MS-630: Rabbi Alexander M. Schindler Digital Collection, 1961-1996.
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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.

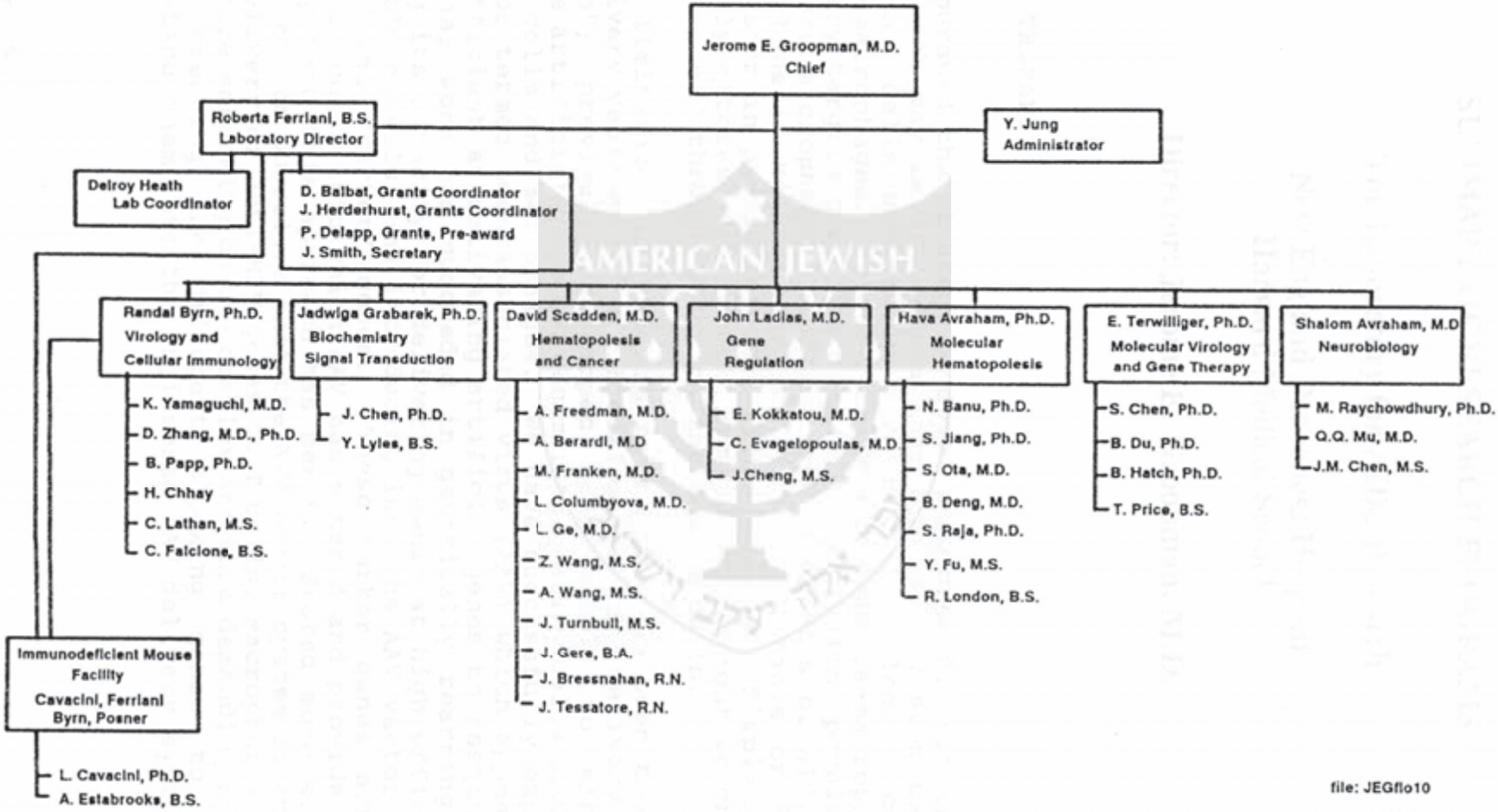
Dr. Groopman's team has helped develop a number of different (protease "scissor") blockers, which are a promising new family of potent and effective anti-HIV drugs. Trials on human AIDS patients of the first generation of protease inhibitors have begun at Deaconess Hospital this month. It is hoped that 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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NEW YORK, NY 10017-3204
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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

MEMORANDUM

cc: [illegible] memo (no attachments) to: AG 1/23 [illegible]

From Rabbi Janet R. Marder

Date January 7, 1991

To Rabbi Alexander M. Schindler

Copies

Subject

(5) [illegible]

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 ליהדות 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

Rac

[illegible] ter traces from this town, [illegible]rby Ocosingo and most of [illegible]lets and roadblocks they [illegible]ny of them vowed that [illegible]turn to fight another day.

[illegible]t forces moved aggres- [illegible] control of the area. But

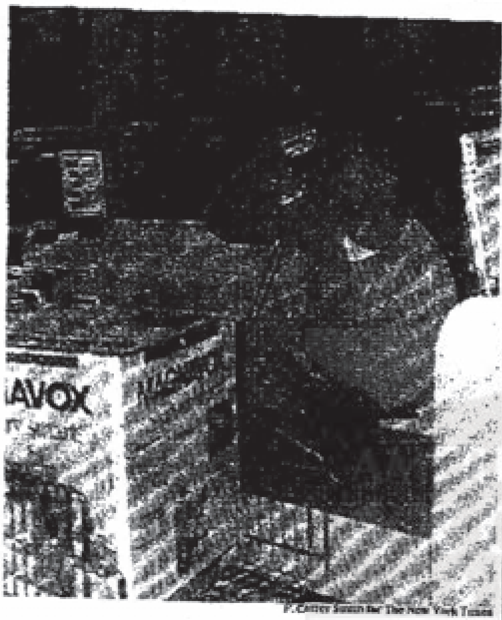
[illegible] on Page A7, Column 1

[illegible]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

[H]ouston, 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

[...]PY BIRTHDAY!: AK, BD, CH, [...]K, LS, MK, MM, NW, RT, TS.

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

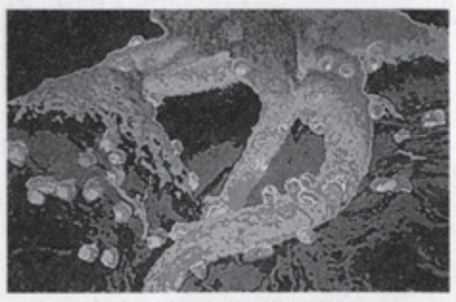
Intentional tourist
An interesting trip around the world with the essays of Pico Iyer. Page 53.

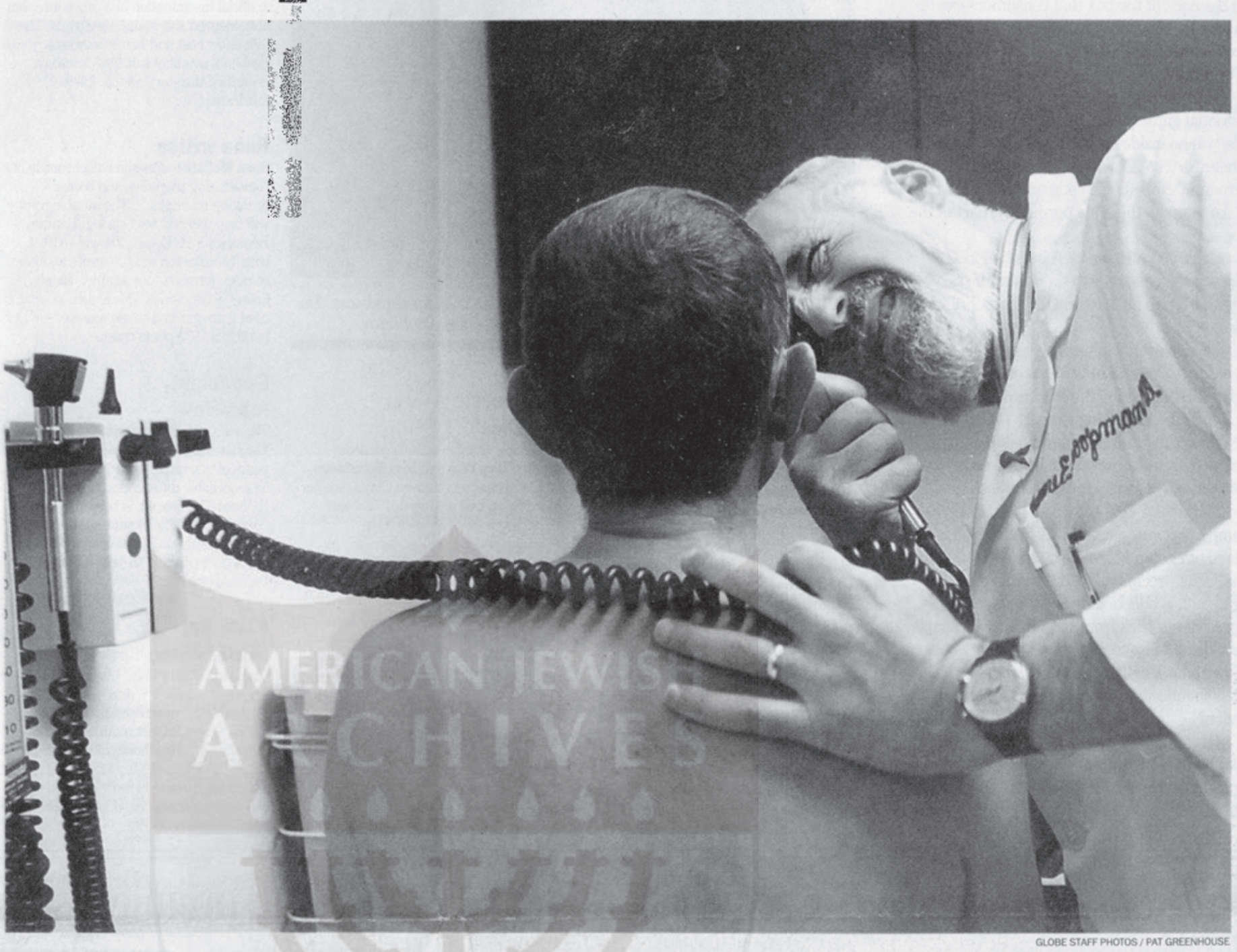
Living|Arts

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 marage 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.

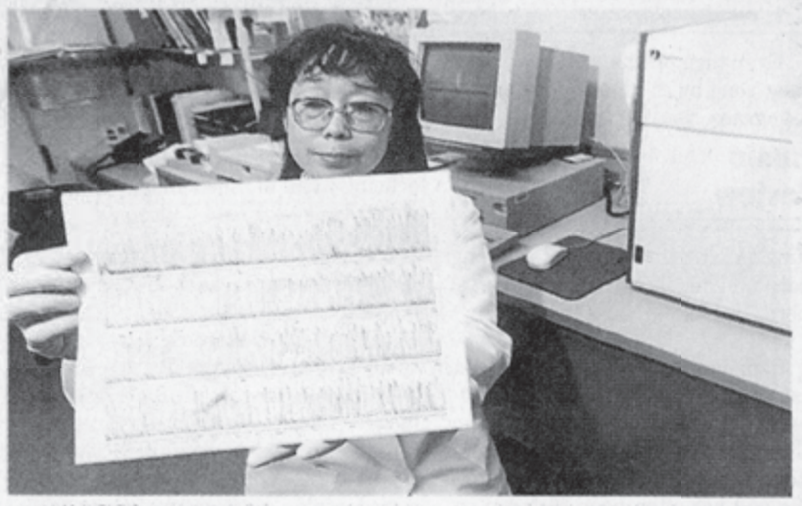
He knows the deepest crevices of the body, where it hides, silently, in the dark, often for years . . . waiting . . . waiting. He understands that it hunts like a smart bomb, wired with 9,213 bits of genetic information, programmed to destroy.

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).

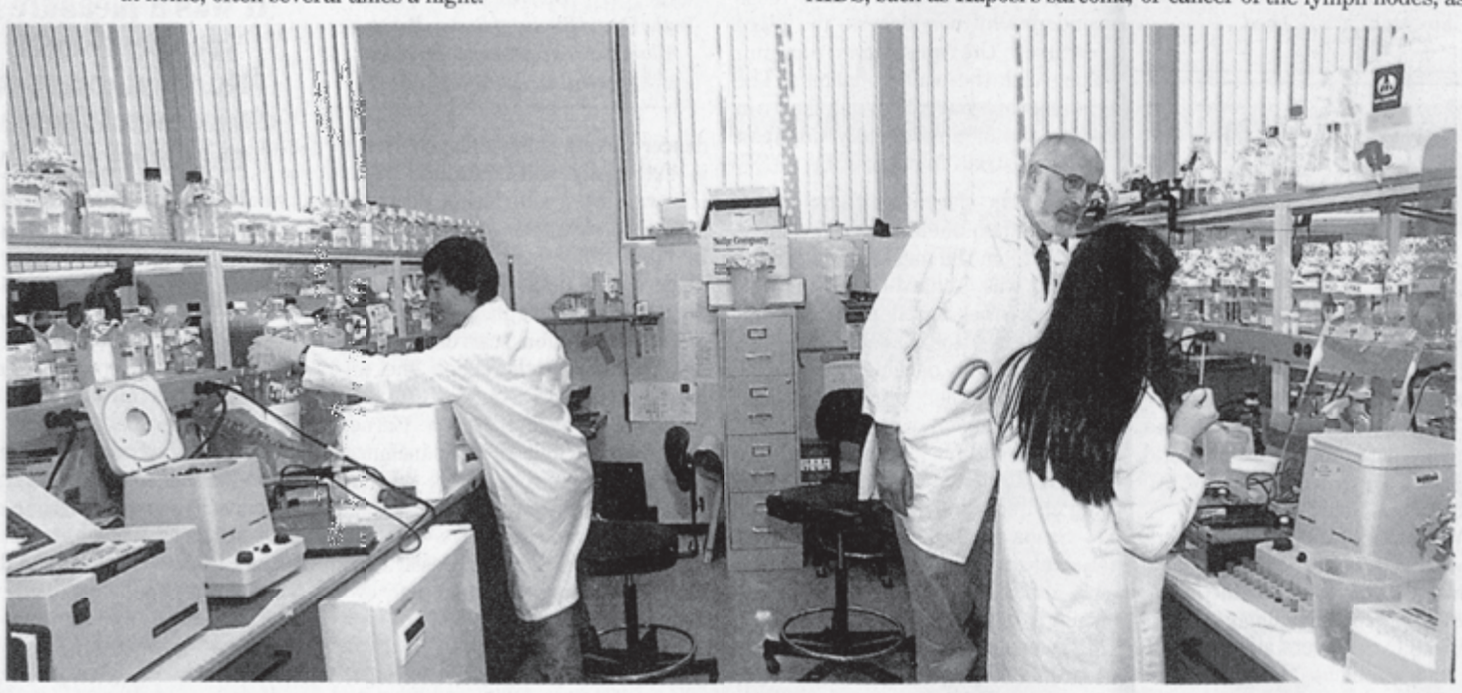
He also knows the epidemic continues to gallop along.

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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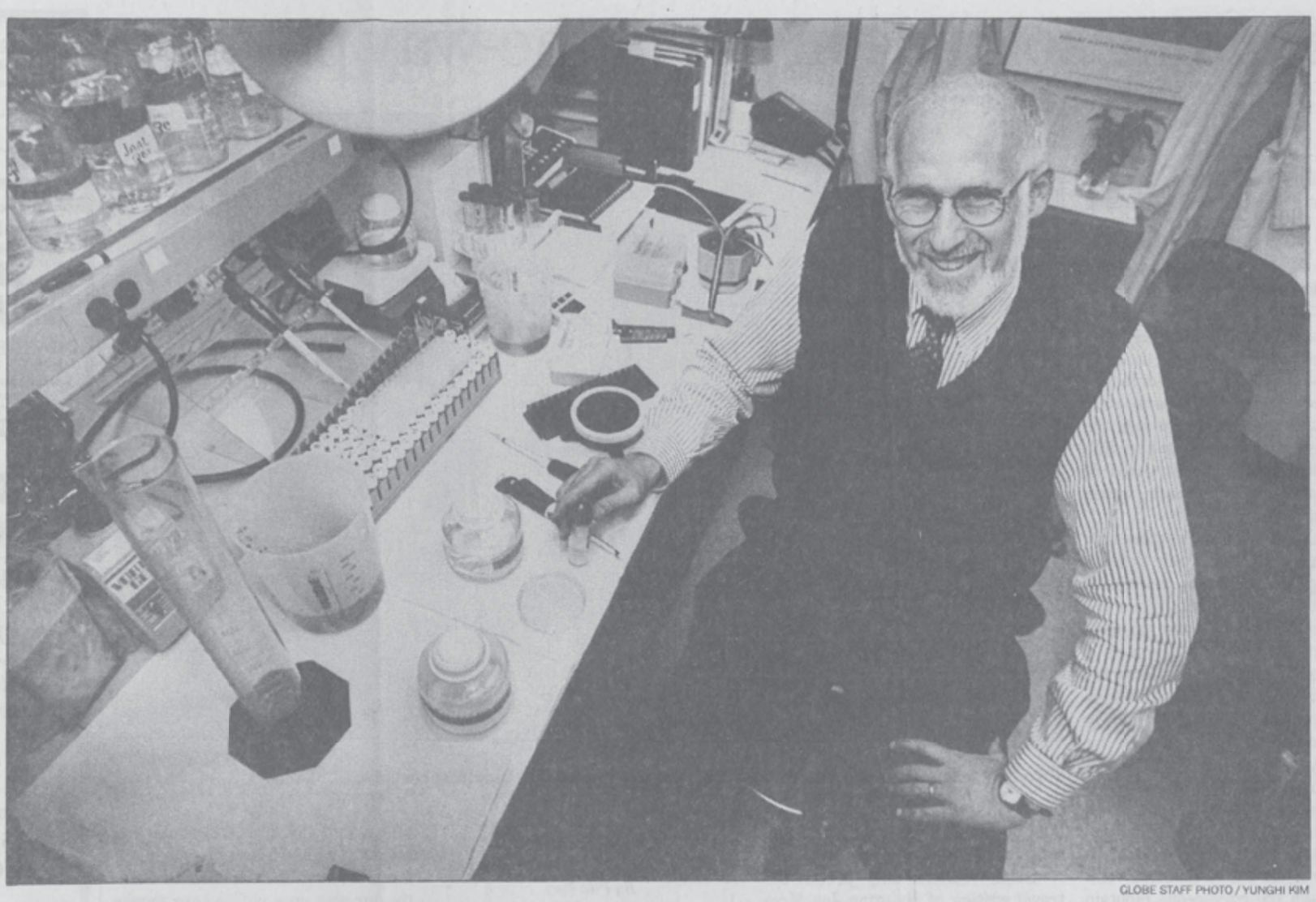
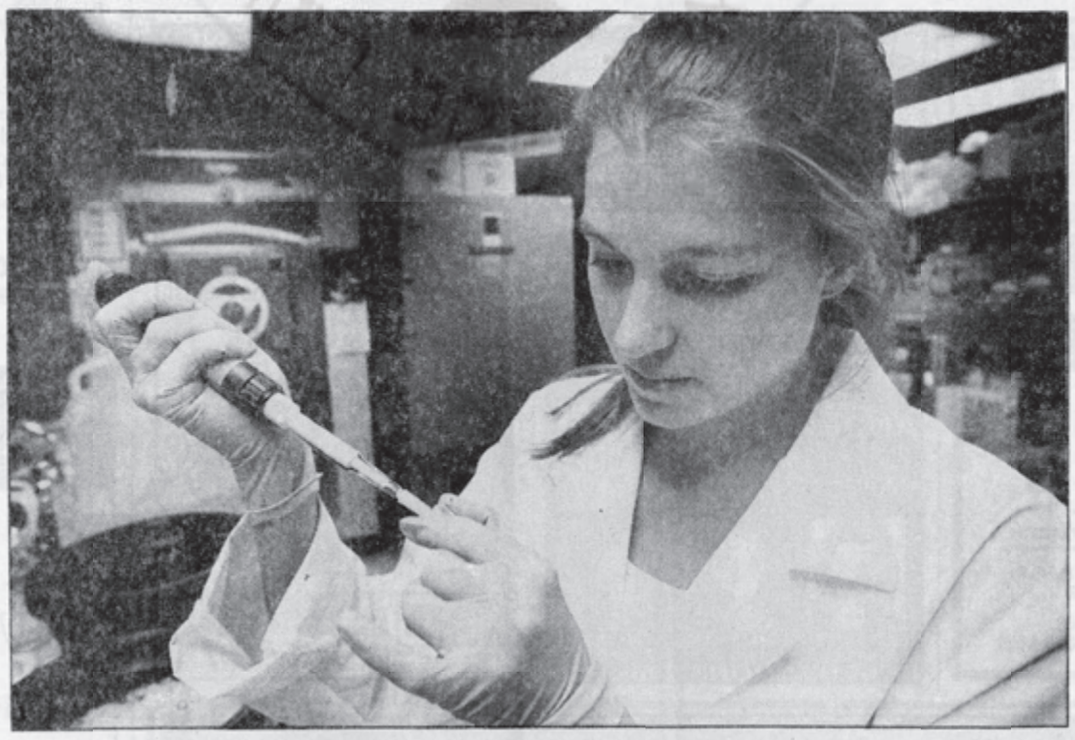


GLOBE STAFF PHOTO / YUNGHI KIM

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.

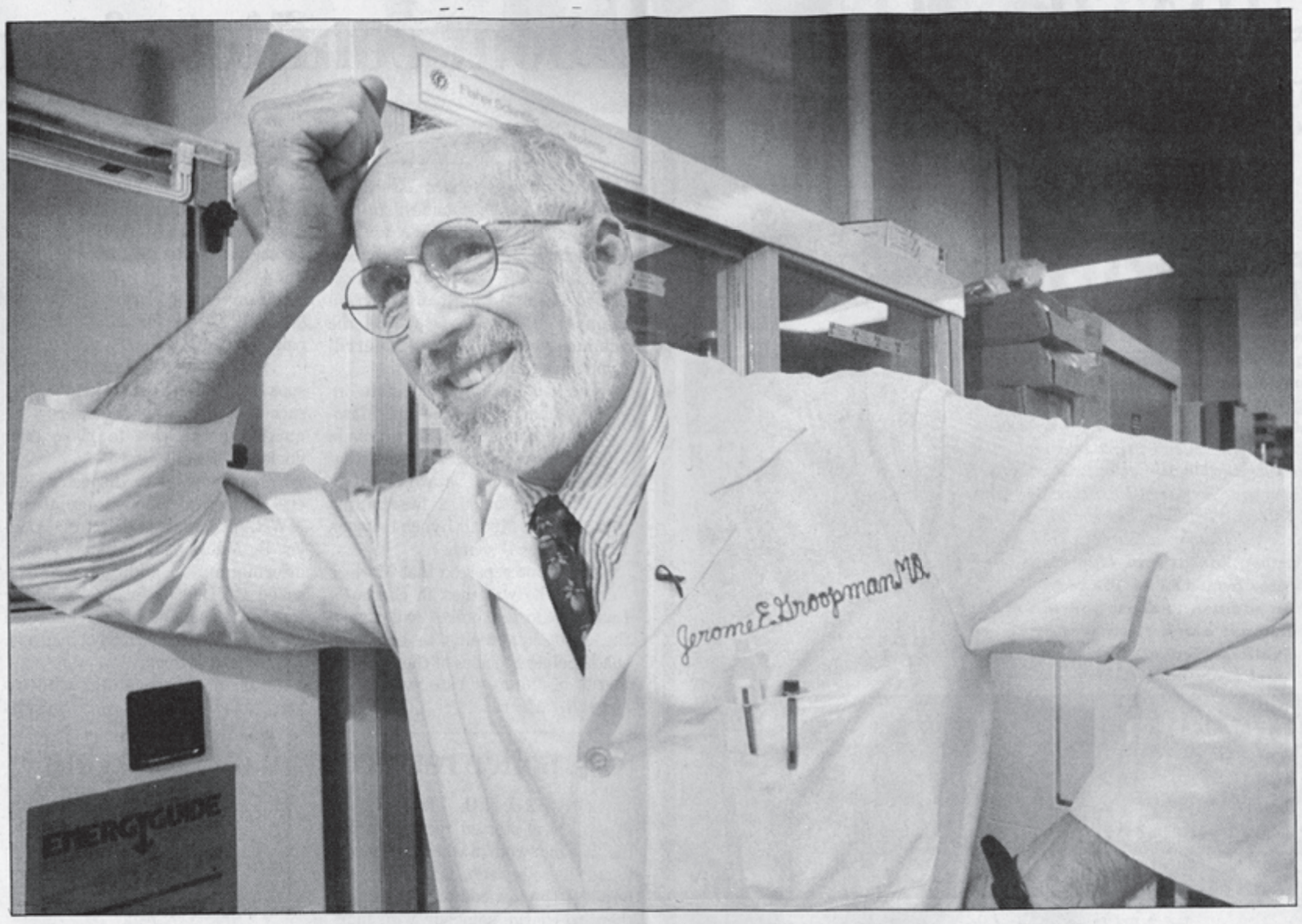
In the United States alone, there are probably 100 cities where competitive AIDS research is being done, including San Francisco; Bethesda, Md.; Baltimore; Boston, and Durham, N.C. And there are legions of researchers, virologists, epidemiologists, pharmacologists, molecular biologists and oncologists – 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

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Am Far

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: Rabbi 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 10017-3204
TEL (212) 682-7440
FAX (212) 682-9812

October 11, 1993

Rabbi Alexander M. Schindler
President,
UNION OF AMERICAN HEBREW CONGREGATIONS
638 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 light. 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 kidduah; 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 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

1185 SHERIDAN ROAD, GLENCOE, ILLINOIS 60022, 708/835-0724, FAX 708/835-5613

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 prctected 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.

Ads

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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

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 from Rabbi Kelly providing I 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.

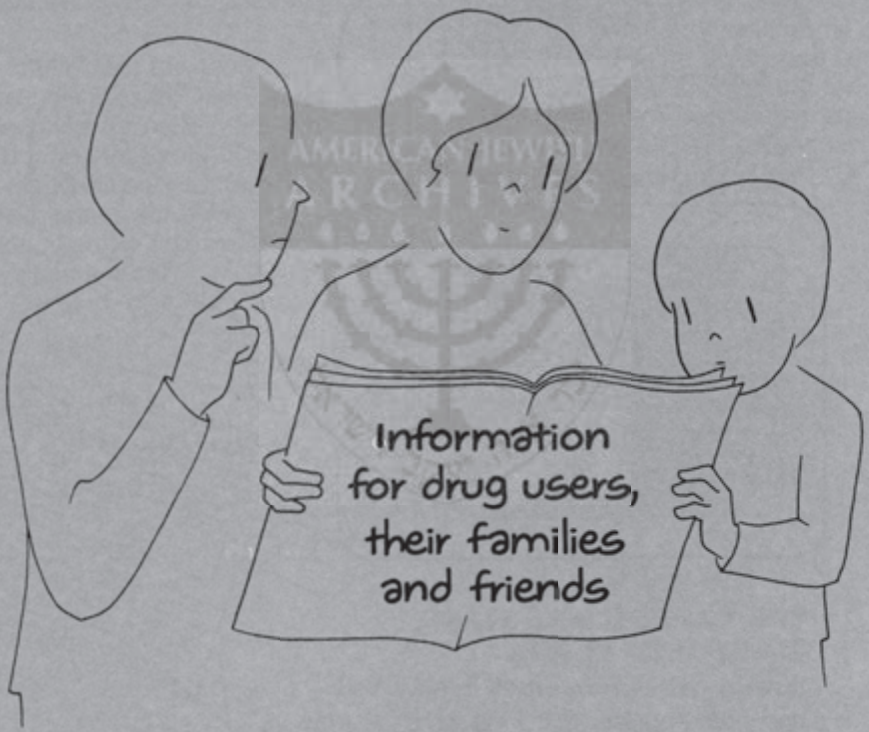
We are members of different faiths. Our traditions teach us different ways to embrace God. We represent humanity's wide range of ways to be human. Across our diversity, AIDS magnifies the fact that we are also one, bound together in relatedness. Great care must be taken to hear each other, so different 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

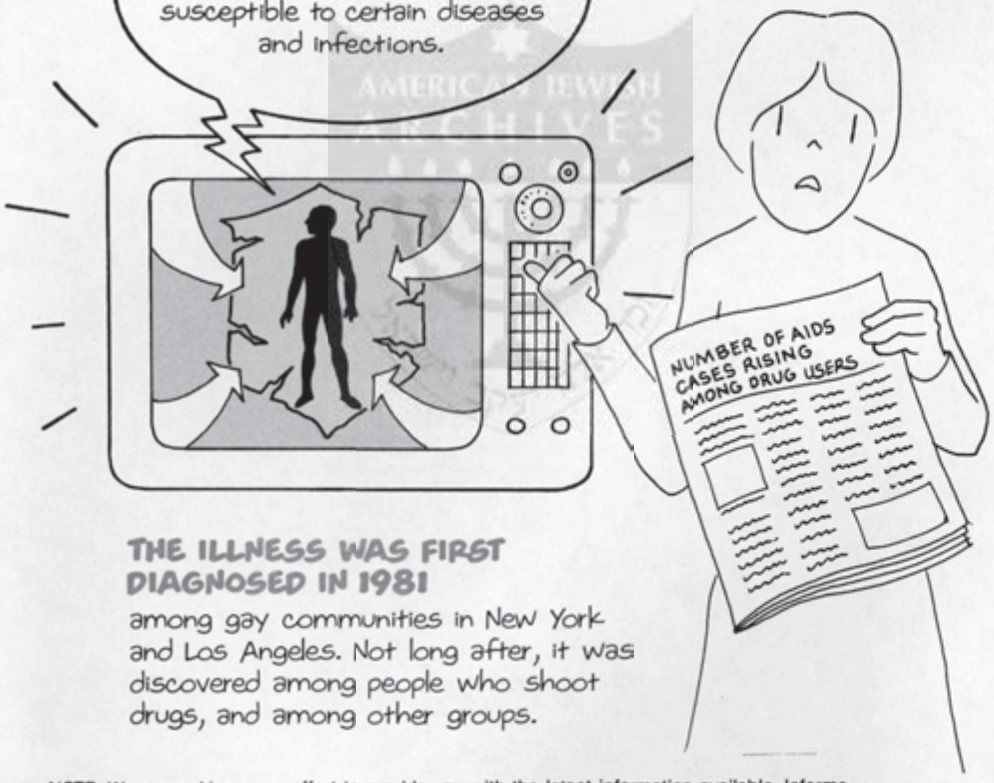


CHICAGO DEPARTMENT OF HEALTH

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

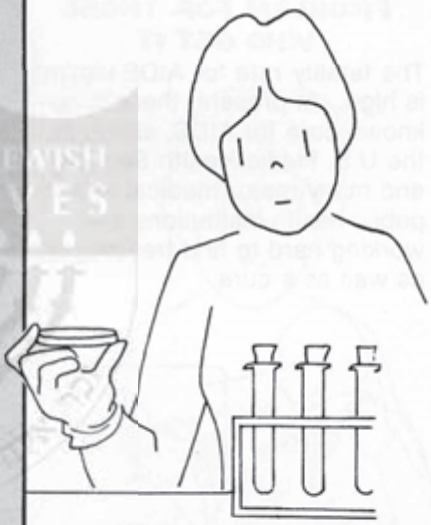
Perhaps no other illness of our time has been so dominated by both ignorance and misinformation. For many people, the fear surrounding AIDS has been far more threatening than the illness itself.

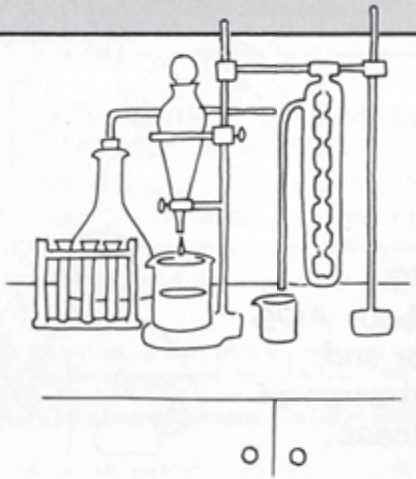
KNOWING THE FACTS

-- <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.

HOW is the virus that causes AIDS **PASSED** from one person to another ?

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!

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:

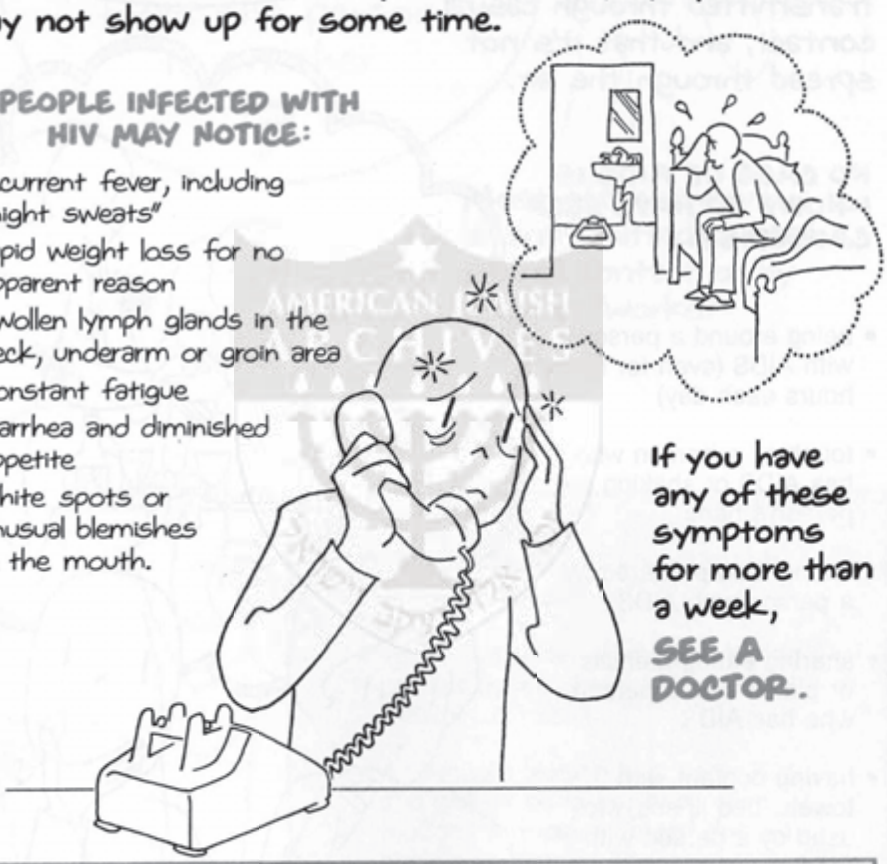
- being around a person with AIDS (even for many hours each day)
- touching a person who has AIDS or shaking the person's hand
- eating food prepared by a person with AIDS
- sharing eating utensils or plates with a person who has AIDS
- having contact with towels, bed linens, etc., used by a person with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

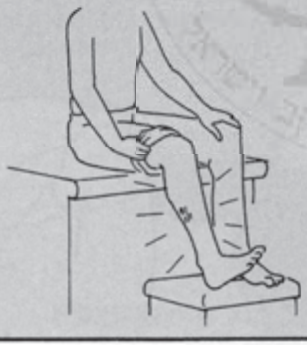
- get regular checkups for their babies
- tell their doctor why they're concerned about AIDS.

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.

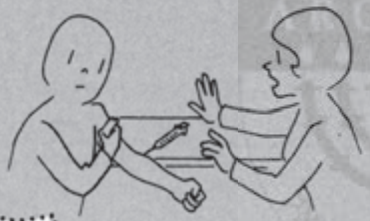
Scientific research shows that HIV may also attack the nervous system, causing damage to the brain and spinal cord. Signs of damage may include memory loss, indifference, inability to make decisions, partial paralysis, loss of coordination, and other problems in controlling the body.

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,

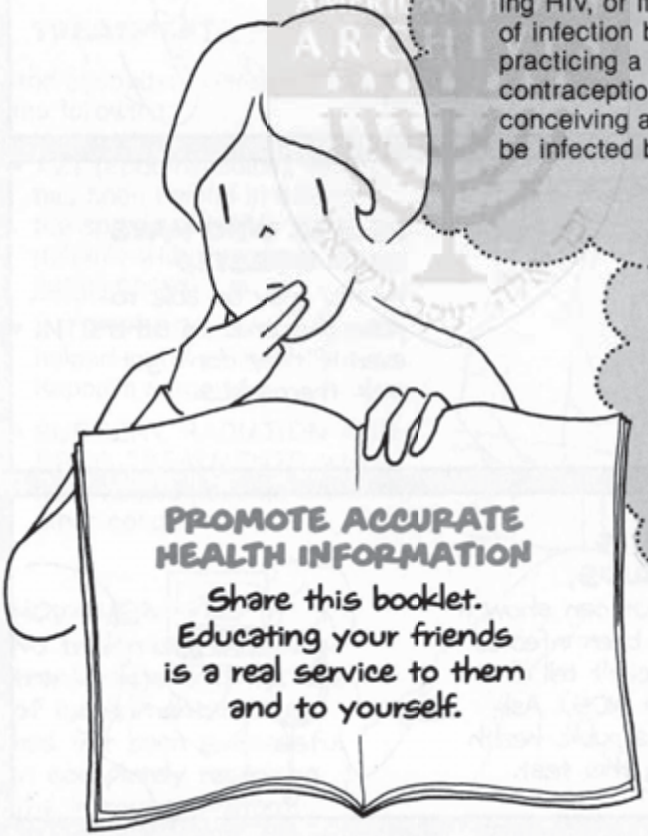
and avoid having sex or exchanging body fluids with any partner who might be infected. Use of a rubber with a spermicide* may help reduce your risk of getting or giving AIDS.

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.

THE PUBLIC HEALTH SERVICE (PHS)

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

THE NATIONAL INSTITUTES OF HEALTH (NIH)

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

THE CENTERS FOR DISEASE CONTROL (CDC)

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.

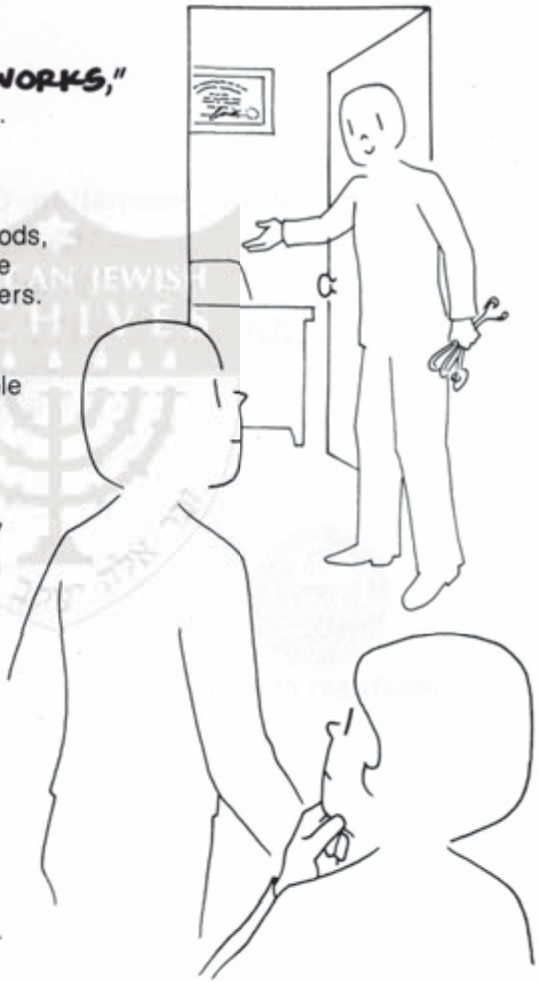
THE FOOD AND DRUG ADMINISTRATION (FDA)

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.