle children attended. When they learned in April, 1986, that their son Jamie had AIDS, the McCardles didn't tell anyone, not even their own children. Many months later, however, after the whole family had worked its way through the denial and then the worst of the pain, they determined that keeping the secret was tearing the family apart. They would enjoy a peaceful Christmas holiday, Bill and Fran decided. Then they would talk to the principal of Jamie's school.

As a family, the McCardles had known more than their share of hard times. Bill's first wife, Mary, died of cancer in 1982; Bill's mother, who came to take care of the children, also died suddenly. But then things seemed to turn around. Bill met Fran, a teacher in the inner-city schools and later a social worker, a woman with the kind of instinctive warmth that could gradually win the affection of the grieving children of another mother. Together they rebuilt a family and had another child of their own.

Jamie had been adopted in May of 1982, just months before Mary's cancer was diagnosed. The boy's natural parents were both intravenous drug users who had abandoned him when he was 6 weeks old, and Jamie had lived in foster homes until he was nearly 2. "When he came to us he was totally withdrawn—not a normal child emotionally," Bill recalls. Though he was plagued by a string of minor health problems, the boy had gradually emerged from his shell. "We have had the joy of watching him develop," says Bill. Then, in April, 1986, came the news from the adoption agency: Jamie's mother had full-blown AIDS. The boy, when tested, was found to have the virus.

Suddenly Jamie's long bouts of illnesses made sense. And suddenly, says Fran, "our world cracked."

Initially, mother and father responded differently. To Fran, it was important to talk through what the news meant, to explain it to Jamie and his brothers and sisters and to tell people who would come to know their son. But Bill was deep into denial. For months he was hell-bent on insisting on his rights, on fighting for his son's privacy and his own.

As soon as the diagnosis was in, Bill started reading everything he could find on AIDS. He learned what Ryan White had gone through fighting to remain in school in Kokomo, Ind., and he didn't want that to happen to his son. Bill worried that bricks would come flying through his living-room window. When the McCardles had talked with their pediatrician about the possibility that Jamie had AIDS, the doctor had told them bluntly that he wanted nothing to do with the boy. What would the schools say?

Slowly, though, the story began to leak out. One day just before the 1986 Christmas vacation Jamie whispered to his teacher, Jane Gold (not her real name), that his mother had told him a secret. "She said that when I was in my mom's stomach, my mom passed a disease on to me before I was born. But if I eat the right food, I'll probably live to be okay." A worried Jane Gold phoned Fran McCardle, who said, "Let me work on this over vacation; then I'll explain what's going on."

Fran was worried about how other mothers would react when they learned that their children were playing with a boy who had AIDS, and she told several of her neighbors. The other McCardle children each told a best friend or two.

Fran and Bill had gone to the Howard Brown Memorial Clinic, a gay-run Chicago center for treatment of AIDS and sexually transmitted diseases, and had received both good advice and needed comfort. The initiative was Fran's, but the experience had had an especially deep impact on Bill. He used to be

scornful of homosexuals, but now he became deeply admiring of how gays supported the sick and dying among them and deeply angered at how, in his view, the Reagan administration was playing on the nation's fear of homosexuality. By December, Bill says, "I realized, finally, that I had a child who was going to die. I should be dealing with that reality in our family, not only for Jamie but for the other children and for myself."

On the morning of Jan. 6, 1987, not knowing what to expect, the McCardles called on Nilsen at Central School. "Part of me was ready to say, 'Here's our lawyer,'" Fran remembers, but that wasn't necessary. "I'm glad you've come here," principal Nilsen told them. "This is where your son belongs."

From talking with Gold and another teacher in whom Jamie had confided, Nilsen knew that something was up. But he has been putting parents at ease since he became Central's principal in 1971. There is nothing especially imaginative about Central Elementary School's program; as with the rest of the Wilmette schools, Central is, as District 39 School Board President Don Stephan characterized it, "on the cutting edge—but a bit behind the blade." What makes Nilsen special is the respect and behind-the-scenes support he offers his teachers, the care he devotes to the concerns of the parents and the teddy-bearish warmth in which he envelops the students, who greet him by name as he walks through the halls. "If AIDS had to happen someplace in our schools," says Gussner, "it's good that it was at Central."

The day after the McCardles went to see Nilsen, Gussner and Stephan met for their weekly breakfast. "Just one more thing," the superintendent recalls telling the board president after the third cup of coffee. "Make it quick," replied Stephan, who was running late for an appointment. "There's a boy with AIDS at Central," Gussner said. Stephan sat back down.

Nilsen had gone to Gussner immediately after his meeting with the McCardles, and together they began mapping out strategy. Now Stephan made his contribution. Though AIDS was not something he knew much about, the board president's profession gave him a head start in thinking about how Wilmette should proceed. Stephan is an executive with Hill and Knowlton Inc., one of the biggest public relations firms in the business and a specialist in handling corporate crises. AIDS had the potential of being Wilmette's Bhopal.

The decisions came thick and fast. Secrecy was essential if Wilmette was to be prepared by the time the story broke, and the number of people the McCardles had already told meant that could happen at any time. The idea was for Gussner and Nilsen to keep up their daily rounds while quietly slipping in the AIDS work that had to be done. Other key administrators and the members of the board would be brought into the picture at regular meetings over the following week.

Eventually a hotline was set up, and everyone who had a stake in the enterprise was given a packet of articles and question-and-answer material that explained why a child with AIDS does not endanger his classmates. The list of those who were informed included all the people who worked in the schools, from teachers to secretaries and janitors, other town officials (who had to be assured that Wilmette planned no cover-up); all the local pediatricians, the

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staff at St. Francis Xavier parochial school; the clergy; the media; and, most important, the parents.

In deciding what course Wilmette should follow, the school board found little to debate; the only disagreements were over the details of how to get the message out. The decision was essentially self-dictating, Stephan says, because of the medical and legal advice that Wilmette had received. A year earlier the school administrators had quietly adopted the AIDS guidelines of the Centers for Disease Control while asking their lawyers to draft a policy statement covering infectious diseases in general. Board members prided themselves on checking their emotions at the door and making a decision based on medical and legal evidence. The last thing they wanted was for Wilmette to be seen as another Kokomo, which in their minds connoted irrationality.

Early on, Gussner and Stephan decided that the school would be identified. That would localize the concern, thus minimizing the possibility of panic. But to maintain confidentiality, no other details were ever released to the public: not the name of the child or his grade level; not how he had been exposed to the AIDS virus or even his sex. Whenever Nilsen or Gussner referred to the youngster, it was always "he or she." Indeed, Gussner was so insistent on keeping the secret that Stephan had to order him to divulge it to him as the board president.

It was not until Jan. 20, two weeks after the McCardles had met with Nilsen, that Wilmette went public. That morning 2,000 copies of the AIDS information packet were mailed to parents. The superintendent and the board president made the rounds of all the schools, accompanied by Dr. Ellen Chadwick, the area's top pediatric AIDS specialist who happened to be one of the referring doctors working on the case, and Fred Lifton, the district's longtime attorney.

There was an audible gasp from the teachers at Central, Stephan remembers, when they were told, first thing in the morning, that one of their students had AIDS. At the other Wilmette schools, the reaction ranged from "That's their problem" to "Why does this child have to be in school?" to "We trust you." At Central that day the children learned from their teachers that one of their classmates had a disease called AIDS. "We didn't want a big assembly," says Nilsen. "The classroom teachers are really counselors to their kids."

At 4:30 that afternoon, Stephan and Gussner met in Gussner's office. Gussner had been attending a superintendent's meeting in Florida. He had flown back that morning and sped from O'Hare to Wilmette in the midst of a blizzard; he was wiped out. As soon as they walked into the office, the superintendent and the board president were joined by Rick Rosenthal, a Chicago TV reporter/anchorman whose child, it so happened, had gone to the Central the previous year. According to Wilmette's timetable, the media were not supposed to come into the picture for another day; by then, the packet would have been in the parents' hands. "Gentlemen, you have a prob-

lem," said Rosenthal. "We do now," Stephan replied.

Don Stephan knew that the way the media handled the AIDS story was crucially important, but there was no way to predict the angle reporters would take. Wilmette was the lead story on each of the TV stations that night, and it was page-1 news in both Chicago papers the next morning. What the reporters wanted was the identity of the child, but that, they were told, was legally privileged information. When one of the TV crews went out to Central School to gather parent reaction, they happened upon a parent who had adopted three handicapped children. From the school district's point of view, the interview couldn't have gone better. "Life is full of risks," the parent told the interviewer. The papers described what The Tribune's reporter called the careful balancing act the Wilmette schools were engaging in as they weighed the rights and needs of a sick child against the concerns of the community.

Within 48 hours, as the first meetings with parents were being held in Central's auditorium, the media had its angle: Wilmette was the community that cared, the town that had bucked the panic that had ripped other places apart. It helped that key media figures knew Wilmette firsthand: Two of the TV reporters lived there, as did the reporter covering the story for the Sun-Times and the managing editor of The Tribune. It helped, too, that Don Stephan knew how to talk to reporters and that Bill Gussner had regularly faced tough questioning while promoting integration in Missouri.

The facts were also more or less in line with the media's version of events. In the days following the announcement, parents weren't pulling their children out of Central Elementary School, and civility continued to reign. One of the local weeklies, Wilmette Life, noted the "business as usual" atmosphere at Central, just one day after the story hit the news. The teachers' union president was quoted as saying that the teachers at Central "were dealing with the children's concerns rather than their own."

There were, to be sure, parents who told reporters they believed that the child should be kept home, parents who didn't want their children exposed to what one mother called "the modern-day plague." But these comments were effectively neutralized by the words of those fathers and mothers who endorsed what the schools were doing and who cautioned that "this is the time for this community to remain cool."

On Jan. 23, three days after Wilmette had gone public with its decision, the Sun-Times rhapsodized about the "admirable example" the town had set. So conscripted was the media to Wilmette's cause that when one unhappy parent leaked Jamie's name a few days later, no one would go public with it.

The parents' meetings were not in fact always so calm or the parents themselves invariably so rational. Among the 400 mothers and fathers who packed Central school for the sessions held the afternoon and evening of Jan. 22 there were those who insisted that the procedure that had been adopted, taking questions on 3-by-5 cards, effectively sanitized the discussion; charges of censorship were in the air. Other parents were unconvinced that the decision to keep a child with AIDS made sense. Fran McCardle was sitting in the audience, a silent observer who absorbed all the fears.

"I'm very concerned, very nervous and very frightened," said Dr. Alieh Arjmand, an obstetrician from India with a practice in Chicago. Arjmand buttonholed everyone she could find, parents and administrators and reporters, telling them that she wanted to transfer her two children out of Central. Dr. John Phair, a Northwestern University medical school professor and a nationally known AIDS expert who spoke at the parents' meetings, a man who looks every bit the part of the all-wise doctor, recalls another uncomfortable moment: An angry buzzing spread through the audience when, following the advice of Fred Lifton, the cautious school attorney, Phair told them that the way in which the child had contracted AIDS was irrelevant. "How do we know there isn't a molester on the loose?" one parent demanded.

Fears about a molester were eventually put to rest when Phair, known to many in the audience because he lives in neighboring Winnetka, prevailed on Lifton to allow him to reassure parents that the child had not been sexually abused. Most of the parents' questions were far more mundane. Ph.D.'s cited references to medical journals when they asked about the scientific evidence; lawyers inquired about legal liability. The team of experts picked by Gussner deftly fielded even the most technical issues, and the audience seemed generally satisfied.

At the end of the session, a man who had insisted on speaking rose and faced the audience. Don Stephan braced himself for the worst, but what he heard couldn't have sounded sweeter if it had been drafted by the public relations man himself. "I hope to God you're doing the right thing. But I think that all of us in this room support you and appreciate the courage it took for this family to come forward." The meeting ended in applause.

The McCardle's decision to come forward, to share their secret with the town, moved many parents. But that weekend there were new fears, spread by supporters of political extremist Lyndon LaRouche. LaRouche was known all too well in the Chicago area. The previous spring, in a stunning bit of political guerrilla theater, two of his hand-picked candidates had walked off with the Democratic Party's nominations for two statewide offices. The ensuing attempt by the honest-to-God Democrats to disassociate themselves from the LaRouche Democrats probably cost the party the Illinois statehouse.

LaRouche had made AIDS a cornerstone of his political agenda, with the slogan "Spread panic, not AIDS." His National Democratic Policy Committee platform called for mass AIDS testing and quarantining of all those—by now, numbering in the millions—who had been exposed to the virus. In California the previous fall, LaRouche followers had gotten an AIDS quarantine proposition on the ballot. It took a $2 million campaign to defeat the proposition, and LaRouche had vowed to go to the voters again.

Schools were an obvious place for Lyndon LaRouche's forces to spread panic. As early as the fall of 1985 they had vainly tried to stir things up in the Brighton neighborhood of Boston. More recently, in Granby, Conn., a small town just outside Hartford, Paul Cameron, a psychologist and ally of LaRouche's, crusaded—also unsuccessfully—against allowing a child with AIDS in school.

The LaRouchites know how to fight dirty—when they are trying to silence an opponent, they are trained to shout "He has AIDS! He has AIDS!"—but in sedate Wilmette they prudently couched their message in the quieter terms of pseudoscience. LaRouche supporters handed out leaflets to parents attending the informational meetings and stuck fliers on the windshields of the parents' cars. Several hundred families received a fat packet of articles from the New American, the party's house organ, warning what happens "When Perversion Prospers" and

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issuing an "AIDS Warning: The Surgeon General's Report May Be Hazardous to Your Health." The weekend after Wilmette's announcement, a sound truck broadcasting the LaRouche message of fear cruised the streets.

The Wilmette police quickly put a stop to the campaign: They escorted the sound truck to the edge of town, and they shooed off the leafleteers. Local ordinances banning sound trucks and requiring permits before leafleting backed them up.

Wilmette was not yet home free, though. At the third forum, held on Monday, Jan. 26, three visibly anguished women made their way to the front of the auditorium. They turned toward the waiting cameras as they entered the assembly hall. Throughout the meeting, the women seethed. "That's not so," they muttered while Phair and Gussner were answering questions from the audience. "Tell the truth."

A card turned in to Stephan, who was chairing the meeting, greatly worried the school board president. "The AIDS patient is in my son's special-education class," the card read. "Not only will the school district not remove the student from the class, they will not allow us to remove our children to save them. The AIDS patient constantly puts toys and pencils in his mouth." Stephan ignored the raised hands of the women until the end of the meeting, when the TV crews had left to file their stories. Then the mother who had written down her accusation turned to the assembled parents and said her piece. "At that moment," Stephan recalls, "I thought it had come undone."

Yet what the audience apparently heard in the voice of this mother was the unraveling edge of hysteria, not a factually rooted claim of danger. By now, over the course of three meetings, seemingly all of the parents' hardest questions had been answered, all the contingencies explored. It was time, almost, for business as usual. Still it was clear that some of the parents whose children were in Jamie's class had unanswered questions. Jamie had been sensitive to all the talk about AIDS, and the boy innocently told one of his classmates that he was the child in question. That boy's mother turned out to be the woman who had submitted the 3-by-5 card. That night she and her son telephoned everyone else in the class with the news. That alarmed both the youngsters and their parents.

Among all the parents these were the ones most likely to be alarmed. They were also the fathers and mothers whose understanding and support mattered most if Jamie was to continue leading a normal school life. At this point the McCardles took a brave step. They decided to host a meeting for all these parents at their house. Ellen Chadwick, Jamie's doctor, would be there, as would teacher Gold and principal Nilsen. And everything, including the story of how Jamie had contracted AIDS, would be told.

It was a tense group that gathered up all the seats in the house, the big rocker and the plaid couch and the oak dining chairs, to listen to the McCardles tell how Jamie came into their lives. Shortly after Jamie had been diagnosed, both of the parents had been tested for AIDS, as had two of the children who wanted the reassurance that they were not infected and wanted it badly enough to brave the taking of blood. At the meeting the McCardles could tell the parents of Jamie's classmates that "for years, we didn't know that he had AIDS, and we took no precautions. None of us has AIDS."

All the parents in that living room talked about how sorry they were for what the McCardles were going through and praised their bravery in coming forward. We feel good that you told us, they said. One couple, both doctors, who described themselves as hypochondriacs about their own child's health, added reassuring words. "If we thought that there was one chance in a million that our child could catch this virus, we wouldn't be here tonight."

The mother who had worried so about Jamie's biting on pencils and toys was too overwrought to hear what was being said; she even insisted, against all the evidence, that she knew of someone who had contracted the disease in 1971. But it was Chadwick who made the biggest impression on the parents. It wasn't just that she had the facts to back up her reassurances. She was very visibly pregnant. "Do you think that I would be caring for children with AIDS if I believed that I was endangering my child?" she asked.

By then the controversy really was over—at least the public part. A bomb scare a few days later was treated matter-of-factly. And when the Wilmette News-Voice, a local shopper, tried to make an issue out of that famous 3-by-5 card, townspeople lit into the paper for being irresponsible. Support for the family came from all sides. The Central School PTA's executive board passed a resolution offering whatever help might be needed to a family whose identity they still did not know; and in the spring the Junior League asked Paul Nilsen to find out if the family had a favorite charity to which they could contribute. The answer came back: Please make your donation to the Howard Brown Memorial Clinic, which had seen the McCardles through the roughest times.

It fell to Jamie's teacher to talk with his classmates about AIDS, explaining in simple terms how the disease spread and about Jamie's condition. "What you have heard is true," Gold said. "Jamie has AIDS. Eventually he is going to die."

Some children needed reassurance that they would not catch AIDS; others were simply caught up in their own grief. "He's my friend, I don't want him to die!" one boy in the class said, while another asked whether "AIDS is going to hurt Jamie."

It was fine to talk about Jamie and AIDS in class, teacher Gold said, but "this is a family matter, we're not going to talk about it in gym or music or art," and the class kept the confidence. They talked about how to keep his identity secret from the reporters who, it was feared, would snoop around. "If a reporter asks, we can all say we're the kid who has it," one child said, a sentiment that recalls the historic moment when when Adolf Hitler demanded that the Jews in Denmark wear yellow arm bands, and everyone in Denmark wore them.

There were changes in the class routine. Jamie's behavior was unobtrusively monitored—to make sure, for instance, that he wasn't sharing his food. Hugging time, which had been a daily ritual, was abandoned because it made Gold uncomfortable. But the children continued to hug one another, and they went out of their way to hug Jamie. For several weeks Gold scrubbed Jamie's desk with bleach water every time he sneezed. Eventually she decided that she was being hypercautious.

"We suffered together, but we all learned to be kind and to love one another," says Gold, who recalls those days when she was almost too sad to teach, when only her sense of obligation to the children kept her going. The lesson of caring was heard. A parent of one of Jamie's classmates told Gold that her son had been walking around the house dressed up in a doctor's costume. "I'm going to find a cure for AIDS," he told his mother, "Jamie isn't going to die."

As the teachers at Central listened to the children ask why one among them had to die of this bad disease, they realized that Wilmette needed instructional materials not only about AIDS but also about death, pitched at a level that young children could understand.

The school district responded with customary efficiency, hiring a specialist to produce the needed curriculum. The McCardles, meanwhile, tried to absorb the implications of what was happening. Their son had been welcomed into the Wilmette schools. Their neighbors had rallied around them. And, within a few years, their son was going to die.

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Paul Nilsen drove to Chicago's Pilsen Community Academy, 15 miles from Wilmette, the morning of Feb. 27. Three days earlier, William H. Levin, Pilsen's principal, had been summoned to the office of Deputy Supt. of Schools Joseph Lee and told that a child who had been exposed to the AIDS virus would soon be enrolling in his school. Levin had called the principal at Central Elementary School looking for help, and Nilsen had offered to spell out Wilmette's strategy at a meeting of community leaders.

This was not like dealing with the Wilmette village manager or the principal at St. Francis Xavier; that much Nilsen quickly figured out. All the other school principals in Pilsen Academy's district (one of 20 [illegible] as well as officials from the city's Health Department and the Board of Education, and priests from the six Catholic churches in Pilsen.

The community organizers were there, too. They ran the neighborhood action programs that handled job training and day care, renovated rundown homes and mediated among rival gangs – programs that made Pilsen a real community.

Chicago would be holding mayoral and aldermanic elections in just six weeks, and both candidates for 25th Ward alderman were also present. A Democratic mayoral candidate, Thomas Hynes, had asked if he could attend, but Levin diplomatically demurred. To invite Hynes meant inviting Harold Washington, and if Washington and Hynes showed up, Pilsen's AIDS problem might become a citywide political issue.

Levin knew that there was no way to keep the Pilsen Academy situation wholly out of politics in a city where even the most trivial event of daily life can become a matter of clout. The principal's hope was to make sure that the politics stayed localized, and that meant persuading all the constituencies in the neighborhood, the parents and politicians and priests, that they could live with the decision. Levin knew that if he failed, if the community wound up being split over AIDS, there would be serious trouble.

The meeting came off without a serious hitch, as did Bill Levin's other attempts that week to touch base with everyone who had a stake in the AIDS issue. It was only some days later, when Lyndon LaRouche's followers made a determined effort to broaden the issue by evoking a panic that knew no geography, that the effort to emulate Wilmette began to unravel.

Under Mayor Richard Daley, if you wanted a favor—a job, a zoning variance, a sewer connection—you went to the ward committeeman or alderman where you lived and paid back the favor come election time.

But another and very different kind of politics had grown up in Chicago in the Daley years—the politics of community organizing. Few Chicago neighborhoods have generated more forceful leaders than Pilsen, home to approximately 30 percent of the Mexican populace in Chicago. Though Pilsen is just a mile southwest of the Loop, the two places literally do not speak the same language.

Since Mexicans first began settling in Pilsen in 1917 in the aftermath of the revolution, the neighborhood has been cohesive, with its own traditions and its own organizations. It is not Mexico in Yanqui-land, though, for the Anglo culture inevitably intrudes. Stores in Pilsen have names like "Descuento Center," and children speak their own made-up language of Spanish and English.

Nearly four families in ten continue to live in overcrowded housing, according to a University of Chicago study, more than double the city-wide average, and one resident in four lives in poverty. Many Mexicans emigrating to Chicago still come first to Pilsen, while second- and third-generation Mexican-Americans move away if they can.

The six Catholic churches that line West 18th, the neighborhood's main street, are the backbone of the community; they all draw huge crowds for Sunday mass. The priests, a number of them Hispanic, see their mission in social terms, taking up such issues as immigration as their cause, finding common ground with a host of community groups.

In Pilsen, as in other black and Latino neighborhoods, a new generation of leaders emerged from the events of the 1960s. These were the people who fought for their own neighborhood high school and bilingual education, for decent jobs and health care, people who were not afraid to conduct a sit-in at City Hall or stage a walkout at the local school. Under Harold Washington, some of these leaders have moved on to citywide jobs. With federal dollars scarce, the local organizations—Casa Aztlán, the Latino American Association, the Pilsen Youth Organization—are no longer as strong as they had been a decade earlier, and they are given to bickering with each other. There are those who complain that Pilsen Neighbors, which over the years became the most powerful of these groups, has lost its commitment to local concerns. Nonetheless, it was to the local leaders that Pilsen Academy principal Bill Levin turned, out of instinct and necessity, when the AIDS issue arose.

"One night, a few weeks before I got the call from the central office," Levin remembers, "I had a nightmare that a child with AIDS was being sent to Pilsen. I couldn't go back to sleep, couldn't stop worrying." Worrying is habitual with Levin, a Chicago native who pushes himself 10 and 12 hours a day, 6½ days a week, teaching drivers' ed and adult courses, running three miles and doing 50 pushups daily as well as running Pilsen Academy. He is a perfectionist by nature, constantly wondering whether he could be doing a better job. "My family," he says, "calls me Calamity Jane."

Levin has been principal of Pilsen Academy since 1973. The school, almost entirely Hispanic, enrolls 1,000 students, and from the outset Levin was the foreigner, the Jewish Anglo who speaks no Spanish but who had been assigned by the downtown bureaucrats to a Latino world. A boycott organized by neighborhood groups had forced out his predecessor, a woman with a reputation as a disciplinarian who displayed too little love for her charges and who, it was said, looked down on the Pilsen community. Some years later, those neighborhood organizations reportedly arranged with the Board of Education to secure a Hispanic superintendent for the district. That history has led Levin to cultivate the leaders of the neighborhood groups as if they were hothouse orchids.

Over the years Levin has remade his school. He has been able to do what any successful principal must do in the city of clout, use his contacts in the bureaucracy to wheedle extra books and state-of-the-art computers out of a central office that chronically pleads poverty. When Pilsen became a magnet school in 1982, able to offer special programs and to attract students from a wider geographical area, Levin secured not only additional teachers but, equally important, the authority to choose his staff. "What matters most is the quality of the teachers in the classroom," he says. "If you don't have good teachers, you don't have anything." Perhaps the best testimony to Levin's perfectionism is his file of 50 staff members he has eased or pushed out over the years, a startlingly high number in a strongly unionized school system.

Although Levin is not without ambition—he imagines himself a high-school principal or a superintendent in a suburban town—it is not personal power but institutional performance that drives him. In several grade levels, his new teachers have brought the reading and mathematics scores of Pilsen Academy students up to nationwide averages. School attendance figures are among the highest in Chicago, partly because Levin cares so much about students' coming to class that he hands out awards for good attendance. A sophisticated testing program that identifies the learning problems of kindergartners, developed at the school, has won national attention. All this has earned Levin the Citizens School Committee award as Chicago's outstanding principal.

Though Levin has sometimes found himself in hot water with the union for his handling of teachers, the parents have rallied to his defense. So has Pilsen Neighbors, a community group that has received help from the principal in raising money. The principal knows that he can never become district superintendent in this part of the city. "We need one of our own," he was told by one of his closest allies in the community. But Levin figures he is solid with the parents and the teachers. "I get maybe 60 Christmas presents a year from the teachers and 'superior' evaluations from almost all of them.... Right after the AIDS thing settled down they chipped in $400 for an escape weekend."

The principal wasn't the picture of confidence, though, as he headed to Deputy Supt. Joseph Lee's office on Feb. 24 in response to a cryptic summons. "What have I done wrong?" he was asking himself. Lee had been Levin's district superintendent before moving up to the No. 2 job, the man who ran day-to-day operations for the system, and he was Levin's godfather in the bureaucracy. But in the web of fragile alliances that forms the 430,000-student Chicago school system, things could fall apart at any time.

Lee, Levin recalls, explained the reason for all the secrecy: A child who had been exposed to AIDS had been reviewed by the systemwide medical screening panel and was being assigned to Pilsen. Levin wanted to know if the youngster lived in the neighborhood, thinking the answer would affect how the parents in Pilsen reacted. But Lee said no, but that the child—who is Mexican—belongs in Pilsen Academy because the school was "the appropriate educational placement."

"Like a good second lieutenant," says Levin, "I took my marching orders." There would be a teachers' meeting the next day, Feb. 25, with school officials and a nurse—but no doctor—present to answer questions; a few days later, there would be a meeting of community representatives, and an explanatory letter would be sent out over Lee's signature to all the parents. It was "chancy" to inform so many people, Lee acknowledged, for information invites problems. But not telling the community could create far greater problems if the news ever leaked out. Bob Saigh, director of pubic information for the Chicago schools, volunteered to assist Levin; otherwise, the principal was on his own.

The procedure that the deputy superintendent followed for Pilsen had been generally set down in the AIDS policy that Chicago's Board of Education had hammered out the previous year, a policy that itself had been the center of controversy. For months on end there was talk about AIDS among the 11-member Board of Education, a racial and ethnic microcosm of the Chicago schools picked by the mayor for five-year terms. The school administrators were anxious to adopt guidelines that followed the recommendation of the Centers for Disease Control—keep children with AIDS in school unless there is some special reason to fear contagion—but some board members disagreed. Draft after draft was sent up for review, first to the board's management committee and then to the full board.

The dissenters got their ammunition from Dr. [illegible], a local pediatrician [illegible]

as a consultant. Early in the history of the AIDS epidemic, Mendelsohn had urged that those with the disease be quarantined and that researchers announce their sexual orientation, apparently as a way of signaling their biases. In his testimony before the board, Mendelsohn dismissed the "so-called prestigious experts" from whom the board had heard, attacked the studies showing that AIDS had not been spread in the households of AIDS patients and derided the Centers for Disease Control as "hysterical." Experts on "both sides of the question" should decide whether a child infected with the AIDS virus could attend school, Mendelsohn argued.

The school administrators feared that they had lost their fight. Eventually, they persuaded the board members with loads of reassuring information on how AIDS is transmitted. Or almost persuaded them: When the Board of Education finally adopted its AIDS guidelines, in June, 1986, Mendelsohn was named to the medical screening panel.

In January, 1987, when the young child who was eventually assigned to Pilsen came before the medical panel, Mendelsohn's was the only vote against admission to school. What the public knew was only that although he or she had tested positive to the AIDS virus, there were no signs of the disease. The public was never told that the child's mother and two siblings had full-blown AIDS.

The school administration treated the decision of the medical panel and the subsequent placement recommendation made by a committee of educators as part of the bureaucratic routine laid down in the guidelines. What they hoped for, recalls Deputy Supt. Lee, "was a quiet, purposeful approach—a low-key approach. No one thought the LaRouchies were working that neighborhood." George Muñoz, then president of the Board of Education, learned about the medical panel's determination through channels in a matter-of-fact memo from General Supt. of Schools Manford Byrd Jr., and when Muñoz inquired, he was told that things were in capable hands.

The Chicago school administrators saw little reason to take any special measures in Pilsen. After all, the act of adopting a policy had put them in the forefront on AIDS in Chicago. Although the city has the seventh largest number of AIDS cases in the country—917 as of Oct. 30, 1987—Chicago had not really awakened to the epidemic. With Chicago not yet caught up in the AIDS issue, it made bureaucratic sense to play Pilsen by the book. That was what the school bureaucracy habitually did. They were leaving matters in the hands of the locals, a strategy assiduously promoted by Byrd, who believed that principals had credibility that the central office sometimes lacked.

With such a laissez-faire attitude, it was indeed "providential that the first AIDS case should be in a school headed by someone with Bill Levin's capabilities," Deputy Supt. Lee observed—the same sentiment that Bill Gussner expressed about Paul Nilsen in Wilmette. And Levin recalls thinking: "We'll be compared to Wilmette. It's important to leave no stone unturned."

On the morning of Feb. 25 the teachers at Pilsen Academy heard the news. It was an awkward session. "The top brass just said, 'There is no choice,'" recalls teacher Nydia Gonzalez. "There were lots of unanswered questions when we walked out of that room." But once the teachers recovered from their initial shock, once they had had a chance to ask questions about risk and health insurance, about bringing the disease home and the district's legal liability, they came around. None of the teachers took up Levin's offer to arrange a transfer to another school, and Mary Jane Andrade, a teacher's aide, volunteered to work with the AIDS-stricken youngster. "I had tuberculosis as a child," she said, "and I know how it feels to be pushed aside."

Levin helped restore the teachers' confidence by making himself available every day that week, before and after school, to talk through their concerns. He was collecting articles on AIDS, informing himself and passing along the materials. "If this had to happen any place in Chicago, it is a godsend that it happened at Pilsen," became the teachers' mantra.

That same day Levin contacted his allies in the neighborhood. Among the key people, there was Lucy Gutierrez, who as a member of the local alderman's staff had been helping the residents of Pilsen for years. Gutierrez had collected 10,000 signatures for a new health center in the early 1970s; now her daughter was a teacher's aide at the school. There were also Lourdes Ortega and Sylvia Domingues from the school's parents council, and Andrade, who had been so helpful at the staff meeting and whose daughter was enrolled at Pilsen Academy. And there was Raquel Guerrero, an organizer with a migrant workers' group who had moved to Pilsen with her family in 1957, fixing up a falling-down house and shepherding her children through the public schools.

Early in the 1980s Guerrero had come to the rescue of Pilsen Neighbors, mortgaging her home to bail out the community organization when it was in danger of folding. That gesture put her in a financial bind, yet Guerrero never took a cent from any neighborhood group. Nor would she accept a job as an aide at the school; the money would keep her from speaking her mind, she felt.

"We're No. 1 in everything," said Guerrero. "But why are we No. 1 in this?" Yet she agreed to help Levin. "I had a son who died of hepatitis," Guerrero says. "My neighbors weren't sympathetic. They said: 'What did he die of? I need to take my child for a shot.' I knew how the mother of that child was feeling."

The support from these three women gave Levin some credibility at the meeting of the school officials and the Pilsen community leaders, the session that Paul Nilsen attended, held on Feb. 27. But the principal had a hard selling job. The community organizers expressed their support for the school—but not for the Chicago school system or its AIDS policy. All they would promise was to stay away and keep mum rather than risk turmoil by making their worries about AIDS generally known.

When Levin asked Ortega of the parents' council how families would react, her response was graphic: she mimed slitting her throat. Carlos Valencia, president of Casa Aztlán, angrily accused the school district of plotting against Pilsen, and Saigh, the spokesman for the school system, replied, "Do you think we would pick a school in the most politically active neighborhood in Chicago to place a child with AIDS if we had any choice?"

As Levin walked out of that meeting, he believed that he was over the worst. The letters to parents had gone out, and the school had set up a hotline. The priests would speak out from their pulpits in support of the schools, and in devoutly Catholic Pilsen their voices would be heard. The principal, working with Saigh, had lined up a raft of speakers for the public forum, scheduled for the following Thursday, March 5. Politicians, school officials and doctors

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would all be giving the same message. The enrollment of the child was a compassionate act that posed no medical risk. A Catholic Chicago bishop, who happened to be the brother-in-law of one of the city's top school officials, would give a homily in Spanish. Following the procedure that had worked well in Wilmette, questions would be submitted in advance; since many of the parents spoke only Spanish, several teachers had been lined up to translate. But before the question-and-answer period could begin, the supporters of Lyndon LaRouche turned the meeting into a wide-open brawl.

This was not the LaRouchites' first adventure in Pilsen, nor were all the LaRouchites outsiders. "I was born in Pilsen," said Herman Garza, a staunch LaRouche supporter. "We work here, we organize." In 1979 the LaRouche organization held its first public meeting in Pilsen; a year later, when Lyndon LaRouche ran for president, he campaigned in the streets of Pilsen.

Driving home from his meeting with Joe Lee earlier in the week, Levin had spotted a van belonging to the National Democratic Policy Committee, LaRouche's party, which was fielding candidates in the upcoming Chicago elections. "Quarantine All AIDS Cases," read the banner hanging from the van, and Levin shuddered. During the first days of March, while the principal readied himself for the forthcoming community meeting, things were quiet in Pilsen. The hotline had almost no calls, and Levin caught himself thinking that "this could be a piece of cake." But the LaRouche activists were busy taking their message of fear door-to-door in Pilsen.

Several of Levin's old antagonists were among the parents that the LaRouchites conscripted to their cause. Their reaction was partly genuine fear about AIDS, partly Pilsen politics.

It wasn't clear until the March 5 meeting just how effective the LaRouche forces had been, and by then it was too late. "When I came home at 3 that morning," Levin recalls, "I crawled into bed and told my wife that I wanted to cry.... We had tried so hard to keep the LaRouchies out by using lists of all the parents, but they slipped past us by posing as spouses of single parents."

Nearly 500 people crowded into the school's auditorium that meeting night. Every seat was filled, and people stood in the aisles. For the first half hour, things went smoothly enough. But when Levin began to speak about the "misconceptions" that surrounded the youngster who would be enrolled at Pilsen, the LaRouche supporters, who had positioned themselves in the front rows of the auditorium, made their move. "Liar, liar," they started shouting as Levin pleaded vainly for a chance to communicate the facts. "Where are the guarantees?" they yelled, and then demanded that the matter be put to a vote.

Levin tried switching to the questions and answers, but when the shouting persisted, he returned to the planned format. There was a brief calm when Dr. Lonnie Edwards, commissioner of the city's Health Department, beseeched the audience to "open up your ears and hear the truth we have to tell you. Use your minds, use your hearts." Then the tumult began all over again.

Levin turned to LaRouche sympathizer Garza, who had loudly been demanding the floor, and invited him to speak. Levin thought he had a deal—Garza would talk and the session would continue—but Garza rushed the stage, bent on taking over. At that moment, a furious Raquel Guerrero gave Garza a shove, and pandemonium broke out. It was *mano a mano* in the auditorium as LaRouche backers mixed it up with angry parents. "Is this Russia?" the LaRouche supporters cried when members of the Chicago police force, who had let the school administrators know that they would intervene only if things got violent, began carting off the antagonists. The meeting collapsed.

As Levin and Saigh spent the succeeding days planning a series of 24 simultaneous AIDS information sessions to be held on March 12 at Pilsen Academy and carefully limited to parents, the LaRouche supporters stepped up their noisemaking. They spent the weekend cruising the neighborhood, exhorting parents to keep their children home. On Monday, March 9, 190 children stayed away from the 1,000-student school, four times the usual number of absences. Many parents had brought their children to school but were scared off by talk of a bomb inside the school.

The children who came to class that day were learning about AIDS. When Levin visited a 6th-grade classroom, the students recited the ways AIDS could be transmitted. One child asked the principal a question that had become all too familiar: "Why don't our parents vote on whether to admit a child exposed to AIDS to school?" Levin explained that this wasn't the kind of thing people voted on—"Would you want people voting on whether you were in school?"—and then took an informal poll. Almost unanimously the youngsters said that the child should be allowed in school. "You've got more compassion than the people out there," he told them.

Outside the school, the LaRouche activists were picketing, blaring their message in Spanish. "This school is being used as an AIDS experiment because it is a minority school," they claimed. Raquel Guerrero stood down her antagonists. "Go home! Go home!" she demanded, waving her finger in the face of the leaders, while other parents encircled the LaRouche contingent with signs saying "LaRouche Must Go" and "LaRouchies Are AIDS." Levin, who had anticipated the LaRouche protest, called the police; when they tried to move the demonstrators along, the LaRouche contingent became "very combative," in the words of the police. Six people were arrested, including two parents of Pilsen children.

By now the Chicago news media were all over the Pilsen story. There was lengthy coverage on the Spanish TV stations, which had never previously paid much attention to any AIDS issue. Levin became a TV fixture, talking about "hand-to-hand combat with the LaRouchies"; Guerrero and Gutierrez, the longtime Pilsen organizers, and José Cerda, one of the principal's familiar adversaries, were also frequently seen on the nightly news.

"They don't ask the parents," Cerda complained. "We have no rights." But other parents, quizzed by the newsmen, contended that the LaRouche activists were "here to twist our minds; they said the whole school is contaminated with AIDS." When WBBM-Ch. 2's Walter Jacobson questioned Levin closely about the risks involved, the principal came off looking like a man who knew his stuff.

Levin looked like a leader, too. "We will listen to parents and respond to their concerns," Levin told the TV reporters. "We've got 90 percent of the parents now," Levin said on March 10, the second day of the LaRouche-organized boycott, when absences had been cut in half. "Our job is to convince the other 10 percent." By week's end, as even the most skeptical parents began bringing their children back to school in the aftermath of the AIDS informational meetings, both The Tribune and the Sun-Times offered editorial pats on the back to the "responsible" citizens of Pilsen.

Levin was putting up a brave front—"We'll be like Wilmette in a couple of weeks," he declared—but behind the scenes things weren't going entirely smoothly. The mother of the AIDS child had suddenly vanished, unnerved by the outcry, taking her child with her, and for several days the principal could not locate them. In the face of the school's troubles, the administrators were remaining mute.

Other principals were calling Levin, telling him he was crazy to let a child with AIDS in his school. "I'd be fighting this," they said.

These neighborhood leaders had been led to believe that the AIDS dispute could be readily contained, that there really were no serious medical concerns. The appearance of LaRouche backers gave them another reason to side with the schools, for it was important to them that LaRouche not gain added support in Pilsen. Several years earlier, in a fight over the placement of a drug treatment center in Pilsen, Gutierrez and Guerrero had been wooed by the LaRouchites, who had concealed their identities. "They wound us all up," remembers Gutierrez. Guerrero had even been sent to a convention of the National Democratic Policy Committee in Detroit. "A bunch of walking mummies," Guerrero called the conventioners, who cheered every word of their leader. "I didn't want to listen to this philosophy of hatred." Pilsen had to be preserved as *their* turf, not Lyndon LaRouche's.

Yet in the days before and after the disrupted meeting, as parents kept hearing stories about mosquitoes, saliva and sweat while the Health Department and the Board of Education were nowhere in sight, these women started wondering whether they had been misled. Their credibility—their only real resource—was suddenly on the line.

The small in-school meetings organized by Levin and Saigh, from which the LaRouchites were effectively barred, answered some of the parents' questions. But it was time to enlist some new allies, Gutierrez and Guerrero and the others decided. On Wednesday, March 11, a Pilsen contingent marched into a Board of Education meeting to demand that the board—particularly George Muñoz and Linda Coronado, the two Chicano board members—make an appearance in the community.

Coronado, the board's newest member, was a familiar and trusted face in Pilsen, for she had been an organizer in the neighborhood and had run the women's center there. Muñoz, the board chairman, was less well known. Though Muñoz had grown up poor, one of 12 children in a home where only Spanish was spoken, his brains and industriousness had been his ticket out—to Harvard Law School and a partnership in one of the most prestigious downtown law firms.

Muñoz knew that his Hispanic heritage was a principal reason for his being on the board. Now, in Pilsen, he was being called upon to put his credibility on the line for his constituency.

There were about 200 people in the auditorium the evening of March 13 to hear Muñoz, Coronado and three Hispanic doctors, including Jorge Prieto, the septuagenarian president of the Chicago Board of Health who over a third of a century has delivered a thousand babies in Pilsen. Muñoz regarded Prieto as the ideal medical spokesman for Pilsen, and Prieto was only too happy to oblige.

The school was heavily guarded to keep the LaRouche supporters away. When Levin appeared, Guerrero politely but firmly ushered him out. "You are part of the system," she said, "and the parents want to hold this discussion without any influence from the school system." The principal understood, but he couldn't help feeling hurt; he went back to his office, turned on the public address system and listened. He had done his part. Now it was time for the community leaders to take charge.

The doctors were closely questioned by the parents, who by now knew all the questions, and the women kept things calm. "Don't get too emotional, doctor," Lucy Gutierrez said when one of the doctors started slipping into a passionate peroration about the risks of everyday life. Prieto, when asked about guaranteeing the safety of the children at Pilsen, won over some of the parents by saying: "I'll sign a guarantee that your child won't get AIDS in school if you will guarantee that your child won't have sexual intercourse, in school or out."

The school board members, Coronado and Muñoz, got a thorough going-over, too. "Why did you abandon us?" one parent asked. And another again raised the possibility of putting the matter to a vote. A community organizer framed the matter of accountability squarely. "We trust you. If you tell us it's okay to let this child in our school, we'll do it."

That Sunday, March 15, AIDS was what all the parish priests spoke about. The priests of the community had joined to send a pastoral letter to their parishioners about the child who had been exposed to AIDS. At Providence of God Church, where the Pope had stopped briefly in 1979, Father Tim McCormick preached about AIDS in Spanish to 800 parishioners. "It is the outsiders who are the problem," McCormick said. "We have to remember who we are. We know more than anyone what oppression is. We can't become the oppressors. . . ."

Muñoz got Supt. Byrd to commit a full-time nurse to Pilsen and confirmed that the medical advisory panel would closely monitor the situation at the school. At a session at Pilsen the following Monday the board president tossed out these ideas as possibilities; quickly they became community demands that Muñoz could then satisfy.

That strategy almost proved too clever. "You keep telling us there is nothing to worry about," one parent said to Muñoz. "Why are you taking all these extra precautions?" Yet by this time, nearly three weeks after Levin had first learned that a child exposed to AIDS would be assigned in Pilsen, things were back to normal at the school. The LaRouche contingent had vanished. The community skeptics were quiet; Jose Cerda, who had demanded that his children be allowed to transfer, sent his wife in to apply for a job on the school bus that took the infected youngster to and from school.

Inside Pilsen Academy, things had returned to normal, too—in one case, far too normal. When Levin went to see how the AIDS-infected pupil was being treated, he was horrified to learn that teachers were

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being very casual in cleaning up her nosebleeds; the principal promptly bought disposable gloves from a medical supply house. By the end of the school year, it was hard to locate a parent in Pilsen who would admit to harboring serious misgivings about what the school had done, harder still to find anyone who would acknowledge any sympathy for the LaRouche contingent. Levin was still working his 6½-day weeks, still handling questions about AIDS in the schools. The principal still hadn't had a chance to take his wife on that holiday weekend the teachers had chipped in to pay for.

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"I can't keep him in a bubble," the foster father of a young boy suffering from AIDS-related complex (ARC) complained to a Chicago Sun-Times reporter. It was early February, 1987, and the school district still hadn't decided how to handle the Pilsen case. This second Chicago case was potentially even harder.

Although the youngster being sent to Pilsen had been exposed to the AIDS virus, this child was already displaying the signs of a weakened immune system that ARC—and AIDS, to which ARC is often a precursor—signifies. Medically that made little difference, since it is the virus that is potentially contagious, not the diseases brought on by the virus. Indeed, public health experts argue that it is irrational to single out those displaying signs of the disease while many more children, unknown and unknowable to school authorities, are daily carrying the AIDS virus into the schools. Yet some parents, and some school officials, too, saw things differently. It was a comfort to those at Pilsen that the youngster who would be coming to their school was, and indeed might remain, perfectly healthy.

There was another complicating element in the case of the second Chicago schoolchild, one that was never on the table but was clearly in the minds of the decisionmakers: The foster-father was 43, single, and lived in New Town, the Chicago neighborhood that much of the city's gay community calls home.

Chicago school officials maintained a scrupulous silence about the particulars of the case. But the boy's father, who did not identify himself by name, talked to the reporter about his anger at the school system for having delayed its decision.

Nine months earlier the foster father had finally succeeded in beating the bureaucracy. For two years he had been trying to become a foster father in the Parent to Parent program, run by a Catholic service agency. That program placed troubled teenagers with foster parents in hope of eventually reuniting the youngsters with their natural families. Paul Swenson (his name has been changed) was an obvious choice to be a foster father: Since 1981 he had been a volunteer at Chicago's Children's Memorial Hospital and before that had worked with retarded youngsters.

Working with children, says Swenson, was "a mission." That's why the Vietnam veteran had saved up enough to quit his high-powered management job; he wanted nothing to do with "the yuppie bag." Yet for some reason, never explained—Swenson thinks it is because the social service officials believed, mistakenly, that he was homosexual—he never got the required foster-parent license from the Illinois Department of Children and Family Services. Just as he was contemplating taking the agency to court, a social worker with the state agency called him. A young boy with AIDS-related complex named David (not his real name) had just been handed over to them for placement. If Swenson took this child, he would get his license.

The call angered Swenson. "They want to put the two hot potatoes together," he speculated. But Swenson was "frustrated with all the Mickey Mouse," and his nest egg was almost gone. He went to Children's Memorial and talked with the pediatric AIDS specialists, including Ellen Chadwick, David's doctor, who later also treated Wilmette's Jamie. Then he met the youngster, a curly-haired moppet with pie-sized brown eyes. "He needs a guardian angel," Swenson figured, and he was it.

Swenson brought David home from a place he calls a war zone. His mother, a woman who divided her life between Chicago and San Juan, Puerto Rico, was a drug addict, diagnosed with AIDS and barely able to care for her son; she died a month after giving him up. The boy had no blanket, no food, no clothes. "It was a miracle he didn't die there," Swensons says. From the outset, though, David was an irresistible urchin unafraid of strangers, filled with enough energy for two kids, finding affection wherever he could. The foster father and his son spent all their time together and quickly became inseparable. "I haven't done a conventional parent trip," says Swenson. "I didn't know how long he would live, and I didn't want to deprive him of anything. The only thing I make him do is to eat healthy foods."

When the issue of enrolling David in school first came up, Swenson worried about the risks of infection that contact with other youngsters might entail for his foster son. "The risk is all on his side," he thought. During the spring of 1986 the boy, when he was diagnosed as having ARC, had been through a bout of pneumonia. But he had been healthy since then and hadn't picked up the flu his foster father contracted during the winter or developed any of the "opportunistic" diseases that signal full-blown AIDS. So appealing, so full of life were the child and his father they they were asked to talk at a meeting of the Children's Home and Aid Society, which was just beginning to work with AIDS children, and at a Lenten mass in Lake Forest. "We're like show-horses," Swenson says proudly. "While I speak, David works the crowd."

The boy's doctors and nurses agreed that he was "doing so well." He needed the chance of being in school, they said, and in January, 1987, Swenson tried to register his son in Nettelhorst Elementary School, 3252 N. Broadway, just a few blocks from his condo. Things didn't go as planned. "I thought the agency would have warned the schools about David, but they didn't. When we came to the place on the application where it asks about AIDS, their

jaws dropped."

Swenson filed all the necessary forms. Ellen Chadwick wrote to the schools, urging that David be admitted, for he was a healthy and happy boy. From the Chicago public school system, though, there was only silence. The next month Swenson sought out the Sun-Times reporter. "I had no other influence," he says. In early May, he made contact with the Chicago Public Guardian, Patrick Murphy. Murphy made a phone call to the school board, then drafted a "see you in court" letter. "Let's wait until after Memorial Day, then, if we have to, we'll file a lawsuit," Murphy said.

Nettelhorst, a solid brick building dating to the early days of the century, stands in the middle of Chicago's largest gay neighborhood. It is a mixed North Side community, with yuppie couples moving in, blacks and migrants from Appalachia hanging onto places they've lived in for years, and it is also where many of Chicago's most popular gay bars and restaurants are located.

The preschool-through-grade-8 school isn't a central part of this community. Many of the parents in the neighborhood who are most ambitious for their youngsters send them to magnet schools elsewhere in the city or to private schools, and many of the children of Nettelhorst come from outside the neighborhood. Youngsters from overcrowded Hispanic schools nearby are sent there, as are children with behavioral, emotional and learning problems. One quarter of the school's 500 pupils are in its 13 special classes.

Since 1978 Peggy Lubin has presided over this racially balanced confederacy of instructional offerings. And although Lubin doesn't have the power to select teachers that a magnet school principal like Bill Levin enjoys, this able and energetic Chicago native has put her mark on the place. "We take whoever shows up at the door," says Lubin. "That's great, it works."

At Nettelhorst the parents have a say in how the school is run. Lubin was intensely screened for her job by a parent committee—"Twenty-three people sat in a circle around me; for an hour they asked questions"—and an advisory council meets monthly. But for a school that draws on such a dispersed population, it is hard to keep more than a handful of parents involved in schoolwide issues. Most of the parents who do spend time at the school are concerned with one of the special programs; they join the special-education support group or the bilingual parents' council.

Lubin made AIDS the topic of the parents advisory council meeting that was held early in May. A dozen parents and teachers showed up to hear Dr. Roberta Luskin, a pediatrician at nearby St. Joseph's Hospital, explain the facts of the disease. Pilsen had gotten the attention of school administrators throughout Chicago; immediately after the troubles in Pilsen began, James Maloney, Lubin's district superintendent, had asked all the principals to speed up the AIDS education effort.

A pamphlet on AIDS was attached to the spring report cards at Nettelhorst, which parents had to pick up at the school. "That," says Lubin, "is where you put the information you want to make sure isn't lost." She had wanted to set up an AIDS session with the advisory council earlier, but local budget hearings and scheduling conflicts got in the way. Lubin didn't know yet that a child infected by the AIDS virus would be sent to her school. But the principal had read the Sun-Times article that told of a second youngster exposed to AIDS, and she had a hunch that "because Nettelhorst is in the gay com-

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munity, we're going to get that child."

Soon after the advisory council session on AIDS, Lubin began getting a series of strange phone calls from Deputy Supt. Lee. "I'm going to ask you questions about your enrollment," Lubin recalls Lee saying. "Your answers have to be absolutely accurate, and I can't explain anything." Lubin called the district office and asked for Maloney, only to learn that he was in conference with Lee. On Friday, May 22, Lubin was told to come to a meeting at Lee's office. Lee asked Lubin if she had figured out what was going on. She had.

The Chicago schools had learned something from the Pilsen experience. Now there were extensive materials on AIDS that Bill Levin had collected; Levin turned these over to Lubin, offering to give her whatever help she needed. Again, as in Pilsen, parents and teachers would be informed. This time, though, the principal was asked whether she wanted any of the top officials to attend the parents' meeting. Lubin declined the offer. Her intention, she told Lee, was to keep things as normal as possible, and it wasn't every day that the deputy superintendent made an appearance at Nettelhorst.

"When should the child be enrolled?" Lubin was asked. "As soon as possible," she replied.

At the end of the school year children begin counting down the days and hours until vacation. For teachers and parents, too, attention is focused elsewhere. That was why Lubin wanted to admit the child then, rather than waiting until the fall, when school is once again the centerpiece in so many people's lives.

"For two weeks, AIDS was all that I did," Lubin recalls. Immediately after the session in Deputy Supt. Lee's office, she and District Supt. Maloney met with the entire Nettelhorst staff. That day and the next,

Lubin visited each of the teachers, conscripting them in the effort to inform parents. "What should we be doing?" she asked. Two hours after requesting disposable gloves and other AIDS precautions, the supplies were on the scene. That broke all school-district speed records and helped allay the teachers' concerns. Students in the school's upper grades got a plain-talk lecture on AIDS. "When you think of AIDS," they were told, "think of blood and sex."

Letters pinned on the shirts of all the students, noting that a child with ARC would be enrolling at the school, were sent home to all the Nettelhorst parents. On May 28, the parents met to talk about AIDS—this time not in the abstract.

Lubin didn't know whether to expect a repeat of Pilsen, but nothing of the sort happened. No outsiders came—just parents, 38 of them, mostly mothers—and they went through the basics on AIDS transmission with Luskin. The young doctor was knowledgeable without being intimidating. She stood before the group, easily fielding questions, talking in language the parents could understand.

The one potentially explosive moment came when a parent declared: "I won't send my child to this school, no matter what. You don't know the answers." It was another parent, a mother who had been to the earlier advisory council session, who replied: "You don't know if the waiter in a restaurant where you're eating has the virus. What are you going to do, stop living?"

A second meeting was held a few days later for the Spanish-speaking parents, who had lots of questions. But the discussion stayed within the four walls of Nettelhorst. There were no LaRouche activists on the scene, no calls for a boycott.

Swenson knew nothing about these gatherings. "That's because he wasn't a Nettelhorst parent at the time," says Lubin, "and the meetings were only for parents." The first word he received from Nettelhorst came the Tuesday after Memorial Day. "You can bring David in to class tomorrow," he was told.

There was no publicity—not a single news article or TV piece—about what was happening at the school. Lubin thought that was a miracle: "All those announcements of the meeting were floating around the community, and nobody picked up the story." Schools spokesman Saigh had heard from reporters that, in the aftermath of Pilsen, they were now "all AIDS-ed out."

During the last days of the school year life at Nettelhorst proceeded without incident. Just one parent, the woman who had voiced her upset at the meeting, kept her child out of school. At kindergarten graduation, a cap-and-gown affair at the school, several parents told Lubin that they would be sending their children to parochial school in the fall, but that is something that happens every year. And there were actually fewer parents than usual seeking to transfer their children from Nettelhorst to a magnet school for the following fall.

Lubin thought that the events in Wilmette and Pilsen, as well as those AIDS education materials that the Nettelhorst parents had been given during the spring, made her job easier. "If you get that word—AIDS—in front of parents, in the context of the schools," she says, "they have a chance to think the issue through before being confronted with a case of AIDS in their own school."

Then one morning at the very end of May, Lubin happened to be present when a young boy—a "gorgeous little boy," Lubin describes him—came into the classroom holding his father's hand. "He was thrilled to be there," she says. "He wasn't shy at all. 'I'm going to play,' he said, and he dived right in."

In Wilmette the parents who brought their sharp questions to the January, 1987, meetings went away convinced that the school officials they knew and the outside experts were right. Besides, as the parents kept telling newsmen, who wanted to be another Kokomo? In Pilsen, two months later, those who carried the day were the Hispanic doctors and the educators—and a Jewish school principal—whom parents knew and trusted. Nettelhorst proved to be a happy anticlimax for school authorities, in part because a lot had been learned from the Pilsen experience. And a lot had been said about AIDS at Nettelhorst during the immediately preceding weeks.

These successes can be traced partly to the people who happened to be in charge, three principals and a suburban superintendent who came out strongly for what was right. These men and women had the backing of parents who had known them for years. They faced down their antagonists. And they managed their encounters in the spotlight with aplomb. Perhaps the most important thing these leaders did was to trust the communities whose children they educated, resisting the temptation to slip the decision by unknowing parents. The conversations they launched gave parents a chance to have their say about something that intimately touched their lives.

This story has no tidy ending. Other towns will be facing similar circumstances for years, other re-enactments of community pride and prejudice. During August and September of 1987, towns in Pennsylvania and Tennessee were doing whatever they could to keep children with AIDS out of schools. And the Arcadia, Fla., fire that leveled the home of three hemophiliac brothers believed to have been exposed to the AIDS virus, came to symbolize the madness that fears about the disease can bring to the surface.

Much closer, in south suburban Dolton, the school board voted 6-1 in late September to keep a child with ARC out of school. "The concept of the greatest good for the greatest number" was the reason for the decision, says board president Joyce Forbes—even as school officials acknowledged that the child being barred posed no danger to anyone. Within days of the board's vote, the family of the unnamed child filed a lawsuit in federal court.

In Wilmette, things were very different. Until the end of the school year in June, Jamie McCardle had remained one of his gang—the three musketeers, Fran called them. But during the early days of summer, Fran talked to the other two mothers. "Don't feel that your boy has to see so much of Jamie during the vacation. Maybe they all could use a break from the sadness."

Jamie himself was beginning to understand the meaning of his own inevitable death. "I don't want you to die!" his 10-year-old sister Sally told him, and he answered stoically: "I just have to."

One day, as the boy and his mother drove past a cemetery on their way to an appointment with Dr. Chadwick, Jamie asked, "That's where I'll go when I die, isn't it?" "That's where your body goes," Fran answered. "The inner you goes to heaven—a great big bakery, with lots of cookies and cakes."

Jamie could live for years, the doctors told the McCardles, or he could die suddenly, and that uncertainty weighed on the family. Meanwhile, Bill and Fran McCardle and those Wilmette parents whose children attended school with Jamie would share more cups of coffee and more revelations about the plague that had entered all their houses. ■

CASE STUDY: QUESTIONS, CONCERNS AND ISSUES FOR CLERGY IN RELATION TO HIV TESTING PRIOR TO MARRIAGE

Ann and Tom approach a clergyperson three months before they wish to get married. They have already rented the place for the reception. For both sets of parents this is the first wedding. Ann and Tom remember hearing something about a special blood test before marriage.

They wonder: 1) what the test is; 2) when they should get it; 3) how much it costs; 4) who pays for it and any subsequent confirmatory test; 5) who orders the test; 6) where they get it performed 7) what a positive result means in terms of the marriage itself and their plans for a family; 8) who knows the results and who needs to know; 9) how their partner became exposed to the virus if he or she is positive; 10) whether the exposed partner will develop AIDS or ARC and when that is predicted to occur; 11) whether the exposed partner is really gay/bisexual or IV drug user; 12) whether they are truly safe in light of their recent sexual history.

The clergyperson wonders: 1) whether they will tell him the results of the test; 2) whether he should ask about the results; 3) what happens if one or both are true positives or false positives; 4) what to do in the interval between the ELISA tests and the confirmatory Western blot test; 5) how to help the couple deal with parents if the time frame between the confirmatory test and the wedding date overlaps; 6) whether he should perform the ceremony if one party is positive or if they intend to have children despite that fact; 7) what if one party commits suicide because of a true or false positive result; 8) how will he help them deal with the lingering doubt that a false positive result can engender in their marriage.

If one factors into this scenario the real life issues of preparation time for marriage, poverty, gender, sexual orientation, race and ethnic background, one can readily understand the complexities that will arise.

Let no one diminish the magnitude of the problem by looking only at the number of projected positive test results (2,000). Even <u>one person</u> or <u>one family</u> whose life will be disrupted is worthy of care and concern.

Finally, if you have questions regarding the case or terms used in it or in the accompanying letter, you have need of more information. If you project that need to clergy who have distanced themselves from AIDS issues for whatever reasons, you sense the magnitude of the problem.

CEM/JE
12/23/87

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ARTICLE FOR TEMPLE BULLETIN (NEWSLETTER)

AIDS (Acquired Immune Deficiency Syndrome) is a devastating illness that was first described in this country in 1981, and that has already attacked over 28,000 people. It is estimated that by 1991 over 270,000 people will have AIDS, and since it is uniformly fatal at this time, one can understand the frightening impact of this disease. Currently it is seen most frequently in the homosexual community, but it is also found among heterosexuals in ever increasing numbers.

Our congregation is concerned about widespread myths and unfounded prejudices that are associated with AIDS. We have received much helpful information from the UAHC Committee on AIDS, and are ready to support and counsel those in need. If you or a member of your family or a friend or loved one has AIDS, please know that a call to the Temple office will be met with a sensitive and caring response. We are prepared to help.

AIDS

In response to many requests for copies of Rabbi Kirschner's Kol Nidre sermon, it is reproduced herewith:

Usually, when a rabbi quotes his ancient predecessors, he does so with approval, even reverence. Our sages of blessed memory were remarkably wise and perceptive, noble and compassionate. But not always. I quote from an ancient midrash on the 13th chapter of Leviticus, dealing with the subject of leprosy. The sages are discussing what they do when they see a leper (Lev. R.16:3). R. Johanan says: I go no closer to a leper than four cubits. R. Shimon says: If the wind is blowing, I go no closer than 100 cubits. R. Ammi and R. Assi say: We do not even go near a place where lepers are known to live. R. Eleazar b. Shimon was still afraid: If he heard that a leper was in the vicinity, he would hide. Then there was the great sage Resh Lakish. When he saw a leper, he would throw stones at him, shouting: "Stop contaminating us and go back to where you came from!"

I am not proud of this passage. I quote it now because I think it has something to teach us on Yom Kippur, when we ask forgiveness for our sins. Scholars have shown (Encyclopedia Judaica 11:38) that by the time this passage was written, the segregation of lepers enjoined by the Bible was no longer required. In a case where a rabbi himself came down with leprosy, the decision was handed down that he could enter the synagogue together with everyone else. No, the hostility of our passage does not arise merely from the fear of contagion. After all, to avoid a leper is one thing; to throw stones at him is another. In rabbinic literature, lepers are accused of everything from murder to incest, idolatry to robbery, perjury to blasphemy to slander (Preuss, Biblical and Talmudic Medicine 337). In the days of our sages, to be a leper was not only to be afflicted with disease but to be despised for it. It was not only to suffer but to be forsaken. It was not only to die a terrible death, but to be accused of deserving it.

Today, leprosy is called Hansen's disease, and those who suffer from it may walk among us without fear. No longer must they bear—as if their illness were not enough—the crushing weight of anathema. But now there is a new multitude of sufferers to fear and to shun. Theirs is the new dread affliction, the new mark of doom: AIDS.

The condition now known as AIDS, Acquired Immune Deficiency Syndrome, was first recognized in 1981. Patients with AIDS have developed a severe loss of their natural immunity to disease, leaving them vulnerable to lethal infections and cancers. To date, no treatment has been able to restore the immune system of an AIDS patient to normal function. Almost 75% of the people who have developed AIDS are dead. The vast majority, upwards of 90%, are either homosexual and bisexual men or intravenous drug abusers.

Like the ancient rabbis, we prefer to keep our distance from the victims of this illness. Like them, we are afraid of catching it. But according to the medical experts, those outside the high-risk groups are highly unlikely to do so. The growing number of AIDS patients is almost completely confined to homosexuals and drug abusers. Only one percent of all reported cases involve a transfusion recipient or a child born with the mother's infection. Here in San Francisco, more than 98% of all AIDS patients are gay men. Of over 13,000 cases nationwide, not one has been attributed to casual contact with AIDS patients. Of those caregivers who are constantly exposed to AIDS and frequently tested for it—doctors, nurses, hospice workers, family members—none outside of the high-risk groups has caught it.

Yet despite the evidence, we are still afraid. Not enough is yet known about AIDS. The fear of contagion is itself contagious and likely to persist. It explains, in part why we stay away from people with AIDS. But, as in the case of the ancient lepers, it does not explain it all. Our aversion, too, goes beyond the fear of infection. We shrink from people with AIDS not only because they are sick but because we don't like how they got sick. When it comes to homosexuals and drug addicts, our sympathy for their affliction is diluted by the suspicion that they deserve it. Like the ancient leper, the AIDS patient suffers not only the torment of his illness but the stigma of it. He is shunned not just for what he has but for what he is. His life, and now his death, are alike regarded as a kind of disgrace.

Tomorrow afternoon, traditional Jews around the world will read the 18th chapter of Leviticus. This is where homosexuality is described as an abomination (18:22) punishable by death (of 20:13). But Reform Judaism departs from the Torah on occasion. We do not stone adulterers; we do not ostracize children of forbidden marriages; we do not sprinkle lepers with blood. Such biblical legislation, we believe, is the work not of divine but of mortal and fallible hands, and we consign it to the antiquity from which it came. The divine content of the Torah, we believe, is found in its transcendant vision of justice, peace, and compassion. The God we revere is the One who, as R. Akiba taught (M Ab. 3:18), creates each of us because He loves us, who as the Mishnah says (Sanh 4:5) considers each life to be worth the life of the whole world. The God we revere is the One who, as the Torah itself insists, sides not with the mighty but with the forlorn who hears the cry of the helpless and defends the defenseless (Ex 22:21 ff.). The God we revere is the One who loved us when we were the unwanted, the unwelcome, the exiled and the outcast. A belief in this God, to my way of thinking, simply cannot be reconciled with a judgment of anathema upon homosexuals, or lepers, or any other of His children. "Blessed art Thou, O Lord." says our prayerbook, "who has made me according to His will." Each of us, in our unique being, is the work of His hands and the bearer of His image; each of us—even someone with AIDS.

In my reading of the local Jewish press, I cannot recall—either in article, editorial or letter—even one expression of regret or sympathy for the loss of life to AIDS, not one word of protest or indignation at the ostracism of its victims. Imagine if a Jew—let us say, one who does not happen to have AIDS—were fired from his job or evicted from his apartment, or expelled from a hospital, because his Jewish disease was fatal and no one wanted to work with him or live near him, or care for him. Imagine the outrage of the Jewish community if, God forbid, such things were to happen. Then imagine what the gay community must feel at this moment, and imagine what they must think of our silence.

A friend of mine, Father Michael Lopes, told me something that happened on a visit to ward 5B at San Francisco General Hospital. This is where the most desperately ill AIDS patients

are treated and comforted before they die. Father Lopes walked into one of the rooms on the ward. The blinds were closed; only a little shaft of light penetrated the darkness. The patient lay in bed in agony. His entire body was covered with purple lesions of the cancer called Kaposi's sarcoma. His face was terribly swollen and disfigured and his mouth was infected with fungus. So appalled was Father Lopes that he could hardly bring himself to come near. But just then, the patient turned in his bed, and the little shaft of light came to rest on his eyes—bright blue eyes, clouded with pain but now suddenly filled with gratitude at the sight of his visitor. Looking into those eyes, Father Lopes said, he remembered that beneath the mass of lesions was a person, a human being, hurting so badly that the mere presence of a visitor was a benediction.

My friends: as surely as God is in heaven, so is He with the patients on Ward 5B. As surely as his light shines above this ark, it shines above their beds. But God has no other hands than ours (cf. Dorothea Soeile, Suffering 149, 174). If the sick are to be healed, it is our hands, not God's, that will heal them. If the lonely and frightened are to be comforted, it is our embrace, not God's, that will comfort them. The warmth of the sun travels on the air, but the warmth of God's love can travel only through each one of us.

A few weeks ago, Father Lopes took me to Ward 5B. While I was there I met Dr. Donald Abrams, Assistant Director of the San Francisco AIDS Clinic. The Clinic is where AIDS patients are first identified, tested and counseled. The number of cases has increased to the point that the Clinic must expand to another floor. But there is a shortage of hospital beds. Dr. Abrams explained to me that the special beds needed cost over $1,000 each and the Clinic cannot afford that many. My friends: *We* can.

On this Yom Kippur, our Day of Atonement, let us determine to fulfill a great mitzvah. Let us, as a congregation, as we have done before for the victims of African famine, as we are doing now for the victims of the earthquake in Mexico, let us together establish a Temple fund for the care of people suffering from AIDS. Let us start by donating a few hospital beds, and then let us see what else we can do. Let us together fulfill the exalted commandment to comfort the sick and the dying, who need us and who deserve our kindness, not our lectures.

Confronted by the enormity of human suffering in this world, the vast numers of the helpless and the wretched from Ethiopia to Mexico and back again, we may be tempted to despair. As small a gift of compassion as a contribution toward a hospital bed may seem trivial and unavailing. But then I return, this time with great pride, to the teaching of our ancient sages. Where, they asked, shall we look for the Messiah? Shall he come to us on clouds of glory, robed in majesty and crowned with light? The Talmud (b. Sanh. 98a) reports that R. Joshua b. Levi put this question to no less an authority than the prophet Elijah himself.

"Where," R. Joshua asked, "shall I find the Messiah?"
"At the gate of the city," Elijah replied.
"How shall I recognize him?"
"He sits among the lepers."
"Among the lepers!" cried R. Joshua. "What is he doing there?"
"He changes their bandages," Elijah answered, "He changes them one by one."

That may not seem like much for a Messiah to be doing. But apparently, in the eyes of God, it is a mighty thing indeed.

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AIDS Resources in the Chicago Area

as of January 12, 1987

AIM Chicago 236-6977
Medical; psychological services

AIDS Alternative Care Health Project 327-6437
c/o Integrative Therapies
2944 N. Broadway, Chicago 60657
Tuesday and Thursday, 9 AM - 4 PM

AIDS Foundation of Chicago 525-9466
2035 North Lincoln, Room 619
Chicago, IL 60614

AIDS Hotline, Statewide: 1 (800) AID-AIDS
Howard Brown Memorial Clinic Help Lines
10 AM - 10 PM, 7 days, except holidays
Spanish Speaking Operator on Duty, Monday - Thursday, 6 - 10 PM and Sunday, 10 AM - 2 PM

AIDS Pastoral Care Network 975-5180
Monday - Friday, 9-5 or by appointment.

Chicago House (office) 248-5200
801 W. Cornelia, #2N, Chicago 60657
Residence Phone 334-2630
Residence for persons with AIDS/ARC.

Chicago Medical Society (TEL-MED) 670-3670
8:30 AM - 7 PM, weekdays.
Request AIDS info tape.

Cook County Hospital AIDS Program 633-7810
1835 W. Harrison, Chicago 60612

DuPage County AIDS Project 682-7400
111 County Farm Road, Wheaton, 60817

Gay Community AIDS Project (G-CAP) (217) 351-AIDS
P.O. Box 713, Champaign 61820

(Gay and Lesbian) Horizons 929-HELP
Gay umbrella service organization, general information hotline.

Howard Brown Memorial Clinic 871-5777
945 W. George, Chicago 60657
STD testing, primary AIDS resource center
Also legal services (wills, powers of attorney and living wills) for PWAs who cannot afford legal services.

(SEE OTHER SIDE)

Kupona Network 536-3000
4611 S. Ellis, Chicago 60653
Outreach for Black gays
HIV counseling and referral program

National Association of Persons with AIDS 278-5060
Chicago Chapter

Northern Lights Alternatives 951-6498
1140 N. Wells, Suite 2, Chicago 60653
AIDS Mastery Workshop and support services

PASSAGES Project (Horizons) 929-HELP
7-11 PM nightly

Reimer Foundation 935-SAFE
P.O. Box 300, 606 W. Barry, Chicago 60657
Safer Sexual Behavior/Condoms

Stop AIDS Chicago 871-3300
2676 N. Halsted, Chicago 60614
Discussion Group

Test Positive Aware 728-1943
1340 W. Irving Park, Suite 259, Chicago 60613
HIV+ Fellowship and Information Network

Unabridged Bookstore
3251 N. Broadway, Chicago 60657
Mainstream Bookstore with a large gay section and a comprehensive selection of books on AIDS

Notes

Compiled by Norman Sandfield from listings in Chicago's three gay and lesbian newsweeklies: Windy City Times, Outlines, Gay Chicago.

This list mainly contains organizations that have a direct AIDS service to provide. We can add the ACLU, and other gay outreach and medical resources that can provide support services to PWAs.

We need to expand and check the credentials of each listing before distributing this list.

Another supplement or replacement for this resource list could be the 8 page Chicago Medical Society's AIDS Service Directory, last edition dated April, 1987. Call 670-2550, x211.

At HBMC, Sally Mason or Bill Belzner, legal referrals.

ADOPTED BY THE GENERAL ASSEMBLY

of the

UNION OF AMERICAN HEBREW CONGREGATIONS

October 29 - November 3, 1987 - Chicago

CONFRONTING THE AIDS CRISIS

BACKGROUND:

Two years ago, the Union of American Hebrew Congregations issued a call to action on AIDS. We called for increased financial and human resources for prevention and treatment, prohibition of discrimination, and community education about this terrible new epidemic. We created our own Committee on AIDS, which has developed, and distributed widely, educational materials integrating our sacred teachings with professional expertise.

Tragically, the epidemic continues to rage, and more needs to be done. An estimated two million Americans are already infected with the AIDS virus. Most, if not all, will suffer chronic immunological and/or neurological problems throughout their lifetimes. At the current rate of infection, the federal government estimates that millions more will become so infected by 1991. Yet, the process of developing new treatments which combat AIDS virus infection and restore immune functioning have been severely hampered by the lack of adequate funding and unnecessary political obstacles.

We find society today dangerously paralyzed by partisan moral agendas as the acute crisis of the epidemic continues. The best evidence of the damage inflicted by the polarization of American society is the ineffectiveness of the President's Commission on AIDS.

With increased public awareness and fear have come proposals for mandatory AIDS testing of various segments of our population. Those most knowledgeable in the field of public health have opposed these proposals. They argue persuasively that mandatory testing is ineffective as a public health measure because it will open the door to increased discrimination against People with AIDS (PWA), will inevitably drive underground these members of high risk groups whom we most need to reach, and will distract the public from the imperative tasks of education, counseling, and behavior modification.

CONFRONTING THE AIDS CRISIS - 2.

THEREFORE BE IT RESOLVED that the Union of American Hebrew Congregations:

1. Express profound appreciation to the United States Surgeon General, Dr. C. Everett Koop, for his courageous leadership in educating the American people of all ages to the realities of AIDS.

2. Join those who:

   A. Argue that any testing must be accompanied by education, counseling, and confidentiality consistent with sound public health practice.

   B. Affirm that those infected with the AIDS virus must be protected from all forms of discrimination, such as discriminatory housing, employment, and health care delivery practices.

   C. Associate ourselves with those who support voluntary testing and oppose mandatory testing for AIDS.

3. Call upon every individual to accept responsibility to observe those health practices which minimize the risk of infection.

4. Call on every congregation to:

   A. Affirm the mitzvah of Pekuach Nefesh (the saving of lives) by instituting comprehensive, effective, and age-appropriate educational programs about preventing transmission of the AIDS virus.

   B. In the spirit of Bikur Cholim (visiting the sick) reach out to individuals infected with the AIDS virus, their families, and their friends by providing food, clothing, legal assistance, transportation, and empathetic listening.

   C. Form and join area coalitions to develop action programs for the prevention of AIDS and assistance to those with the disease.

   D. Include appropriate sex education at every level in religious schools.

RECOMMENDATIONS FOR CHILDREN AND EMPLOYEES WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME/HIV
INFECTION IN THE SYNAGOGUE SETTING*

Recommendations for the Education of Children

Human Immunodeficiency Virus (HIV) is the viral agent responsible for Acquired Immune Deficiency Syndrome (AIDS). Persons who become infected with HIV may develop AIDS, may develop AIDS Related Complex (ARC), or may experience no symptoms of disease. At the present time AIDS is always fatal. ARC is a less severe illness, but may progress to AIDS.

The perinatal spread of HIV infection to infants, who have not reached school age or children who become infected via blood transfusion (prior to the implementation of blood screening), has resulted in questions regarding whether and how these children can be managed or placed in the school setting. Highly charged emotional issues related to HIV infection require that the placement and/or management of these children in the school setting be based on available evidence regarding the risks of transmission of HIV to others in the school setting and the risks to the child with HIV infection of acquiring other infectious agents in the school setting, along with the careful consideration of the confidentiality and legal issues involved.

Based on current evidence, casual person to person contact as would occur among school children poses no risk of transmission of HIV, the viral agent responsible for AIDS. However, a theoretical potential for transmission between young children or neurologically handicapped children who lack control of their body secretions may exist; this theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes of a susceptible person to the blood and possibly other body fluids of an infected person.

Since HIV infections may result in immune deficiency, the infected child may have a greater risk of acquiring infectious agents. Assessment of this risk to the immuno-depressed child is best made by the child's physician who is specifically aware of the individual child's immune status.

The following recommendations apply to all children known to be infected with HIV, regardless of whether or not actual symptoms of disease are present:

1. Decisions regarding the type of educational setting for the HIV infected child should be made on a case-by-case basis taking into account the child's behavior, neurologic development, and physical condition. These decisions are best made using the team approach, including the child's physician, the child's parent or guardian, and personnel from the Synagogue and local health department, and should be reviewed and approved by the Director of Education and Rabbi.

   A. For school-aged children infected with HIV, the benefits of an unrestricted setting in most cases outweigh the risks of their acquiring potentially harmful

infections in the school setting. These children should be allowed to attend school and after school day care in an unrestricted setting. A mechanism for the sharing of information between the child's physician and the school authorities is recommended so that any significant change in the child's medical status can be addressed. In addition, if the school experiences an outbreak of a communicable disease which could be threatening to a child infected with HIV, (e.g. chickenpox, measles), the child should be temporarily excluded by the Educator, pending consultation with the child's physician.

B. HIV infected preschoolers and older children should be considered for exclusion from the classroom if they:

1. lack control of body secretions;

2. exhibit behavioral problems, such as biting;

3. have uncoverable oozing lesions.

Evaluation to assess the continued need for exclusion should be performed regularly.

2. Persons involved in the education of HIV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept to the minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase, e.g., bleeding injury. In individual situations, such people may include the following: Director of Education, Rabbi and the child's teacher(s). Notification should be done by a process that would maximally assist patient confidentiality--ideally, by direct person-to-person contact. It is not necessary to notify parents of other school children regarding the HIV status of any school child.

3. Screening for HIV infection as a condition for school entry is not warranted based on available data.

4. All schools should adopt routine procedures to minimize the transmission of any communicable diseases. Handwashing (with soap and running water for 15-30 seconds and drying with disposable paper towels) is the single most important technique for preventing the spread of disease and should be done frequently. In addition, specific precautions should be taken whenever there is potential for contact with the blood or body fluids of children:

A. Exposure of open skin lesions or mucous membranes to blood or body fluids should be avoided. If open lesions

are present, disposable gloves should be worn. A disposable apron should be worn if clothing is likely to be soiled by blood/body fluids.

B. Surfaces soiled with blood or body fluids should be immediately and thoroughly cleaned. It is advisable to cover the blood/body fluids with paper towels, flood with a solution of one cup of household bleach in 9 cups of water, and allow it to remain for at least 15 minutes before disposing of paper towels in sealed plastic bags.

C. Disposable materials, e.g. gloves, paper towels, sanitary napkins, should be promptly discarded into sealable plastic bags.

D. Mops and other non-disposable cleaning materials are not recommended, but if used, should be rinsed in the disinfectant.

E. Hands should be washed thoroughly after contact with the blood or body fluids of any child, including after removing disposable gloves.

Recommendations for Synagogue Employees

No evidence supports the spread of AIDS/HIV through casual contact, such as that which occurs in the Synagogue setting. Epidemiologic evidence at this time has only implicated blood, seman and vaginal secretions in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HIV, and it has not been shown to be transmitted by contaminated food or water.

In view of this evidence, the following recommendations are made:

1. Screening for HIV infection as a condition for Synagogue employment is not warranted.

2. Decisions regarding Synagogue employees known to be infected with HIV should be made on a case-by-case basis, utilizing existing mechanisms for employee health in consultation with the local health department.

3. Adequate steps must be taken to protect the confidentiality of the Synagogue employee with HIV infection.

4. Since no known risk of transmission to co-workers or others exists from HIV infected workers in the Synagogue

setting, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities or drinking fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HIV infection status, should be cleaned with soap, water, and household bleach as described in the section on recommendations for the education of children.

*Congregations should be advised that federal, state, and local discrimination laws may also affect their employment and school attendance policies. A federal disrict court in California recently held that federal physical handicap laws guaranteed the right of an Atascadero public school boy to attend despite having AIDS. More than twenty states have determined that their physical handicap laws protect persons with AIDS, and a number of cities in California and elsewhere have passed or are considering passing AIDS anti-discrimination laws as well.

Modified from information prepared by the Maryland Department of Health and Mental Hygiene and the Governor's Task Force on AIDS.

affects are terrible, both for the individual involved and those dear to her. Although we can empathize with her wish to commit suicide, it would be difficult for us to approve of this act as Judaism has and continues to object strongly to suicide. The problems which arise under slightly different conditions with other diseases or other circumstances do not make it possible for us to assent to her wish, but we understand it.

June 1983

82. JEWISH REACTION TO EPIDEMICS (AIDS)*

QUESTION: The current AIDS epidemic has led to much fear in various communities. Individuals afflicted with this disease have been removed from positions, ostracized socially, and their children excluded or segregated in schools. What has been the traditional approach of Judaism to such epidemics for which there is no known cure? (Rabbi G. Stern, New York, NY)

ANSWER: We must be concerned with the victims of AIDS as the disease is fatal; they need our compassion. We will not deal with the problems of sexual morality raised by AIDS in this responsum, but only with fear of the potential epidemic. The fear of the general population is understandable as little is known about the disease, its incubation period, or potential cure. Concern for both the individual and the community when a member is afflicted with a dangerous disease has been shown since Biblical times. The book of Leviticus contains detailed instructions of how a skin disease (*metzora*) is to be diagnosed and handled (Lev. 13). During the period of his illness the afflicted person was isolated. The priest who made the diagnosis examined that person after seven days, as well as subsequently. When the disease had come to an end, a complex ritual of purification was provided (Lev. 14 ff). The precautions extended from the individual to the house in which he lived and it, too, was examined, and if necessary scraped and replastered and a ritual of purification was mandated.

Although we do not know the nature of the disease called *metzora* by the *Bible*, it was clearly contagious and led to vigorous efforts to isolate the individuals involved. These procedures were developed further by the *Mishnah* and *Talmud*. There are fourteen chapters in the

Mishnah Negaim which deal with the subject in considerable detail.

Metzora was treated only from a ritual point of view by some authorities, so they did not apply the rules of non-Jews (*M.* Neg. 3.1). All contact with Jews who were afflicted was to be avoided. This included the sick person, his room, any food near him and even the air near the sick room (San. 76b; *Lev. Rabba* 17.3). Insects and flies which had contact with the diseased person were to be avoided (Ket. 77b). For example, when the diseased person came to the *bet hamidrash* in order to study, he was separated from the other students by a wall which was to be "ten handbreadths high and four wide." It was also mandated that he enter the building first and leave it last (*M.* Neg. 13.12). These individuals were excluded from the community and usually lived outside of the cities (II Kings 7.3). If a man was afflicted by this illness his wife had a right to divorce and vice versa (*M.* Ket. 7.9) Those who suffered from such diseases were to avoid sexual intercourse (Ket. 77b).

In the Talmudic period, individuals so afflicted were considered akin to the dead (Ned. 64b). In the *New Testament* some such diseased individuals called to Jesus from a distance as they were obviously prohibited from approaching anyone in the community (Luke 17.12).

Discussions in the *Talmud* and the later responsa literature which dealt with other epidemic diseases usually were less drastic; they suggested that a fast be decreed as the pestilence was thought to be the result of community sins (*M.* Avot 5.12; Ta-anit 3.4, 19b). Jews in the Middle Ages like the rest of the population often fled whenever a plague or epidemic threatened. An epidemic existed if a smaller city suffered three deaths from a known disease on three consecutive days, or nine deaths in three days in a larger city [one which could provide 1500 young men as soldiers] (Ta-anit 21b).

The Jewish medical works of the seventeenth century contain regulations which govern epidemic diseases. As the garments of the sick were considered to provide a source of contagion, they were to be avoided until thoroughly aired. All drinking water was to be purified as a preventive against the epidemic (Tobiah Hakohen *Ma-aseh Tuvyah*, Frankfurt, A. M., 1707, in Max Grunwald's *Die Hygiene der Juden*, p. 262). Dr. Leon Elias Hirschel suggested a number of ways of fighting smallpox; they included quarantine and washing with vinegar by those who came in contact with the ill ("Abhandlung von den Vorbauungs - und Vorbereitungsmitteln bei den Pocken," Berlin, 1770, *Ibid.* p. 265). Israel Salanter took a humane and courageous

approach to a cholera epidemic in Vilna during his lifetime as he urged the community to assist the victims (D. Katz *Tem-ot Hamusar*, Vol. I, pp. 156 ff).

It is clear from all this that our forefathers sought to protect themselves through whatever ways were available from epidemics. The avenues of quarantine and flight were used.

In the current situation as we deal with AIDS, we should begin by following the advice of the medical community. The current medical opinion suggests that the disease is spread through sexual contact (homosexual or heterosexual), intimate contact and blood transfusions. Little is yet known, however, and there is no cure or preventive vaccine for AIDS, nor is anything known about its incubation period.

The fear and anxiety of employers, parents and others, therefore, can be understood. It is our duty to calm that fear and counteract the pressure of the media. In some instances quarantine or other measures may be appropriate, but they should not be undertaken lightly.

We should do whatever we can to minimize the suffering of the victims of this disease and help them and their families adjust to its tragic consequences. We should follow the advice of public health authorities in our attitude to employees and school-aged children.

November 1985

83. QUALITY OF LIFE AND EUTHANASIA*

QUESTION: Does Jewish tradition recognize the "quality of life" as a factor in determining medical and general care to preserve and prolong life? I have four specific cases in mind. In the first the patient is in a coma, resides in a nursing home and has not recognized anyone for several years. In the second, the patient is in a nursing home, completely paralyzed and can not speak or make his wishes known in any way. The third is a victim of a stroke, sees no hope for recovery or even major improvement, wishes to die and expresses this wish constantly to anyone who visits. The fourth is slowly dying of cancer, is in great pain and wants a prescription which will relieve her of pain but will probably also slightly hasten death. All of these patients are in their early eighties; none is receiving any unusual medical attention. Should we hope for a new medical discovery which will help them? (Rabbi R. H. Lehman, New York, NY)

ANSWER: The considerations which govern euthanasia have been discussed by the Committee in a recent responsa (W. Jacob, *American Reform Responsa*, #79, 1980). The conclusion of that responsum stated:

> "We would not endorse any positive steps leading toward death. We would recommend pain-killing drugs which would ease the remaining days of a patient's life.
>
> "We would reject any general endorsement of euthanasia, but where all 'independent life' has ceased and where the above-mentioned criteria of death have been met, further medical support systems need not be continued."

The question here goes somewhat further as we are not dealing with life threatening situations, but with the general question of prolonging life when its quality may be questionable. In none of these situations has any current extraordinary medical attention been provided. In two of the cases the cognitive and/or communicative ability seems to have ended. In the third there is a strong wish for death. In the fourth, the primary concern is relief from pain. Let us look at each of these cases individually.

For the patient in a coma and the one completely paralyzed and unable to communicate, a segment of the brain which provides intelligence seems to be damaged beyond repair. Judaism does not define human life only in terms of mental activity. Every person has been created in the image of God (Gen. 1.26), and so even those individuals who may be defective, i.e. the retarded, the blind, the deaf, the mute, etc., have always been considered as equally created in the image of God; their life is as precious as any other. It is necessary to guard their life and protect it just as any other human life. This is also true of an elderly individual who has now lost some of her mental ability or power of communication. In fact, we owe a special duty toward these individuals who are weak and more likely to be neglected by society just as to the orphan, the widow and the poor (Deut. 14.29, 27.13, Jer 7.6; Is. 1.17; Shab. 133b; Meg. 31a; San 74a; Yoma 82b).

Let us turn to the individual who seeks death and constantly reiterates his wish to die. Although some rabbinic authorities feel tha neither an individual nor his family may pray for his death (Hain Palagi *Hiskei Lev*, Vol. I, Yoreh Deah #50), most of our tradition would agree that a person may ask God to be relieved of suffering. Th decision, of course, lies with God. A servant of Judah Hanasi prayed for his release (Ket. 104a). Other ancient authorities pointed to simila examples (Ned 40a and Commentaries). We would, however, discour

enough to them to risk sharing his anger and frustration. Since there is often expectation that love within family will remain constant no matter what, family may be the only safe "target" for these feelings.

18) Encourage families to provide support without being over-protective. In this way, the loved one does not give in to the sense of helplessness and passivity that is common. He should be encouraged to maintain as much control as possible in those areas he can. Helping him to do things he can do himself is not help. The patient can't be rescued from the disease but he can be comforted by a shoulder to cry on.

19) Most important of all is to help families be there for their loved ones. Families should not abandon the ill person because of their own difficulties in dealing with the diagnosis. It's not important to say "the right thing" or do something exceptional. Touching and smiling can convey much affection and reassurance. All their loved one wants to know is that this illness has not altered their feelings of love and affection.

This pamphlet was created by Leila Bender Laitman, M.D., a member of the Union of American Hebrew Congregations' Committee on AIDS, with the assistance of other members of the committee.

UAHC
COMMITTEE
ON
AIDS

SUGGESTED GUIDELINES FOR

COUNSELLING FAMILY MEMBERS OF PEOPLE WITH AIDS

While you may not be personally asked to counsel a person with AIDS, you might very well have contact with parents, siblings, lovers or friends of people with AIDS in your congregation who need your support very much. The following thoughts and suggestions might prove helpful in dealing with them.

1) Be open to discussion of homosexuality or drug abuse which may have been revealed for the first time to family due to the dignosis of AIDS. To learn this news while coping with the fatal prognosis can be overwhelming. People do not know what to tell friends and neighbors. They may even be afraid to speak to you about it fearing your disapproval or some moral judgment. Help them deal with shock, embarrassment, hurt, and anger.

2) Avoid judgmental pronouncements regarding the person with AIDS and his life style. Your goal is to help the family be as open as possible in discussing things with you and be as accepting and supportive as possible in dealing with their loved one.

3) Encourage them to get to know their loved one's friends and close relationships as these might be people whom family can turn to especially for assistance in household chores, bedside care, transportation, orientation to an unfamiliar city and answers about available services. In addition, they may be able to share the emotional burdens as well.

4) Sometimes family members must make decisions about their loved one's medical care such as whether to institute life support machines in an emergency situation when the patient himself cannot say what to do. Be open to discussion of ethical issues involved. Encourage family members to include the person with AIDS in decision making in advance so the loved one's feelings are clear and he has a feeling of control. Remind family that their loved one's lover, care partner or roommate should be part of the decision process.

5) Realize that conflict may develop over the person with AIDS feeling that his lover or friends are also his family. Encourage family members to respect this and to lend support to the lover, care partner or roommate as they may also be suffering. Care partners may also need a small break from the illness from time to time just as family members do. They may wish to be included in all decisions made as they may know the patient better than the family and act as an advocate for his wishes.

6) Stress that the single most important thing a family can offer their loved one is a willingness to go through this experience with him.

7) Help them acknowledge their worries and fears for their own health and well being (even though there is no danger of contracting AIDS through ordinary contact). At an appropriate time, the fears can be discussed with the loved one as part of going through the experience together.

8) Encourage them not to set aside their own needs all the time. It is important to the person with AIDS and other loved ones that family members maintain good health themselves.

9) Help correct misinformation about AIDS. Reassert that there has been no reason to believe that AIDs is spread by casual household contact and that the person with AIDS is the one who is more at risk in having to combat even common viruses and infections like colds, coughs and flu with an impaired immune system. If family members or friends do not feel well themselves, they should visit by telephone.

10) Be open to discussing fear of losing a loved one. This fear can sometimes block expressions of understanding and affection from family members which AIDS patients desperately need for support.

11) Help family members realize they must try to relax and not insist the loved one eat more or sleep more or do *anything* to get better. Try and step back from the immediacy of situations and gain beneficial perspective.

12) A sense of humor is important to encourage in family members when dealing with the emotional trials of AIDS.

13) Encourage family to help the loved one celebrate Jewish and other holidays by decorating home or hospital room or bringing flowers and including him in holiday festivities.

14) Help family members realize that there are little things that they can do to make life for their loved one more pleasant like take him for a walk or outing; help answer correspondence with which he may have difficulty dealing; shop for him; bring books, periodicals, taped music, a poster for the wall, home-baked cookies or delicacies to share with visitors. Always keep promises that are made. Encourage old friends or long lost family to visit if he wants them to.

15) Be aware that the strain of serious illness in one family member can cause problems in other relationships both at home and at work for the rest of the family. Be willing to talk about these problems too and not just center on talking about the relationship with the AIDS victim himself. Perhaps it would be helpful to ask how things are going apart from dealing with the sick loved one.

16) Help family members make sure that their loved one's personal affairs are in order such as knowing about current wills, bank accounts, charge accounts, outstanding loans. Family members might want to enlist your help in making funeral arrangements for a proper Jewish burial.

17) Help family members tolerate anger that may be projected toward them by their loved one. Let them realize they've done nothing wrong and should feel no guilt. They should feel flattered that he is close

AIDS EDUCATOR

San Francisco AIDS Foundation Publications Catalog Spring 1987 No. 1

San Francisco AIDS Foundation
333 Valencia Street
Fourth Floor
San Francisco, CA 94103
415-864-4376

Dear Friend:

Since 1982, the San Francisco AIDS Foundation has been a pioneer in the field of AIDS education. During that time, we have provided quality AIDS education materials to thousands of health professionals and social service providers like yourself. We're proud to have assisted you, and we want to continue to meet your AIDS information needs — quickly and efficiently.

In this catalog you'll find the widest variety of materials with which to address your AIDS education needs. Our materials are internationally recognized as models for effective AIDS education. They have proved successful in the education and social service programs conducted by the Foundation. Programs that have earned the Foundation the 1987 Edward R. Loveland Memorial Award from the American College of Physicians, honoring a lay organization "...for distinguished contributions in the health field."

We are also pleased to offer resources produced by other AIDS educators. These materials have been reviewed by our health educators and have been chosen for their outstanding educational features.

I invite your comments on our materials and suggestions for new titles. I am very interested in providing you with only the most effective and useful materials.

Please read and enjoy your new catalog. We look forward to serving your AIDS education needs.

Sincerely,

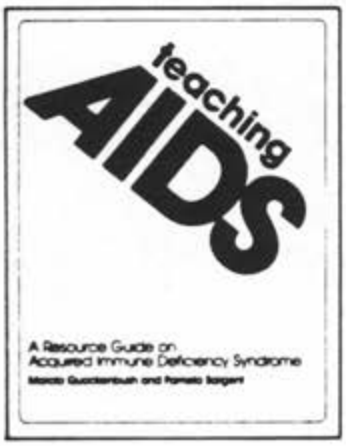
Thomas E. White
Marketing Manager

CONTENTS:

AIDS EDUCATOR is published quarterly by the San Francisco AIDS Foundation and distributed free of charge.

Initial funding for development of this catalog was provided by a grant from the Richard and Rhoda Goldman Fund and the Columbia Foundation.

NEW ITEMS!



"AIDS is no longer the concern of any one segment of society; it is the concern of us all."

— U.S. Surgeon General's *Report on AIDS*, 1986

GENERAL POPULATION

For brochure pricing and shipping information see page 18.

AIDS Lifeline

The Best Defense Against AIDS is Information

One of our most popular brochures, this highly informative publication explains basic facts about AIDS: prevention, cause, risk, transmission, symptoms, treatment and diagnosis. Over 250,000 copies distributed in its first year.

English-Spanish-Chinese (Braille in English only)

Co-produced with KPIX-TV

(1985) 8½ × 11"/2 folds/2 colors

Straight Talk About Sex and AIDS

Very much in demand, this pamphlet is aimed at sexually active heterosexual adults and teens. An easy-to-read guide, it promotes open communication between partners about sexual history and drug use, and encourages condom use to prevent transmission of the AIDS virus.

English-Spanish

Produced in conjunction with the SF Dept. of Public Health

(1986) 8¼ × 11¼"/2 folds/2 colors

Women & AIDS

Our primary educational brochure for women, this nationally recognized publication presents current guidelines on AIDS prevention for women. It describes the specific circumstances when women risk infection and how they can protect themselves. It also addresses concerns about pregnancy, breastfeeding and artificial insemination.

Text by Women & AIDS Network

(1986) 8½ × 14"/3 folds/2 colors

BONUS!
FIGHT THE FEAR WITH THE FACTS!
FREE POSTER!
See page 14 for details

You have two easy ways to order materials: Use the convenient order form on page 19, or call our Materials Distribution Office at 415/861-3397. Also use that number for inquiries or additional information.

Your Child & AIDS

This important brochure answers parents' questions about the risk of contracting AIDS through bites, cuts, bruises or contact with other children who have AIDS. Guidelines established by the National Centers for Disease Control are reproduced here. Straightforward and credible.

Co-produced with the SF Medical Society, SF Department of Public Health and SF United School District. Partially funded by the SF Dept. of Public Health and the California Dept. of Public Health Services.

(1986) 8½ × 11"/2 folds/2 colors

When A Friend Has AIDS

Sensitive and practical, this brochure provides suggestions for friends, family or loved ones of people with AIDS or ARC. It presents specific ways to communicate, consider, listen and touch, and encourages the reader to find positive ways to meet his or her own needs.

Originally developed by Chelsea Psychotherapy Associates of New York. This version created with permission from Chelsea by the SF Community Partnership on AIDS

(1985) 8½ × 11"/2 folds/2 colors

Fact vs Fiction

Ten Things You Should Know About AIDS

This easy-to-read brochure lists ten 'true' or 'false' statements about AIDS transmission, diagnosis, and who can get the disease. It encourages the reader to find out more about what can be done to help and emphasizes the importance of financial support. Most appropriate as part of a fund-raising campaign.

(1986) 8½ × 7"/1 fold/2 colors

"The best defense against AIDS is information."
— AIDS Lifeline

(See p. 18 for all brochure prices)

WOMEN, TEENS, & CHILDREN

Women & AIDS Clinical Resource Guide

This comprehensive manual provides up-to-date information on risk, transmission, diagnosis, prevention, infection control, program development, children, teens, psychosocial issues, and substance abuse. An invaluable tool for health care workers and social service providers concerned about women and AIDS. *Prepared by Women's Health Outreach*
(1986) 367 pgs, photocopied $40.00

Model Programs for Women's AIDS Education and Services

A critical report on the transmission and demographics of women with AIDS. Includes a thorough overview of networks, forums, research efforts, medical and support services currently being offered in the San Francisco Bay Area.
Written by Nancy Shaw, Ph.D.
(1985) 28 pgs $5.00

NEW! AIDS & The Women's Community

VIDEO

This video provides an in-depth view of the critical impact the AIDS epidemic has had on the lesbian community. It includes presentations by a physician, a therapist, and an attorney. Topics include risk factors, transmission, safe sex, emotional issues, job discrimination, and political aspects.
Co-produced with Bay Area Career Women
(1986) 44 min. Purchase $45.00 Rental $25.00 Preview $15.00

Brochures:
Lesbians & AIDS: What's the Connection?

Highly informative, this publication discusses the emotional and political impact of AIDS, as well as possible AIDS risk factors for lesbians. It presents information on donor insemination, substance abuse, and safe sex.
Prepared by Women's AIDS Network (See p. 18 for prices)
(1986) 8½ × 11"/2 folds/2 colors

For our **WOMEN & AIDS, YOUR CHILD & AIDS,** and **STRAIGHT TALK ABOUT SEX AND AIDS** brochure descriptions, see page 4.

Women & AIDS Clinical Resource Package

This package includes the **Women & AIDS Clinical Resource Guide, Model Programs for Women's AIDS Education and Services**, and the video, **AIDS & the Women's Community**, and 200 different brochures (your choice: up to 4 different titles) $115.00

Safe Sex Guidelines for Women at Risk for AIDS Transmission

This fact sheet lists safe and unsafe activities and presents information on the use of condoms, spermicides, latex or rubber gloves and barriers. Sexually explicit. *Compiled by Women's AIDS Network, Covote, Project Aware, and Lesbian Insemination Project* (1986) 8½ × 11" 10¢

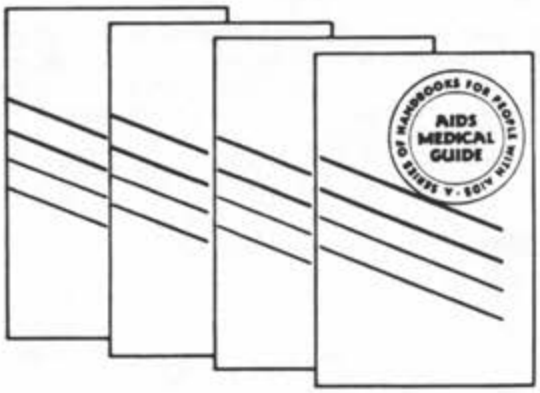
Women & AIDS

A Referral Manual for Women with Concerns about AIDS
An exhaustive listing of agencies in the San Francisco Bay area serving women and people with AIDS/ARC.
(1985) Second Edition, 31 pgs. $5.00

Help us expand our mailing list. If you're reading someone else's catalog and you would like your own copy, send us your name and address. If you have colleagues whom you think should receive this catalog, send us their names and addresses on the coupon on page 16.

BOOKLETS FOR PEOPLE WITH AIDS/ARC

Two easy ways to order: Use the convenient order form on page 19, or call 415/861-3397 between 9 am & 4:30 pm (PST).



AIDS Medical Guide

This booklet provides detailed information about the host of opportunistic infections that affect the AIDS patient. It describes symptoms and available treatments in laymen's language. An invaluable guide for people with AIDS or others who want to understand the medical facts about the disease.

(1986) 5½ × 8½"/21 pgs.

Coping With AIDS

Written by people with AIDS and staff members at San Francisco General Hospital, this booklet provides assistance in coping with the emotional, physical and financial consequences of AIDS. It includes thought-provoking segments by people with AIDS on their personal experiences.

(1984) 5½ × 8½"/10 pgs.

The Family's Guide to AIDS

This booklet addresses the friends and family of people with AIDS, discussing issues like patient advocacy, the hospital environment, insurance forms, sharing medical information, and emotional stress in a concise format. It concludes with local referrals and a short booklist.

(1984) 5½ × 8½"/9 pgs.

Coping With ARC

This comprehensive booklet discusses the most important aspects of AIDS Related Complex. Methods of diagnosis, possible treatments, and the effects of drugs and alcohol on the immune system are examined, along with issues related to confidentiality, employment, sex, and personal support. Two appendices provide a comprehensive definition of ARC and an extensive list of financial benefits and social services in California.

(1986) 5½ × 8½/18 pgs.

Resource Manual For People With AIDS/ARC

This comprehensive guide is an invaluable aid in locating the proper resources for the AIDS & ARC patient, friends, family and care-givers in the SF Bay Area. It contains more than 40 pages of local resource listings, a thorough summary of federal financial and medical benefit programs, along with a glossary of terms related to AIDS and medical care.

(1987) Fourth Edition, 5½ × 8½"/Stapled

All of the booklets in this series were partly funded by the SF Dept. of Public Health and the California Dept. of Health Services.

GUARANTEE

All materials purchased from the San Francisco AIDS Foundation are guaranteed. If for any reason you are not completely satisfied, contact our office within 30 days and arrange to return the purchased materials in original condition for a full refund or credit.

Infection Precautions For People With AIDS Living in the Community

This fact sheet provides simple, specific common sense hygienic measures for people with AIDS who are able to care for themselves at home.

(1984) 8½ × 11"/2-sided 10¢

Booklet Prices

For our Aids Medical Guide, Coping with AIDS, the Family's Guide to AIDS, Coping with ARC, Resource Manual for People with AIDS/ARC and AIDS & Your Legal Rights (see p. 7):

25-499	90¢	1500-4999	75¢
500-1499	80¢	5000 & up	70¢

We request a minimum order of 25 booklets. Up to six booklets may be requested as free samples.

LEGAL ISSUES & AIDS

Getting Your Affairs In Order

This two-paged publication enables the reader to compile information concerning financial matters and legal records. It enables a lover or family member to locate and settle the sick person's affairs. Includes listing of SF Resources.

Co-produced with Bay Area Lawyers for Individual Freedom. Partly funded by the SF Dept. of Public Health and the California Dept. of Health Services.
(1983) 8½ × 11"/2 folds/color

NEW! AIDS and Your Legal Rights

Detailed and comprehensive, this ten-page booklet answers 25 vital questions on the effect of the AIDS epidemic on civil rights for patients, employees, gay or bisexual males, etc. Specific questions related to antibody testing, insurance, job discrimination, government programs, and wills are included.

Produced by National Gay Rights Advocates.
(1986) 8½ × 7"/1 fold/8 pgs.
See p. 18 for brochure prices.

Need sample copies? Fill out the coupon on page 16. Or order our sampler pack for $4.

NEW! Wills Give You Power

Offering much needed information on the protection a will offers, "Wills . . ." covers important questions on probate, joint ownership, creating your own will, etc. Specifically designed to address issues unique to gays & lesbians.

Produced by National Gay Rights Advocates.
(1985) 8½ × 11"/2 folds/1 color

NEW! AIDS Practice Manual: A Legal & Education Guide

An extensive guide to the legal and financial concerns facing a person with AIDS or ARC, this publication enables the reader to prepare someone for incapacity and terminal illness. It summarizes the medical and psychological issues involved, and provides detailed information on estate planning, conservatorships, durable powers of attorney, wills, directives to physicians, trusts and obtaining public benefits.

Produced by National Gay Rights Advocates.
(1986) 8½ × 11"/99 pgs., photocopied.
$25.00

ETHNIC COMMUNITIES

Information for People of Color

This publication presents information on how AIDS has affected different ethnic communities. It describes various methods of transmission in clear detail and lists specific symptoms associated with AIDS. Lists resources specific to the SF Bay area.

Written by the Third World Advisory Task Force.
(1985) 8½ × 11"/2 folds/4 colors
(See p. 18 for prices)

Reaching Ethnic Communities in the Fight Against AIDS

This timely report summarizes findings from attitudinal research conducted with leaders from San Francisco's Black, Asian and Latino communities on AIDS risk reduction. It begins with an assessment of current levels of awareness and risky behavior, and concludes with ways to communicate most effectively to minority groups. Appropriate for most urban communities.

Prepared by Communication Technologies and Research & Decisions Corporation.
(1986) 16 pgs.
$5.00

See p. 17 for Brochures & Cards in other languages.

AIDS IS STRIKING PEOPLE OF COLOR. "It is not limited to gay white men. In fact two out of five Americans with AIDS are Black, Latino, Asian, American Indian and other People of Color. Among women with AIDS, half are Black and one in five are Latina. More than four out of five U.S. children with AIDS are from People of color."

— Information for People of Color

SAFE SEX MATERIALS FOR GAY/BISEXUAL MEN

Several titles are available in Spanish. See page 17 for listing.

Guidelines For AIDS Risk Reduction

This popular and effective brochure provides an in-depth discussion of AIDS symptoms, transmission and risk reduction. It includes a detailed discussion of safe sex. Sexually explicit.

English-Spanish

Written by the Scientific Affairs Committee of the Bay Area Physicians for Human Rights.

(1984) 8½ × 14"/2 folds/1 color (see p. 18 for prices)

Can We Talk?

This colorful, lively brochure uses cartoons and direct language to explain safe and unsafe sex practices for gay and bisexual men. Sexually explicit. *(For bulk orders of more than 100 pieces outside Northern California, please write to the Harvey Milk Lesbian/Gay Democratic Club, POB 14368, San Francisco, CA 94114.)*

(1985) 5½ × 24"/5 folds/2 colors (see p. 18 for prices)

Safe Sex Cards

A wallet-sized card that outlines safe and unsafe sex practices. Great for easy reference; easy to pass out at street fairs and other events.

English-Spanish

Written by Bay Area Physicians for Human Rights.

(1985) 1 × 3"/2 sided 5¢

Free materials are available for conferences, workshops, training events and classes. We will be happy to provide you with:

- **SF AIDS Foundation catalogs**

Informational Fliers on:

- **Women and AIDS Educational Resources**
- **AIDS and the Workplace — Educational Program and Consulting Services**
- **AIDS: Care Beyond the Hospital Videotape**
- **Sex, Drugs and AIDS — 18-minute videotape**
- **Lifeguard: Safe Sex Video for Gay Men**

Let us know what you need, how many, and when. There is no charge for materials, except for rush service.

Send your order at least 5 weeks in advance, and include complete shipping information. For further information, or to receive display copies of selected titles, call us at 415/861-3397.

Can You Pass the Safe Sex Test?

A factual chart of safe and unsafe sex practices. Sexually explicit.

AIDS Safe Sex Guidelines

For sexually active men and women, this poster provides basic information on safe and unsafe practices. Explicit language.

(1985) 8½ × 11" 10¢ each

The Hot 'N Healthy Times

This 4-page newspaper is designed to eroticize condom use for gay men. Lively articles cover all of the issues related to condoms: how safe they are; how to overcome resistance to condoms (your own or a partner's); how to choose between brands; and how to make condom use pleasurable. Graphic center spread shows exactly how to put condoms on. Contains sexually explicit language and nudity. *Erotic us Publications*

(1985) 11 × 17" [illegible] bulk rates

Lifeguard: The Safe Sex Video

VIDEO

A full-length video featuring well-known gay porn stars, this video shows sensuous safe sex in full color. It also includes a brief presentation of safe sex guidelines by Dr. Robert K. Bolan, past president of the SF AIDS Foundation's Board of Directors. Includes one copy of "Guidelines for AIDS Risk Reduction." *Produced by HIS Video/VCA Labs.*

(1986) (74 min.) $39.95

Condom Commercials

VIDEO

This full-color video uses humorous sketches to encourage viewers to use condoms. It contains two 60-second and two 30-second spots. Use it in bars, bathhouses, or other meeting places. Suitable for any gay male gathering place. Not sexually explicit.

VHS or Beta $20.00 ¾" Master $40.00

"Play Safe" Condoms NEW!

A matchbook-sized package containing one lubricated condom and graphic directions on proper use. Can be customed-printed with local resource referrals. Call for price

ALCOHOL, DRUGS & NEEDLE USE

Alcohol, Drugs & AIDS

This brochure discusses links between the use of alcohol and drugs, damage to the immune system and increased susceptibility to the AIDS virus. It describes the biological effects of alcohol, amphetamines, marijuana and poppers.

English on one side; Spanish on the reverse.

Written by the Committee on Substance Abuse and AIDS, SF. Funded partly by SF Dept. of Public Health and California Dept. of Health Services.
(1986) 8½ × 17"/4 folds/2 colors

Shooting Up & Your Health

This pamphlet discusses the major health risks associated with intravenous drug use and the three most deadly infections which may be contracted by sharing needles: AIDS, hepatitis-B, and endocarditis. Emphasizes the need for clean works and not sharing needles. Lists SF Bay area resources.

English-Spanish

Prepared by the Haight-Ashbury Free Medical Clinic.
(1985) 8½ × 11"/2 fold/2 colors

Poppers

Your Health & AIDS . . .Can You Afford the Risk?

Shaped like a bottle of poppers, this publication discusses the possible link between poppers and susceptibility to the AIDS virus and Kaposi's Sarcoma.

Prepared by the Substance Abuse and AIDS Task Force with the Committee to Monitor Poppers. Partially funded by the SF Dept. of Public Health.
(1985) 11¼ × 6¼"/3 folds/2 colors

NEW! This Bottle Could Save Your Life

A clear, graphic representation of how to clean hypodermic needles with bleach and water. Effective for use in treatment centers and public areas. Also useful as a handout.
(1986) 8½ × 11"/4 colors 25¢

NEW! Needle Use & AIDS

A wallet-size card that gives clear directions on cleaning needles to avoid exposure to the AIDS virus. Emphasizes not sharing needles as the best form of prevention.
(1987) Call for prices.

VIDEO

NEW! Sex, Drugs & AIDS

This lively 19-minute film speaks frankly to teenagers in their own language. The first segment dispels myths about AIDS casual contagion; the second explains exactly how AIDS is transmitted (through sex and I.V. needle use) and describes how people can protect themselves from infection.

The film also strongly emphasizes compassion for people with AIDS, who are portrayed here as a gay man, a straight woman, a Black teenage mother, and a blood recipient. Highly recommended. Some sexually explicit language.

Hosted by movie and television star Rae Dawn Chong.

Includes discussion guide and current student fact sheet.

(1986) *Produced by ODN Productions. Funded in part by the New York City Board of Education and the Maurice Falk Medical Fund.*

Video	
Preview	$ 20.00
Purchase	$325.00
Rental (5 days)	$ 75.00
Film (16mm)	
Purchase	$400.00

"Of the women who have gotten AIDS, over half have been I.V. drug users."
— Women and AIDS

For brochure and booklet pricing and shipping information see page 18.

The more brochures or booklets you order, the lower your unit cost.

AIDS IN THE WORKPLACE

1986 CINE Film Award Winner!

Our **AIDS in the Workplace** package is a comprehensive multi-media education program suitable for any workplace. Developed with the assistance of top business leaders, this package is invaluable for employees at any level, as well as health educators employed in the workplace.

Less than a year after its release, this package has set an internationally-recognized standard for the corporate response to AIDS.

The five-part program consists of:

VIDEO

- **An Epidemic of Fear: AIDS in the Workplace** This widely acclaimed 23-minute videotape uses real-life situations to educate managers and employees about AIDS. Includes interviews with medical experts, corporate managers, employees with AIDS and their co-workers.
- **An Educational Guide for Managers** A 68-page how-to guide that tells decision-makers what they need to know about AIDS and provides a model for educating employees. Also includes answers to common workplace-related questions about AIDS and a list of educational resources. Arranged in a premium quality 3-ring binder.
- **Strategy Manual** This 53-page manual is based on the experience of companies which have successfully dealt with AIDS in the workplace. It provides hands-on suggestions for the development of policies and guidelines for responding to AIDS in the work environment.
- **Strategy Manual Appendix** A comprehensive collection of resource materials, including samples of actual corporate policies and guidelines, newsletter articles and other valuable information.
- **Brochures: AIDS In The Workplace: A Guide for Employees** This pamphlet answers questions about AIDS transmission and casual contagion in the workplace. Each package includes ten sample copies. Other brochures provided are: **AIDS Lifeline**, **When A Friend Has AIDS** & **AIDS Antibody Testing at Alternative Test Sites.** (5 copies each) *See Index on p. 17 to locate brochure descriptions.*

"Offices, factories, and other work sites should have a plan in operation for education of the work force and accommodation of AIDS or ARC patients before the first such case appears at the work site."
— U.S. Surgeon General's Report on AIDS

This award-winning program was developed in cooperation with the Business Leadership Task Force of the San Francisco Bay Area. Members of the Task Force include Levi Strauss & Co., Pacific Bell, Mervyn's, Bank of America, Wells Fargo Bank, AT&T and Chevron Corp. These businesses and their associated foundations also funded the development and production of our **AIDS in the Workplace** *materials.*

PRICE SCHEDULE FOR AIDS IN THE WORKPLACE

Total package	$398.00
Videotape & Leadership Guide	$275.00
Strategy Guide & Appendix	$125.00
Videotape alone	$195.00
Leadership Guide	$125.00

Employee Brochures

1-9	45¢
10-99	35¢
100-499	30¢
500-4999	28¢
5000-& up	25¢

Nonprofit AIDS agencies are eligible for special discounts on **AIDS in the Workplace**.
Call for more information: (415) 861-3397.

AIDS ANTIBODY TESTING

AIDS Antibody Testing At Alternative Test Sites

VIDEO

Video: A full-color, 11-minute educational presentation on the pros and cons of the AIDS antibody (HIV) test. The video uses sophisticated graphics to describe how the test determines the presence of antibodies to the AIDS virus, and includes group discussions on the social, psychological and medical issues surrounding the test. Designed to help individuals make their own decisions about whether or not to take the test.

Version 1: contains references to San Francisco program.

Version 2: for any location with anonymous testing program.

Customizing available. Call for details.

(1985) VHS or Beta. Purchase or preview only.

Preview	$ 20.00
Single copies	$300.00
AIDS agency	$200.00

AIDS Antibody Alternative Testing at Test Sites

A decision-making guide for those considering the AIDS antibody test. Useful for answering questions on test procedures, personal concerns and the meaning of test results.

English-Spanish

Prepared with assistance of the SF Dept. of Public Health

(1985) 8½ x 22"/3 folds/2 colors

(See p. 18 for brochure prices.)

Personalize brochures with your agency's resource information.
See page 17 for more information.

Research Paper

A summary of findings from the Researcher's Conference on the Psychological and behavioral consequences of AIDS Antibody Testing. (1986) 8½ x 11"/9 pgs. $2.00

TRAINING MATERIALS

AIDS Hotline Training Manual

This comprehensive, clearly written, and up-to-date manual provides everything you need to train volunteers on an AIDS hotline. A valuable resource for all AIDS educators. It includes:

- an in-depth AIDS education program
- active listening techniques
- appropriate language and phone responses
- how to handle crisis calls
- using TDDs to communicate with deaf callers
- hotline rules and regulations
- an appendix of AIDS reference materials

Available in February, 1987. Call for price.

Teaching AIDS

This resource guide offers a comprehensive curriculum on AIDS for teachers, youth leaders and health educators. Written in language appropriate for teenagers, junior college students and community education, the curriculum is clear and exact. Not sexually explicit. In addition to the curriculum, **Teaching AIDS** includes these useful features:

- sample lecture and guidelines
- seven teaching plans for single-session classes
- six exercise worksheets for soliciting student responses
- a 10-question test on AIDS transmission and prevention

Developed in conjunction with the Youth and AIDS Prevention Program/AIDS Health Project of the University of California, SF. Written by Marcia Quakenbush and Pamela Sargent. Published by Network Publications.

1-9 copies	$14.95
10+ copies	$11.95

"Because of their sexual behavior and drug-use patterns, teenagers are certainly at risk . . . 50% of teenage women have had sexual intercourse, with some 16% reporting 4 or more partners."
Teaching AIDS, Network Publications

HEALTH CARE & HOSPICE PERSONNEL

VIDEO

NEW!
Exploring the Heart of Healing with Stephen Levine & Ram Dass

This three-hour video presents an in-depth exploration of self-healing within the context of a community living and dying with AIDS. Part I explores healing the body and soul, opening out of separateness, life as an opportunity for growth, cultivating spiritual practice, a message to grieving parents, and audience questions & answers. Part I is most appropriate for those personally involved with AIDS and other life-threatening diseases.

Part II includes segments on symbolic overload and AIDS, supporting ourselves and others in the living/dying process, providing skillful service and dealing with burn-out. It captures the essence of Ram Dass' most recent book, "How Can I Help?", and is most appropriate for care-givers. The second half closes with a 15-minute healing meditation.

Both tapes provide excellent training material for volunteers, students, professionals, people with AIDS and their loved ones.

Part I: Two hours	$ 75.00
Part II: One hour	$ 75.00
Both tapes:	$125.00
Preview (5 days) each tape:	$ 20.00

(1986) *Produced by the Access Group, Novato, California*

"AIDS: Care Beyond the Hospital is an excellent educational resource for home care providers. Nurses, social workers, attendants, and volunteers will benefit from this sensitive and professional approach to home care for persons with AIDS."

— Jeannee Parker Martin, RN, MPH, Director, AIDS Home Care & Hospice Program, Hospice of San Francisco

VIDEO

AIDS: Care Beyond the Hospital

This videotape is designed as a teaching tool for health care providers who will be working with people with AIDS in the home. It discusses the psychosocial impact of AIDS on the patient, the range of social responses, the common physical problems caused by AIDS-related infections and malignancies, and the home care needs of a person with AIDS. It is an excellent source of help in developing a case management plan for a chronically or terminally ill patient.

There are two versions of the tape. The 45-minute Case Management version is directed toward nurses, social workers, discharge planners, and physicians. The 30-minute Attendant Care version omits the case management section and outlines basic home hygiene techniques. It is intended for home health aides, attendants, and volunteers. (The video presentation is not to be shown to general audiences, lay people, or to groups of gay men not providing services to people with AIDS or any mass media.) Free descriptive brochure available.

Specify Case Management or Attendant Care version.

½" VHS $ 75.00 ¾" $115.00

Previews are $20 for each version, for a period of one week.

Rentals are $25 for one week. Please specify date needed. Slide show format available as rental in Northern California only.

HEALTH CARE & HOSPICE PERSONNEL

NEW!
AIDS Home Care and Hospice Manual

This exciting publication is a training guide for home health agencies and hospice programs in the care of persons diagnosed with AIDS. Based on the first AIDS Home Care and Hospice program at VNA of San Francisco, it provides educational guidelines and resources for administrators, staff and volunteers. Includes an overview of AIDS and ARC, the epidemiology of the disease, infection control requirements, physical and psychosocial interventions, easy reference tools for field staff, local, state and national resources, and examples of documentation used for reimbursement.

For-profit corporation: $195 Nonprofit agency: $ 95
Individual clinician: $ 50

AIDS & The Health Care Worker

Graphically illustrated, this brochure addresses health care workers' fears about AIDS. It describes specific methods of infection control to ensure both worker and patient safety, and provides current information on people at risk.

Produced by Service Employees International Union, Washington, DC.

(1986) 8½ × 14"/3 folds/2 colors (See p. 18 for prices.)

Medical Evaluation of Persons At Risk for Acquired Immune Deficiency Syndrome

Designed for physicians, this manual presents an in-depth discussion of the most common symptoms associated with AIDS, including fever, lymphadenopathy, pulmonary problems, gastrointestinal syndromes, neurological complaints and dermatological manifestations. Guidelines for evaluating the worried well are provided, along with safe sex guidelines for people at risk. Covers history-taking, physical exam, laboratory tests and suggested treatments.

Prepared by the Scientific Affairs Committee of the Bay Area Physicians for Human Rights, SF. Co-editors: J.M. Campbell, M.D. and W.L. Warner, M.D.

(1985) 40 pgs., photocopied $10.00

All revenues from sales of materials go towards fulfilling the San Francisco AIDS Foundation's nonprofit educational and social service goals.

How Infections Are Transmitted

This fact sheet presents general information on infection, contagion, germs, immunity, and certain illnesses such as diarrhea in simple language. It includes specific infection control guidelines for health care workers or anyone who is likely to come into contact with blood and other bodily fluids.

(1984) 8½ × 11"/5 pages photocopied 50¢

EDUCATIONAL CAMPAIGNS

Order all your AIDS information needs at one time. You'll save money with our quantity discounts.

Designing an Effective AIDS Prevention Campaign Strategy

This is a series of four public opinion surveys, three conducted among San Francisco's gay and bisexual male population, and one devoted to heterosexual men and women with multiple sexual partners.

The first three studies, conducted at one-year intervals, provided data critical to the development of our risk reduction education campaign aimed at gay and bisexual men. The fourth study was designed to provide data on the potential size and composition of the risk groups in the heterosexual segment of the population. All four studies provide detailed information about attitudes toward and awareness of AIDS, risky behavior, and safe sex among the populations studied.

(a) Results from the First Probability Sample of an Urban Gay Male Community (1984) Specify #1
(b) Results from the Second Probability Sample of an Urban Gay Male Community (1985) Specify #2
(c) Results from the Third Probability Sample of an Urban Gay Male Community (1986) Specify #3
(d) Results from the first Probability Sample of Multiple/High-Risk Partner Heterosexual Adults (1986) Specify #4

All the above reports were prepared by Research & Decisions Corporation $25.00 each

Health Education Planning for AIDS Risk Reduction in the Gay/Bisexual Male Community: The Precede Framework

Detailed and thorough, this report presents the basic principles of developing AIDS risk reduction strategies for gay and bisexual men. The *PRECEDE* framework helps health educators "identify critical non-behavioral factors which affect risky behavior but which must be addressed by social agencies, community organizations, or social action groups . . ." The appendix includes four examples of AIDS risk reduction display advertisements.

1985. *Prepared by Robert K. Bolan, M.D.* $4.00

FREE BONUS!

NEW!
Some People Think You Can Catch AIDS from a Glass

This two-color poster, suitable for general display, depicts a drinking glass. The brief text explains how AIDS is and is not transmitted. California toll-free hotline numbers are provided. Bulk quantities are available for free only in California. Shipping and handling charges do apply. Poster can be personalized with your local Hotline number. Call for estimate.

Celebrity Public Service Announcements

The first national AIDS PSAs are now available directly to individuals and organizations. 46 prime-time TV stars and other well-known personalities educate the public about various aspects of the fight against AIDS on one videotape.

The PSAs, 64 altogether, have already been distributed nationwide to 650 radio and TV stations. Now you can get Ron Reagan Jr., Eva Gabor and Joe Namath to speak to audiences in your area who aren't reached by local media. Space is provided at the end of each 30-second spot for organizations to add their local resource information.

Production coordinated by the San Francisco AIDS Foundation; co-produced by KPIX-TV San Francisco and Chen Sam Associates, New York. Production funded by KPIX-TV, AIDS Project Los Angeles, American Foundation for AIDS Research, and the U.S. Public Health Service. Initial distribution assisted by the National AIDS Network.

Tapes are available for purchase at minimal cost. For further information contact Mary McFadden, Highland Labs, 840 Battery Street, San Francisco, CA 94111. 415/981-5010. Reference "KPIX AIDS PSA's."

SAN FRANCISCO AIDS FOUNDATION SERVICES

San Francisco AIDS Foundation
333 Valencia Street
Fourth Floor
San Francisco, CA 94103
415-864-4376

Educational Services

The Education Department

- **Telephone Services**
  Well-trained and supervised volunteers staff the AIDS Hotline Monday-Friday 9-9 and weekends 11-5.
- **Educational Events**
  Speakers are provided to diverse audiences requesting AIDS information; forums are organized to address specific areas of concern; and in-depth seminars are held for health care professionals.
- **Media Relations & Advertising**
  Educational messages are developed and placed in various advertising media to increase AIDS awareness locally and nationally. We disseminate accurate AIDS-related information to media professionals.
- **Materials Development and Distribution**
  Literature and audiovisual materials are designed to address specific target audiences and are distributed nationally and abroad.

Direct Services for People with AIDS/ARC

The Social Services Department

- **Social Services Program**
  The Social Services Program meets critical social service needs of people with AIDS or ARC. Social workers assist clients with disability benefits, housing, and employment concerns.
- **Emergency Housing Program**
  The Emergency Housing Program is a short-term housing program serving people with AIDS/ARC.
- **Food Bank**
  The Food Bank is a privately funded, community-supported program which assists low-income people with AIDS/ARC with additional groceries and other necessities.

Northern California Educational Services

The Northern California Service Department

- **800 Toll-Free AIDS Information and Referral Hotline**
  This volunteer-staffed Hotline serves 44 counties in Northern California.
- **Direct Educational Services in Counties without Education Programs**
  Staff provide forums, literature, media education and media advertising to health care providers, people at risk and the general population in specified counties where no such services exist.
- **Program Assistance**
  In order to foster resource-sharing among AIDS agencies and other local departments of public health, staff consult on program development, forums, materials development and distribution, media relations and advertising in specified counties in Northern California.

1987 Award Recipient! The San Francisco AIDS Foundation is the recipient of the Edward R. Loveland Memorial Award from the American College of Physicians — "to honor a lay organization for distinguished contributions in the health field."

For People With AIDS, ARC and Their Families

We do urge people with AIDS, ARC and their families who live in Northern California to call our local hotline numbers to receive free literature suitable to their individual needs. In San Francisco, that number is 863-AIDS. In Northern California, it's (800) FOR-AIDS. Outside California, please call 1-800-342-AIDS.

Hotline: (415) 863-AIDS (800) FOR-AIDS (No. Calif.)

ITEMS TO COME!

- **Dental Patient Management and Office Procedures Resource Manual**
- **A Guide for Living with AIDS** *(Comic Book)*
- **AIDS 101: A Primer of Medical Information on AIDS** *(Booklet)*
- **Safe Sex Information Targeted for Inmates at Correctional Facilities and low literacy populations** *(Low Literacy Brochures and Cards)*
- **Infection Control at Home for People with AIDS and ARC** *(Brochure)*
- **After the AIDS Antibody Test — What's Next?** *(Brochure)*

Posters: AIDS Education in Correctional Facilities

Four posters that clearly communicate basic AIDS risk information to correctional inmates and staff. Each poster uses a focused, textual message and limited graphics. Posters 1 and 2 advise readers to contact their medical officer or counselor. The text in posters 3 and 4 is pertinent for posting in any location.

Developed by the San Francisco Forensic AIDS Task Force

Poster 1: **"The Ultimate Point — Shooting up and sharing needles puts you at risk for AIDS. This fact may save your life!"**

Poster 2: **"The Best Life Insurance Against AIDS is Information — Learn how to prevent the spread of AIDS"**

Poster 3: **"You Cannot Get AIDS From: foods; eating utensils; shaking hands; the air; toilet seats; sneezing and coughing"**

Poster 4: **"AIDS Prevention — Don't share tattoo kits"**

(1985) 17" × 22" **Prices:** 1-10: $3.00 10-100: $2.50 100+: $1.75

All revenues from sales of materials in this catalog go towards supporting the educational and social service goals of the San Francisco AIDS Foundation.

Reader Service Coupon

Name _____

Title _____ Date _____

Organization _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Please send review copies of the following six brochures and/or six booklets:

1: _____ 2: _____

3: _____ 4: _____

5: _____ 6: _____

7: _____ 8: _____

9: _____ 10: _____

11: _____ 12: _____

Do you have any comments about our publications or services? _____

Do you have suggestions for new titles? _____

Names of colleagues who should receive our catalog:

Name: _____ Name: _____

Title: _____ Title: _____

Organization: _____ Organization: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

☐ Please send a **Sampler Packet** for $4 (Includes over 25 brochures & our safe sex card)

PERSONALIZING YOUR BROCHURES

Most of the brochures in this catalog can be personalized with your agency's logo and/or local AIDS resource information. This assures that each brochure is doubly effective in assisting your community's fight against AIDS.

Personalizing can be done in two ways:

1. Printing your logo and/or information on the exposed back panel only. Your information would appear beside existing San Francisco resource information, where space permits. Copy dimensions for this type of personalizing is 1¼" (h) × 3" (w). Imprint is in black. Minimum quantity: 5,000.
2. Removing all or most references to San Francisco resources, wherever they appear in the brochure, and substituting your message(s). This gives you more room to describe your services. And it's especially helpful for brochures that have no space available for personalizing. Copy length varies by brochure. Minimum quantity: 10,000.

	STANDARD RATE	NONPROFIT AIDS AGENCY	QUANTITY
Option 1:	$0.20	$0.15	5,000+
Option 2:	$0.26	$0.20	10,000+

Please enclose clear, complete instructions with your order. If you have a logo or special typeface, please enclose camera-ready artwork. Fifty percent deposit required on all orders.

Call for information on lower rates for quantities of 25,000 or more.

Don't forget that you can combine different brochures to qualify for quantity discounts.

Brochures & Cards Available in Other Languages

	Spanish*	
AIDS Lifeline	AIDS Cable de Salvamento (also in Chinese)	4
Guidelines for AIDS Risk Reduction	Normas Para Reducir el Riesgo de Contraer AIDS (Chinese, Tagalog, Japanese also)	8
Straight Talk About Sex & AIDS	Información a las Parejas Sobre AIDS/SIDA	4
Safe Sex Cards	Prácticas Sexuales Sanas	8
AIDS Antibody Testing at Alternative Test Sites	La Prueba del Anticuerpo de AIDS	11
Shooting Up & Your Health	Inyectandose y Su Salud	9
Alcohol, Drugs & AIDS	Alcohol, Drogas y AIDS	9

INDEX

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ORDERING INFORMATION

Mail Orders

Please use the order form on the inside back cover. It will speed the processing of your order. If the order form is missing, please be sure to include the following information with your order.

TITLE	QUANTITY	UNIT PRICE	TOTAL

SUBTOTAL _____

SALES TAX (CA 6%, SF 6.5%) _____

SHIPPING & HANDLING (See chart below) _____

GRAND TOTAL _____

Agencies/institutions should include purchase order information. Mail your order to:

San Francisco AIDS Foundation
Materials Distribution Dept.
333 Valencia Street, 4th floor
San Francisco, CA 94103

Payment

Please make checks or money orders payable to the **San Francisco AIDS Foundation**. Foreign or Canadian orders must be paid in U.S. dollars.

Phone Orders

You may order by phone between 9 AM and 4:30 PM (PST). Call (415) 861-3397. Please give us the name and quantity of each item when you place your order.

Discount Policy

Nonprofit agencies who serve AIDS, ARC, antibody-positive and predominantly high-risk clients are eligible for a 25% discount on all materials produced by the San Francisco AIDS Foundation. Services provided to these groups should include one or more of the following: housing, medical, legal, education, or counseling. *This discount is intended to assist agencies who would not otherwise be able to purchase educational materials.* Certain items are *not* eligible for the discount: **Teaching AIDS, Exploring the Heart of Healing, Sex, Drugs & AIDS, AIDS in the Workplace,** and the **AIDS Home Care and Hospice Manual.**

Shipping Information

Please allow 4-6 weeks for delivery from the date we receive your order. If you need your order sooner, please specify the date you need to receive it. However, you can be sure of your item's availability by calling ahead. All reasonable efforts will be made to fill your request. We normally ship via UPS. We must have a **street** address for UPS delivery (no P.O. Box addresses).

Partial Shipments

If certain items are out of stock, partial shipments will be made. Your request will be kept on file until those items not yet available can be shipped. Please allow 2-4 weeks for items back ordered.

Bulk Rates

Any combination of brochures, except for **AIDS in the Workplace** brochures, will count toward the quantity necessary to receive the bulk rate. The same holds true for booklets.

Customer Service

We want your order to arrive in good condition and to be exactly what you ordered. If you receive damaged goods, or if there are any problems with your order, please don't hesitate to contact us. Call (415) 861-3397 between 9 AM and 4:30 PM (PST).

Guarantee

All materials purchased from the San Francisco AIDS Foundation are guaranteed. If for any reason you are not satisfied, simply contact our office within 30 days and arrange to return the purchased materials in their original condition for a full and prompt refund or credit.

Pricing

The following schedule is for the purchase and shipment of bulk quantities of brochures, booklets and our tabloid, **Hot 'N' Healthy Times**. The purchase price for manuals, reports, videos, fact sheets, cards and posters are listed inside the catalog with each item description. Shipping charges for each type of item are described below.

Brochures		AIDS in the Workplace Brochures		Booklets		Hot 'n' Healthy Times	
25-99	30¢	1-9	45¢	25-499	90¢	1-9	$2
100-499	20¢	10-99	35¢	500-1499	80¢	10-99	$1
500-999	17¢	100-499	30¢	1500-4999	75¢	100-999	50¢
1000-9999	15¢	500-4999	28¢	5000 & up	70¢	1000 & up	25¢
10,000 – call for quote		5000 & up	25¢				

Shipping

Charges are calculated according to the actual weight of the item, and include a small handling fee.

All Brochures		Booklets	Hot 'n' Healthy		Other Items	
25-499	$ 5.00	Add $5 for every 100	1-249	$ 2.50	Manuals & Reports	$3.00
500-999	10.00	Large orders may require individual estimate.	250	5.00	Videos	2.00
1000-1499	15.00		500-1000	10.00	AIDS in the Workplace pkg	10.00
1500-1999	20.00		Add $10 for every 1000 copies		Women & AIDS pkg	5.00
2000-2500	25.00					

Please add $5 for every 500 brochures

San Francisco AIDS Foundation
333 Valencia Street, Fourth Floor
San Francisco, CA 94103
415-864-4376

ORDER FORM

PLEASE PRINT CLEARLY

PURCHASED BY Date: _____

Name: _____

Title: _____

Organization: _____

Street: _____

City, State, Zip: _____

Telephone: _____ Purchase Order No. (if applicable): _____

If order destination is different from address above, please enclose shipping instructions.

Payment options.

- ☐ I've enclosed payment.
- ☐ Bill my organization. (Terms: Net 30 days.)
- ☐ I've enclosed purchase order # _____

Please send _____ additional copies of this catalog.

Brochures

Quantity	Title (Please Print)	Specify Language	Unit Cost	
	TOTAL number of brochures		¢	Total Brochure Cost
	AIDS In The Workplace Brochures		¢	Total AWP Cost

IMPORTANT:

Personalization instructions are
☐ enclosed

(Be sure to enclose instructions.)

Price entered below is for

- ☐ personalized
- ☐ non-personalized brochures

Booklets

Quantity	Title (Please Print)	Unit Cost	
	TOTAL number of booklets at	¢	Total Booklet Cost

Other Items

Quantity	Title (Please Print)	Unit Cost	
	TOTAL number of other items	TOTAL cost	Total of Other Items

☐ Please send these materials labelled "Educational Materials" without listing SF AIDS Foundation as return address.

* We are required to collect sales tax on all orders
- SF residents 6½%
- Other California residents 6%

SBT

SUBTOTAL	=	$
Less 2% discount (see p. 18)	=	$
SUBTOTAL	=	$
Add applicable sales tax*	=	$
Shipping & Handling (see p. 18)	=	$
ORDER TOTAL	=	$

San Francisco AIDS Foundation
333 Valencia Street
Fourth Floor
San Francisco, CA 94103
415-864-4376

INSIDE THIS CATALOG:

- **Brochures**
- **Videos**
- **Manuals**
- **Booklets**
- **Posters**

AIDS education and training materials for:

- **Substance Abuse Counselors**
- **Health Educators**
- **Health Care Professionals**
- **AIDS Agencies**
- **Hospices**
- **Corporate Managers and Employees**
- **Teachers**

San Francisco AIDS Foundation . . . internationally recognized for effective AIDS education materials.

Mind Games

Problems are a pastime for San Francisco's Brain Exchange

BY GREGG LEVOY

Vyvyn Lazonga is a San Francisco tattoo artist who had a business problem. She needed to find ways to promote her line of tattoo cosmetics, which can be used to disguise scars, apply permanent eyeliner or even out the color of blotchy skin. Part of her problem, however, was that she didn't know of any professional groups to which a tattooist could go for peer advice.

Enter the Brain Exchange, a San Francisco-based group that brainstorms with people to help them find solutions to their entrepreneurial, career, creative or personal problems.

When Lazonga went to her first BE meeting in an uptown office building, she encountered several dozen people from all walks of life, ready to discuss any problems that group members presented. Lazonga readily volunteered to go first, and the response was overwhelming. For 15 minutes, she scribbled frantically as the group stormed her with ideas and possible solutions. Their suggestions ranged from the sublime to the ridiculous, from the practical to the practically insane.

"I got great ideas, though," she says, "even if it was hard not to be overwhelmed by the sheer number. Some of those ideas have really helped me fine tune my professional presentation. I'm making up a brochure and business cards, getting a business wardrobe together, calling on doctors, hospitals, beauty salons and plastic surgeons, and learning how to tap into the clientele I want.

"It really helps to get ideas from outside sources, especially for people who, like me, work alone," Lazonga says. "It's also helpful for people who, again like me, work in fields that others frown upon. The Brain Exchange is so open, positive and non-judgmental. No one frowns. They just want to give away ideas. I've never seen anything like it."

Neither have a lot of people in locales up and down the West Coast—Los Angeles, San Francisco, Sacramento, Seattle and Vancouver Island, British Columbia—where BE now holds meetings in private homes, in corporate boardrooms like that of Merrill Lynch and even over the radio. The organization's current mailing list includes some 800 people, from corporate executives to chiropractors to street performers. All of these individuals have at least one thing in common: They want to take the curse off the word "problem."

Gathering in groups sometimes as large as 50 or 75 people, they demonstrate what can happen when the withering effect of premature criticism is removed from problem solving. The typical BE meeting is spirited, prolific, cathartic and positive.

The Brain Exchange, according to co-director Lee Glickstein, a humor writer and owner of a word-processing service, is "a playful think tank." It is also an antidote to what he calls "the 98 percent blues." Many of us, he submits, "have inherited the unexamined assumption that 98 percent of all possible ideas in the world have been conceived and executed, that 98 percent of all ventures and inventions have been ventured and invented, 98 percent of all creative solutions to finding satisfying work

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Gregg Levoy lives in San Anselmo, California.

have been attempted, and 98 percent of them don't work anyway. Which would leave 98 percent of us gifted children scrounging and competing for the 2 percent supply of available new ideas and avenues.

"The Brain Exchange is dedicated to proving the scarcity-of-possibilities assumption false," he says. "We believe that most of the creative contingencies in our future are unknown to us now. We nurture a stimulating, supportive environment receptive to that knowledge."

In San Francisco, the BE's weekly meetings begin with a go-round introduction during which an average of 50 attendees disclose their "hidden agendas," says co-director Joy-Lily, a textile artist and humor writer. If you're there in hopes of finding a business partner or a baby-sitter, you say that. If you have a service to offer, you offer it. If you have a project in the works, a reigning passion or a problem that needs solving, you tell about it. This is the networking portion of the show, where valuable business connections often are made.

The go-round also reveals that the evening's brainstorming team is composed of people in diverse fields. This is a distinct advantage, according to BE officials, because supposed "experts" in your field often seem to know only what *can't* be done. Thus, exchange devotees contend that the naive often have the best ideas.

"Sometimes you're just too close to a problem," says Byron Mandel, owner of a San Francisco marketing development company. He originally went to the Brain Exchange to mine ideas on how to help a client market a new pizza product. "Sometimes it helps to have input from people who don't see the limitations you do."

Today, this is what brainstorming is all about—putting heads together for the sharing of ideas. That's quite an enlightened concept to attach to a word that was originally coined during a 1907 murder trial to describe a fit of temporary insanity. In fact, it wasn't until the 1940s that Madison Avenue adman Alex Osborn popularized brainstorming as a term for corporate problem-solving sessions.

"I just go to give out ideas. I'm a real idea person and I need somewhere to put them, without worrying if they're practical."

By the end of the '50s, the concept, also referred to as buzz sessions, idearamas and imagineering, already was employed by several of America's top corporations—IBM, General Motors, U.S. Steel, General Electric—as well as the U.S. Army. GE, for example, found that the flow of ideas increased up to 300 percent during

brainstorming sessions, and Osborn's BBD&O ad agency found the process so valuable that it named a vice president in charge of brainstorming. The vice president subsequently held all meetings in a yellow room because yellow was considered conducive to thought.

Studies done during Osborn's era suggested that 6 percent to 10 percent of all ideas generated during corporate brainstorming meetings were practical: Sometimes, more than 100 ideas were proposed in a single half-hour session.

The BBD&O ad agency found the process so valuable that it named a vice president in charge of brainstorming.

Brain Exchange participants may not go home with 100 ideas, but they certainly will get enough input to grease their wheels. Such was the experience of Rebecca Searles, a San Francisco street musician who came to a BE meeting last year in hopes of finding ways to get her name "out there." First off, the group helped her get her problem into proper brainstorming shape; that is, they couched it in terms of an answerable question. In Searles's case, the question ended up being "How many names can I come up with for my street music business?"

Within seconds of asking the group, she was busy scrawling down a barrage of possible names: Drum Schtiks, Duet in the Road, Treble in the Streets, Music for Sewer-Sides, Band on the Run, De-Composer, Keys West, Half Note Will Travel, Music without a Pitch, Concert-ed Efforts, Band in San Francisco.

A grin spread across Searles's face as she struggled to keep up with the flood of ideas. "My head is spinning," she said when it was over.

Other meetings are no less prolific. At one, the problem was, "How many ways can I market my quilt art?" The group's solutions were: Sell quilts to women executives for their offices; make a quilt design for consideration as a postage stamp; make miniature quilts for dollhouses; sell huge quilts to corporate art buyers for bank lobbies and atriums.

Another question was of a more personal nature: "How can I move out of a temporary depression?" Some of the ideas: Find a trampoline to help you bounce back; count your blessings; sing "Poor Poor Pitiful Me"; write the Pope and include a self-addressed stamped envelope; don't read any self-help books; do something new.

At the Brain Exchange, all brainstorming ideas are stated in the imperative. No one says "What about this?" or "Have you tried that?" Glickstein says, because such phrasing can invite excuses for why an idea won't work. ▷

Acquired Immune Deficiency Syndrome (AIDS): An acquired defect in immune system function which reduces the affected person's resistance to certain types of infections and cancers. To qualify as AIDS, the malfunctioning of the immune system must not be linked to genetic disorder, chemotherapy, malnutrition, or deliberately induced medical treatments (as in organ transplant recipients). Although the cause is unknown for certain, it is thought to be a virus (HIV) which is transmitted through intimate sexual contact or exposure to infected blood or blood products. Once immune-depressed, an individual becomes susceptible to a number of opportunistic diseases.

AIDS-Related Complex (ARC): At present, ARC has no "official" definition. Simply stated, ARC is a lesser disease response to the AIDS virus. Some individuals develop a few or many of the symptoms of AIDS, such as swollen lymph glands, night sweats, diarrhea, and fatigue, but do not necessarily go on to develop one of the life-threatening diseases that meet the requirements for an AIDS diagnosis. This makes ARC a very broad catch-all category.

Antibody: A substance formed by the body as a reaction to a foreign agent or antigen. The antibody formed works only against that particular antigen.

ELISA Test: A blood test which indicates the presence of antibodies to the AIDS virus. (Various ELISA tests are used to detect other infections as well.) The HIV ELISA test does not detect the disease AIDS but only indicates if viral infection has occurred. The test is used to screen blood supplies, is used in certain research projects, and has also been used in specific health-care situations.

Helper/Suppressor T-cells: T-cells are lymphocytes (white blood cells) that are formed in the thymus and are part of the immune system, which has been found to be abnormal in people with AIDS. The normal ratio of helper T-cells to suppressor T-cells is approximately 2:1. This becomes inverted in people with AIDS but may also be temporarily abnormal in people for many other reasons.

HTLV-3/LAV/ARV: The three names previously given for the virus which causes AIDS. Respectively, the three names stand for Human T-cell Lymphotropic Virus-Type Three, Lymphadenopathy Associated Virus, and AIDS-Related Virus. The virus is now called HIV (see below).

Human Immunodeficiency Virus (HIV): The name chosen by a scientific panel of virologists and other researchers for the AIDS virus. The name was chosen as a generic description to help ease the controversy over different researchers giving the AIDS virus different names.

Person with AIDS (PWA): A term developed by individuals diagnosed with AIDS to counteract the more negative term "AIDS victim" and the less assertive "AIDS patient."

Pneumocystis Carinii Pneumonia: A lung infection seen in immunocompromised people. It is caused by a protozoan present almost everywhere but which is normally destroyed by healthy immune systems. By the age of four years, 70 percent of healthy children have evidence of past exposure. The protozoan is airborne, but cannot be transmitted this way to unaffected individuals. Once a person develops PCP, they are susceptible to recurrence of the disease, and the outcome may be fatal.

Seropositive: A condition in which antibodies to a particular disease-producing organism are found in the blood. The presence of antibodies indicates that a person has been exposed to the organism but does not distinguish between an active infection and a past infection.

Western Blot Test: A blood test used to detect antibodies to the AIDS virus. Compared to the ELISA test, the western blot is more specific and more expensive. It can be used to confirm the results of the ELISA test.

From AIDS: A Self-Care Manual (AIDS Project Los Angeles), Edited by BettyClare Moffat, et al., IBS Press, 1987, pp. 257 ff.

What is the "AIDS test" that is done in blood banks? It is simply a test for the AIDS antibody. The method used is called an "enzyme-linked immunoabsorbent assay" (ELISA). In general it is a very good test. To put it simply, we stick the AIDS virus at the bottom of a test well, adding serum for testing antibodies to the virus. If there is an antibody to the virus, it will stick to the virus because they interlock. Then the well is washed. Another antibody made in a goat recognizes human antibody. So if the blood specimen being tested has an antibody to the AIDS virus, this goat antibody will stick to the human antibody. Attached to the goat antibody is an enzyme. When the substrate of that enzyme is added to the well, a color change occurs. A spectrophotometer reads the color change, produces a value which is then scored as either positive or negative.

There are a number of places where there might be some error, but in general, the test is 99 percent accurate. That means 1 percent are going to be inaccurate....So one percent of those is 110,000 units of blood that need to be discarded because they are read as positive for the AIDS virus, even though, in fact, they are not. Regardless of the uncertainty this information implies, 110,000 people must be told they have been infected with the AIDS virus--even though this is not true.

To avoid these false positives, we do what is called a "confirmatory test." The western blot is another technique available for detecting antibodies to the AIDS virus....

...Again, it isn't the antibodies to the virus that cause the disease. At this time, we do not know the natural history of people who are antibody positive. We don't know if all of them are going to get AIDS twenty years down the line, or if some of them will never have any problem again and just always remain positive to the antibody. It is the virus which causes disease. And the disease is diagnosed clinically, quite easily, without necessarily obtaining a blood test for antibodies. AIDS is a clinical diagnosis. A positive antibody test is not a diagnosis of AIDS.

From AIDS: A Self-Care Manual (AIDS Project Los Angeles), Edited by BettyClare Moffat, et al., IBS Press, 1987, pp. 257 ff.

Before people take the test, we ask them to think about the difference between assuming that they are positive and knowing that they are positive. On one hand, if a person makes the assumption, because he or she has been involved in risky behavior, that he or she is positive, then perhaps that person does not need to take the test, which can be a traumatic experience. On the other hand, some people are engaged in compulsive sexual behavior, and for them taking the test can be a sort of confrontation. Being told in fact, "Yes, you are positive," has helped a number of people to make behavioral changes....

In pretest groups, we notice that people do not know what to expect the test to answer, and they want it to answer things it cannot answer, specifically, "Will I get AIDS?" "Will I live a long life?" "Will I live a happy life?" We cannot stress enough that the test will not tell if one is going to die of AIDS. Nor could any counseling give definitive answers about one's longevity or well-being....

People are given a list of resources for the two-week waiting period, which, for many, is a very difficult time. Upon returning, they meet with a counselor privately. Again, only the number is exchanged--no names are used. At that point the result is given. People are helped to understand the test result, and appropriate referrals are made to resources in the community. A follow-up videotape and resource list are also given. At the end of the session we offer to those who are seropositive or seronegative the opportunity to see a follow-up counselor for a free hour consultation to consider questions or help with problems in adjustment. Few people find this extra session necessary....

Intervention has three goals. The first is to help the person absorb the news and cope with the results, to be able to walk out on the street again. The second is to connect the person to resources. No matter how good the counseling, many do not really hear much of what goes on because they are in shock. Even with negative results, the situation is very complicated. If someone is all geared up for a positive test result, and gets a negative, his or her whole world is turned upside down....

Giving the results is divided into four parts: establishing rapport quickly with the person; giving results as clearly and straightforwardly as possible; working on emotional and cognitive integration, the heart of the interview; and finally, developing a plan....

Informing others is a big issue. We discuss with the person whom to tell, whom not to tell, how to tell them, what that would be like. Telling a lover could result in violent conflict, perhaps a breakup, or it could make the two feel closer. That subject alone could require about ten hours of counseling, so much is involved.

We make sure that at least the person walks out with a resource list and a referral to a counselor. Most people will have a delayed reaction. People are often numb, which is why that resource list is so critical.

We have a plan for potential suicides. We are in touch with the emergency rooms and psychiatric units. It's must more likely, however, that any kind of an emergency reaction will be subacute, necessitating only a walk-in clinic. Here are a few issues that come up during the counseling sessions: sutstance abuse, fear of sex or sex-phobias (many people report being celibate), sexual addiction, sexual identity problems, relationship conflicts, grief over loss or anticipated loss of friends or lovers, general health concerns, excessive anxiety or hypochondriasis or extreme anxiety responses, whom and how to tell, coming out, quality of life, continuing risky behaviors, unwillingness to change sexual behaviors, unwillingness to alter behaviors around cofactors (such as drug use or nutrition), stress reduction, establishing and utilizing a support network, fears of intimacy, health education, health planning, transmission, parenting, and fear of illness or death. There's an awful lot to deal with in a half-hour to an hour....

In settings other than the alternative sites, people receive the results in brief telephone calls from, for example, a health worker. We have heard some fairly bad stories, such as getting positive results from doctor's offices, and then at the time of the next physical examination noting the doctors and nurses putting on gloves. Right after giving results that just does not work. People feel pretty bad anyway. In the initial feedback session when one gets results, a supportive session is most helpful, although very little information can be imparted at this point.

Group members have reported a progression of psychological reactions over time. Days one to three constitute a kind of psychological shock. The first emotion that people report is anger rather than denial: anger at the medical community, anger at the government, anger at various agents, often a projection--questions like "Who did this to me?"

From three days to three months there are waves of depression, with accompanying sleep, eating, and mood disturbances, a sense of isolation and alienation, as well as impotence and a decrease in libidinal drives. Many body image questions come up--feelings of being diseased, feelings of being impotent in the face of this disease, and feelings of being contagious. Sex in a way becomes deadly, sex becomes evil...

Awareness of being seropositive for HIV can promote a sense of weakness of the body, of the self. The knowledge that antibodies cannot fight off the virus, in fact, leads to a certain sense of a weakening of the self, into which the whole question of the will enters, a fundamental kind of psychological problem. Since one cannot do anything, one feels hopeless and impotent. In psychological terms, a positive HIV result can lead to a breaking down of the defense structure....

Psychodynamically, inadequacy, nurturance, and trust themes emerge, the nurturance and trust themes coming from a sense of being affected by the nurturing object. In this case, the nurturing object of sexual affection leads to a disease; in HIV transmission, the person who has it becomes that diseased object and passes it on. That is why a very supportive, nurturing environment is essential to encourage the development of new defenses....

We encourage people not to talk to others outside the group about their test results for a while, until those defenses come back and are a little stronger. Participants have related stories about their experiences, for example, longtime roommates who have moved out, one physician telling a man that he should not live with his children whom he then shipped away to his mother's house....

People are very anxious to hang onto anything you can offer, like a plan to protect their health. Legal plans also come up a lot. People have concerns about what will happen when they die--they equate seropositivity with dying. Psychological advice of the very simplest kind is well taken. Sex is often a question, and along with this of course the emotional release that people need....

Rephrasing the situation into a positive experience is immensely helpful. The positive HIV result is useful for carrying on one's life, facing up to major existential questions. This result can bring a certain immanence to life. It may be time for bibliotherapy--to go back and read that old philosophy that didn't make too much sense when you were in college but may make a lot of sense now, about what it means to be alive today.

People who are seropositive are a new group. Potentially, they might live the rest of their lives being contagious, carrying a disease that can kill other people, and yet they might also live fully through their lives....

The presence of the AIDS antibody in one's blood does provoke profound questions, and the sensitive counselor can help the individual consider them in a frank, honest way. What we have found best is clear information presented in a timely fashion after the test has been performed, accompanied by appropriate referral with the added provision of supportive group experiences. AIDS has made all of us face the harder existential issues of life and death. Knowing that this confrontation is difficult and having sensitivity and compassion for those struggling with

it is the basic key to good HIV antibody test counseling.

From What To Do About AIDS, Edited by Leon McKusick, Berkeley and Los Angeles, University of California Press, 1986, PP. 104-110.

negative, while those who test positive need to know the practical implications (see below).

In the clinical setting, an HIV-positive result is useful in that it may lead the physician to include an AIDS-related condition in the differential diagnosis and to take an aggressive approach to the patient's illness if necessary. Individuals who are identified as positive also require careful counseling.[5,41-43]

Interpretation of Test Results

If the ELISA is negative, a Western blot is usually not done. Blood from ELISA-negative individuals who do not belong to any risk groups may be used for transfusion. Individuals from high-risk groups should be notified that a negative ELISA test does not carry the same degree of confidence as in low-risk individuals.

If the ELISA is positive and is confirmed by Western blot or IFA, then the individual has been infected with HIV.

If the ELISA is positive and the Western blot is completely negative, the patient's blood should, nevertheless, *not* be used for transfusion, although re-entry into the blood donor population may be possible in the future. Such a patient (donor) is probably not infected with HIV. If the Western blot and/or IFA is equivocal, the infection status with HIV is unknown and the Western blot should be repeated on a specimen obtained in four to six months.

Counseling

Information to be communicated to patients with antibody to HIV should include at least the following:

1. The infection is persistent, probably for life, and a certain proportion of those affected will develop AIDS. Approximately 35% of HIV antibody-positive individuals developed AIDS over six to eight years,[44] but having a positive antibody test does not mean that the patient has AIDS.
2. It is not possible to predict who among seropositive individuals will develop AIDS or show clinical symptoms.
3. Antibody-positive persons are potentially infectious to others by sexual exposure, by sharing drug injection paraphernalia, by childbearing, or by donating blood, semen, or body organs.
4. Antibody-positive persons should practice what has come to be known as "safe sex." In the absence of celibacy, this usually means using a condom routinely when having sexual intercourse. Preventing perinatal HIV infection requires that adequate birth control measures be employed.

Underlying all of the above measures for controlling the spread of HIV infection is notification of all individuals who are HIV antibody-positive, providing them with the above information, and being available to answer questions. Information for counseling seropositive individuals is available through state or local health departments and from a number of AIDS information organizations. Antibody-positive individuals should also be encouraged to notify their sexual partners, so that the risk for further transmission may be reduced. The responsibility to notify known sexual partners may fall to the physician if an antibody-positive person refuses to do so, but this area is extremely complex and unsettled. In some jurisdictions, seropositive individuals must be reported to the health department. The advisability of mandatory screening, as in the prenatal setting or for marriage license application, will continue to be debated. The ultimate purpose of such screening is to reduce the incidence of infection by reducing transmission through changes in behavior.

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Table 1

Recommendations to Family, Friends and Household Contacts

1. There is no evidence that AIDS can be transmitted to family, household members or close contacts by routes other than exposure to blood, sex and perinatal transmission.

2. Reasonable precautions should be taken within the household to avoid direct contact with blood and other body fluids. However, these precautions need not interfere with normal interactions.

3. There is no evidence that saliva on household items can transmit infection. Household items may be shared by patients and household members. It is not necessary to have separate dishes and eating utensils for AIDS patients, though they should be washed routinely with hot water and detergent.

4. Razors, toothbrushes or any other items that may be soiled by blood from AIDS patients should not be shared.

5. Blood and other body fluids (urine, feces or items soiled by blood and body fluids) should be handled with care. Disposable gloves should be used and hands should be washed thoroughly with soap and water. Soiled surfaces should be cleaned with a solution of household bleach diluted 1:10 in water.

6. Bathroom facilities (toilet, bathtub and shower) can be used by all household members. Facilities should be kept clean and soilage by body fluids should be cleaned with household bleach diluted 1:10. Blood and other body fluids can be flushed down the toilet.

7. Soiled clothes or linen should be washed with a detergent and/or bleach.

8. Sharp objects used in the home care of patients should be handled carefully to avoid accidental injury and disposed of in impervious sealed containers.

Table 2

Guidelines for the General Public

1. HIV is transmitted by sexual intercourse, the transfusion of blood or sharing of needles contaminated with blood and by perinatal exposure. There is no evidence that other person-to-person interaction among workers, consumers, clients or school children poses a risk for transmission of HIV.

2. Persons with AIDS or HIV infection should not be restricted from work, school or personal interactions. Telephones, office and school equipment, toilets, showers, eating facilities and water fountains can be used safely.

3. Sexual relations with persons at increased risk for HIV infection can result in HIV transmission. The risk increases with increasing numbers of sexual partners. The use of condoms may reduce the risk of HIV transmission.

4. The use of intravenous drugs with the sharing of needles and syringes can result in HIV infection.

5. Persons at risk for HIV infection should not donate blood, semen or organs.

6. Women of child-bearing age who are at risk for HIV infection should determine their HIV antibody status before conception or defer pregnancy by use of barrier contraception.

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AIDS: A Jewish View

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Introduction:

The acquired immunodeficiency syndrome (AIDS) has been described as this century's greatest health peril. Thousands have already died from the disease and there is no cure in sight. The emotional toll on patients with AIDS, their families and their caregivers needs to be actively and aggressively addressed. The public hysteria should be alleviated by a well planned, coordinated and implemented educational program involving not only health professionals but the mass media and press which have in part fueled the public fear about AIDS. Prudent practices in the health care and private industry work places have been suggested and should be followed. Governmental involvement in terms of increased AIDS treatment and research funding is sorely needed. Finally, public policy decisions need to be made with compassion and understanding and the conviction that this disease can be tamed and eventually overcome by a concerted effort of all parties concerned.

Homosexuality and Drug Abuse in Judaism

Ninety per cent of all patients with AIDS are homosexuals or intravenous drug abusers. The Torah labels homosexual intercourse as an abomination[1] and ordains capital punishment for both transgressors,[2] though minors under thirteen years of age are exempt from this as from any other penalty[3]. This biblical directive is codified by Rambam:[4]

> In the case of a man who lies with a male, or causes a male to have connection with him, once sexual contact has been initiated, the rule is as follows: If both are adults, they are punishable by stoning, as it is said, "Thou shalt not lie with a male", i.e., whether he is the active or the passive participant in the act.

The prohibition of homosexuality proper is omitted from the *Shulchan Aruch*, which omission reflects the virtual absence of homosexuality among Jews rather than any difference of views of the criminality of these acts.[5] The Torah only refers to incidents involving homosexuality in regard to the sinful city of Sodom[6] and in regard to the conduct of a group of Benjaminites in Gibeah, leading to a disastrous civil war.[7] Isolated cases are also described in the Talmud.[8]

Rabbi Jakobovits cites rabbinic sources for the strict ban on homosexuality which is included among the seven commandments of the sons of Noah.[9] It is an unnatural perversion debasing the dignity of man, it frustrates the procreative purpose of sex, and it damages family life. He concludes that Jewish law rejects the view that homosexuality is merely a disease or morally neutral.

In an earlier issue of this Journal, Rabbi Barry Freundel posited that Jewish law views the homosexual or drug addict as no different than a Sabbath desecrator or an adulterer.[10] He has no greater or lesser rights or obligations and deserves no special treatment or concessions. The term "homosexual," says Freundel, is inappropriate. We should refer to this individual as a person engaged in homosexual activity. The term is not a noun but an adjective. The Jewish community should, therefore, deal with the practitioner of homosexuality as a full-fledged Jew, albeit a sinner; he should be counselled and treated and be the concern of outreach and proper education.

The use of consciousness-expanding drugs such as LSD or other addictive substances is generally considered to be proscribed by the halacha. According to Rabbi Moshe Feinstein, the harmful effects of marijuana is one of the reasons to prohibit its use.[11] The same can be said about smoking in Judaism.[12] Certainly the abuse of narcotics and other substances by the intravenous and other routes is detrimental to one's health and, therefore, prohibited in Judaism, for the Torah instructs us not to intentionally place ourselves in danger: "Take heed to thyself, and take care of thy life"[13] and "take good care of your lives."[14] The avoidance of danger is exemplified in the biblical commandment to make a parapet for one's roof so that no one fall therefrom.[15] Hence, the smoking of marijuana and the abuse of intravenous narcotics, which constitute a definite danger and hazard to life, are considered pernicious habits and should be prohibited. The subterfuge of "it is no concern of others if I endanger myself" is specifically disallowed by Rambam[16] and the *Shulchan Aruch*.[17]

Jewish Legal Questions Relating to AIDS

Not only is the intentional endangerment of one's health or life by the use of intravenous drugs prohibited in Jewish law, but wounding oneself without fatal intent is also disallowed in the Talmud[18] and the Codes of Maimonides[19] and Rav Yosef Karo.[20] Since most patients with AIDS are homosexuals and/or drug addicts, they are considered sinners, thereby raising a variety of

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1. Leviticus 18:22
2. *Ibid* 20:13
3. *Sanhedrin* 54a
4. *Mishneh Torah, Hilchot Issurei Biah* 1:14.
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6. Genesis 19:5.
7. Judges 19-20
8. *Sotah* 13b and Jerusalem Talmud *Sanhedrin* 6 a, 23c.
9. *Sanhedrin* 57b – 60a
10. "Homosexuality and Judaism," *Journal of Halacha and Contemporary Society*, No. II Spring 1986, pp. 70-87.
11. *Iggerot Moshe, Yoreh Deah*, Section 3 #35
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13. Deuteronomy 4:9
14. *Ibid*. 4:15
15. *Ibid*. 22:8
16. *Mishneh Torah, Hilchot Rotze'ach* 11:4 ff.
17. *Shulchan Aruch, Choshen Mishpat* 427 and *Yoreh Deah* 116
18. *Baba Kamma* 91b
19. *Mishneh Torah, Hilchot Chovel Umazik* 5:1
20. *Shulchan Aruch, Choshen Mishpat* 420:31 and *Orach Chayim* 571.

Jewish legal questions. Should a Jewish drug addict who develops AIDS as a result of sinful activity be treated any differently than any other patient? Should the Jewish homosexual who develops AIDS as a result of "abominable" behavior be treated? Does Judaism teach compassion for all who suffer illness irrespective of whether or not the illness is the result of practices which Judaism abhors and prohibits? Should every effort be made to heal these patients or at least alleviate their pain and suffering? Is a physician or nurse or other health worker obligated to treat a patient with AIDS or other contagious disease if there is a risk that they may contract the illness from the patient? Should the Jewish community expend resources for AIDS research and treatment since most such patients are sinners? Should not the resources better be allocated to the health of law-abiding citizens? Can patients with AIDS be counted in a quorum of ten men (*minyan*)? Can they serve as cantors or Torah readers? Should they be given honors in the synagogue? Can a *kohen* with AIDS go up to the *duchan* and offer the priestly blessing? Can a patient with AIDS serve as a witness in a Jewish legal proceeding? Is a patient with AIDS to be given all the usual burial rites? Is mourning to be observed for such a patient? These and other halachic questions pertaining not ony to AIDS patients but to sinners in general were addressed in two separate discourses delivered by Rabbi Hershel Schachter and Rabbi Moshe Tendler, both senior faculty members at Yeshiva University. The following discussion is based in part on those discourses.

Obligation of the Physician to Heal a Sinner

The physician's license to heal is based on the biblical phrase "and heal he shall heal"[21] from which the talmudic Sages[22] deduce that divine authorization is given to the human physician to heal. In his biblical commentary, Rabbi Moses Nachmanides, known as Ramban, states than since the physician may inadvertently harm his patient, divine permissibility to heal was necessary to absolve the physician of responsibility for any poor medical outcome, provided he was not negligent. Other commentaries assert that since sickness is divinely inflicted as punishment for sin, divine permission to heal is required to allow a human physician to intervene and provide healing.

Maimonides expands the permissibility for the human physician to heal into an obligation or mandate based on the biblical commandment for restoring a lost object to its righful owner[23] — if a physician is able to restore a patient's lost health, he is obligated to do so. If a patient dies as a result of a physician's refusal to heal him, the physician is guilty of shedding blood for having stood idly by.[24] A detailed discussion of the physician's obligation to heal in Judaism can be found elsewhere.[25]

G-d cherishes the life of every human being and therefore requires all biblical and rabbinic commandments except idolatry, incest, and murder to be waived in order to save the life of a person in danger (*pikuach nefesh*). The Sabbath must be desecrated to save a human life.[26] But is the desecration of the Sabbath allowed and/or mandated to save the life of a sinner who is guilty of a crime such as homosexuality for which the death penalty might be imposed?

The Talmud[27] permits the killing of a pursuer (*rodef*) to prevent him from killing the person he is pursuing; the one who kills him has no sin because the pursuer is considered to be legally (halachically) like a dead man (*gavra ketila*). For the same reason, one may *not* desecrate the Sabbath to save the life of the pursuer if a building collapses on him and his life is in danger. The same is true of a person sentenced to death by the court (Beth Din) in that one may not desecrate the Sabbath on his behalf if his life is in danger because he, too, is halachically considered like a dead man. However, a sinner who has not been sentenced by the Beth Din is considered as a live human being. As a result, although he is a transgressor, all biblical and rabbinic commandments must be suspended to save his life. Therefore, it seems clear that patients with AIDS should be treated medically and psychosocially no differently than other patients, and physicians and other medical personnel are obligated to heal patients with AIDS. The Talmud[28] clearly states that every life is worth saving without distinction as to whether the person whose life is in danger is a criminal or transgressor or law-abiding citizen. In fact, the Talmud requires that one expend money from one's own pocket to provide whatever is necessary to save another's life.

Some contemporary writers[29] raise the issue of the difference between a provocative sinner (*mumar lehachis*) and a lustful sinner (*mumar lete'avon*). The Talmud rules[30] that a provocative sinner is not to be helped but actually hindered (*moridin velo ma'alin*). The commentary of Rashi there and the code of Maimonides[31] interpret a provocative sinner to refer to one who habitually and willfully sins. On the other hand, one who only occasionally sins out of lust or appetite is considered like one whose life and property are to be protected and carefully treated.[32] It would seem therefore that physicians and other health personnel have an obligation to care for patients with AIDS no differently than for other patients.

Danger to Medical Personnel Treating Patients with AIDS

Jewish law requires that if one sees his neighbor drowning or mauled by beasts or attacked by robbers, he is bound to save him.[33] Elsewhere the *Shulchan Aruch*[34] rules that if one observes a ship sinking with Jews on board, or a river flooding over its banks thereby endangering lives, or a pursued person whose life is in danger, one is obligated to desecrate the Sabbath to save them. The commentaries of *Mishnah Berurah*[35] and *Pitchei Teshuvah*[36] add that if there is danger involved to the rescuer, he is not obligated to endanger his life because his life takes precedence over that of his fellow man. If there is only a doubtful risk (*sofek sakanah*) to the rescuer, he should carefully evaluate the small risk or the potential danger to himself and act accordingly.

What should a physician do if his patient is suffering from a contagious disease which the physician might contract? Is the physician allowed to refuse to treat the patient because of the risk or the fear by the physician of contracting the disease? What if the risk is very small? What is the definition of *sofek sakanah*? If there is a 50% chance of the physician contracting the disease from his patient, halacha would certainly agree that such odds are more than doubtful and the physician would not be obligated to care for that patient without taking precautionary measures to protect himself. If he wishes to do so in spite of the risk, his act is considered to be a pious act (*midat chasidut*) by some writers, and folly (*chasid shoteh*)[37] by others. But if the risk is very remote, the physician must care for that patient because "the Lord preserveth the

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21. Exodus 21:19.
22. *Baba Kamma* 85a.
23. Deuteronomy 22:2.
24. *Mishneh Torah, Hilchot Rotze'ach* 1:14.
25. Rosner, F. *Modern Medicine and Jewish Ethics*. pp. 7-13.
26. *Shulchan Aruch, Orach Chayim* 328:2.
27. *Sanhedrin* 27b.
28. *Ibid.* 73a.
29. Norah D. personal communication.
30. *Avodah Zarah* 26b.
31. *Mishneh Torah, Hilchot Rotze'ach* 10:12.
32. Commentary of Tosafot, *Avodah Zarah* 26b s.v. *amr*, Maimonides' *Mishnah* Commentary on *Nedarim* 4:4, *Shulchan Aruch, Choshen Mishpat* 425:5.
33. *Sanhedrin* 73a. *Shulchan Aruch, Choshen Mishpat* 426:1. *Shulchan Aruch, Orach Chayim* 329:8.
34. *Shulchan Aruch, Orach Chayim* 329:8.
35. *Mishnah Berurah* 329:19.
36. *Pitchei Teshuvah, Choshen Mishpat* 426:2.
37. *Mishnah Berurah* 328.

simpletons."[38] This phrase is invoked in the Talmud[39] in relation to the remote danger of conception in a minor child and discussed in great detail by Rabbi Moshe Feinstein[40] in a lengthy responsum concerning the use of a contraceptive device by a woman in whom pregnancy would constitute a danger to her life. Contraception, states Rabbi Feinstein, is permissible for *sofek sakanah* but not where the risk is extremely small. Rabbi Shneur Zalman of Lublin[41] and Rabbi Chayim Ozer Grodzensky[42] respectively discuss whether the above biblical phrase is invoked for a minor risk (less than 50%) or for a very remote and rare risk.

Rabbi Yitzchok Zilberstein[43] discusses the case of a female physician in her first trimester of pregnancy who is called to see a seriously ill patient with rubella (German measles). The physician is at 50% risk of acquiring rubella and possibly giving birth to a seriously defective baby (blind, deaf, or mentally retarded) or she may abort or have a stillbirth. Although there are no fetal indications in halacha which would allow abortion, Rabbi Zilberstein posits that halacha considers miscarriage to be a situation of *pikuach nefesh* and rules therefore that the female physician is not obligated to care for a patient with rubella.

The question as to whether or not a person is obligated to subject himself to a risk in order to save another person's life is discussed in great detail in several recent articles[44] and briefly summarized by Professor A.S. Abraham[45] in an article on human experimentation. The matter is related to the well-known difference of opinion recorded in the two Talmuds. The Jerusalem Talmud[46] posits that a person is obligated to potentially endanger his life (*sofek sakanah*) to save the life of his fellow man from certain danger (*vadai sakanah*). This position is supported by Rabbi Meir Hacohen[47] as cited by Rav Yosef[48] and by Rav Karo himself.[49] On the other hand, the Babylonian Talmud[50] voices the opinion that a person is not obligated to endanger his life to save that of another even if the risk is small (*sofek sakanah*). The ruling from the Jerusalem Talmud is omitted from the Codes of Rif, Rambam, Rosh, *Tur*, and Ramo.

The prevailing opinion among the various rabbinic sources seems to be the one cited by the Radvaz:[51] If there is great danger to the rescuer, he is not allowed to attempt to save his fellow man; if he nevertheless does so, he is called a pious fool. If the danger to the rescuer is small and the danger to his fellow man very great, the rescuer is allowed but not obligated to attempt the rescue, and if he does so his act is called an act of loving kindness (*midat chasidut*). If there is no risk at all to the rescuer or if the risk is very small or remote, he is obligated to try to save his fellow man. If he refuses to do so, he is guilty of transgressing the commandment "thou shalt not stand idly by the blood of thy fellow man."[52] This approach is also adopted by recent rabbinic decisors including Rabbi Moshe Feinstein[53] and Rabbi Eliezer Yehudah Waldenberg.[54] Since the risk to physicians and other health personnel in caring for AIDS patients is infinitessimally small (less than a fraction of one per cent), it follows that a physician is obligated under Jewish law to care for such patients.

The same logic is used to allow but not require healthy people to donate a kidney to save the life of a close relative dying of kidney failure. Most rabbis, including Rabbi Ovadiah Yosef,[55] Rabbi Jacob Joseph Weiss,[56] Rabbi Eliezer Waldenberg,[57] and others[58] support this halachic position.

Visiting Patients with Infectious Diseases such as AIDS

It is a duty incumbent upon everyone to visit the sick, for G-d visits the sick[59] and we must emulate Him.[60] Rabbi Jakobovits[61] points out that the question whether the duty to visit the sick extends to visiting patients suffering from an infectious or contagious disease was already answered with a qualified affirmative by the Ramo[62] against the view of some later authorities who questioned the need to expose oneself to the hazard of contagion in the fulfillment of this precept. Ramo holds that there is no distinction in respect of visiting the sick between ordinary and infectious diseases, with the sole exception of leprosy. A recent re-examination of this question, continues Rabbi Jakobovits, leads one to the conclusion, based on several talmudic narratives,[63] that the ruling of Ramo applies only to an infection which would not endanger the life of the visitor even if he caught it, but that one is not required to risk one's life for the sake of fulfilling merely the rabbinic precept of visiting the sick, nor can anyone be compelled to serve such patients. Elsewhere[64] Rabbi Jakobovits asserts that in practice, the view of Ramo did not prevail and approval was expressed for the custom not to assign visitations of plague-stricken patients to anyone except specially-appointed persons who were highly paid for their perilous work. Rabbi Jakobovits also cites the seventeenth century records of the Portuguese Congregation in Hamburg[65] which indicate that even the communal doctors and nurses were exempt from the obligation to attend to infectious cases and that the required services were rendered by volunteers entitled to special remuneration.

Rabbi Yekuthiel Yehudah Greenwald[66] states that if there is hope to heal the patient from his illness, one is obligated to visit and serve him even if there is a risk of contracting the disease because, according to the Jerusalem Talmud, one is obligated to accept a small risk in order to save one's fellow man from a definite danger. However, if there is no chance of saving the patient, one should not endanger one's own life by visiting the patient.[66]

The Talmud states[67] that those sent to perform a religious duty do not suffer harm (*shiluchei mitzvah aynon nizakin*). This rule is also codified in Jewish law[68] but only where there is no danger involved to the person performing the precept. Where there is prevalent danger (*hezekey matzui*), the rule may not apply and the person may be foolhardy to risk his life to perform the precept (*chasid shoteh*). However, if the risk is infinitessimally small such as one in a thousand or less, the person should fulfill the precept.

38. Psalms 116:6.
39. *Yevamot* 12b.
40. *Iggerot Moshe, Even Haezer* #63.
41. *Torat Chesed, Even Haezer* #44.
42. *Achiezer*, part 1 #23.
43. Zilberstein, Y. *Assia* (Jerusalem), Vol 11 #11 (Nissan 5746), May 1986, pp. 5-11.
44. Hershler, M. *Halacha Urefuah*, Jerusalem, Regensburg Inst., Vol. 2, 1981, pp 52-57, Sloshitz, M.Y., *Halacha Urefuah*, Vol 3, 1983, pp 158-163; Metzger, A. *Harefuah Le'or HaHalachah*, Jerusalem, Vol 4, 1985, pp 10-34; Abraham, A.S. *Hamayan*, Nissan 5742, pp. 31 ff.
45. Abraham, A.S. *Assia* (Jerusalem) Vol 5 1986, pp 18-23.
46. *Terumot*, end of chapter 8, according to *Ha'amek She'elah, She'iltot* 147:1.
47. Known as *Hagahot Maimuni*.
48. *Keseph Mishneh* Commentary on *Hilchot Rotze'ach* 1:14.
49. *Bet Yoseph, Tur Shulchan Aruch, Choshen Mishpat* 426.
50. *Sanhedrin* 73a, according to *Agudat Aizov, Derushim* folio 3b and *Hashmatot* folio 38b.
51. *Radvaz*, Part 5 (Part 2 in *Leshonot HaRambam*, section 1, 582). *Radvaz*, Part 3 #627, and *Sheilot Radvaz* 1:52.
52. Leviticus 19:16
53. *Iggerot Moshe, Yoreh Deah*, Part 2, #174:4.
54. *Tzitz Eliezer*, Vol. 10 #25:7.

55. Yosef, O. *Halachah Urefuah*, Vol 3, 1983, pp 61-63
56. Weiss, J.J. Responsa *Minchat Yitzchok*, Part 6 #103:2
57. *Tzitz Eliezer*, Vol 10 #25:7
58. Mendelman, M. *Halachah Urefuah*, Vol 2, 1981, pp 114-121 Hershler, M. *Halachah Urefuah*, Vol 2, 1981, pp 122-127
59. Genesis 18:1
60. *Sotah* 14a
61. Jakobovits, I. *Journal of a Rabbi*, New York, Living Books, 1966, p 156
62. Responsa *Ramo* #19 (end)
63. *Nedarim* 39b, *Berachot* 22b, and Rashi in *Shabbat* 30a
64. Jakobovits, I. *Jewish Medical Ethics*, New York, Bloch, 1959, pp 108-109.
65. Cassuto, J. *Jahrbuch der Juedisch-Literarischen Gesellschaft*, Vol 10,1912, pp 252 and 280 (in minutes dated 1664 and 1666)
66. *Mishneh Torah, Hilchot Shemirat Hanefesh* 1:7.
67. *Pesachim* 8b
68. *Turei Zahav* (Taz) on *Shulchan Aruch, Orach Chayim* 455:3

The risk of contracting AIDS by visiting or touching the patient seems to be nil. No case of AIDS has yet been contracted by casual contact with an AIDS patient. The virus is only transmitted through the blood and by sexual contact. Hence, physicians are obligated to care for patients with AIDS and everyone is obligated to visit patients sick with AIDS. The only precaution one need take is to avoid sticking oneself with a needle used to draw blood from or given as an injection to an AIDS patient.

Allocation of Resources for AIDS Research and Treatment

Some people claim that governmental and societal resources should not be devoted to AIDS research because the disease is self-inflicted. This approach is obviously invalid because some patients acquire AIDS through no fault of their own, i.e., through blood transfusions as in hemophiliacs, or transplacentally as in infants born of AIDS mothers. Even if a disease occurs only in sinners, society is still obligated to expend resources to try and conquer the disease, and physicians are obligated to heal patients suffering from that disease. The Talmud[69] clearly states that every life is worth saving without distinction as to whether the person whose life is in danger is a criminal or law-abiding citizen.

The problem of the allocation of the resources of society when money for health care and medical research is limited is discussed in greater detail elsewhere.[70] Similarly, physicians have to allocate their time and energy among their various patients, raising halachic questions such as the permissibility (or prohibition) for a physician to leave one patient to care for another much sicker patient. This topic, however, is beyond the scope of this essay.

Can Patients With AIDS Be Counted As Part of A Minyan?

May patients with AIDS who are homosexuals and/or drug addicts be counted as part of a quorum of ten men (*minyan*)? The *Shulchan Aruch*[71] states that a sinner who transgressed the decrees of the Jewish community or who committed a biblical or rabbinic transgression can be counted as part of a *minyan* as long as he was not excommunicated. Even if he was excommunicated and cannot be counted as part of a *minyan*, a sinner is allowed to pray in the synagogue unless the congregants strongly object.[72] The *Mishnah Berurah*[73] cites the *Pri Megadim*, who says that this rule applies only if the sinner is one who sins occasionally out of lust or appetite (*mumar le-te'avon*), but a provocative sinner (*mumar le-hachis*) or one who worships idols or who publicly desecrates the Sabbath is judged like a non-Jew and cannot be counted for a *minyan*.

Rabbi Yechiel Weinberg[74] quotes earlier Hungarian rabbis who say that today no Jew is excommunicated and, therefore, all Jews, even sinners, can be counted as part of a *minyan*. However, he continues, other rabbis say that if a person is worthy of being excommunicated by virtue of transgressions he has committed, he cannot be counted as part of a *minyan* even though he is not actually excommunicated." The clarification of this rabbinic disagreement is important, for homosexuality is a sin for which the transgressor is worthy of being excommunicated. Nevertheless, this responsum of Rabbi Weinberg is difficult to understand in view of the clear statement in *Shulchan Aruch* that unless the sinner is actually excommunicated, he may be counted as part of a *minyan*.

Can Patients With AIDS Lead Synagogue Services?

The question has been raised as to whether or not a patient with AIDS can lead services in the synagogue as a cantor (*shaliach tzibur*) or Torah reader. Jewish law requires[75] that the cantor be worthy, be free of sins, and not have a bad name even when he was younger. Moreover, he should be humble and desired by the congregants, have a sweet voice, and study Torah regularly. Rabbi Moshe Isserles[76] asserts that if someone transgressed unintentionally (*beshogeg*) and repented, he is allowed to serve as a *shaliach tzibur*, but not if he sinned intentionally (*bemayzid*) because he had a bad name before he repented. The *Mishnah Berurah*[77] cites *Magen Avraham*, who quotes many rabbinic decisors that even if one sinned intentionally, he can serve as a *shaliach tzibur* if he repented. However, on fast days and on the High Holy Days, one should not appoint him as a cantor, although once appointed he should not be removed.

For the High Holy Days, one should seek out a cantor who is most worthy, most learned in Torah, who has performed many meritorious deeds, who is married, and over thirty years of age.[78] The *Mishnah Berurah*[79] adds that the cantor and the one who blows the *shofar* should have fully repented from their sins, although one who begins as a cantor or *shofar* blower should not be removed. It thus seems that if an AIDS patient has repented from his sins, including the sin of homosexuality, and if he meets the above qualifications and is acceptable to the congregation, it is permissible to have him lead synagogue services or blow the *shofar* or read from the Torah.

Should a kohen with AIDS Recite the Priestly Blessing?

Is it permissible for a *kohen* to offer the priestly benediction (go up to the *duchan*) if he has AIDS related to homosexuality or drug addiction? The *Shulchan Aruch*[80] states that if a *kohen* killed someone even unintentionally he should not offer the priestly blessing even if he repented. Ramo adds, in the name of many rabbinic decisors: "If he repented, he is allowed to recite the priestly blessing and this is the practice which one should follow."

The *Shulchan Aruch*[81] also asserts that if the *kohen* is an apostate he should not recite the priestly blessing although some rabbis allow him to do so if he repented. If a *kohen* is intoxicated, he should not recite the priestly blessing.[82] So, too, if he married a divorced woman.[83]

However, continues Rav Karo,[84] if none of the above circumstances which prevent a *kohen* from reciting the priestly blessing are present, even if he is not careful about the observance of other commandments, he is allowed to recite the blessing. The *Mishnah Berurah*[85] explains that such commandments include even serious prohibitions such as forbidden sexual relationships (*arayot*). It would appear, therefore, that a *kohen* with AIDS is permitted to offer the priestly benediction. *Mishnah Berurah*,[86] quoting the *Zohar*, adds that if the *kohen* is despised by the congregation, he should not recite the priestly blessing. The reason why even a *kohen* who has sinned is allowed to offer the priestly blessing is that one should not prevent him from performing the positive commandment of blessing the people, thus adding to his sins by not allowing him to fulfill this and other commandments.[87]

Someone might ask: what good is his blessing if he is a sinner? The answer is that the *kohen* only recites the words but the actual blessing comes from G-d, as it is written: "and I will bless them."[88]

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69. *Sanhedrin* 73a.
70. Rosner, F. *Modern Medicine and Jewish Ethics*, pp. 339-354.
71. *Shulchan Aruch, Orach Chayim* 55.11.
72. Ibid. 55.12.
73. *Mishnah berurah* 55.11.40.
74. Responsa *Seridei Aish*, Part 2 86.
75. *Shulchan Aruch, Orach Chayim* 53.4.
76. *Ramo on Orach Chayim* 53.5.
77. *Mishnah Berurah* 53.5.22.
78. *Ramo on Orach Chayim* 581.1.
79. *Mishnah Berurah* 581.1.11.
80. *Shulchan Aruch, Orach Chayim* 128.35.
81. *Ibid* 128.37.
82. *Ibid* 128.36.
83. *Ibid* 128.40.
84. *Ibid* 128.39.
85. *Mishnah Berurah* 128.39.143.
86. *Ibid* 128.10.37.
87. *Havaget of Rawal*, Jerusalem 5744, (1984), *Hilchot Nesiyat Kapayim* 15.6.
88. Numbers 6.27.

Should a Patient With AIDS Be Honored in the Synagogue?

The Talmud[89] states that it is prohibited to flatter the wicked in this world because it encourages them to believe that they are not doing anything wrong. Furthermore, if a homosexual AIDS patient is honored in the synagogue by being called up to the Torah, people may be misled into thinking that his behavior is acceptable. Thus honoring a sinner might constitute transgression of the negative precept of "not placing a stumbling block before the blind."[90] The same question arises when a person who publicly violates biblical commandments is honored at a testimonial dinner. Is not the bestowing of such an honor prohibited because it misleads the sinner and the public into believing that the person's violations are being condoned?

Rabbi Feinstein[91] discusses the case of a very philanthropic and charitable Jewish physician who performs many deeds of loving kindness but is married to a non-Jewish woman. Ordinarily, one should not give this physician any honors in the synagogue because of "the stumbling block that is being placed before the blind" in that such honors might mislead him into believing that his marriage to a non-Jew is not wrong. However, if the honor might lead the sinner to repent, or if one tells him that what he is doing is wrong, it is permissible to give him the honor. In the case under discussion, Rav Feinstein concludes that it is permissible to have the physician open and close the holy ark and remove and subsequently return the Torah to the ark because all the congregants know that he is being honored because of his philanthropy and good deeds, thus the honor does not represent acquiescence to his wrong-doing. Furthermore, the public is in need of his services (*rabim tzerichim loh*) because of his expertise as a physician and he may, therefore, be accorded the aforementioned honor.

However, the *Chatam Sofer*[92] rules that one should not call a sinner to the Torah for a portion of the Torah reading (*aliyah*) because of the aforementioned possibility of misleading the sinner and/or the public into believing that the sin is being condoned.

Can a Patient With AIDS Serve as a Witness?

Maimonides[93] lists ten classes of individuals who are ineligible to attest or testify before a Jewish court: women, slaves, minors, the mentally deficient, deaf-mutes, the blind, transgressors, the contemptible, relatives and interested parties. Transgressors are ineligible as witnesses by biblical law, for it is written: "Put not thy hand with the wicked to be an uprighteous witness"[94] which is interpreted as "accept not the wicked as a witness."[95] Maimonides then enumerates the various types of transgressors, including those who are liable to be flogged, thieves, robbers, tricksters, gamblers, usurers, as well as idlers and vagabonds who are suspected of spending their leisure time in criminal activity.[96]

How should one classify the transgressions of homosexuality and drug addiction, the most common risk factors for the development of AIDS? Those who sin unintentionally are eligible to serve as witnesses, but AIDS patients who are homosexuals know what they are doing. Perhaps such patients can be considered to lack self-control over their strong desire; Jewish law states that a person who sins under compulsion is divinely exempted from punishment (*onus rachamanah patrey*). Support for this position can be found in the talmudic commentary known as Tosafot[97] who quote the passage[98] which states that one who is suspected of adultery is nevertheless eligible as a witness.

Burial, Funeral Rites and Mourning For an AIDS Patient

Two cases known to this writer involved AIDS patients who died, where the members of the burial society (*chevra kadisha*) refused to perform the ritual purification of the deceased (*taharah*) because of their fear of contracting AIDS. It is now known that one cannot acquire AIDS by casual contact and their fear was unfounded. However, the problem arises with deceased individuals who had a real contagious disease vis-a-vis the ritual purification for the dead. If the members of the burial society can take precautions such as wearing masks, gloves, and gowns, they should do so. If they cannot or will not do so out of fear, they are not obligated to perform the *taharah* because the latter is only a custom and not a law.[99]

Are the laws of mourning (*avelut*) to be observed for a homosexual patient who died of AIDS? Jewish law states[102] that there is no mourning for those who cast off the yoke of commandments and act like apostates. However, if they repent, mourning is observed for them. Rabbi Abraham Sofer[103] distinguishes between a sinner who suffers for weeks, months or years before his death and one who died suddenly. The former probably repented, the latter did not. Therefore, AIDS patients who suffer for variable periods of time before their death should probably be mourned on the assumption that they repented.

It is certainly not proper to honor an AIDS patient after death by naming a school or playground after him. The Talmud[104] interprets the biblical phrase, "But the name of the wicked shall rot,"[105] to mean that rottenness enters their names in that none name their children after them. If it is public knowledge that the AIDS patient was a sinner, he should not be honored after death by having a person or thing named after him. It is also a punishment for the wicked not to honor them after death.

Use of the Ritualiarium (Mikvah) by Women Fearful of Contracting AIDS

The Talmud states[106] that if wine or olive sap falls into a ritual bath or ritualarium (mikvah) and changes its color, it becomes invalid. Based on this ruling, some rabbis prohibit the addition of chlorine to a mikvah because the color of the water is changed to green. As a result of this prohibition, some women are afraid of using such a mikvah for fear of contracting AIDS from the water used by other women whose husbands may have AIDS. However, this fear is totally unfounded since AIDS cannot be transmitted through water but only by sexual contact or through blood or blood products. Secondly, most rabbis do not prohibit the use of chlorine because only a minute amount is used to provide antisepsis of the mikvah water. (Sufficient chlorine to make the water change color to green would be intolerable to humans and produce serious eye irritation and skin burning. The greenish color of some mikvahs is due to the green or blue tiles lining the mikvah.) Furthermore, the rabbis who prohibit the use of chlorine because of the problem of the change in the appearance (*shinuy mareh*) of the water can offer the solution of using chlorine crystals rather than liquid chlorine. The addition of solids such as foods or chemicals, states the talmudic commentary called *Mishnah Acharonah*,[107] does not invalidate a mikvah even if the color of the water is thereby changed.

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89. *Sotah* 41b
90. Leviticus 19:14
91. *Iggerot Moshe, Orach Chayim*, Part 2 #51
92. *Chatam Sofer, Orach Chayim* #15
93. *Mishneh Torah, Hilchot Eydut* 9.1.
94. Exodus 23.1.
95. *Mishneh Torah, Hilchot Eydut* 10.1
96. *Ibid* 10.2-3
97. Tosafot on *Sanhedrin* 9b s.v. *lwtzono*
98. *Sanhedrin* 26b
99. *Chochmat Adam*, beginning of the customs of the *chevra kadisha*
102. *Shulchan Aruch, Yoreh Deah* 345.5.
103. Responsa *Ketav Sofer, Yoreh Deah* #171.
104. *Yoma* 38b
105. Proverbs 10.7
106. *Mikva'ot* 7.3
107. *Ibid*

Circumcision of a Baby with AIDS

The AIDS virus can be transmitted through the placenta from an AIDS-suffering woman, usually a drug addict or sexual partner of an AIDS man, to her unborn fetus. AIDS in newborns or infants is a rare but well-recognized disorder. Is it permissible or mandatory to perform a ritual circumcision (*brit milah*) on such a male infant on the eighth day of life? Must it be postponed until the child recovers from the illness? But there is no cure for AIDS! How does one perform the *metzitzah*, or sucking, which is part of the ritual circumcision? May *metzitzah* be omitted in cases of AIDS?

In a lengthy article, Dr. Abraham Steinberg[108] discusses medical-halachic considerations in the performance of *brit milah*. He reviews the reasons for this divine commandment and the various medical conditions for which the circumcision may or must be postponed. Steinberg cites numerous rabbinic responsa which address these issues. The rules on these matters can be found in the classic codes of Maimonides[109] and Rav Yosef Karo.[110]

If an infant has a generalized illness from which he is not expected to recover, but the physicians state that circumcision would not in any way endanger the infant nor add to the illness, *brit milah* should be performed, preferably on the eighth day.[111] Some rabbis rule[112] that a baby who cannot live for twelve months should be circumcised on a weekday but not on the Sabbath. The *Chatam Sofer*[113] gave a similar ruling in the case of a baby who was not expected to live three months.

On the other hand, Rabbi Bakshi-Doron[114] refused to allow a baby with spina bifida and paraplegia to be circumcised in spite of the medical testimony that the baby had no feeling in the lower half of his body and would not be harmed medically by a *brit milah*. This rabbi and others rule that circumcision should be postponed in any baby with a generalized illness "until it recovers". Most infants with AIDS are critically ill, and circumcision is usually medically and therefore halachically contraindicated.

Conclusion

At the same time that we condemn homosexuality as an immoral act characterized in the Torah as an abomination, we are nevertheless duty bound to defend the basic rights to which homosexuals are entitled. The Torah teaches that even one who is tried, convicted and executed for a capital crime is still entitled to the respect due to any human being created in the image of G-d. Thus, his corpse may not go unburied overnight.[115] The plight of Jewish AIDS victims doomed to almost certain death should arouse our compassion.

In Judaism, the value of human life is infinite. Whether a person is a homosexual or not, we are obligated to give him proper care if he is sick, charity if he is needy, food if he is hungry, and a burial after death. If he breaks a law of the Torah, he will be punished according to the transgression. Even if AIDS is a punishment by G-d for the sin of homosexuality, Jewish tradition teaches us that such a divine affliction may serve as an atonement for that sin or the patient may repent while ill, making the AIDS victim even more deserving of our mercy and loving kindness as a fellow Jew.

The compassion of Jewish law in requiring treatment for AIDS patients, however, should not be confused with acquiescence of the behavior of homosexuals who develop AIDS. Under no circumstances does Judaism condone homosexuality, which we characterize as an abomination. Nevertheless, the patient with AIDS should be treated and his life saved. To stand idly by and see the homosexual die without trying to help him is prohibited.[116] Evil should be banned but the evildoers should be helped to repent.[117]

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108. Steinberg, A. *Assia* (Jerusalem) 5743 (1983) Vol. 4, pp. 207-228
109. *Mishneh Torah, Hilchot Milah* 1:1ff
110. *Shulchan Aruch, Yoreh Deah* 260 ff
111. *Minchat Yitzchak*, Vol. 5 §11
112. *Maharam Schick, Yoreh Deah* §243
113. *Chatam Sofer* §64.
114. Bakshi-Doron, E. *Halachah Urefuah*, Vol. 2, 1981, pp. 268-272
115. Deuteronomy 21:23.
116. Leviticus 19:16
117. Psalms 104:35

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cont. from page 3

mistake be made? They believed that they could define right and wrong on the basis of their own knowledge.

Torah precludes the possibility of such an error. It forces us to constantly measure our behavior against an objective standard. The Shulchan Aruch has laws and guiding principles that relate to the totality of our behavior. If it prohibits a certain action, a Jew is forbidden to perform it, regardless of all reasons and explanations to the contrary. If it requires the performance of a particular deed, then there is no way a Jew can free himself from that obligation.

A similar concept is demonstrated through the Ten Commandments. They were given in two tablets. The first contained the first five commandments, the laws that pertain primarily to the relationship between man and G-d. The second, containing the second five, dealt essentially with relations between man and man. Both were given as a single entity, thus demonstrating that the two services cannot be separated. The connection between man and G-d must be extended to the point where we relate to G-d not only as a transcendent spiritual being, but recognize and relate to Him as He is manifest in the physical creation and particularly in our fellow man. Also, our relationship with our fellow man must be preceded by a relationship with G-d. There can be no consistent moral approach to dealing with other people without the prior acceptance of G-d and a willingness to follow His will. Without this prerequisite, there will constantly be times when our selfishness and personal desires will cause us, even unknowingly, to ignore and mistreat our fellow man.

Adapted from Likutei Sichos, Vol. II, pgs. 561-562; Sichos Shabbos Parshas Mikeitz, 5731.

RECOMMENDATIONS FOR CHILDREN AND EMPLOYEES WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME/HIV
INFECTION IN THE SYNAGOGUE SETTING*

Recommendations for the Education of Children

Human Immunodeficiency Virus (HIV) is the viral agent responsible for Acquired Immune Deficiency Syndrome (AIDS). Persons who become infected with HIV may develop AIDS, may develop AIDS Related Complex (ARC), or may experience no symptoms of disease. At the present time AIDS is always fatal. ARC is a less severe illness, but may progress to AIDS.

The perinatal spread of HIV infection to infants, who have not reached school age or children who become infected via blood transfusion (prior to the implementation of blood screening), has resulted in questions regarding whether and how these children can be managed or placed in the school setting. Highly charged emotional issues related to HIV infection require that the placement and/or management of these children in the school setting be based on available evidence regarding the risks of transmission of HIV to others in the school setting and the risks to the child with HIV infection of acquiring other infectious agents in the school setting, along with the careful consideration of the confidentiality and legal issues involved.

Based on current evidence, casual person to person contact as would occur among school children poses no risk of transmission of HIV, the viral agent responsible for AIDS. However, a theoretical potential for transmission between young children or neurologically handicapped children who lack control of their body secretions may exist; this theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes of a susceptible person to the blood and possibly other body fluids of an infected person.

Since HIV infections may result in immune deficiency, the infected child may have a greater risk of acquiring infectious agents. Assessment of this risk to the immuno-depressed child is best made by the child's physician who is specifically aware of the individual child's immune status.

The following recommendations apply to all children known to be infected with HIV, regardless of whether or not actual symptoms of disease are present:

1. Decisions regarding the type of educational setting for the HIV infected child should be made on a case-by-case basis taking into account the child's behavior, neurologic development, and physical condition. These decisions are best made using the team approach, including the child's physician, the child's parent or guardian, and personnel from the Synagogue and local health department, and should be reviewed and approved by the Director of Education and Rabbi.

   A. For school-aged children infected with HIV, the benefits of an unrestricted setting in most cases outweigh the risks of their acquiring potentially harmful

infections in the school setting. These children should be allowed to attend school and after school day care in an unrestricted setting. A mechanism for the sharing of information between the child's physician and the school authorities is recommended so that any significant change in the child's medical status can be addressed. In addition, if the school experiences an outbreak of a communicable disease which could be threatening to a child infected with HIV, (e.g. chickenpox, measles), the child should be temporarily excluded by the Educator, pending consultation with the child's physician.

B. HIV infected preschoolers and older children should be considered for exclusion from the classroom if they:

1. lack control of body secretions;

2. exhibit behavioral problems, such as biting;

3. have uncoverable oozing lesions.

Evaluation to assess the continued need for exclusion should be performed regularly.

2. Persons involved in the education of HIV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept to the minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase, e.g., bleeding injury. In individual situations, such people may include the following: Director of Education, Rabbi and the child's teacher(s). Notification should be done by a process that would maximally assist patient confidentiality--ideally, by direct person-to-person contact. It is not necessary to notify parents of other school children regarding the HIV status of any school child.

3. Screening for HIV infection as a condition for school entry is not warranted based on available data.

4. All schools should adopt routine procedures to minimize the transmission of any communicable diseases. Handwashing (with soap and running water for 15-30 seconds and drying with disposable paper towels) is the single most important technique for preventing the spread of disease and should be done frequently. In addition, specific precautions should be taken whenever there is potential for contact with the blood or body fluids of children:

A. Exposure of open skin lesions or mucous membranes to blood or body fluids should be avoided. If open lesions

are present, disposable gloves should be worn. A disposable apron should be worn if clothing is likely to be soiled by blood/body fluids.

B. Surfaces soiled with blood or body fluids should be immediately and thoroughly cleaned. It is advisable to cover the blood/body fluids with paper towels, flood with a solution of one cup of household bleach in 9 cups of water, and allow it to remain for at least 15 minutes before disposing of paper towels in sealed plastic bags.

C. Disposable materials, e.g. gloves, paper towels, sanitary napkins, should be promptly discarded into sealable plastic bags.

D. Mops and other non-disposable cleaning materials are not recommended, but if used, should be rinsed in the disinfectant.

E. Hands should be washed thoroughly after contact with the blood or body fluids of any child, including after removing disposable gloves.

Recommendations for Synagogue Employees

No evidence supports the spread of AIDS/HIV through casual contact, such as that which occurs in the Synagogue setting. Epidemiologic evidence at this time has only implicated blood, seman and vaginal secretions in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HIV, and it has not been shown to be transmitted by contaminated food or water.

In view of this evidence, the following recommendations are made:

1. Screening for HIV infection as a condition for Synagogue employment is not warranted.

2. Decisions regarding Synagogue employees known to be infected with HIV should be made on a case-by-case basis, utilizing existing mechanisms for employee health in consultation with the local health department.

3. Adequate steps must be taken to protect the confidentiality of the Synagogue employee with HIV infection.

4. Since no known risk of transmission to co-workers or others exists from HIV infected workers in the Synagogue

setting, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities or drinking fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HIV infection status, should be cleaned with soap, water, and household bleach as described in the section on recommendations for the education of children.

*Congregations should be advised that federal, state, and local discrimination laws may also affect their employment and school attendance policies. A federal disrict court in California recently held that federal physical handicap laws guaranteed the right of an Atascadero public school boy to attend despite having AIDS. More than twenty states have determined that their physical handicap laws protect persons with AIDS, and a number of cities in California and elsewhere have passed or are considering passing AIDS anti-discrimination laws as well.

Modified from information prepared by the Maryland Department of Health and Mental Hygiene and the Governor's Task Force on AIDS.

C.C.A.R. RESPONSA COMMITTEE
1950 Bathurst Street, Toronto, Ont. M5P 3K9
Tel. (416) 789 3291 Fax (416) 789 9697

Tevet 14, 5750/January 11, 1990

To Rabbi Alexander M. Schindler
838 Fifth Ave., New York, NY 10021, USA

Dear Alex,

enclosed is our *teshuvah* on AIDS. Since I involved all members of the Committee in the process, including one colleague in Israel, the matter has taken a bit longer than anticipated.

Thank you for asking this particular *she'elah*, it has given us a good deal to think about. Incidentally, this is our first effort.

With fond regards from house to house,

Cordially,

Gunther

And thanks again for your kind letter of concern. Elizabeth is fine again, or nearly so.

MEMORANDUM

From Rabbi Alexander M. Schindler

Date January, 1990

To Members, UAHC Executive Committee

Copies

Subject RESPONSA

Some time ago I addressed an inquiry to the Responsa Committee of the CCAR. The answer is enclosed herewith, not only because the specific issue might be of interest to you, but because it is a good example of how Reform Judaism at its best enters into a dialogue with Tradition.

Warm regards.

Union of American Hebrew Congregations
838 FIFTH AVENUE, NEW YORK, N.Y. 10021 (212) 249-0100

Rabbi Alexander M. Schindler 1/30/90

Rabbi Joseph B. Glaser

Rabbis Samuel Karff & Daniel B. Syme; Albert Vorspan

Thanks for sharing Mike Rankin's letter with me, as well as your own thoughts on the workibeing undertaken by our movement in the area of AIDS. First of all, you should know the use of the term "Commission" is purely Mike's doing...we never created a Commission, we have a Committee on Aids.

Be that as it may, your comments are well taken and I do agree, we should maintain this work under the designation of a Joint Committee. These helps avoid some of the more technical woes you state in your note but provides for a continuation of the important work undertaken by this group under the aegis of both the Union and the Conference.

Warm regards/

c

Rabbi Joseph B. Glaser

1/24/90

Dear Alexander

This AIDs thing is driving me crazy. See Rankin letter now. Then continue my note...

I called Rankin, welcoming his initiative, because I think it's dumb for CCAR to have its own c'tee. The UAHC is doing a good job and there are 13 rabbis on it not including UAHC staff. But there are those in CCAR who want "CCAR presence ... visibility". Rankin says all says a joint Commission is now OK by you and CCAR shouldn't worry about travel expense, Rankin assuming there is UAHC money available. Secretaries, I called all and he formally contradicted this, Rankin borrowed his understanding. All and I would prefer status quo but call it a "joint Committee" so we don't get into the technicalities and woes of a Commission, letting UAHC continue to run the whole shebang and CCAR will pay for the equal of 5 rabbis travel once a year. They can split it up any which way they want. How's that?

Regards.

Joe

CCAR • 192 Lexington Avenue
New York, New York 10016
(212) 684-4990

cc: Sam Karff, Al Vorspan, Dan Syme

c

Outpatient Clinic

2221 Martin Luther
King Jr Way
Oakland CA 94612

December 26, 1989

Department of Veterans Affairs

Note to Sam Karff – lets hold up on the c'tee – Joe

In Reply Refer to:

Rabbi Joseph B. Glaser
Executive Vice President, CCAR
192 Lexington Avenue
New York, N.Y.

Dear Rabbi Glaser,

As you may know, we've had a change in the leadership of the UAHC Commission on AIDS. Rabbis Janet Marder and Sandy Seltzer have replaced Rabbi Sternberger as staff coordinators, and I've assumed the chair from Bo O'mansky, who is heading up Local Arrangements for the Baltimore Biennial.

The two rabbis and I spoke recently with Al Vorspan regarding the relationship between the Commission and the CCAR, and it was suggested that I communicate directly with you on the matter.

I know that we in the Union, and you in the CCAR want to do all we can to combat this terrible epidemic. The only question is, how do we do that most effectively? Thus far the Commission has functioned as a UAHC entity, with a number of rabbis serving on it. And Rabbi Moss was recently appointed by the CCAR to serve as its representative on the Commission. We may want to continue that arrangement. But we may also want to consider an alternative whereby the UAHC and the CCAR could work closely together, perhaps as a joint committee. I'm writing to see how that sounds to you and your colleagues in the Conference.

The advantages to the joint committee are several, it seems to me. First, we would avoid duplication of effort that is sure to occur if we have two separate committees. And second, a joint committee might have more "clout" with the congregations and the College-Institute, and with the lay and rabbinic leadership of our movement.

There may also be disadvantages, but I think they could be overcome. The Commission does not make UAHC policy, of course--only the Board of Trustees can do that. But we do suggest policy to the Board, usually as a resolution. There could come a time when the majority of the joint committee wanted to recommend something that was not necessarily supported by the majority of the Conference. I have no idea what that might be, but if such an issue did come before us, I'd hope we could find a satisfactory compromise.

In any case, I'd like to talk with you about all this. Let's both get past the holiday rush, and I'll give you a call in early January. Or, you can call me if you like. My card is enclosed, with both office and home numbers.

Every good wish for a healthy and productive new year.

Sincerely,

Mike Rankin

Robert M. Rankin, M.D.

August 29, 1989
28 Av 5749

The Rev. Leontine Kelly, Bishop
United Methodist Church
and
The Rev. Donald Eastman
Second Vice Moderator
Universal Fellowship of
Metropolitan Community Churches
475 Riverside Drive - 10th floor
New York, NY 10015

Dear Rev. Kelly and Rev. Eastman:

Many thanks for your most gracious invitation to join the Honorary Host Committee for a national consultation on AIDS - The Moral Imperative: A Call to National Leadership. This is a critical gathering and and I am delighted to join with distinguished colleagues as a member of the Honorary Host Committee.

I look forward to further word on this gathering and will do my utmost to participate in the advance planning.

With kindest greetings, I am

Sincerely,

Alexander M. Schindler

AIDS National Interfaith Network

August 25, 1989

Rabbi Alexander Schindler
President
Union of American Hebrew Congregations
838 Fifth Avenue
New York, NY 10021

Dear Rabbi Schindler:

On December 4, 1989, the Carter Presidential Center, with the AIDS National Interfaith Network and Atlanta AIDS Interfaith Network, will host a national consultation entitled, AIDS - The Moral Imperative: A Call to National Leadership. Invited will be approximately 250 elected or appointed religious leaders from metropolitan centers in the nation with the highest reported rates of HIV infection and from selected smaller cities, heads of communions and religious bodies, and national interfaith leaders.

We enclose, for your information, the draft agenda for the consultation. We hope that you will plan to attend the consultation, formal invitations to which will be mailed by the Carter Presidential Center within a few weeks.

We are writing at this time to invite you to serve on the Honorary Host Committee for this important consultation. In addition to being identified on the letter of invitation, members of the Host Committee will have a primary oversight role in the drafting of a consensus statement on religious responses to the AIDS pandemic. The consensus statement will be circulated for endorsement among consultation invitees and other religious leaders in preparation for public presentation on December 4th. Enclosed you will find a listing of persons invited to serve on the Honorary Host Committee.

We anticipate the Honorary Host Committee will need to meet once in late September or early October to

~~132 West 31 Street, 17th Floor, New York, NY 10001 (212) 239-8700~~
475 Riverside Drive, 10th Fl., New York, NY 10115 (212) 870-2100

outline the scope and general content of the consensus statement and to agree upon a process for the writing, review, finalization and circulation of the consensus statement. In addition, some Honorary Host Committee members will participate in presenting the consensus statement at the December 4th consultation.

Since the letter of invitation to the consultation will be sent in early September, a timely response regarding your willingness to serve on the Honorary Host Committee would be much appreciated. We will then be in contact with those willing to serve to arrange a mutually acceptable date and site for the Honorary Host Committee meeting.

If you have questions, please telephone Rev. Don Eastman at (213) 464-5100.

This consultation will provide an important opportunity for leaders of the nation's interfaith community to focus attention upon the moral imperative of responding meaningfully to the many human needs and challenges of the AIDS pandemic. We hope you will join with us in preparing for this historic event.

Most sincerely,

Leontine Kelly

The Rev. Leontine Kelly
Bishop, United Methodist Church

Donald Eastman

The Rev. Donald Eastman
Second Vice Moderator
Universal Fellowship of Metropolitan Community Churches

LK/DE:bj
enclosures

RABBI ALEXANDER M. SCHINDLER • UNION OF AMERICAN HEBREW CONGREGATIONS
PRESIDENT 838 FIFTH AVENUE NEW YORK, N.Y. 10021 (212) 249-0100

May 22, 1989
17 Iyar 5749

Rabbi Yoel H. Kahn
Congregation Sha'ar Zahav
22 Danver at Caselli
San Francisco, CA 94114

Dear Yoel:

I have now seen your letter and I thank you for your most encouraging words. It was good of you to take the time to write and share your reaction to my AIDS address.

I am also grateful for the wonderful cookbook. You should know that I actually purchased a copy when I was at the convention in Monterey. But, we will keep the copy you sent because of the beautiful personalized inscription, which I appreciate very much. The copy we bought will be given to one of our children. I know it will be enjoyed by one and all, for leafing through it is really a delight and there are some fine recipes.

Thank you for the information about Tristano Palermino. I appreciate your thoughtfulness in giving me this information.

With repeated thanks and fondest good wishes, I am

Sincerely,

Alexander M. Schindler

cc: Robin Leonard,
President

Dr. Mike Rankin

RABBI ALEXANDER M. SCHINDLER • UNION OF AMERICAN HEBREW CONGREGATIONS
PRESIDENT 838 FIFTH AVENUE NEW YORK, N.Y. 10021 (212) 249-0100

July 18, 1989
15 Tammuz 5749

Dr. Boris L. O'Mansky
3400 Woodvalley Drive
Pikesville, MD 21208

Dear Bo:

Thank you so much for your letter of July 12th and the enclosures. Your comments will be of help to me.

I may not present the resolution just as you have it, but something will be said along those lines.

All the very, very best. I hope that you, too, have a relaxing Summer, which will renew your strength and spirit.

Fondly,

Alexander M. Schindler

May 17, 1989
12 Iyar 5749

Rabbi Yoel H. Kahn
Congregation Sha'ar Zahav
220 Danvers at Caselli
San Francisco, CA 94114

Dear Rabbi Kahn:

Your letter of April 21 and the exciting cookbook published by Congregation Sha'ar Zahav arrived after Rabbi Schindler had left the office to attend Board meetings of the UAHC, which will be followed by staff meetings. Both of these are to be held out of the city. Thus, he has not as yet had an opportunity to see the book or to read your letter. I know we will be grateful for your very kind comments about his AIDS sermon delivered at the service in Los Angeles. And, I am confident he will want to read your own talk on Silence = Death: A Jewish Response to AIDS.

I will be bringing your letter and the cookbook to the Board meeting tomorrow, but I did not want to leave the city before at least acknowledging receipt of your gracious gift to Rabbi Schindler. I know he will be grateful for the cookbook -- it looks very exciting and just leafing through it I have noted a number of wonderful recipes.

With warm good wishes, I am

Sincerely,

Edith J. Miller
Assistant to the President

Congregation Sha'ar Zahav

שער זהב

Member, Union Of American Hebrew Congregations

Rabbi Yoel H. Kahn

220 Danvers at Caselli San Francisco, California 94114 (415) 861-8932

April 21, 1989
16 Nisan 5749

Rabbi Alexander M. Schindler
President
UAHC
838 Fifth Ave.
New York, New York 10021

Dear Alex;

Mike Rankin, our peripatetic and ever-busy new UAHC national board member, was kind enough to give me a copy of your address at the Jewish Community Service in support of people with AIDS in Los Angeles. Separately, I've received another two or three copies from rabbis and community members who were present.

I cannot express how moved I was to read your words. They came to me truly as <u>nechamta</u> at a time of need for me; they surely were inspiring and uplifting to all who heard them.

Mike informs me that you are planning on printing the text of your remarks in an upcoming issue of <u>Reform Judaism</u>. I heartily support this. I think that this truly prophetic message needs to be circulated as widely as possible in our movement and in the wider community.

At the Regional Biennial in Monterey, you had a brief chat with a member of our congregation, Tristano Palermino. When you asked him about his family, Tristano was too embarrassed to explain that though he is from Palermo, his family is not Jewish. That is why you had never heard of any Italian Jewish families by this name! (Both he and his lover, David Glassberg, member of our Regional AIDS Committee, are living with AIDS.)

I have taken the liberty of including the text of my recent talk, "A Jewish Response to AIDS: Silence = Death," which I delivered at Holy Blossom Temple this February. I thought that you might be interested in the concept of "safe sex as <u>mitzvah</u>" which I discuss at the beginning of the second section.

Our congregation is pleased to have published <u>Out</u>

of Our Kitchen Closets: San Francisco Gay Jewish Cooking. In addition to passing on many nice recipes, $3 from the sale of every book goes to the San Francisco AIDS Foundation Food Bank. We sold out our first printing last year and gave the Food Bank a check for over $7,000; we are now selling the second edition. Please accept the enclosed copy as a gift from our congregation.

Respectfully,

Yoel Kahn

Rabbi Yoel H. Kahn

YHK/jh
cc: Robin Leonard, President
Dr. Mike Rankin

Enclosures

Congregation Sha'ar Zahav שער זהב

Member, Union Of American Hebrew Congregations

Rabbi Yoel H. Kahn

220 Danvers at Caselli San Francisco, California 94114 (415) 861-6932

SILENCE = DEATH: A JEWISH RESPONSE TO AIDS
Holy Blossom Temple, Toronto, Canada
February 17, 1989 Shabbat Tetzaveh

Thank you, Rabbi Moskowitz. It is an honor to speak from the bimah of this congregation and a special pleasure for me to be in Toronto. Although this is the first time I have ever been here, this city has always had a special place in my family's collection of oftold stories - my parents met in 1947 when they were both students at the University of Toronto. I am especially honored to have some of their oldest friends here this evening. I would like to express my thanks to the Rabbis of this Temple for inviting me to speak here and to Chutzpah, Toronto's organization of gay and lesbian Jews, who have made this visit possible under the auspices of the Sheldon Ross Memorial Symposium. I am honored to greet the members of the Ross family here this evening as well.

Over the last two years, a simple statement has become the rallying cry of those organized to seek more attention to AIDS and to those whose lives it has touched. In the United States it was first popularized at the largest civil rights march in history, in October 1987, when more than 600,000 lesbian and gay men, their families and their friends gathered in Washington. Many of the marchers wore a shirt or button which featured a pink triangle on a black background and the slogan Silence = Death. The pink triangle, the Nazis' identifying label for homosexuals (comparable to the yellow star), has become an international symbol of gay pride and resistance. Elie Wiesel, our generation's prophet of memory, has repeatedly reminded us that "Never Again" is more than a call for Jews to resist anti-Semitism; it is a summons to the world to resist all oppression and genocide.

In the United States, there have been more than 80,000 diagnosed cases since 1981. In Canada, there are a reported 2,375 cases (as of Feb. 3rd; source: Health Ministry AIDS Hotline). Worldwide, there have been 140,000 reported cases to date; the real number is without doubt several times higher. Here in Toronto, eighty people are testing positive for HIV-antibodies each week. Since the beginning of the epidemic, the organized Jewish community has been virtually silent on this health emergency. With the exception of our Reform movement, no national Jewish group in the U.S. or Canada has made a public statement about the AIDS epidemic and its social, public policy or religious dimensions. Our silence directly affects the length and quality of the lives of everyone with AIDS, ARC or HIV infection. Since the incubation period for the virus can be as long as five, ten years or more, most of the people who are being diagnosed today probably were infected several years ago. Even if the rate of new infection is slowed, the number of new cases is projected to continue to rise for the foreseeable future. But the further spread of this disease can be stopped - if the silence is broken. Silence about AIDS leads to death. I have come this evening to ask you to break the silence.

I.

Safe sex is a mitzvah (commandment) for our generation. We must teach our children - and ourselves - that safe sex is not only healthy, life-saving and good - but also that it is what God wants of us. Our youth movements and camps are effective at teaching about social justice, from Central America, to the boat people, in the context of traditional Jewish religious values. Yet in the realm of personal moral values and sexual standards, we expect only fundamentalists and the Catholic Church to take a public stand. Surely there is a middle ground in sexual behavior and

standards between unrealistic and unenforceable puritanism and the idealized promiscuity of prime-time TV. Silence in education equals death.

To be effective, our sex education must be explicit. It is insufficient to teach that the HIV virus can be transmitted by "having sex." It is not transmitted by having too many sexual partners. It is not transmitted only through homosexual, as opposed to heterosexual, acts. This virus is far too simple and methodical to make cultural and social distinctions. It is controlled by biological and physiological determinants: the HIV virus' primary route of transmission is through the exchange of body fluids during unprotected vaginal and anal intercourse, when sharing needles to shoot intravenous drugs, and from and infected mother to her foetus. Until we say these words out loud, show pictures, and speak in the language that children, youths and adults use and understand, we are still silent. Safe-sex education belongs in Jewish education in the context of teaching about responsible personal decision making. Sex education in the schools, when it is permitted, is largely limited to the details of plumbing; the mitzvot of responsible sexual behavior in the context of mutually loving respectful and healthful relationships will only be learned if we teach them at home, in our summer camps and youth programs, and in our synagogues.

While gay men have been the hardest hit by this virus, they have also been the most successful in educating each other and changing their own sexual behavior. The rate of new infection among gay men in San Francisco is now effectively zero. This change in sexual behavior is astounding when we consider the other life-threatening circumstances which people have the power to change, yet usually don't - from smoking to not wearing seat-belts. Tragically, most gay men who will develop AIDS were infected before the disease and its methods of transmission were recognized. But new infection among other at-risk populations can be prevented only if we risk speaking out.

II.

For the person diagnosed with AIDS or at risk of diagnosis, silence leads to death. AIDS is not transmitted by casual contact, but the fear of AIDS is. This unfounded fear, coupled with the absence of correct and explicit public information, has created the climate for discrimination, hysteria and violence in which, for instance, the home of three children infected by the virus was firebombed in Arcadia, Florida. Even the Reagan administration, hardly a pro-gay biased source, concluded in a recent study that gays and lesbians are "probably the most frequent victims" of hate crimes [U.S. Justice Dept, Oct. 1987].

Besides the threats of physical assault, there is a more subtle violence which the person with AIDS or HIV infection, or who is at risk, must face. This person must lie at work for fear of losing a job or tenure, be careful of whom to tell for fear of losing an apartment, and carefully decide who to inform among friends, families and acquaintances, lest they all disappear. A young man from my synagogue went home to the town where he grew up, became ill, and unexpectedly spent two months in the hospital. No one visited him during this period outside his immediate family - not his rabbi, nor his high school classmates, nor old family friends. Only when he left the hospital did he learn that his parents had not told anyone he was sick, for fear of the stigma of having a son with AIDS.

Although AIDS is not a gay disease it is impossible to separate the history of this epidemic from the history of oppression and violence against gay and lesbian people. The greatest violence has been the passivity of governments and institutions - national, state, provincial and local - in the face of a disease which only affected "them." The stigmatizing and oppression of gay men and lesbians has in turn kept many people in the closet, reinforcing gay people's invisibility. For

the person who has never come out to parents, spouse or family, the twin secrets of homosexuality and an HIV-infection or illness can be overwhelming. The affected person instead retreats into silence, carrying this tremendous burden alone, perhaps becoming ill and dying cut off from family, friends and community just when they are needed most.

III.

For the mourners who cannot share their pain and therefore do not heal, silence too leads to death. If, as we teach, the enduring power of memory is the key to eternal life, then death is victorious when the survivors never speak for fear of being cut off themselves from their own communities. When the man I described above, who spent months in social isolation in the hospital, was dying in San Francisco, I asked his parents for permission to call their hometown rabbi and inform him of their son's impending death. The mother pleaded with me not to say a word: "Please, I have to go back and live with these people." Do the families touched by HIV disease in this congregation feel safe?

The deep wounds and loss do not heal, but instead become scars on the soul, hidden deep within, self-fulfilling prophecies in which the fear of social death leads to the death of the spirit and a turning away from the healing power of remembrance. Meanwhile, the friend, neighbor, co-worker or fellow synagogue member who has suffered a similar loss also mourns alone, each thinking: "I am the only one."

IV.

Lurking behind the AIDS health crisis is a crisis of faith. Jerry Falwell, together with some isolated Jewish voices, has explained AIDS as a form of punishment. In an August 1987 Gallup poll, forty-two percent of the people surveyed agreed with the statement: "I sometimes think that AIDS is a punishment for the decline in moral standards." [NYT, August 30, 1987] Regardless of our attitude towards homosexuality, the conclusion that a particular disease represents a direct expression of divine displeasure is only possible within a biblical fundamentalist and literalist mindset, which is completely alien to the Jewish tradition and the modern Jewish world-view. AIDS cannot be considered as "divine punishment" visited upon those whose lives it touches, unless we are ready to declare sickle-cell anemia as divine punishment on blacks, Tay-Sachs disease as a punishments on Jews, and the earthquake in Armenia a punishment for the Soviet government's erroneous ways. If AIDS is a punishment for irresponsible actions, and therefore those affected by it are not deserving of our sympathy and support, should not the same conclusion be made about middle-aged men with type-A personalities who suffer heart attacks?

The Jewish religious tradition suggests an alternative explanation through its theology of suffering. The Jewish people has wrestled with the meaning of suffering for hundreds of years. After the expulsion from Spain in 1492, Jews eventually came to interpret their pain and exile not as the will of God but rather as the consequence of shevirat ha-kelim - the incomplete nature of the cosmos. Their pain and anguish was not a punishment from God but instead a reflection of a process within the Godhead itself. There will be inexplicable evil in the world, and pain and suffering will not be eliminated, until the tikkun is complete. We are not so arrogant as to assume that floods or droughts or diseases- great forces of nature - have their genesis in our own private histories.

The AIDS virus is best understood as an evolutionary and natural phenomenon which follows natural laws, just like gravity follows its laws. AIDS derives neither from some satanic source nor from divine judgment. It is a virus which follows the laws of biochemistry. People of faith need to speak out

lagainst those who, like Job's misguided friends, continually try to blame a victim who has done no wrong. To date, the public theology of AIDS has focused on "AIDS as punishment." Does not our tradition suggest that God is best known as Ha-Rachaman, the loving and Comforting One?

Our rabbis taught that when Israel goes into exile, the Shechinah goes into exile too. When Israel cries, they taught, God sheds a tear. God shares in our pain and God comforts us in our time of sorrow. Where is God in this epidemic? God is beside and supporting those who are ill and those who care for them. As Rabbi Robert Kirschner has taught, God has no hands to heal with but our hands, no voice to comfort with but our voices, no arms to embrace with but our arms. God's presence in this epidemic is found in the reservoirs of strength which volunteers summon up to continue their service despite the hardship and grief, in the continuing attention and devotion of family, friends and lovers who provide care, and in the courage of those who are living with this illness. Over and over again, I have met these heroes of spirit and faith, affirming life in the face of death. Harvey Milk, San Francisco's martyred gay county supervisor once wrote: "We cannot live on hope alone. I know that. The important thing is not that we can live on hope alone but that life is not worth living without it." God as the Source of Hope and Comfort is perhaps a less dramatic figure than the hoary God of Retribution who sends lightning and disease to a sinful world. Until now, we have abandoned the public theological debate- with its attendant influence on public policy debate - to those whose religious and social outlook is most contradictory to our own. Silence cuts off the soul from God and cuts off our community from its own source of healing.

V.

AIDS belongs on the political agenda of the Jewish community. In the United States, reporter Randy Shilts' important book, And the Band Played On, documented in painful detail how the United States government deliberately avoided becoming involved and committing resources to fight this epidemic. The Canadian government, too, has been slow to respond. Through vigorous public education, the life-saving message of safer sex has successfully been transmitted in San Francisco and some other large cities. The AIDS education available in Canada is entirely financed at the provincial level, and the education programs which are being promoted are not targeted to those at greatest risk. Continuing silence today means life-threatening illness tomorrow. The Jewish people, whose slogan is "Never Again" surely recognizes that when a government allows thousands to perish who could be saved, because it considers them unimportant, Jews have a special responsibility to act.

[Many of the political issues raised by the AIDS crisis are, in fact, already on the progressive agenda. Many politicians who oppose federal funding for agencies which "promote homosexuality" by teaching about safe-sex also oppose federal funding for family planning clinics which counsel women about abortion. These are public policy matters in which we can find common ground with our counterparts in other religious communities, along with minority and civil rights organizations. There is an urgent need for a liberal religious coalition to speak out with prophetic courage on public policy.]

VI.

How then can Jews and the Jewish community end the silence? First, it is essential to stop treating AIDS as something totally unfamiliar. It is a tragedy of enormous proportions, but the human needs in this epidemic are the same as in any health emergency. The people who are ill need care, comfort and attention. And the caregivers, both professional and volunteer, along with family members, lovers and friends, are constantly on the edge of burnout. The Jewish tradition is clear on our task.

In the Book of Genesis, we learn that when our parent Abraham was recuperating from illness, they Holy One came to visit him. How did God arrive? In the guise of an angel, one of the three visitors who appear at Abraham's tent. From this story our rabbis derived the mitzvah of bikkur cholim - visiting

and caring for the sick. In virtually every major city in this country, the local AIDS service organizations are in desperate need of volunteers and support. The existing institutions of the Jewish community can open their doors and reach out to the people touched by AIDS and their families. A model which we started in San Francisco and is now being duplicated elsewhere is our Jewish Emergency Assistance Network's AIDS Family Assistance Project. Under the auspices of our Jewish Family and Children's Service, the program has served over 150 Jews with AIDS and their families, with counseling, holiday meals, support groups, home hospitality and care. In addition, thousands of Jews have been educated through the out-reach efforts of the project staff and volunteers. As individuals and through the work of your congregation's AIDS Sub-Committee, you can act, giving of your most precious gift, yourself. A pressing need for people living with any life-threatening illness is to write a will and put their legal affairs in order. I am informed that in Toronto, there are only six attorneys, out of the thousands in practice in the city, who have agreed to help people with AIDS prepare wills and deal with their legal affairs.

It is not always easy for us to care for people touched by this illness. We will not overcome our discomfort until we face our homophobia, our embarrassment about sexuality, and our fear of death. In our culture, we have grown accustomed to making things better, ever confident that with the proper technology or pill or procedure or practitioner, all will be well. In this epidemic many are not getting better. There are good days and there bad days. Many are hanging on; others, despite the best care and a determined spirit, are fading. It is very painful to be a witness. What can we say or do?

Once again, silence only denies the pain. The topic of AIDS cannot remain taboo, spoken of shamefully or in whispers. We need to open ourselves, our families, our synagogues and our communal institutions to the reality of this disease. We need to stop thinking about "them" and start talking about "us." Rabbis must speak about AIDS from their pulpits. The sisterhood and the brotherhood, Hadassah and B'nai Brith, our schools and youth groups, together with the Rotary Club, the Masons, the Scouts and all the other forums where we gather, must put AIDS education on their agenda. Chutzpah, Toronto's organization of gay and lesbian Jews, has been and out of necissity will continue to be on the front line; its members and programs need and deserve your support.

Through the painful lessons of history we have come to know that Silence = Death. Over the last year, a new slogan has appeared. Against the same black background and beneath the same pink triangle appears: "Action = Life." As Jews, we are summoned by our history and by the call of Elohim Chaim, the God of Life: "U'becharta b'chaim... Now therefore choose life."

Yoel Kahn is rabbi of Congregation Sha'ar Zahav in San Francisco.

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Union of American Hebrew Congregations

PATRON OF HEBREW UNION COLLEGE-JEWISH INSTITUTE OF RELIGION
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PACIFIC SOUTHWEST COUNCIL

Rabbi Lennard R. Thal
Director

Rabbi Janet Ross Marder
Assistant Director

March 15, 1989

Rabbi Alexander M. Schindler
838 Fifth Avenue
New York, NY 10021

Dear Alex,

I am sure that I did not adequately express my thanks to you at the conclusion of Sunday's Service. To tell you the truth, your sermon left me speechless. So let me now tell you how grateful I am for your words. I had expected the sermon to be forceful and eloquent; what I did not anticipate was the deeply personal tone of your remarks. That made your speech extraordinarily moving and set it apart from other "official" statements on AIDS that I have heard. I think that all of us in the sanctuary realized how remarkable it was to hear the national leader of a religious movement declare his solidarity with homosexuals and all those suffering from AIDS. It certainly went far beyond the usual calls for "compassion for AIDS victims." As you said, it crossed the boundary of "otherness."

The hours of thought and struggle you devoted to this issue have truly generated a magnificent statement.

I feel privileged to have witnessed your talk, and honored to be part of the movement you lead.

Sincerely,

Rabbi Janet R. Marder
Assistant Director

JRM/hpr

איתוד
ליהדות
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PACIFIC SOUTHWEST COUNCIL
Rabbi Lennard R. Thal
Director
Rabbi Janet Ross Marder
Assistant Director

January 13, 1989

Rabbi Alexander Schindler
Union of American Hebrew Congregations
838 Fifth Ave.
New York, N.Y. 10021

Dear Alex,

I hope this letter finds you well. Here are some thoughts about your sermon at the AIDS service on March 12:

First, a couple of things to avoid. It would be better if you did not refer to AIDS "victims" but to "people with AIDS." Because the term "victim" suggests passivity and helplessness, those who are struggling with this disease prefer not to have it applied to them. I would also urge you not to dwell too much on the inevitably fatal nature of the disease, since there will be people there who are fighting to survive and trying desperately to maintain some hope.

On the positive side, I would love to hear you call for the Jewish community to face the truth and recognize that AIDS is in our midst--that it touches nice, white, middle-class Jewish families. It is important that you address the issue of their (often self-imposed) isolation--the intense fear and anxiety that keeps them from coming forward to seek help. It is very common for mothers and fathers to tell no one of their sons's diagnosis with AIDS, and to emphasize that even at the funeral the secret must not slip out. They rarely turn to the Jewish community for help, I believe, because they have no expectation of finding help there--only judgment, gossip, and fear of contamination. Quite often, the assistance they need is basic and concrete: someone to visit, help with cooking, laundry or transportation. We Jews have been concerned about protecting ourselves from AIDS; when will we be ready to go beyond our fear and offer help on this simple, human level? I'd like to see you discuss why we should help and how we can help.

The point to stress is that we can't wait for people affected by AIDS to come to us and ask for help; synagogues must make a conscious effort to reach out to the AIDS community by contributing to the AIDS Project Food Bank, sponsoring blood drives, inviting PWA's to Shabbat meals or Passover Seders at the temple or in homes, offering meeting space to groups serving PWA's and so forth. Synagogue members could volunteer with agencies serving PWA's; those who are professionals (lawyers, accountants, dentists, insurance agents, etc.) could offer their services free or at reduced cost to a PWA. All temple members should continue to learn about AIDS, even though it's depressing, and make an effort to educate those around them, dispelling ignorance and

irrational fears whenever they encounter them.

The most important message that should be conveyed is not pity or compassion for those suffering from AIDS, but a sense of solidarity--a feeling that Jews affected by AIDS are part of us and belong to us. The other day I heard a priest say, "The Church has AIDS," and was much struck by his words.

I also think it's important for you to explain why AIDS is a Jewish issue that needs to be on our agenda, and why we should care about people with AIDS even if they're not Jewish. Most people don't understand the impact that AIDS is having, and will have, on our entire society.

I'd love to hear you make a statement against homophobia, especially in the religious community, and point out how homophobia has contributed to our society's appalling delay in responding to this epidemic. It would be wonderful if you could acknowledge the magnificent work the gay community has done in caring for the sick and dying; they have truly been leaders for all of us. And when you refer to people affected by AIDS, it's very important to mention families, friends and lovers. It would mean a lot for you to acknowledge the existence of loving, courageous gay couples who battle this disease.

I'd also like to see you praise the heroic efforts of nurses, doctors and other caregivers (many of them Jewish) who have devoted to their lives to people with AIDS with extraordinary tenderness, energy and dedication. It would also be appropriate to pay tribute to our own UAHC AIDS Committee.

Finally, I hope you'll make a strong statement of love and acceptance to those individuals, couples and families who are coping with AIDS or mourning the loss of a dear one. They need to feel embraced by their community, and you are the voice of that community.

We want to make this service an affirmation of life, as well as a remembrance of those who have died. We'd like people to leave feeling hopeful and united--a sense that all of us, the sick and the well, stand together against this disease and hold one another up.

I realize that this is a lot to ask for, but I have heard you speak and know that your words will be inspiring. Please feel free to contact me with any reactions to my suggestions. Once again, let me express my deep appreciation to you for taking part in this service. I am very proud to be part of the movement you lead.

B'shalom,

Janet

Rabbi Janet R. Marder
Assistant Director

BB:

Peter-Joseph Avitabite requested that I write to you and share a copy with him...he wants to use my letter to further his work in behalf of the Saint Peter's Momentum Aids Outreach Project which, as you know, he directs.

Have a great Summer.

AMS

July 6, 1988
21 Tammuz 5748

Rabbi Balfour Brickner
Stephen Wise Free Synagogue
30 West 68th Street
New York, NY 10023

Dear Balfour:

I was delighted to learn that the S+ephen Wise Free Synagogue has determined to undertake the Momentum Aids Outreach Program patterned after the program presently undertaken by Central Synagogue in cooperation with St. Peter's Chucch.

On several occasions I have gone over to St. Peter's Church and participated in the preparation and serving of meals for the guests affected by AIDS and their spouses. I have seen the effective impact which this effers has as well asthe take-home food baskets which are given to the guests as they leave the Church.

This is a true service of the heart, one which merits replication not just by you but by many other synagogues throughout the land. WC must do everything we humanly can to counter-act the mindless discrimination to which the victims of this dread malady are subjected - that wave of hysteria whose symptoms include ostracism, prejudice and violance. This secondary scourge is as deadly as is the primary affect of the illness itself and must be counteracted by every means at our command.

I salute the members of your congregationuundertaking this project, it is in the tradition of a synagogue which has always been known for its concern for the well-being of that community of which it is a part.

Fondly,

Alexander M. Schindler

cc: Peter-Joseph Avitabite, M.A.

(212) 995.2200

Peter - Joseph Avitabile, M.A.
Saint Peter's Momentum Kids Outreach Director

306 24 A. 96
NY C 10010

(212) 683-7165

June 13, 1988
28 Sivan 5748

Rabbi Morley T. Feinstein
Temple Beth-El
305 West Madison Street
South Bend, IN 46601

Dear Morley:

I am simply delighted that the students of Temple Beth-El's Confirmation Class of 1988 and the 8th grade class have contributed their Tzedakah funds to the AIDS Committee of the UAHC. Their thoughtful gift means much to all of us and I hope that you will convey to the 8th grade class the profound appreciation of the Union and the AIDS Committee. Even as I, by means of a copy of this letter to Lauren Sarnat and Marc Rosenthal, ask that they convey to the Confirmation Class our deep felt gratitude.

It is heartening to know that the young people of our congregations are concerned about the scourge of AIDS. Through their generosity our work in seeking to create awareness and education among our congregants will be strengthened.

With warmest good wishes, I am

Sincerely,

Alexander M. Schindler

cc: Mr. Lauren Sarnat
Mr. Marc Rosenthal
Chairpersons of Confirmation
Class tzedakah.

Sonja L. Young June 10, 1988

Mrs. Randi Locke

Please find the enclosed checks (two) and letter from Temple Beth El, South Bend, Indiana. Rabbi Schindler has sent his personal thank you to the students.

Thanks.

sly

TEMPLE BETH-EL
305 WEST MADISON STREET
SOUTH BEND, INDIANA 46601
(219) 234-4402

June 2, 1988

Rabbi Alexander M. Schindler
Union of American Hebrew Congregations
838 Fifth Avenue
New York, NY 10021

Dear Rabbi Schindler:

On behalf of the Confirmation Class of 1988 - 5748, I am pleased to present you with a check for $62.50 in support of the Union of American Hebrew Congregations AIDS Project.

The class selected this as their recipient of tzedakah for the year, and hope that the UAHC will do all it can to promote public education about AIDS and support of people with AIDS.

The 8th grade class also chose to support the AIDS Project, and their check in the amount of $18.50 is enclosed as well.

The Confirmation Class tzedakah chair people were:

Lauren Sarnat
50858 Mercury Drive
Granger, In 46530

Marc Rosenthal
15721 Hunting Ridge Trail
Granger, IN 46530

Many, many thanks, and all best wishes for a wonderful summer.

Shalom,

Morley T. Feinstein
Rabbi

MTF:jj

cc Rhea 5/11/89

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May 8, 1989

Personal

Rabbi Alexander Schindler
Union of American Hebrew Congregations
838 Fifth Avenue
New York, New York 10021

Dear Alex:

Thank you so very much for sending me a copy of your deeply moving address on AIDS. I treasure it especially because of your very thoughtful and much appreciated inscription.

The address, as I experienced when I read your previous draft, affected me profoundly. I felt its wonderful sincerity and inspiring religious message. It made me "wrestle with demons" of my own--and the good Lord knows they are there--and motivated my own confessions.

You have my deep admiratrion for not heeding all of my counsel and expressing your own feelings as your integrity and conscience dictate. I find that when one is called upon to advise another, one is tempted to adopt an institutional perspective and become cautious. This is the danger. I am inordinately pleased that you decided to say it as it is. May you go from strength to strength.

As ever,

Eugene Mihaly

EM:pg

or rather as it should be!

AMS

From: Rabbi Joe Edelheit

Prologue

Working Draft

THE RABBI AND THE ABYSS OF AIDS

The story is told of one of the disciples of Rebbe Barukh. The disciple had followed the dangerous path leading to darkness. They say he had read forbidden books, played with perilous thoughts, and looked into hidden areas which only the chosen may approach. Now the disciple stood on the edge of the abyss, tempted by damnation. The storyteller of our time, Elie Wiesel, explains that Rebbe Barukh finally decided to go and see his disciple who had strayed from the path of righteousness. Without telling anyone, the Rebbe journeyed to the far away town to confront his disciple. Before the young man could collect his thoughts and utter a word, the Rebbe spoke to him, "You are surprised to see me here in your room. You shouldn't be--I can read your thoughts. I know your innermost secrets. You are alone and trying to go deeper into your loneliness; you have already passed through one after the other. All but the last of the 50 gates of knowledge and doubt. And I know how you did it. You began with one question and explored it in depth to discover the first answer, which then allowed you to open the first gate. You crossed that gate and found yourself confronted by a new question. You worked on its solution and found the second gate, and the third, and the fourth, and the tenth. One leads to the other, one is a key to the other, and now you stand before the 50th gate.

Look--it is open, and you are frightened, aren't you? The open gate fills you with fear because if you walk through it, you will face a question to which there is no human answer, and if you try, you will fall into the abyss, and you will be lost forever. You didn't know that, but I did, but now you also know."

"What am I to do?" cried the disciple. "What can I do? Go back to the beginning, back to the first gate?"

"Impossible," said Rebbe Barukh. "A human being can never go back. It is too late. What is done cannot be undone."

There was a long silence. Suddenly the young disciple began to tremble. "Please, Rebbe, please, Rebbe, help me. Protect me. What is there left for me to do? Where can I go from here?"

"Look," said Rebbe Barukh, "look in front of you, beyond the gate, what keeps a human being from running, dashing over its threshold, what keeps a human being from falling--faith. Yes, beyond the 50th gate there is not only the abyss, but also faith, and they are next to one another" (Somewhere a Master, Elie Wiesel, pp. 73-74).

This story, as told by Elie Wiesel, has always moved me a great deal. One can certainly read it as an anti-enlightenment story, a story that warns about the reading of secular books and thinking of secular thoughts, but like so many Hasidic tales recovered within our own time, its value is more than merely that of a closed

religious piety. I now read the story and tell the story and understand myself to be in the story; because of my work with AIDS, I have been transformed and the story carries a different set of nuances. The 50 gates are opened by 50 questions which are not from radical secular books, nor do they destroy my faith in God or separate me from the Jewish people. These questions which have led me to the edge of this abyss come from human beings who have touched my life, the lives which make up the essential third dimension of the oft reported statistics of the AIDS epidemic.

Mary Catherine Bateson and Richard Goldsby, in Thinking AIDS, note, "AIDS will cause psychological and social reactions that may change the character of human social life....This kind of danger to the way that society is organized is the basic threat of the AIDS epidemic (p. 120). For some these words are merely an intellectual or social critique of a disease and contemporary crisis, but ~~[illegible]~~ Bateson and Goldsby illuminate the transformative character of AIDS and the sobering awareness that once transformed, one stands on the edge of the abyss, because you have walked through the 50 gates--opened by the 50 questions which can only come from the lives touched by AIDS.

These present reflections are stimulated by a review of these questions that have led me and others to a place we did not expect to be. These reflections are not meant to be an indictment, though they are judgmental. This essay is

an autobiographical touchstone, woven through a series of questions that must be asked again and again and ultimately answered, even if we have to wait for the Messiah for the answer. Some of these questions shatter previous answers to previous questions. Mine is but a small voice in a growing chorus of those who are aware that life is completely different; our work with AIDS has transformed us. This awareness opens us to the reality that we are living through a caesura, a rupture in history, in which our behaviors, attitudes, and beliefs, will change. How we learn to live with these changes will determine what we do when we look beyond the 50th gate and realize that we stand on the edge of the abyss.

(add Berkowitz - w. Margaret Mitchell)

The first question which led to the first gate still rings in my ear. The young woman called on behalf of her brother who was gravely ill in the hospital with PCP, pneumocystic carinii, the pneumonia most related to the HIV virus. He had wanted to see a rabbi and could I please visit him. I asked, Were they affiliated, Did they have a rabbi? I did not want to infringe unethically on someone else's congregant.

I was told that the man's rabbi had rejected him shortly after he had been diagnosed with AIDS, saying that there was no place in Judaism for him. I refused to accept that statement, it was impossible--no rabbi could possibly say that, no rabbi could have done that. I didn't want to

believe it. Already the questions beyond the first question were opening gates beyond gates which I could never have imagined. Without knowing what the implications were, I walked beyond each gate, and reflected on each question. With each new gate, and each new question, there was new learning which tested my credulity, and slowly but perceptibly, I accepted new insights, and I struggled with an awareness of a new suffering. I ask myself again, I ask anyone who will listen, Can a rabbi help rekindle a soul which has been smashed by another rabbi's callous homophobia? Can rabbis be homophobic? To the degree that rabbis in American today are like anyone else, they are like everybody else, with their fears, their prejudices, and their ignorance. If rabbis are ignorant and sometimes homophobic, who will reach out to those Jews who have turned away because of callous silence? Are there enough rabbis and laypersons who will hear the call of those in need? This was the first PWA to teach me by his patience and his extraordinary courage. He held his hand out to me, and I tentatively and fearfully reached back. Month laters I held his hand as he died, and I faced a new set of questions. His mother told me in the hospital room that she could not tell the school at which she was a nurse that her son died of AIDS; therefore there could be nothing in the eulogy about her son's illness or about his gay Jewish identity. New questions are asked about how you deliver eulogies in euphemisms. And how do you help

interpretation of rituals. Does one include a homosexual lover as an avel (mourner)? Does one give a kriah ribbon to a lover? A gay Jewish man, at the funeral of a Jewish PWA, asked me whether he should say kaddish. Was kaddish an obligation, not an option for a homosexual lover as for a spouse? I quickly reviewed in my mind all of the laws about those who are categorized Halachically as mourners, but none of tradition had anything to do with this question at this moment. I said, "Yes, you are obligated to say kaddish." Had I abused my rabbinic authority, had I misinterpreted the law? Each question like this which is "radically" new is always raw, but the gates always open so quickly.

There have been more funerals and more PWAs and more questions. What does one do about the embalming of a PWA--when the state requires a steel casket liner without embalming? How does one explain to a Jewish funeral director that it is ignorance and prejudice which stigmatize a family, when the director says that a PWA's remains will infect those in the chapel without a steel casket liner? What does one do for the Methodist lover of a Jew who has died from AIDS, and after his death, asks for a memorial service in the synagogue? Who is "the rabbi" for a gay Jew who died from AIDS who was so alienated from the Jewish community that he had not affiliated for 25 years? Should

a rabbi facilitate a memorial service in a Methodist church because there is no synagogue which is open because he was unaffiliated? I answered the question by leading the services and then did a service at the cemetery crypt for his ashes. I continue to ask the question now--what does the statement from Isaiah--"My house shall be a house of prayer for all peoples" really mean? Should we read that statement with an exclusion of PWAs, gays, lesbians?

The first time I preached on AIDS was on Erev Rosh Hashanah and there were all of those "professional" questions about rabbinic sensitivity to politically controversial issues. Can you use as a sermonic foil the Unesaneh Tokef because as a prayer of providential theology it now sounds harsh and cruel as if God were using AIDS as a punishment? I shared with the congregation my own introduction to AIDS and how it had already changed me, and I beseeched them to look into their hearts and confront their own prejudice and fear and ignorance. There was some shock, incredulity, and even anger. Then more questions--how could you do this on this Erev Rosh Hashanah? The questions were always a "mild" form of chastisement. Should a rabbi's pulpit take the leadership on issues which go beyond merely reading the Torah? Had I abusively tampered with a sensitive medieval piyyut (poetic prayer) of the High Holy Day liturgy when I rewrote the Unesaneh Tokef? The sermon was the "tangible" experience of recognition that there were already too many

questions behind me, too many gates now closed to go back. I was beginning to understand that there is a difference between being a rabbi "before" and "after" AIDS. Randy Shilts is correct in The Band Played On: there is a "before" and an "after"; most of us just don't realize we are already living in the "after."

There was the Board of Trustees meeting at the synagogue at which someone got up and challenged me, asking me whether I wanted all of the homosexuals in Chicago to join our Congregation. Wouldn't the Congregation change, and didn't I know that homosexuality was a sin in the Torah? The questions conveyed such contempt, I stood alone, and the board was so silent. I answered: Yes, Leviticus 18:22 does refer to homosexuality as an abomination, but Deuteronomy 22:5 says that a woman wearing a man's clothing is an abomination, too. Your wife and daughters wear slacks--are they an abomination? Then I was asked: If I cared so much about gays, would I start "marrying" them? That is a question that I had not heard before asked in that way, though I would hear it again and again, and for the first time, I listened to it differently.

All rabbis must ask, especially those who become involved in caring for the dying and who bury the dead and who care for the grieving, How shall we relate differently to the living, when the living are gay men and lesbian women? Can we ever read Leviticus 18:22 in the same way? Can we ethically refuse to read it, expurgating it from the text of Torah? What shall we do, when that weekly portion comes again? What is the

imperative regarding he or she who reads from the Torah and what they read? What they believe?

The first time I went on a TV show about AIDS and the Jewish community, I tried to explain why there was confusion, apathy, and fear. The question from the interviewer which one hears again and again and again was: "Why is AIDS a Jewish problem and not merely a human problem?" One can answer the question in terms of the lives of Jews as PWAs, as lovers, as parents, as grandparents, as sisters and brothers. And then another question: "But how many Jews are we talking about? Five percent? Ten percent?" How does one answer that question? Why is AIDS a Jewish problem? Because there are Jews dying of it, Jews living with it, and Jews grieving over it. All of this is obvious. Why is any problem a Jewish problem? Did we ask how many Jews were being discriminated against in the South in the 50's and 60's for civil rights to be a Jewish problem? Did we ask how many Jews were dying in Viet Nam for that to be a Jewish problem? Do we ask how many Jews are homeless when we proclaim that homelessness and poverty are a Jewish problem? I have been asked why AIDS is a Jewish problem more than 50 times that have opened more than 50 gates.

Should a rabbi be obligated to teach in the Religious School about AIDS when the students are learning about it in public school? One enraged mother argued, Why should you take time away from teaching Torah by teaching about AIDS? Then she took her child out of the school. Should a rabbi, a

Jewish educator, and a Jewish school, be responsible for teaching about sexuality with an emphasis on celibacy and with an equal emphasis on condoms? Does this also include teaching "safer sex" about homosexuality? Is it a Jewish problem if there is a sakanah--a danger, in which someone has information which can prevent harm for themselves or someone else? Must there be pasuk--a verse, in the Torah which defines the problem as Jewish for it to be a Jewish problem? Must 10% of those touched by AIDS be Jews for us to recognize a new reality? Should rabbis and Jewish leaders only be concerned about Jewish problems?

In Illinois ~~it~~ rabbinic involvement in AIDS became a ~~necessity~~ when every premarital couple was required to take an HIV Antibodies blood test. Educating other clergypersons, especially rabbis, I wondered why clergy seem so ill-equipped as clergy to deal with issues beyond the scope of simple seminary pastoral counseling. How does a rabbi handle a young male who turns to his fiancee and says, "I guess you ought to know before we have the HIV test that he had had ~~there was~~ a chance bi-sexual encounter. What does a rabbi do when a young man calls crying three days after an initial premarital sessions and admits that he had joined his fraternity brothers in going to a whorehouse and obviously had had high risk exposure? Is the rabbi obligated to tell the fiancee, and what if either had tested positive? Should I, as a rabbi who requires Tay-Sachs testing, require the HIV test before conception? Nothing in the Torah, the Talmud, on in the Shulchan Aruch, or in any of the commentaries to these texts,

answers these questions. No professor in the Seminary ever taught me anything about this. Yet there are people who come to me, whose eyes glisten with tears, and whose hearts race as I try to explain that the HIV Antibodies Test is not an AIDS test, and that they should go to a doctor they trust and not a street clinic. I explain what an ELISA test is and what the Western blot confirmatory test is. I worry each time I speak to a premarital couple about their emotional strength as individuals and as a couple when their sexual behavior of the past ten years is tested.

How do rabbis teach other rabbis about AIDS? We rarely talk together about sexuality and IV drug use and certainly not with such graphic vocabulary. Is there an impropriety of z'nut (immodesty) which impedes rabbis from opening themselves to these worldly matters? When one is trying to achieve a communal rabbinic support for an AIDS education program, should ideological differences compromise rabbinic integrity? Can there be an AIDS program which does not emphasize the use of condoms when premarital sexuality is not recognized by the traditional rabbinate? Should the organized Jewish community through the Federation support AIDS education programs which ignore homosexual behavior in order to achieve Orthodox support? Was it appropriate to change the title "rabbi" to "doctor" in order to teach a group of Orthodox rabbis about AIDS and premarital counseling? Should anyone be forced to argue with a journal editor that an article on HIV antibodies must be accepted because the first reader who rejected it was homophobic

rather than a critical scholar? Is it significant that major rabbinic organizations seem to find time to discuss almost every other priority issues in the Jewish and secular world except AIDS?

How does a rabbi answer the questions about becoming involved in community task forces on AIDS? Should a rabbi try to set up a Jewish communal or interfaith coalition on AIDS? Should rabbis spend outside-non congregational time involved in such community organizations? Why are there been so few rabbis consistently involved in this? Most rabbis honestly are facing the crush of several pressing issues. Besides, some rabbis will admit--as long as one rabbi is so involved, why is it necesasry for more rabbis to press the issue? Some rabbis have suggested AIDS is too controversial, and besides, it only involves them intellectually--they haven't seen any PWA's. Some rabbis simply never respond to the many letters and calls. There are too many AIDS meetings, yet there are not enough meetings for all of the problems that AIDS brings us. Sometimes those who have been through the gates and have been transformed feel lonely, angry, and resentful that they are carrying the burden of AIDS for others.

There are a lot of other issues like Israel, mixed marriage, outreach, the homeless, and Jewish education, as well as the primary context of our own congregational needs which require a rabbi's personal profession time + energy. Surely there must be other rabbis among the voices who find the time and the words to speak on so many of these other issues; yet many of my otherwise courageous colleagues and many of the

otherwise outstanding lay leaders remain ignorant and thus so very silent.

Dennis Altman, in his provocative essay, "Legitimation Through Disaster," in AIDS: Burdens in History, has noted that paradoxically the gay community has been legitimated through the epidemic of AIDS more than at any time prior in history. Thus, even though we have all tried to separate AIDS from the gay community, those of us who have done AIDS work are necessarily drawn closer and closer to the homosexual community. Will the Jewish community's leaders have any choice but to confront the valid claims of the gay and lesbian community? Are we ready to move beyond the mere rhetoric of supporting synagogues with special outreach to the gay and lesbian Jewish community? How will we respond to the needs of the gay and lesbian rabbis? What will we eventually do with the liturgies for life cycle events as they pertain to the gay and lesbian Jewish community?

We cannot stop asking these quetions merely because they aren't questions within Jewish tradition. We cannot merely say, Homosexuality is an "abomination" and therefore we cannot ask. Because of the transformative nature of AIDS, we must be able to begin to talk about these questions, recognizing that we cannot go back to living as if AIDS were not going to be our reality for the foreseeable future.

Rabbis, educators, and Jewish lay leaders are like everyone else. We weren't more ready than anyone else for AIDS, and for many, there may be an intuitive sense that AIDS,

with all of its ramifications, is bigger than some people can handle politically, morally, emotionally, and psychologically. ~~AIDS is a hole that does not seem to have a bottom~~. AIDS is the abyss at which I and others stand after going through the 50 gates, provoked by 50 different questions asked 50 times over.

We may ~~well~~ be experiencing what ~~only~~ a vanguard ~~handful~~ of people experienced in 1955, '56, and '57, before civil rights became the tidal wave that changed America socially, economically, and emotionally.

Those same kind of changes are on the horizon as the pressures of the AIDS epidemic provide the crucible within which the foundations of the twenty-first century are forged. Is it merely coincidental that neither of the presidential candidates spoke at all about AIDS? Is it coincidental that a presidential commision delivered its report, but the most significant finding of the report--anti-discrimination legislation--has not been acted upon?* Is it coincidental that we are all still dealing with a disease which is so complex that its name is acronyms--AIDS and HIV. We do not have any referential categories which explain it. We do not know how to evaluate the daily, weekly, and monthly statistics. How many are dead from AIDS does not even begin to explain how we are coping with those who are living with AIDS. ~~[illegible]~~ How will we help those who will die--die with dignity, whether they are gay, an IV drug user, a hemophiliac, a person of color, or a Jew?

* Will the war on drugs be won by conceding the war on AIDS in the Communities of Color?

Those of us who have been transformed by the work we have already done with AIDS know that we cannot go backwards through the fifty gates and deny the fifty questions. The complexities of AIDS and all of its ramifications are overwhelming to many people. In these first few years of the epidemic, the extraordinary and completely transformative nature of AIDS is still not fully accessible to a lot of people. It took more than twenty years for most of the Jewish community to accept the foundational role of the Holocaust/Shoah in Jewish identity. Learning to deal with death, survival, hatred, fear, and the ignorance of others is still a primary goal of Jewish leadership. AIDS is no less a challenge in scope and influence. We must all be more patient with one another, especially if we have walked through the gates of transformation. We must be willing to reduce our expectations of rabbinic and lay involvement. In the short term we must simply look to a smaller group that will eventually bring AIDS to a larger group.

Like Rebbe Barukh's disciple, caught in a grip of terrible fear and simultaneous hope--we who have been transformed through our work with AIDS look to others with a sense of desperate need: How do we translate our desperation, our own fears, our anger, and our sense of urgency? In time, AIDS will have an impact on more and more people, who having gone through experiences of each question, will go beyond each gate and eventually become aware that they stand at the edge of the abyss, and then--like the Hasidic tale--each

will peer beyond the 50th gate, knowing in their heart of hearts, that alongside the abyss of AIDS, which has no bottom, there is faith. Like the [redacted] people who preceded me, and knowing in my heart of hearts that there will be others who follow me, I now pass through the 50th gate, and closing my eyes and feeling the presence of God at my side, I leap.

Joseph A. Edelheit
Rabbi, Emanuel Congregation
UAHC Committee on AIDS
AIDS Pastoral Care Network Board
Co-Chair, UAHC-CARR AIDS Task Force

March 22, 1988
4 Nisan 5748

Dr. Boris L. O'Mansky
Valley Pediatric Associates, PA
9199 Reisterstown Road
Owings Mills, MD 21117

Dear Bo:

Thank you for enlightening me on the College-Institutees problem in regard to the Aids Conference. The news is not happy, but at least I don't live in blissful ignorance.

With warm regards and every good wish, Iaam

Sincerely,

Alexander M. Schindler

Rabbi Alexander M. Schindler

Mr. Albert Vorspan

March 22, 1988
4 Nisan 5748

Enclosed is a letter from Bo O'Mansky. Were you aware of this situation? What can or should be done?

VALLEY PEDIATRIC ASSOCIATES, P.A.

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March 13, 1988

Rabbi Alexander M. Schindler
Union of American Hebrew Congregations
838 FifthAvenue
New York, NY 10021

Dear Rabbi Schindler,

I have just received a copy of your letter to Chuck Rothschild concerning the HUC-JIR program on AIDS. Unfortunately, I cannot report that this is a harmonious joint program.

Last summer Rabbi Kerry Olitzky contacted Dick Sternberger and asked if we would meet with him concerning having the UAHC Committee on AIDS develop an all day program on AIDS for the New York Campus of HUC-JIR. He asked that we bring a suggested program. I offered to stay in New York when I was there for a meeting in the Fall, and Dick and I met with Rabbi Olitzky and his assistant, and presented the program we had prepared. Rabbi Olitzky was quite pleased, so we selected a date, and Dick and I left the meeting with the understanding that we should flush out the language of the program and send it to them, and then recruit the speakers. We had been asked if we could help fund the program, and explained this was not possiblewith our budget, but that we would try to recruit speakers from our committee who would donate their time.

We submitted the final program and hearing nothing, I began lining up speakers. Dick then received a call from Rabbi Olitzky to check on our progress and expressed some dissatisfaction with our speakers. Dick suggested he call me, but Rabbi Olitzky stated that lay people didn't have to be involved, and that the professionals could handle it. Dick called me and I tried to reach Rabbi Olitzky and finally spoke with his assistant. She told me there should be no problem with our speakers, but I continued trying to reack Rabbi Olitzky andfinally was successful. He then rejected all of our speakers for various reasons. He asked if I would help him find other speakers, and I explained I had nocontacts in New York beyond ourcommittee. Hethen asked if our committee would continue to co-sponsor the program and I said we would. When he asked me to agree to help cover any overages in expenses, I once more explained we had no funds for this. He then withdrew the invitation to co-sponsor.

It is of interest that the HUC-JIR has decided to use our program, as the first half of the program is exactly as we presented it, word for word. We proposed three workshops, and they combined these into two. They even kept our logo in the title, "Confronting the AIDS Crisis".

We thought we were originally approached because of the expertise of our committee. In the two years of our existence, whenever we have been asked to develop a program, we have assumed full responsibility for program and speakers. We were never led to believe that Rabbi Olitzky wanted the right to veto everything.

We have gone through a most distasteful experience with Rabbi Olitzky. We wonder if the primary reason we were asked to be involved was so that we would help pay for the program. In conversations with several members of the UAHC staff, they expressed no surprise that we had problems with Rabbi Olitzky.

I'm sorry I couldn't give a positive response to your inquiry. In summary, the HUC-JIR is using our program, but providing their own speakers. If you have further questions, I'll be happy to answer them.

Sincerely,

Bo

Bo O'Mansky

cc: Mr. Charles J. Rothschild, Jr.