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

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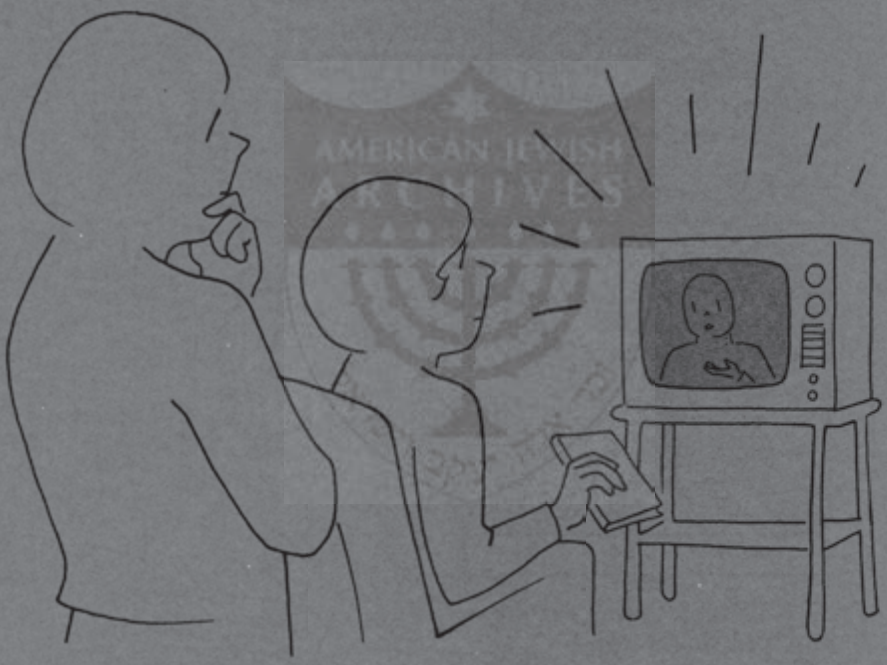
What **EVERYONE** should know

ABOUT AIDS

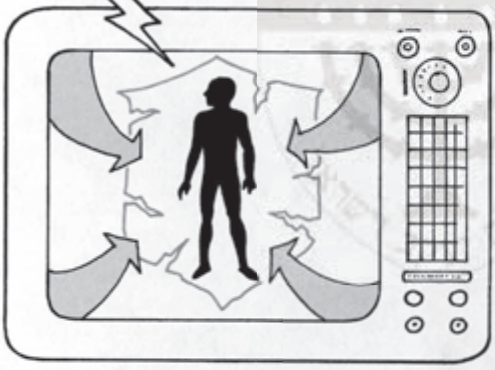


CHICAGO DEPARTMENT OF HEALTH

What is AIDS ?

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

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



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

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

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

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WHY should I KNOW ABOUT AIDS ?

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

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

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

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

What CAUSES AIDS?

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

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

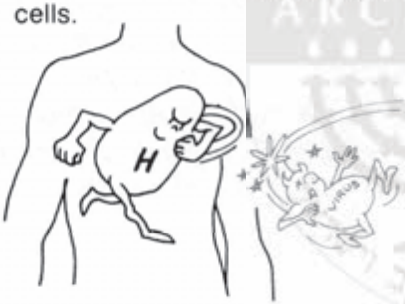
* *People who suspect they've been exposed to HIV should consult a physician -- rather than donate blood in order to be tested.*

HOW A HEALTHY IMMUNE SYSTEM WORKS

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

"HELPER" CELLS

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



"SUPPRESSOR" CELLS

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

IN A HEALTHY PERSON,

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

IN A PERSON WITH AIDS,

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

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

IS AIDS HIGHLY CONTAGIOUS?

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

WHO GETS AIDS?

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

HOMOSEXUAL AND BISEXUAL MEN

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

HETEROSEXUAL INTRAVENOUS DRUG ABUSERS

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

HOMOSEXUAL AND BISEXUAL MEN WHO ABUSE INTRAVENOUS DRUGS

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

HEMOPHILIACS AND PEOPLE WHO HAVE HAD BLOOD TRANSFUSIONS

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

HETEROSEXUALS

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

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

EFFECTS ON THE BODY

DURING THE INCUBATION PERIOD,

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

AS THE INFECTION PROGRESSES,

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

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

SOME PEOPLE INFECTED WITH HIV

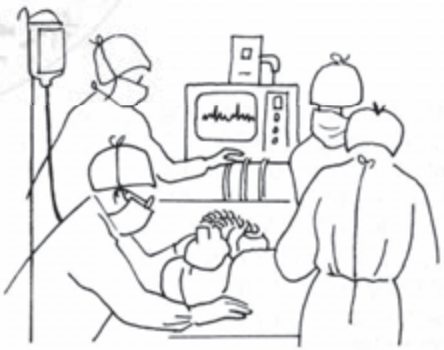
go on to develop AIDS. Their immune system becomes severely weakened, turning normally mild, harmless, and rare diseases into potentially fatal conditions. The two most common illnesses of this type are:

KAPOSI'S SARCOMA

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

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.



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

Some steps being taken to

PREVENT THE SPREAD OF HIV AND AIDS

HOSPITALS

are taking precautions to protect patients as well as employees.

SPECIAL HANDLING, LABELING AND ISOLATION PROCEDURES

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

TRANSFUSIONS

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

BLOOD BANKS

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

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

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

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

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

it is recommended that you avoid having sex with:

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

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

Is there a **CURE FOR AIDS ?**

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

TREATMENTS FOR AIDS

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 being headed by the federal government will make it possible to develop 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 on 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 FOOD AND DRUG ADMINISTRATION (FDA)

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

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

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

Some QUESTIONS and ANSWERS

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

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

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

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

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

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

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


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

For More Information, Call Toll Free:

1-800-AID-AIDS

or Write:

AIDS ACTIVITY OFFICE

50 W. Washington
Chicago, IL 60602

DEPARTMENT OF HEALTH

CENTRAL INFORMATION NUMBER:
744-8500

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Director

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

PACKET INFORMATION

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

The HIGH ROAD

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

Article by David L. Kirp
Photos by Val Mazzenga

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

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

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

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

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

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

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

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

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

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David L. Kirp is a professor of Public Policy and lecturer in law at the University of California at Berkeley. He has spent the last 18 months researching "Suffer the Children," a book on AIDS in U.S. schools, for fall, 1988, publication from which this article is excerpted. Val Mazzenga is a Tribune photographer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

continued on page 16

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AIDS

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

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

Wilmette was not yet home free, though. At the third forum, held on Monday, Jan. 26, three visibly anguished women made their way to the front of the auditorium. They turned toward the waiting cameras as they entered the assembly hall. Throughout the meeting, the women seethed. "That's not so," they muttered while Phair and Gussner were answering questions from the audience. "Tell the truth."

A card turned in to Stephan, who was chairing the meeting, greatly worried the school board president. "The AIDS patient is in my son's special-education class," the card read. "Not only will the school district not remove the student from the class, they will not allow us to remove our children to save them. The AIDS patient constantly puts toys and pencils in his mouth." Stephan ignored the raised hands of the women until the end of the meeting, when the TV crews had left to file their stories. Then the mother who had written down her accusation turned to the assembled parents and said her piece. "At that moment," Stephan recalls, "I thought it had come undone."

Yet what the audience apparently heard in the voice of this mother was the unraveling edge of hysteria, not a factually rooted claim of danger. By now, over the course of three meetings, seemingly all of the parents' hardest questions had been answered, all the contingencies explored. It was time, almost, for business as usual. Still it was clear that some of the parents whose children were in Jamie's class had unanswered questions. Jamie had been sensitive to all the talk about AIDS, and the boy innocently told one of his classmates that he was the child in question. That boy's mother turned out to be the woman who had submitted the 3-by-5 card. That night she and her son telephoned everyone else in the class with the news. That alarmed both the youngsters and their parents.

Among all the parents these were the ones most likely to be alarmed. They were also the fathers and mothers whose understanding and support mattered most if Jamie was to continue leading a normal school life. At this point the McCardles took a brave step. They decided to host a meeting for all these parents at their house. Ellen Chadwick, Jamie's doctor, would be there, as would teacher Gold and principal Nilsen. And everything, including the story of how Jamie had contracted AIDS, would be told.

It was a tense group that gathered up all the seats in the house, the big rocker and the plaid couch and the oak dining chairs, to listen to the McCardles tell how Jamie came into their lives. Shortly after Jamie had been diagnosed, both of the parents had been tested for AIDS, as had two of the children who wanted the reassurance that they were not infected and wanted it badly enough to brave the taking of blood. At the meeting the McCardles could tell the parents of Jamie's classmates that "for years, we didn't know that he had AIDS, and we took no precautions. None of us has AIDS."

All the parents in that living room talked about how sorry they were for what the McCardles were going through and praised their bravery in coming forward. We feel good that you told us, they said. One couple, both doctors, who described themselves as hypochondriacs about their own child's health, added reassuring words. "If we thought that there was one chance in a million that our child could catch this virus, we wouldn't be here tonight."

The mother who had worried so about Jamie's biting on pencils and toys was too overwrought to hear what was being said; she even insisted, against all the evidence, that she knew of someone who had contracted the disease in 1971. But it was Chadwick who made the biggest impression on the parents. It wasn't just that she had the facts to back up her reassurances. She was very visibly pregnant. "Do you think that I would be caring for children with AIDS if I believed that I was endangering my child?" she asked.

By then the controversy really was over—at least the public part. A bomb scare a few days later was treated matter-of-factly. And when the Wilmette News-Voice, a local shopper, tried to make an issue out of that famous 3-by-5 card, townspeople lit into the paper for being irresponsible. Support for the family came from all sides. The Central School PTA's executive board passed a resolution offering whatever help might be needed to a family whose identity they still did not know; and in the spring the Junior League asked Paul Nilsen to find out if the family had a favorite charity to which they could contribute. The answer came back: Please make your donation to the Howard Brown Memorial Clinic, which had seen the McCardles through the roughest times.

It fell to Jamie's teacher to talk with his classmates about AIDS, explaining in simple terms how the disease spread and about Jamie's condition. "What you have heard is true," Gold said. "Jamie has AIDS. Eventually he is going to die."

Some children needed reassurance that they would not catch AIDS; others were simply caught up in their own grief. "He's my friend, I don't want him to die!" one boy in the class said, while another asked whether "AIDS is going to hurt Jamie."

It was fine to talk about Jamie and AIDS in class, teacher Gold said, but "this is a family matter, we're not going to talk about it in gym or music or art," and the class kept the confidence. They talked about how to keep his identity secret from the reporters who, it was feared, would snoop around. "If a reporter asks, we can all say we're the kid who has it," one child said, a sentiment that recalls the historic moment when when Adolf Hitler demanded that the Jews in Denmark wear yellow arm bands, and everyone in Denmark wore them.

There were changes in the class routine. Jamie's behavior was unobtrusively monitored—to make sure, for instance, that he wasn't sharing his food. Hugging time, which had been a daily ritual, was abandoned because it made Gold uncomfortable. But the children continued to hug one another, and they went out of their way to hug Jamie. For several weeks Gold scrubbed Jamie's desk with bleach water every time he sneezed. Eventually she decided that she was being hypercautious.

"We suffered together, but we all learned to be kind and to love one another," says Gold, who recalls those days when she was almost too sad to teach, when only her sense of obligation to the children kept her going. The lesson of caring was heard. A parent of one of Jamie's classmates told Gold that her son had been walking around the house dressed up in a doctor's costume. "I'm going to find a cure for AIDS," he told his mother, "Jamie isn't going to die."

As the teachers at Central listened to the children ask why one among them had to die of this bad disease, they realized that Wilmette needed instructional materials not only about AIDS but also about death, pitched at a level that young children could understand.

The school district responded with customary efficiency, hiring a specialist to produce the needed curriculum. The McCardles, meanwhile, tried to absorb the implications of what was happening. Their son had been welcomed into the Wilmette schools. Their neighbors had rallied around them. And, within a few years, their son was going to die.

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Paul Nilsen drove to Chicago's Pilsen Community Academy, 15 miles from Wilmette, the morning of Feb. 27. Three days earlier, William H. Levin, Pilsen's principal, had been summoned to the office of Deputy Supt. of Schools Joseph Lee and told that a child who had been exposed to the AIDS virus would soon be enrolling in his school. Levin had called the principal at Central Elementary School looking for help, and Nilsen had offered to spell out Wilmette's strategy at a meeting of community leaders.

This was not like dealing with the Wilmette village manager or the principal at St. Francis Xavier; that much Nilsen quickly figured out. All the other school principals in Pilsen Academy's district (one of 20 elementary school districts in the city) were in attendance that morning, as well as officials from the city's Health Department and the Board of Education, and priests from the six Catholic churches in Pilsen.

The community organizers were there, too. They ran the neighborhood action programs that handled job training and day care, renovated rundown homes and mediated among rival gangs – programs that made Pilsen a real community.

Chicago would be holding mayoral and aldermanic elections in just six weeks, and both candidates for 25th Ward alderman were also present. A Democratic mayoral candidate, Thomas Hynes, had asked if he could attend, but Levin diplomatically demurred. To invite Hynes meant inviting Harold Washington, and if Washington and Hynes showed up, Pilsen's AIDS problem might become a citywide political issue.

Levin knew that there was no way to keep the Pilsen Academy situation wholly out of politics in a city where even the most trivial event of daily life can become a matter of clout. The principal's hope was to make sure that the politics stayed localized, and that meant persuading all the constituencies in the neighborhood, the parents and politicians and priests, that they could live with the decision. Levin knew that if he failed, if the community wound up being split over AIDS, there would be serious trouble.

The meeting came off without a serious hitch, as did Bill Levin's other attempts that week to touch base with everyone who had a stake in the AIDS issue. It was only some days later, when Lyndon LaRouche's followers made a determined effort to broaden the issue by evoking a panic that knew no geography, that the effort to emulate Wilmette began to unravel.

Under Mayor Richard Daley, if you wanted a favor—a job, a zoning variance, a sewer connection—you went to the ward committeeman or alderman where you lived and paid back the favor come election time.

But another and very different kind of politics had grown up in Chicago in the Daley years—the politics of community organizing. Few Chicago neighborhoods have generated more forceful leaders than Pilsen, home to approximately 30 percent of the Mexican populace in Chicago. Though Pilsen is just a mile southwest of the Loop, the two places literally do not speak the same language.

Since Mexicans first began settling in Pilsen in 1917 in the aftermath of the revolution, the neighborhood has been cohesive, with its own traditions and its own organizations. It is not Mexico in Yanqui-land, though, for the Anglo culture inevitably intrudes. Stores in Pilsen have names like "Descuento Center," and children speak their own made-up language of Spanish and English.

Nearly four families in ten continue to live in overcrowded housing, according to a University of Chicago study, more than double the city-wide average, and one resident in four lives in poverty. Many Mexicans emigrating to Chicago still come first to Pilsen, while second- and third-generation Mexican-Americans move away if they can.

The six Catholic churches that line West 18th, the neighborhood's main street, are the backbone of the community; they all draw huge crowds for Sunday mass. The priests, a number of them Hispanic, see their mission in social terms, taking up such issues as immigration as their cause, finding common ground with a host of community groups.

In Pilsen, as in other black and Latino neighborhoods, a new generation of leaders emerged from the events of the 1960s. These were the people who fought for their own neighborhood high school and bilingual education, for decent jobs and health care, people who were not afraid to conduct a sit-in at City Hall or stage a walkout at the local school. Under Harold Washington, some of these leaders have moved on to citywide jobs. With federal dollars scarce, the local organizations—Casa Aztlán, the Latino American Association, the Pilsen Youth Organization—are no longer as strong as they had been a decade earlier, and they are given to bickering with each other. There are those who complain that Pilsen Neighbors, which over the years became the most powerful of these groups, has lost its commitment to local concerns. Nonetheless, it was to the local leaders that Pilsen Academy principal Bill Levin turned, out of instinct and necessity, when the AIDS issue arose.

"One night, a few weeks before I got the call from the central office," Levin remembers, "I had a nightmare that a child with AIDS was being sent to Pilsen. I couldn't go back to sleep, couldn't stop worrying." Worrying is habitual with Levin, a Chicago native who pushes himself 10 and 12 hours a day, 6½ days a week, teaching drivers' ed and adult courses, running three miles and doing 50 pushups daily as well as running Pilsen Academy. He is a perfectionist by nature, constantly wondering whether he could be doing a better job. "My family," he says, "calls me Calamity Jane."

Levin has been principal of Pilsen Academy since 1973. The school, almost entirely Hispanic, enrolls 1,000 students, and from the outset Levin was the foreigner, the Jewish Anglo who speaks no Spanish but who had been assigned by the downtown bureaucrats to a Latino world. A boycott organized by neighborhood groups had forced out his predecessor, a woman with a reputation as a disciplinarian who displayed too little love for her charges and who, it was said, looked down on the Pilsen community. Some years later, those neighborhood organizations reportedly arranged with the Board of Education to secure a Hispanic superintendent for the district. That history has led Levin to cultivate the leaders of the neighborhood groups as if they were hothouse orchids.

Over the years Levin has remade his school. He has been able to do what any successful principal must do in the city of clout, use his contacts in the bureaucracy to wheedle extra books and state-of-the-art computers out of a central office that chronically pleads poverty. When Pilsen became a magnet school in 1982, able to offer special programs and to attract students from a wider geographical area, Levin secured not only additional teachers but, equally important, the authority to choose his staff. "What matters most is the quality of the teachers in the classroom," he says. "If you don't have good teachers, you don't have anything." Perhaps the best testimony to Levin's perfectionism is his file of 50 staff members he has eased or pushed out over the years, a startlingly high number in a strongly unionized school system.

Although Levin is not without ambition—he imagines himself a high-school principal or a superintendent in a suburban town—it is not personal power but institutional performance that drives him. In several grade levels, his new teachers have brought the reading and mathematics scores of Pilsen Academy students up to nationwide averages. School attendance figures are among the highest in Chicago, partly because Levin cares so much about students' coming to class that he hands out awards for good attendance. A sophisticated testing program that identifies the learning problems of kindergartners, developed at the school, has won national attention. All this has earned Levin the Citizens School Committee award as Chicago's outstanding principal.

Though Levin has sometimes found himself in hot water with the union for his handling of teachers, the parents have rallied to his defense. So has Pilsen Neighbors, a community group that has received help from the principal in raising money. The principal knows that he can never become district superintendent in this part of the city. "We need one of our own," he was told by one of his closest allies in the community. But Levin figures he is solid with the parents and the teachers. "I get maybe 60 Christmas presents a year from the teachers and 'superior' evaluations from almost all of them.... Right after the AIDS thing settled down they chipped in $400 for an escape weekend."

The principal wasn't the picture of confidence, though, as he headed to Deputy Supt. Joseph Lee's office on Feb. 24 in response to a cryptic summons. "What have I done wrong?" he was asking himself. Lee had been Levin's district superintendent before moving up to the No. 2 job, the man who ran day-to-day operations for the system, and he was Levin's godfather in the bureaucracy. But in the web of fragile alliances that forms the 430,000-student Chicago school system, things could fall apart at any time.

Lee, Levin recalls, explained the reason for all the secrecy: A child who had been exposed to AIDS had been reviewed by the systemwide medical screening panel and was being assigned to Pilsen. Levin wanted to know if the youngster lived in the neighborhood, thinking the answer would affect how the parents in Pilsen reacted. But Lee said no, but that the child—who is Mexican—belongs in Pilsen Academy because the school was "the appropriate educational placement."

"Like a good second lieutenant," says Levin, "I took my marching orders." There would be a teachers' meeting the next day, Feb. 25, with school officials and a nurse—but no doctor—present to answer questions; a few days later, there would be a meeting of community representatives, and an explanatory letter would be sent out over Lee's signature to all the parents. It was "chancy" to inform so many people, Lee acknowledged, for information invites problems. But not telling the community could create far greater problems if the news ever leaked out. Bob Saigh, director of pubic information for the Chicago schools, volunteered to assist Levin; otherwise, the principal was on his own.

The procedure that the deputy superintendent followed for Pilsen had been generally set down in the AIDS policy that Chicago's Board of Education had hammered out the previous year, a policy that itself had been the center of controversy. For months on end there was talk about AIDS among the 11-member Board of Education, a racial and ethnic microcosm of the Chicago schools picked by the mayor for five-year terms. The school administrators were anxious to adopt guidelines that followed the recommendation of the Centers for Disease Control—keep children with AIDS in school unless there is some special reason to fear contagion—but some board members disagreed. Draft after draft was sent up for review, first to the board's management committee and then to the full board.

The dissenters got their ammunition from Dr. Robert Mendelsohn, a local pediatrician whose [illegible]

as a consultant. Early in the history of the AIDS epidemic, Mendelsohn had urged that those with the disease be quarantined and that researchers announce their sexual orientation, apparently as a way of signaling their biases. In his testimony before the board, Mendelsohn dismissed the "so-called prestigious experts" from whom the board had heard, attacked the studies showing that AIDS had not been spread in the households of AIDS patients and derided the Centers for Disease Control as "hysterical." Experts on "both sides of the question" should decide whether a child infected with the AIDS virus could attend school, Mendelsohn argued.

The school administrators feared that they had lost their fight. Eventually, they persuaded the board members with loads of reassuring information on how AIDS is transmitted. Or almost persuaded them: When the Board of Education finally adopted its AIDS guidelines, in June, 1986, Mendelsohn was named to the medical screening panel.

In January, 1987, when the young child who was eventually assigned to Pilsen came before the medical panel, Mendelsohn's was the only vote against admission to school. What the public knew was only that although he or she had tested positive to the AIDS virus, there were no signs of the disease. The public was never told that the child's mother and two siblings had full-blown AIDS.

The school administration treated the decision of the medical panel and the subsequent placement recommendation made by a committee of educators as part of the bureaucratic routine laid down in the guidelines. What they hoped for, recalls Deputy Supt. Lee, "was a quiet, purposeful approach—a low-key approach. No one thought the LaRouchies were working that neighborhood." George Muñoz, then president of the Board of Education, learned about the medical panel's determination through channels in a matter-of-fact memo from General Supt. of Schools Manford Byrd Jr., and when Muñoz inquired, he was told that things were in capable hands.

The Chicago school administrators saw little reason to take any special measures in Pilsen. After all, the act of adopting a policy had put them in the forefront on AIDS in Chicago. Although the city has the seventh largest number of AIDS cases in the country—917 as of Oct. 30, 1987—Chicago had not really awakened to the epidemic. With Chicago not yet caught up in the AIDS issue, it made bureaucratic sense to play Pilsen by the book. That was what the school bureaucracy habitually did. They were leaving matters in the hands of the locals, a strategy assiduously promoted by Byrd, who believed that principals had credibility that the central office sometimes lacked.

With such a laissez-faire attitude, it was indeed "providential that the first AIDS case should be in a school headed by someone with Bill Levin's capabilities," Deputy Supt. Lee observed—the same sentiment that Bill Gussner expressed about Paul Nilsen in Wilmette. And Levin recalls thinking: "We'll be compared to Wilmette. It's important to leave no stone unturned."

On the morning of Feb. 25 the teachers at Pilsen Academy heard the news. It was an awkward session. "The top brass just said, 'There is no choice,'" recalls teacher Nydia Gonzalez. "There were lots of unanswered questions when we walked out of that room." But once the teachers recovered from their initial shock, once they had had a chance to ask questions about risk and health insurance, about bringing the disease home and the district's legal liability, they came around. None of the teachers took up Levin's offer to arrange a transfer to another school, and Mary Jane Andrade, a teacher's aide, volunteered to work with the AIDS-stricken youngster. "I had tuberculosis as a child," she said, "and I know how it feels to be pushed aside."

Levin helped restore the teachers' confidence by making himself available every day that week, before and after school, to talk through their concerns. He was collecting articles on AIDS, informing himself and passing along the materials. "If this had to happen any place in Chicago, it is a godsend that it happened at Pilsen," became the teachers' mantra.

That same day Levin contacted his allies in the neighborhood. Among the key people, there was Lucy Gutierrez, who as a member of the local alderman's staff had been helping the residents of Pilsen for years. Gutierrez had collected 10,000 signatures for a new health center in the early 1970s; now her daughter was a teacher's aide at the school. There were also Lourdes Ortega and Sylvia Domingues from the school's parents council, and Andrade, who had been so helpful at the staff meeting and whose daughter was enrolled at Pilsen Academy. And there was Raquel Guerrero, an organizer with a migrant workers' group who had moved to Pilsen with her family in 1957, fixing up a falling-down house and shepherding her children through the public schools.

Early in the 1980s Guerrero had come to the rescue of Pilsen Neighbors, mortgaging her home to bail out the community organization when it was in danger of folding. That gesture put her in a financial bind, yet Guerrero never took a cent from any neighborhood group. Nor would she accept a job as an aide at the school; the money would keep her from speaking her mind, she felt.

"We're No. 1 in everything," said Guerrero. "But why are we No. 1 in this?" Yet she agreed to help Levin. "I had a son who died of hepatitis," Guerrero says. "My neighbors weren't sympathetic. They said: 'What did he die of? I need to take my child for a shot.' I knew how the mother of that child was feeling."

The support from these three women gave Levin some credibility at the meeting of the school officials and the Pilsen community leaders, the session that Paul Nilsen attended, held on Feb. 27. But the principal had a hard selling job. The community organizers expressed their support for the school—but not for the Chicago school system or its AIDS policy. All they would promise was to stay away and keep mum rather than risk turmoil by making their worries about AIDS generally known.

When Levin asked Ortega of the parents' council how families would react, her response was graphic: she mimed slitting her throat. Carlos Valencia, president of Casa Aztlán, angrily accused the school district of plotting against Pilsen, and Saigh, the spokesman for the school system, replied, "Do you think we would pick a school in the most politically active neighborhood in Chicago to place a child with AIDS if we had any choice?"

As Levin walked out of that meeting, he believed that he was over the worst. The letters to parents had gone out, and the school had set up a hotline. The priests would speak out from their pulpits in support of the schools, and in devoutly Catholic Pilsen their voices would be heard. The principal, working with Saigh, had lined up a raft of speakers for the public forum, scheduled for the following Thursday, March 5. Politicians, school officials and doctors

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would all be giving the same message. The enrollment of the child was a compassionate act that posed no medical risk. A Catholic Chicago bishop, who happened to be the brother-in-law of one of the city's top school officials, would give a homily in Spanish. Following the procedure that had worked well in Wilmette, questions would be submitted in advance; since many of the parents spoke only Spanish, several teachers had been lined up to translate. But before the question-and-answer period could begin, the supporters of Lyndon LaRouche turned the meeting into a wide-open brawl.

This was not the LaRouchites' first adventure in Pilsen, nor were all the LaRouchites outsiders. "I was born in Pilsen," said Herman Garza, a staunch LaRouche supporter. "We work here, we organize." In 1979 the LaRouche organization held its first public meeting in Pilsen; a year later, when Lyndon LaRouche ran for president, he campaigned in the streets of Pilsen.

Driving home from his meeting with Joe Lee earlier in the week, Levin had spotted a van belonging to the National Democratic Policy Committee, LaRouche's party, which was fielding candidates in the upcoming Chicago elections. "Quarantine All AIDS Cases," read the banner hanging from the van, and Levin shuddered. During the first days of March, while the principal readied himself for the forthcoming community meeting, things were quiet in Pilsen. The hotline had almost no calls, and Levin caught himself thinking that "this could be a piece of cake." But the LaRouche activists were busy taking their message of fear door-to-door in Pilsen.

Several of Levin's old antagonists were among the parents that the LaRouchites conscripted to their cause. Their reaction was partly genuine fear about AIDS, partly Pilsen politics.

It wasn't clear until the March 5 meeting just how effective the LaRouche forces had been, and by then it was too late. "When I came home at 3 that morning," Levin recalls, "I crawled into bed and told my wife that I wanted to cry.... We had tried so hard to keep the LaRouchies out by using lists of all the parents, but they slipped past us by posing as spouses of single parents."

Nearly 500 people crowded into the school's auditorium that meeting night. Every seat was filled, and people stood in the aisles. For the first half hour, things went smoothly enough. But when Levin began to speak about the "misconceptions" that surrounded the youngster who would be enrolled at Pilsen, the LaRouche supporters, who had positioned themselves in the front rows of the auditorium, made their move. "Liar, liar," they started shouting as Levin pleaded vainly for a chance to communicate the facts. "Where are the guarantees?" they yelled, and then demanded that the matter be put to a vote.

Levin tried switching to the questions and answers, but when the shouting persisted, he returned to the planned format. There was a brief calm when Dr. Lonnie Edwards, commissioner of the city's Health Department, beseeched the audience to "open up your ears and hear the truth we have to tell you. Use your minds, use your hearts." Then the tumult began all over again.

Levin turned to LaRouche sympathizer Garza, who had loudly been demanding the floor, and invited him to speak. Levin thought he had a deal—Garza would talk and the session would continue—but Garza rushed the stage, bent on taking over. At that moment, a furious Raquel Guerrero gave Garza a shove, and pandemonium broke out. It was *mano a mano* in the auditorium as LaRouche backers mixed it up with angry parents. "Is this Russia?" the LaRouche supporters cried when members of the Chicago police force, who had let the school administrators know that they would intervene only if things got violent, began carting off the antagonists. The meeting collapsed.

As Levin and Saigh spent the succeeding days planning a series of 24 simultaneous AIDS information sessions to be held on March 12 at Pilsen Academy and carefully limited to parents, the LaRouche supporters stepped up their noisemaking. They spent the weekend cruising the neighborhood, exhorting parents to keep their children home. On Monday, March 9, 190 children stayed away from the 1,000-student school, four times the usual number of absences. Many parents had brought their children to school but were scared off by talk of a bomb inside the school.

The children who came to class that day were learning about AIDS. When Levin visited a 6th-grade classroom, the students recited the ways AIDS could be transmitted. One child asked the principal a question that had become all too familiar: "Why don't our parents vote on whether to admit a child exposed to AIDS to school?" Levin explained that this wasn't the kind of thing people voted on—"Would you want people voting on whether you were in school?"—and then took an informal poll. Almost unanimously the youngsters said that the child should be allowed in school. "You've got more compassion than the people out there," he told them.

Outside the school, the LaRouche activists were picketing, blaring their message in Spanish. "This school is being used as an AIDS experiment because it is a minority school," they claimed. Raquel Guerrero stood down her antagonists. "Go home! Go home!" she demanded, waving her finger in the face of the leaders, while other parents encircled the LaRouche contingent with signs saying "LaRouche Must Go" and "LaRouchies Are AIDS." Levin, who had anticipated the LaRouche protest, called the police; when they tried to move the demonstrators along, the LaRouche contingent became "very combative," in the words of the police. Six people were arrested, including two parents of Pilsen children.

By now the Chicago news media were all over the Pilsen story. There was lengthy coverage on the Spanish TV stations, which had never previously paid much attention to any AIDS issue. Levin became a TV fixture, talking about "hand-to-hand combat with the LaRouchies"; Guerrero and Gutierrez, the longtime Pilsen organizers, and José Cerda, one of the principal's familiar adversaries, were also frequently seen on the nightly news.

"They don't ask the parents," Cerda complained. "We have no rights." But other parents, quizzed by the newsmen, contended that the LaRouche activists were "here to twist our minds; they said the whole school is contaminated with AIDS." When WBBM-Ch. 2's Walter Jacobson questioned Levin closely about the risks involved, the principal came off looking like a man who knew his stuff.

Levin looked like a leader, too. "We will listen to parents and respond to their concerns," Levin told the TV reporters. "We've got 90 percent of the parents now," Levin said on March 10, the second day of the LaRouche-organized boycott, when absences had been cut in half. "Our job is to convince the other 10 percent." By week's end, as even the most skeptical parents began bringing their children back to school in the aftermath of the AIDS informational meetings, both The Tribune and the Sun-Times offered editorial pats on the back to the "responsible" citizens of Pilsen.

Levin was putting up a brave front—"We'll be like Wilmette in a couple of weeks," he declared—but behind the scenes things weren't going entirely smoothly. The mother of the AIDS child had suddenly vanished, unnerved by the outcry, taking her child with her, and for several days the principal could not locate them. In the face of the school's troubles, the administrators were remaining mute.

Other principals were calling Levin, telling him he was crazy to let a child with AIDS in his school. "I'd be fighting this," they said.

These neighborhood leaders had been led to believe that the AIDS dispute could be readily contained, that there really were no serious medical concerns. The appearance of LaRouche backers gave them another reason to side with the schools, for it was important to them that LaRouche not gain added support in Pilsen. Several years earlier, in a fight over the placement of a drug treatment center in Pilsen, Gutierrez and Guerrero had been wooed by the LaRouchites, who had concealed their identities. "They wound us all up," remembers Gutierrez. Guerrero had even been sent to a convention of the National Democratic Policy Committee in Detroit. "A bunch of walking mummies," Guerrero called the conventioners, who cheered every word of their leader. "I didn't want to listen to this philosophy of hatred." Pilsen had to be preserved as *their* turf, not Lyndon LaRouche's.

Yet in the days before and after the disrupted meeting, as parents kept hearing stories about mosquitoes, saliva and sweat while the Health Department and the Board of Education were nowhere in sight, these women started wondering whether they had been misled. Their credibility—their only real resource—was suddenly on the line.

The small in-school meetings organized by Levin and Saigh, from which the LaRouchites were effectively barred, answered some of the parents' questions. But it was time to enlist some new allies, Gutierrez and Guerrero and the others decided. On Wednesday, March 11, a Pilsen contingent marched into a Board of Education meeting to demand that the board—particularly George Muñoz and Linda Coronado, the two Chicano board members—make an appearance in the community.

Coronado, the board's newest member, was a familiar and trusted face in Pilsen, for she had been an organizer in the neighborhood and had run the women's center there. Muñoz, the board chairman, was less well known. Though Muñoz had grown up poor, one of 12 children in a home where only Spanish was spoken, his brains and industriousness had been his ticket out—to Harvard Law School and a partnership in one of the most prestigious downtown law firms.

Muñoz knew that his Hispanic heritage was a principal reason for his being on the board. Now, in Pilsen, he was being called upon to put his credibility on the line for his constituency.

There were about 200 people in the auditorium the evening of March 13 to hear Muñoz, Coronado and three Hispanic doctors, including Jorge Prieto, the septuagenarian president of the Chicago Board of Health who over a third of a century has delivered a thousand babies in Pilsen. Muñoz regarded Prieto as the ideal medical spokesman for Pilsen, and Prieto was only too happy to oblige.

The school was heavily guarded to keep the LaRouche supporters away. When Levin appeared, Guerrero politely but firmly ushered him out. "You are part of the system," she said, "and the parents want to hold this discussion without any influence from the school system." The principal understood, but he couldn't help feeling hurt; he went back to his office, turned on the public address system and listened. He had done his part. Now it was time for the community leaders to take charge.

The doctors were closely questioned by the parents, who by now knew all the questions, and the women kept things calm. "Don't get too emotional, doctor," Lucy Gutierrez said when one of the doctors started slipping into a passionate peroration about the risks of everyday life. Prieto, when asked about guaranteeing the safety of the children at Pilsen, won over some of the parents by saying: "I'll sign a guarantee that your child won't get AIDS in school if you will guarantee that your child won't have sexual intercourse, in school or out."

The school board members, Coronado and Muñoz, got a thorough going-over, too. "Why did you abandon us?" one parent asked. And another again raised the possibility of putting the matter to a vote. A community organizer framed the matter of accountability squarely. "We trust you. If you tell us it's okay to let this child in our school, we'll do it."

That Sunday, March 15, AIDS was what all the parish priests spoke about. The priests of the community had joined to send a pastoral letter to their parishioners about the child who had been exposed to AIDS. At Providence of God Church, where the Pope had stopped briefly in 1979, Father Tim McCormick preached about AIDS in Spanish to 800 parishioners. "It is the outsiders who are the problem," McCormick said. "We have to remember who we are. We know more than anyone what oppression is. We can't become the oppressors. . . ."

Muñoz got Supt. Byrd to commit a full-time nurse to Pilsen and confirmed that the medical advisory panel would closely monitor the situation at the school. At a session at Pilsen the following Monday the board president tossed out these ideas as possibilities; quickly they became community demands that Muñoz could then satisfy.

That strategy almost proved too clever. "You keep telling us there is nothing to worry about," one parent said to Muñoz. "Why are you taking all these extra precautions?" Yet by this time, nearly three weeks after Levin had first learned that a child exposed to AIDS would be assigned in Pilsen, things were back to normal at the school. The LaRouche contingent had vanished. The community skeptics were quiet; José Cerda, who had demanded that his children be allowed to transfer, sent his wife in to apply for a job on the school bus that took the infected youngster to and from school.

Inside Pilsen Academy, things had returned to normal, too—in one case, far too normal. When Levin went to see how the AIDS infected pupil was being treated, he was horrified to learn that teachers were

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being very casual in cleaning up her nosebleeds; the principal promptly bought disposable gloves from a medical supply house. By the end of the school year, it was hard to locate a parent in Pilsen who would admit to harboring serious misgivings about what the school had done, harder still to find anyone who would acknowledge any sympathy for the LaRouche contingent. Levin was still working his 6½-day weeks, still handling questions about AIDS in the schools. The principal still hadn't had a chance to take his wife on that holiday weekend the teachers had chipped in to pay for.

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"I can't keep him in a bubble," the foster father of a young boy suffering from AIDS-related complex (ARC) complained to a Chicago Sun-Times reporter. It was early February, 1987, and the school district still hadn't decided how to handle the Pilsen case. This second Chicago case was potentially even harder.

Although the youngster being sent to Pilsen had been exposed to the AIDS virus, this child was already displaying the signs of a weakened immune system that ARC—and AIDS, to which ARC is often a precursor—signifies. Medically that made little difference, since it is the virus that is potentially contagious, not the diseases brought on by the virus. Indeed, public health experts argue that it is irrational to single out those displaying signs of the disease while many more children, unknown and unknowable to school authorities, are daily carrying the AIDS virus into the schools. Yet some parents, and some school officials, too, saw things differently. It was a comfort to those at Pilsen that the youngster who would be coming to their school was, and indeed might remain, perfectly healthy.

There was another complicating element in the case of the second Chicago schoolchild, one that was never on the table but was clearly in the minds of the decisionmakers: The foster-father was 43, single, and lived in New Town, the Chicago neighborhood that much of the city's gay community calls home.

Chicago school officials maintained a scrupulous silence about the particulars of the case. But the boy's father, who did not identify himself by name, talked to the reporter about his anger at the school system for having delayed its decision.

Nine months earlier the foster father had finally succeeded in beating the bureaucracy. For two years he had been trying to become a foster father in the Parent to Parent program, run by a Catholic service agency. That program placed troubled teenagers with foster parents in hope of eventually reuniting the youngsters with their natural families. Paul Swenson (his name has been changed) was an obvious choice to be a foster father: Since 1981 he had been a volunteer at Chicago's Children's Memorial Hospital and before that had worked with retarded youngsters.

Working with children, says Swenson, was "a mission." That's why the Vietnam veteran had saved up enough to quit his high-powered management job; he wanted nothing to do with "the yuppie bag." Yet for some reason, never explained—Swenson thinks it is because the social service officials believed, mistakenly, that he was homosexual—he never got the required foster-parent license from the Illinois Department of Children and Family Services. Just as he was contemplating taking the agency to court, a social worker with the state agency called him. A young boy with AIDS-related complex named David (not his real name) had just been handed over to them for placement. If Swenson took this child, he would get his license.

The call angered Swenson. "They want to put the two hot potatoes together," he speculated. But Swenson was "frustrated with all the Mickey Mouse," and his nest egg was almost gone. He went to Children's Memorial and talked with the pediatric AIDS specialists, including Ellen Chadwick, David's doctor, who later also treated Wilmette's Jamie. Then he met the youngster, a curly-haired moppet with pie-sized brown eyes. "He needs a guardian angel," Swenson figured, and he was it.

Swenson brought David home from a place he calls a war zone. His mother, a woman who divided her life between Chicago and San Juan, Puerto Rico, was a drug addict, diagnosed with AIDS and barely able to care for her son; she died a month after giving him up. The boy had no blanket, no food, no clothes. "It was a miracle he didn't die there," Swensons says. From the outset, though, David was an irresistible urchin unafraid of strangers, filled with enough energy for two kids, finding affection wherever he could. The foster father and his son spent all their time together and quickly became inseparable. "I haven't done a conventional parent trip," says Swenson. "I didn't know how long he would live, and I didn't want to deprive him of anything. The only thing I make him do is to eat healthy foods."

When the issue of enrolling David in school first came up, Swenson worried about the risks of infection that contact with other youngsters might entail for his foster son. "The risk is all on his side," he thought. During the spring of 1986 the boy, when he was diagnosed as having ARC, had been through a bout of pneumonia. But he had been healthy since then and hadn't picked up the flu his foster father contracted during the winter or developed any of the "opportunistic" diseases that signal full-blown AIDS. So appealing, so full of life were the child and his father they they were asked to talk at a meeting of the Children's Home and Aid Society, which was just beginning to work with AIDS children, and at a Lenten mass in Lake Forest. "We're like show-horses," Swenson says proudly. "While I speak, David works the crowd."

The boy's doctors and nurses agreed that he was "doing so well." He needed the chance of being in school, they said, and in January, 1987, Swenson tried to register his son in Nettelhorst Elementary School, 3252 N. Broadway, just a few blocks from his condo. Things didn't go as planned. "I thought the agency would have warned the schools about David, but they didn't. When we came to the place on the application where it asks about AIDS, their

jaws dropped."

Swenson filed all the necessary forms. Ellen Chadwick wrote to the schools, urging that David be admitted, for he was a healthy and happy boy. From the Chicago public school system, though, there was only silence. The next month Swenson sought out the Sun-Times reporter. "I had no other influence," he says. In early May, he made contact with the Chicago Public Guardian, Patrick Murphy. Murphy made a phone call to the school board, then drafted a "see you in court" letter. "Let's wait until after Memorial Day, then, if we have to, we'll file a lawsuit," Murphy said.

Nettelhorst, a solid brick building dating to the early days of the century, stands in the middle of Chicago's largest gay neighborhood. It is a mixed North Side community, with yuppie couples moving in, blacks and migrants from Appalachia hanging onto places they've lived in for years, and it is also where many of Chicago's most popular gay bars and restaurants are located.

The preschool-through-grade-8 school isn't a central part of this community. Many of the parents in the neighborhood who are most ambitious for their youngsters send them to magnet schools elsewhere in the city or to private schools, and many of the children of Nettelhorst come from outside the neighborhood. Youngsters from overcrowded Hispanic schools nearby are sent there, as are children with behavioral, emotional and learning problems. One quarter of the school's 500 pupils are in its 13 special classes.

Since 1978 Peggy Lubin has presided over this racially balanced confederacy of instructional offerings. And although Lubin doesn't have the power to select teachers that a magnet school principal like Bill Levin enjoys, this able and energetic Chicago native has put her mark on the place. "We take whoever shows up at the door," says Lubin. "That's great, it works."

At Nettelhorst the parents have a say in how the school is run. Lubin was intensely screened for her job by a parent committee—"Twenty-three people sat in a circle around me; for an hour they asked questions"—and an advisory council meets monthly. But for a school that draws on such a dispersed population, it is hard to keep more than a handful of parents involved in schoolwide issues. Most of the parents who do spend time at the school are concerned with one of the special programs; they join the special-education support group or the bilingual parents' council.

Lubin made AIDS the topic of the parents advisory council meeting that was held early in May. A dozen parents and teachers showed up to hear Dr. Roberta Luskin, a pediatrician at nearby St. Joseph's Hospital, explain the facts of the disease. Pilsen had gotten the attention of school administrators throughout Chicago; immediately after the troubles in Pilsen began, James Maloney, Lubin's district superintendent, had asked all the principals to speed up the AIDS education effort.

A pamphlet on AIDS was attached to the spring report cards at Nettelhorst, which parents had to pick up at the school. "That," says Lubin, "is where you put the information you want to make sure isn't lost." She had wanted to set up an AIDS session with the advisory council earlier, but local budget hearings and scheduling conflicts got in the way. Lubin didn't know yet that a child infected by the AIDS virus would be sent to her school. But the principal had read the Sun-Times article that told of a second youngster exposed to AIDS, and she had a hunch that "because Nettelhorst is in the gay com-

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munity, we're going to get that child."

Soon after the advisory council session on AIDS, Lubin began getting a series of strange phone calls from Deputy Supt. Lee. "I'm going to ask you questions about your enrollment," Lubin recalls Lee saying. "Your answers have to be absolutely accurate, and I can't explain anything." Lubin called the district office and asked for Maloney, only to learn that he was in conference with Lee. On Friday, May 22, Lubin was told to come to a meeting at Lee's office. Lee asked Lubin if she had figured out what was going on. She had.

The Chicago schools had learned something from the Pilsen experience. Now there were extensive materials on AIDS that Bill Levin had collected; Levin turned these over to Lubin, offering to give her whatever help she needed. Again, as in Pilsen, parents and teachers would be informed. This time, though, the principal was asked whether she wanted any of the top officials to attend the parents' meeting. Lubin declined the offer. Her intention, she told Lee, was to keep things as normal as possible, and it wasn't every day that the deputy superintendent made an appearance at Nettelhorst.

"When should the child be enrolled?" Lubin was asked. "As soon as possible," she replied.

At the end of the school year children begin counting down the days and hours until vacation. For teachers and parents, too, attention is focused elsewhere. That was why Lubin wanted to admit the child then, rather than waiting until the fall, when school is once again the centerpiece in so many people's lives.

"For two weeks, AIDS was all that I did," Lubin recalls. Immediately after the session in Deputy Supt. Lee's office, she and District Supt. Maloney met with the entire Nettelhorst staff. That day and the next,

Lubin visited each of the teachers, conscripting them in the effort to inform parents. "What should we be doing?" she asked. Two hours after requesting disposable gloves and other AIDS precautions, the supplies were on the scene. That broke all school-district speed records and helped allay the teachers' concerns. Students in the school's upper grades got a plain-talk lecture on AIDS. "When you think of AIDS," they were told, "think of blood and sex."

Letters pinned on the shirts of all the students, noting that a child with ARC would be enrolling at the school, were sent home to all the Nettelhorst parents. On May 28, the parents met to talk about AIDS—this time not in the abstract.

Lubin didn't know whether to expect a repeat of Pilsen, but nothing of the sort happened. No outsiders came—just parents, 38 of them, mostly mothers—and they went through the basics on AIDS transmission with Luskin. The young doctor was knowledgeable without being intimidating. She stood before the group, easily fielding questions, talking in language the parents could understand.

The one potentially explosive moment came when a parent declared: "I won't send my child to this school, no matter what. You don't know the answers." It was another parent, a mother who had been to the earlier advisory council session, who replied: "You don't know if the waiter in a restaurant where you're eating has the virus. What are you going to do, stop living?"

A second meeting was held a few days later for the Spanish-speaking parents, who had lots of questions. But the discussion stayed within the four walls of Nettelhorst. There were no LaRouche activists on the scene, no calls for a boycott.

Swenson knew nothing about these gatherings. "That's because he wasn't a Nettelhorst parent at the time," says Lubin, "and the meetings were only for parents." The first word he received from Nettelhorst came the Tuesday after Memorial Day. "You can bring David in to class tomorrow," he was told.

There was no publicity—not a single news article or TV piece—about what was happening at the school. Lubin thought that was a miracle: "All those announcements of the meeting were floating around the community, and nobody picked up the story." Schools spokesman Saigh had heard from reporters that, in the aftermath of Pilsen, they were now "all AIDS-ed out."

During the last days of the school year life at Nettelhorst proceeded without incident. Just one parent, the woman who had voiced her upset at the meeting, kept her child out of school. At kindergarten graduation, a cap-and-gown affair at the school, several parents told Lubin that they would be sending their children to parochial school in the fall, but that is something that happens every year. And there were actually fewer parents than usual seeking to transfer their children from Nettelhorst to a magnet school for the following fall.

Lubin thought that the events in Wilmette and Pilsen, as well as those AIDS education materials that the Nettelhorst parents had been given during the spring, made her job easier. "If you get that word—AIDS—in front of parents, in the context of the schools," she says, "they have a chance to think the issue through before being confronted with a case of AIDS in their own school."

Then one morning at the very end of May, Lubin happened to be present when a young boy—a "gorgeous little boy," Lubin describes him—came into the classroom holding his father's hand. "He was thrilled to be there," she says. "He wasn't shy at all. 'I'm going to play,' he said, and he dived right in."

In Wilmette the parents who brought their sharp questions to the January, 1987, meetings went away convinced that the school officials they knew and the outside experts were right. Besides, as the parents kept telling newsmen, who wanted to be another Kokomo? In Pilsen, two months later, those who carried the day were the Hispanic doctors and the educators—and a Jewish school principal—whom parents knew and trusted. Nettelhorst proved to be a happy anticlimax for school authorities, in part because a lot had been learned from the Pilsen experience. And a lot had been said about AIDS at Nettelhorst during the immediately preceding weeks.

These successes can be traced partly to the people who happened to be in charge, three principals and a suburban superintendent who came out strongly for what was right. These men and women had the backing of parents who had known them for years. They faced down their antagonists. And they managed their encounters in the spotlight with aplomb. Perhaps the most important thing these leaders did was to trust the communities whose children they educated, resisting the temptation to slip the decision by unknowing parents. The conversations they launched gave parents a chance to have their say about something that intimately touched their lives.

This story has no tidy ending. Other towns will be facing similar circumstances for years, other re-enactments of community pride and prejudice. During August and September of 1987, towns in Pennsylvania and Tennessee were doing whatever they could to keep children with AIDS out of schools. And the Arcadia, Fla., fire that leveled the home of three hemophiliac brothers believed to have been exposed to the AIDS virus, came to symbolize the madness that fears about the disease can bring to the surface.

Much closer, in south suburban Dolton, the school board voted 6-1 in late September to keep a child with ARC out of school. "The concept of the greatest good for the greatest number" was the reason for the decision, says board president Joyce Forbes—even as school officials acknowledged that the child being barred posed no danger to anyone. Within days of the board's vote, the family of the unnamed child filed a lawsuit in federal court.

In Wilmette, things were very different. Until the end of the school year in June, Jamie McCardle had remained one of his gang—the three musketeers, Fran called them. But during the early days of summer, Fran talked to the other two mothers. "Don't feel that your boy has to see so much of Jamie during the vacation. Maybe they all could use a break from the sadness."

Jamie himself was beginning to understand the meaning of his own inevitable death. "I don't want you to die!" his 10-year-old sister Sally told him, and he answered stoically: "I just have to."

One day, as the boy and his mother drove past a cemetery on their way to an appointment with Dr. Chadwick, Jamie asked, "That's where I'll go when I die, isn't it?" "That's where your body goes," Fran answered. "The inner you goes to heaven—a great big bakery, with lots of cookies and cakes."

Jamie could live for years, the doctors told the McCardles, or he could die suddenly, and that uncertainty weighed on the family. Meanwhile, Bill and Fran McCardle and those Wilmette parents whose children attended school with Jamie would share more cups of coffee and more revelations about the plague that had entered all their houses. ■

CASE STUDY: QUESTIONS, CONCERNS AND ISSUES FOR CLERGY IN RELATION TO HIV TESTING PRIOR TO MARRIAGE

Ann and Tom approach a clergyperson three months before they wish to get married. They have already rented the place for the reception. For both sets of parents this is the first wedding. Ann and Tom remember hearing something about a special blood test before marriage.

They wonder: 1) what the test is; 2) when they should get it; 3) how much it costs; 4) who pays for it and any subsequent confirmatory test; 5) who orders the test; 6) where they get it performed 7) what a positive result means in terms of the marriage itself and their plans for a family; 8) who knows the results and who needs to know; 9) how their partner became exposed to the virus if he or she is positive; 10) whether the exposed partner will develop AIDS or ARC and when that is predicted to occur; 11) whether the exposed partner is really gay/bisexual or IV drug user; 12) whether they are truly safe in light of their recent sexual history.

The clergyperson wonders: 1) whether they will tell him the results of the test; 2) whether he should ask about the results; 3) what happens if one or both are true positives or false positives; 4) what to do in the interval between the ELISA tests and the confirmatory Western blot test; 5) how to help the couple deal with parents if the time frame between the confirmatory test and the wedding date overlaps; 6) whether he should perform the ceremony if one party is positive or if they intend to have children despite that fact; 7) what if one party commits suicide because of a true or false positive result; 8) how will he help them deal with the lingering doubt that a false positive result can engender in their marriage.

If one factors into this scenario the real life issues of preparation time for marriage, poverty, gender, sexual orientation, race and ethnic background, one can readily understand the complexities that will arise.

Let no one diminish the magnitude of the problem by looking only at the number of projected positive test results (2,000). Even <u>one person</u> or <u>one family</u> whose life will be disrupted is worthy of care and concern.

Finally, if you have questions regarding the case or terms used in it or in the accompanying letter, you have need of more information. If you project that need to clergy who have distanced themselves from AIDS issues for whatever reasons, you sense the magnitude of the problem.

CEM/JE
12/23/87

UAHC
COMMITTEE
ON
AIDS

איחוד
ליהדות
מתקדמת
באמריקה

ARTICLE FOR TEMPLE BULLETIN (NEWSLETTER)

AIDS (Acquired Immune Deficiency Syndrome) is a devastating illness that was first described in this country in 1981, and that has already attacked over 28,000 people. It is estimated that by 1991 over 270,000 people will have AIDS, and since it is uniformly fatal at this time, one can understand the frightening impact of this disease. Currently it is seen most frequently in the homosexual community, but it is also found among heterosexuals in ever increasing numbers.

Our congregation is concerned about widespread myths and unfounded prejudices that are associated with AIDS. We have received much helpful information from the UAHC Committee on AIDS, and are ready to support and counsel those in need. If you or a member of your family or a friend or loved one has AIDS, please know that a call to the Temple office will be met with a sensitive and caring response. We are prepared to help.

AIDS

In response to many requests for copies of Rabbi Kirschner's Kol Nidre sermon, it is reproduced herewith:

Usually, when a rabbi quotes his ancient predecessors, he does so with approval, even reverence. Our sages of blessed memory were remarkably wise and perceptive, noble and compassionate. But not always. I quote from an ancient midrash on the 13th chapter of Leviticus, dealing with the subject of leprosy. The sages are discussing what they do when they see a leper (Lev. R.16:3). R. Johanan says: I go no closer to a leper than four cubits. R. Shimon says: If the wind is blowing, I go no closer than 100 cubits. R. Ammi and R. Assi say: We do not even go near a place where lepers are known to live. R. Eleazar b. Shimon was still afraid: If he heard that a leper was in the vicinity, he would hide. Then there was the great sage Resh Lakish. When he saw a leper, he would throw stones at him, shouting: "Stop contaminating us and go back to where you came from!"

I am not proud of this passage. I quote it now because I think it has something to teach us on Yom Kippur, when we ask forgiveness for our sins. Scholars have shown (Encyclopedia Judaica 11:38) that by the time this passage was written, the segregation of lepers enjoined by the Bible was no longer required. In a case where a rabbi himself came down with leprosy, the decision was handed down that he could enter the synagogue together with everyone else. No, the hostility of our passage does not arise merely from the fear of contagion. After all, to avoid a leper is one thing; to throw stones at him is another. In rabbinic literature, lepers are accused of everything from murder to incest, idolatry to robbery, perjury to blasphemy to slander (Preuss, Biblical and Talmudic Medicine 337). In the days of our sages, to be a leper was not only to be afflicted with disease but to be despised for it. It was not only to suffer but to be forsaken. It was not only to die a terrible death, but to be accused of deserving it.

Today, leprosy is called Hansen's disease, and those who suffer from it may walk among us without fear. No longer must they bear—as if their illness were not enough—the crushing weight of anathema. But now there is a new multitude of sufferers to fear and to shun. Theirs is the new dread affliction, the new mark of doom: AIDS.

The condition now known as AIDS, Acquired Immune Deficiency Syndrome, was first recognized in 1981. Patients with AIDS have developed a severe loss of their natural immunity to disease, leaving them vulnerable to lethal infections and cancers. To date, no treatment has been able to restore the immune system of an AIDS patient to normal function. Almost 75% of the people who have developed AIDS are dead. The vast majority, upwards of 90%, are either homosexual and bisexual men or intravenous drug abusers.

Like the ancient rabbis, we prefer to keep our distance from the victims of this illness. Like them, we are afraid of catching it. But according to the medical experts, those outside the high-risk groups are highly unlikely to do so. The growing number of AIDS patients is almost completely confined to homosexuals and drug abusers. Only one percent of all reported cases involve a transfusion recipient or a child born with the mother's infection. Here in San Francisco, more than 98% of all AIDS patients are gay men. Of over 13,000 cases nationwide, not one has been attributed to casual contact with AIDS patients. Of those caregivers who are constantly exposed to AIDS and frequently tested for it—doctors, nurses, hospice workers, family members—none outside of the high-risk groups has caught it.

Yet despite the evidence, we are still afraid. Not enough is yet known about AIDS. The fear of contagion is itself contagious and likely to persist. It explains, in part why we stay away from people with AIDS. But, as in the case of the ancient lepers, it does not explain it all. Our aversion, too, goes beyond the fear of infection. We shrink from people with AIDS not only because they are sick but because we don't like how they got sick. When it comes to homosexuals and drug addicts, our sympathy for their affliction is diluted by the suspicion that they deserve it. Like the ancient leper, the AIDS patient suffers not only the torment of his illness but the stigma of it. He is shunned not just for what he has but for what he is. His life, and now his death, are alike regarded as a kind of disgrace.

Tomorrow afternoon, traditional Jews around the world will read the 18th chapter of Leviticus. This is where homosexuality is described as an abomination (18:22) punishable by death (of 20:13). But Reform Judaism departs from the Torah on occasion. We do not stone adulterers; we do not ostracize children of forbidden marriages; we do not sprinkle lepers with blood. Such biblical legislation, we believe, is the work not of divine but of mortal and fallible hands, and we consign it to the antiquity from which it came. The divine content of the Torah, we believe, is found in its transcendant vision of justice, peace, and compassion. The God we revere is the One who, as R. Akiba taught (M Ab. 3:18), creates each of us because He loves us, who as the Mishnah says (Sanh 4:5) considers each life to be worth the life of the whole world. The God we revere is the One who, as the Torah itself insists, sides not with the mighty but with the forlorn who hears the cry of the helpless and defends the defenseless (Ex 22:21 ff.). The God we revere is the One who loved us when we were the unwanted, the unwelcome, the exiled and the outcast. A belief in this God, to my way of thinking, simply cannot be reconciled with a judgment of anathema upon homosexuals, or lepers, or any other of His children. "Blessed art Thou, O Lord." says our prayerbook, "who has made me according to His will." Each of us, in our unique being, is the work of His hands and the bearer of His image; each of us—even someone with AIDS.

In my reading of the local Jewish press, I cannot recall—either in article, editorial or letter—even one expression of regret or sympathy for the loss of life to AIDS, not one word of protest or indignation at the ostracism of its victims. Imagine if a Jew—let us say, one who does not happen to have AIDS—were fired from his job or evicted from his apartment, or expelled from a hospital, because his Jewish disease was fatal and no one wanted to work with him or live near him, or care for him. Imagine the outrage of the Jewish community if, God forbid, such things were to happen. Then imagine what the gay community must feel at this moment, and imagine what they must think of our silence.

A friend of mine, Father Michael Lopes, told me something that happened on a visit to ward 5B at San Francisco General Hospital. This is where the most desperately ill AIDS patients

are treated and comforted before they die. Father Lopes walked into one of the rooms on the ward. The blinds were closed; only a little shaft of light penetrated the darkness. The patient lay in bed in agony. His entire body was covered with purple lesions of the cancer called Kaposi's sarcoma. His face was terribly swollen and disfigured and his mouth was infected with fungus. So appalled was Father Lopes that he could hardly bring himself to come near. But just then, the patient turned in his bed, and the little shaft of light came to rest on his eyes—bright blue eyes, clouded with pain but now suddenly filled with gratitude at the sight of his visitor. Looking into those eyes, Father Lopes said, he remembered that beneath the mass of lesions was a person, a human being, hurting so badly that the mere presence of a visitor was a benediction.

My friends: as surely as God is in heaven, so is He with the patients on Ward 5B. As surely as his light shines above this ark, it shines above their beds. But God has no other hands than ours (cf. Dorothea Soeile, Suffering 149, 174). If the sick are to be healed, it is our hands, not God's, that will heal them. If the lonely and frightened are to be comforted, it is our embrace, not God's, that will comfort them. The warmth of the sun travels on the air, but the warmth of God's love can travel only through each one of us.

A few weeks ago, Father Lopes took me to Ward 5B. While I was there I met Dr. Donald Abrams, Assistant Director of the San Francisco AIDS Clinic. The Clinic is where AIDS patients are first identified, tested and counseled. The number of cases has increased to the point that the Clinic must expand to another floor. But there is a shortage of hospital beds. Dr. Abrams explained to me that the special beds needed cost over $1,000 each and the Clinic cannot afford that many. My friends: We can.

On this Yom Kippur, our Day of Atonement, let us determine to fulfill a great mitzvah. Let us, as a congregation, as we have done before for the victims of African famine, as we are doing now for the victims of the earthquake in Mexico, let us together establish a Temple fund for the care of people suffering from AIDS. Let us start by donating a few hospital beds, and then let us see what else we can do. Let us together fulfill the exalted commandment to comfort the sick and the dying, who need us and who deserve our kindness, not our lectures.

Confronted by the enormity of human suffering in this world, the vast numers of the helpless and the wretched from Ethiopia to Mexico and back again, we may be tempted to despair. As small a gift of compassion as a contribution toward a hospital bed may seem trivial and unavailing. But then I return, this time with great pride, to the teaching of our ancient sages. Where, they asked, shall we look for the Messiah? Shall he come to us on clouds of glory, robed in majesty and crowned with light? The Talmud (b. Sanh. 98a) reports that R. Joshua b. Levi put this question to no less an authority than the prophet Elijah himself.

"Where," R. Joshua asked, "shall I find the Messiah?"

"At the gate of the city," Elijah replied.

"How shall I recognize him?"

"He sits among the lepers."

"Among the lepers!" cried R. Joshua. "What is he doing there?"

"He changes their bandages," Elijah answered, "He changes them one by one."

That may not seem like much for a Messiah to be doing. But apparently, in the eyes of God, it is a mighty thing indeed.

AIDS Resources in the Chicago Area

as of January 12, 1987

AIM Chicago 236-6977
Medical; psychological services

AIDS Alternative Care Health Project 327-6437
c/o Integrative Therapies
2944 N. Broadway, Chicago 60657
Tuesday and Thursday, 9 AM - 4 PM

AIDS Foundation of Chicago 525-9466
2035 North Lincoln, Room 619
Chicago, IL 60614

AIDS Hotline, Statewide: 1 (800) AID-AIDS
Howard Brown Memorial Clinic Help Lines
10 AM - 10 PM, 7 days, except holidays
Spanish Speaking Operator on Duty, Monday - Thursday, 6 - 10 PM and Sunday, 10 AM - 2 PM

AIDS Pastoral Care Network 975-5180
Monday - Friday, 9-5 or by appointment.

Chicago House (office) 248-5200
801 W. Cornelia, #2N, Chicago 60657
Residence Phone 334-2630
Residence for persons with AIDS/ARC.

Chicago Medical Society (TEL-MED) 670-3670
8:30 AM - 7 PM, weekdays.
Request AIDS info tape.

Cook County Hospital AIDS Program 633-7810
1835 W. Harrison, Chicago 60612

DuPage County AIDS Project 682-7400
111 County Farm Road, Wheaton, 60817

Gay Community AIDS Project (G-CAP) (217) 351-AIDS
P.O. Box 713, Champaign 61820

(Gay and Lesbian) Horizons 929-HELP
Gay umbrella service organization, general information hotline.

Howard Brown Memorial Clinic 871-5777
945 W. George, Chicago 60657
STD testing, primary AIDS resource center
Also legal services (wills, powers of attorney and living wills) for PWAs who cannot afford legal services.

(SEE OTHER SIDE)

Kupona Network 536-3000
4611 S. Ellis, Chicago 60653
Outreach for Black gays
HIV counseling and referral program

National Association of Persons with AIDS 278-5060
Chicago Chapter

Northern Lights Alternatives 951-6498
1140 N. Wells, Suite 2, Chicago 60653
AIDS Mastery Workshop and support services

PASSAGES Project (Horizons) 929-HELP
7-11 PM nightly

Reimer Foundation 935-SAFE
P.O. Box 300, 606 W. Barry, Chicago 60657
Safer Sexual Behavior/Condoms

Stop AIDS Chicago 871-3300
2676 N. Halsted, Chicago 60614
Discussion Group

Test Positive Aware 728-1943
1340 W. Irving Park, Suite 259, Chicago 60613
HIV+ Fellowship and Information Network

Unabridged Bookstore
3251 N. Broadway, Chicago 60657
Mainstream Bookstore with a large gay section and a comprehensive selection of books on AIDS

Notes

Compiled by Norman Sandfield from listings in Chicago's three gay and lesbian newsweeklies: Windy City Times, Outlines, Gay Chicago.

This list mainly contains organizations that have a direct AIDS service to provide. We can add the ACLU, and other gay outreach and medical resources that can provide support services to PWAs.

We need to expand and check the credentials of each listing before distributing this list.

Another supplement or replacement for this resource list could be the 8 page Chicago Medical Society's AIDS Service Directory, last edition dated April, 1987. Call 670-2550, x211.

At HBMC, Sally Mason or Bill Belzner, legal referrals.

ADOPTED BY THE GENERAL ASSEMBLY

of the

UNION OF AMERICAN HEBREW CONGREGATIONS

October 29 - November 3, 1987 - Chicago

CONFRONTING THE AIDS CRISIS

BACKGROUND:

Two years ago, the Union of American Hebrew Congregations issued a call to action on AIDS. We called for increased financial and human resources for prevention and treatment, prohibition of discrimination, and community education about this terrible new epidemic. We created our own Committee on AIDS, which has developed, and distributed widely, educational materials integrating our sacred teachings with professional expertise.

Tragically, the epidemic continues to rage, and more needs to be done. An estimated two million Americans are already infected with the AIDS virus. Most, if not all, will suffer chronic immunological and/or neurological problems throughout their lifetimes. At the current rate of infection, the federal government estimates that millions more will become so infected by 1991. Yet, the process of developing new treatments which combat AIDS virus infection and restore immune functioning have been severely hampered by the lack of adequate funding and unnecessary political obstacles.

We find society today dangerously paralyzed by partisan moral agendas as the acute crisis of the epidemic continues. The best evidence of the damage inflicted by the polarization of American society is the ineffectiveness of the President's Commission on AIDS.

With increased public awareness and fear have come proposals for mandatory AIDS testing of various segments of our population. Those most knowledgeable in the field of public health have opposed these proposals. They argue persuasively that mandatory testing is ineffective as a public health measure because it will open the door to increased discrimination against People with AIDS (PWA), will inevitably drive underground these members of high risk groups whom we most need to reach, and will distract the public from the imperative tasks of education, counseling, and behavior modification.

CONFRONTING THE AIDS CRISIS - 2.

THEREFORE BE IT RESOLVED that the Union of American Hebrew Congregations:

1. Express profound appreciation to the United States Surgeon General, Dr. C. Everett Koop, for his courageous leadership in educating the American people of all ages to the realities of AIDS.

2. Join those who:

   A. Argue that any testing must be accompanied by education, counseling, and confidentiality consistent with sound public health practice.

   B. Affirm that those infected with the AIDS virus must be protected from all forms of discrimination, such as discriminatory housing, employment, and health care delivery practices.

   C. Associate ourselves with those who support voluntary testing and oppose mandatory testing for AIDS.

3. Call upon every individual to accept responsibility to observe those health practices which minimize the risk of infection.

4. Call on every congregation to:

   A. Affirm the mitzvah of Pekuach Nefesh (the saving of lives) by instituting comprehensive, effective, and age-appropriate educational programs about preventing transmission of the AIDS virus.

   B. In the spirit of Bikur Cholim (visiting the sick) reach out to individuals infected with the AIDS virus, their families, and their friends by providing food, clothing, legal assistance, transportation, and empathetic listening.

   C. Form and join area coalitions to develop action programs for the prevention of AIDS and assistance to those with the disease.

   D. Include appropriate sex education at every level in religious schools.

RECOMMENDATIONS FOR CHILDREN AND EMPLOYEES WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME/HIV
INFECTION IN THE SYNAGOGUE SETTING*

Recommendations for the Education of Children

Human Immunodeficiency Virus (HIV) is the viral agent responsible for Acquired Immune Deficiency Syndrome (AIDS). Persons who become infected with HIV may develop AIDS, may develop AIDS Related Complex (ARC), or may experience no symptoms of disease. At the present time AIDS is always fatal. ARC is a less severe illness, but may progress to AIDS.

The perinatal spread of HIV infection to infants, who have not reached school age or children who become infected via blood transfusion (prior to the implementation of blood screening), has resulted in questions regarding whether and how these children can be managed or placed in the school setting. Highly charged emotional issues related to HIV infection require that the placement and/or management of these children in the school setting be based on available evidence regarding the risks of transmission of HIV to others in the school setting and the risks to the child with HIV infection of acquiring other infectious agents in the school setting, along with the careful consideration of the confidentiality and legal issues involved.

Based on current evidence, casual person to person contact as would occur among school children poses no risk of transmission of HIV, the viral agent responsible for AIDS. However, a theoretical potential for transmission between young children or neurologically handicapped children who lack control of their body secretions may exist; this theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes of a susceptible person to the blood and possibly other body fluids of an infected person.

Since HIV infections may result in immune deficiency, the infected child may have a greater risk of acquiring infectious agents. Assessment of this risk to the immuno-depressed child is best made by the child's physician who is specifically aware of the individual child's immune status.

The following recommendations apply to all children known to be infected with HIV, regardless of whether or not actual symptoms of disease are present:

1. Decisions regarding the type of educational setting for the HIV infected child should be made on a case-by-case basis taking into account the child's behavior, neurologic development, and physical condition. These decisions are best made using the team approach, including the child's physician, the child's parent or guardian, and personnel from the Synagogue and local health department, and should be reviewed and approved by the Director of Education and Rabbi.

   A. For school-aged children infected with HIV, the benefits of an unrestricted setting in most cases outweigh the risks of their acquiring potentially harmful

infections in the school setting. These children should be allowed to attend school and after school day care in an unrestricted setting. A mechanism for the sharing of information between the child's physician and the school authorities is recommended so that any significant change in the child's medical status can be addressed. In addition, if the school experiences an outbreak of a communicable disease which could be threatening to a child infected with HIV, (e.g. chickenpox, measles), the child should be temporarily excluded by the Educator, pending consultation with the child's physician.

B. HIV infected preschoolers and older children should be considered for exclusion from the classroom if they:

1. lack control of body secretions;

2. exhibit behavioral problems, such as biting;

3. have uncoverable oozing lesions.

Evaluation to assess the continued need for exclusion should be performed regularly.

2. Persons involved in the education of HIV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept to the minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase, e.g., bleeding injury. In individual situations, such people may include the following: Director of Education, Rabbi and the child's teacher(s). Notification should be done by a process that would maximally assist patient confidentiality--ideally, by direct person-to-person contact. It is not necessary to notify parents of other school children regarding the HIV status of any school child.

3. Screening for HIV infection as a condition for school entry is not warranted based on available data.

4. All schools should adopt routine procedures to minimize the transmission of any communicable diseases. Handwashing (with soap and running water for 15-30 seconds and drying with disposable paper towels) is the single most important technique for preventing the spread of disease and should be done frequently. In addition, specific precautions should be taken whenever there is potential for contact with the blood or body fluids of children:

A. Exposure of open skin lesions or mucous membranes to blood or body fluids should be avoided. If open lesions

are present, disposable gloves should be worn. A disposable apron should be worn if clothing is likely to be soiled by blood/body fluids.

B. Surfaces soiled with blood or body fluids should be immediately and thoroughly cleaned. It is advisable to cover the blood/body fluids with paper towels, flood with a solution of one cup of household bleach in 9 cups of water, and allow it to remain for at least 15 minutes before disposing of paper towels in sealed plastic bags.

C. Disposable materials, e.g. gloves, paper towels, sanitary napkins, should be promptly discarded into sealable plastic bags.

D. Mops and other non-disposable cleaning materials are not recommended, but if used, should be rinsed in the disinfectant.

E. Hands should be washed thoroughly after contact with the blood or body fluids of any child, including after removing disposable gloves.

Recommendations for Synagogue Employees

No evidence supports the spread of AIDS/HIV through casual contact, such as that which occurs in the Synagogue setting. Epidemiologic evidence at this time has only implicated blood, seman and vaginal secretions in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HIV, and it has not been shown to be transmitted by contaminated food or water.

In view of this evidence, the following recommendations are made:

1. Screening for HIV infection as a condition for Synagogue employment is not warranted.

2. Decisions regarding Synagogue employees known to be infected with HIV should be made on a case-by-case basis, utilizing existing mechanisms for employee health in consultation with the local health department.

3. Adequate steps must be taken to protect the confidentiality of the Synagogue employee with HIV infection.

4. Since no known risk of transmission to co-workers or others exists from HIV infected workers in the Synagogue

setting, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities or drinking fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HIV infection status, should be cleaned with soap, water, and household bleach as described in the section on recommendations for the education of children.

*Congregations should be advised that federal, state, and local discrimination laws may also affect their employment and school attendance policies. A federal disrict court in California recently held that federal physical handicap laws guaranteed the right of an Atascadero public school boy to attend despite having AIDS. More than twenty states have determined that their physical handicap laws protect persons with AIDS, and a number of cities in California and elsewhere have passed or are considering passing AIDS anti-discrimination laws as well.

Modified from information prepared by the Maryland Department of Health and Mental Hygiene and the Governor's Task Force on AIDS.

affects are terrible, both for the individual involved and those dear to her. Although we can empathize with her wish to commit suicide, it would be difficult for us to approve of this act as Judaism has and continues to object strongly to suicide. The problems which arise under slightly different conditions with other diseases or other circumstances do not make it possible for us to assent to her wish, but we understand it.

June 1983

82. JEWISH REACTION TO EPIDEMICS (AIDS)*

QUESTION: The current AIDS epidemic has led to much fear in various communities. Individuals afflicted with this disease have been removed from positions, ostracized socially, and their children excluded or segregated in schools. What has been the traditional approach of Judaism to such epidemics for which there is no known cure? (Rabbi G. Stern, New York, NY)

ANSWER: We must be concerned with the victims of AIDS as the disease is fatal; they need our compassion. We will not deal with the problems of sexual morality raised by AIDS in this responsum, but only with fear of the potential epidemic. The fear of the general population is understandable as little is known about the disease, its incubation period, or potential cure. Concern for both the individual and the community when a member is afflicted with a dangerous disease has been shown since Biblical times. The book of Leviticus contains detailed instructions of how a skin disease (*metzora*) is to be diagnosed and handled (Lev. 13). During the period of his illness the afflicted person was isolated. The priest who made the diagnosis examined that person after seven days, as well as subsequently. When the disease had come to an end, a complex ritual of purification was provided (Lev. 14 ff). The precautions extended from the individual to the house in which he lived and it, too, was examined, and if necessary scraped and replastered and a ritual of purification was mandated.

Although we do not know the nature of the disease called *metzora* by the *Bible*, it was clearly contagious and led to vigorous efforts to isolate the individuals involved. These procedures were developed further by the *Mishnah* and *Talmud*. There are fourteen chapters in the

Mishnah Negaim which deal with the subject in considerable detail.

Metzora was treated only from a ritual point of view by some authorities, so they did not apply the rules of non-Jews (*M.* Neg. 3.1). All contact with Jews who were afflicted was to be avoided. This included the sick person, his room, any food near him and even the air near the sick room (San. 76b; *Lev. Rabba* 17.3). Insects and flies which had contact with the diseased person were to be avoided (Ket. 77b). For example, when the diseased person came to the *bet hamidrash* in order to study, he was separated from the other students by a wall which was to be "ten handbreadths high and four wide." It was also mandated that he enter the building first and leave it last (*M.* Neg. 13.12). These individuals were excluded from the community and usually lived outside of the cities (II Kings 7.3). If a man was afflicted by this illness his wife had a right to divorce and vice versa (*M.* Ket. 7.9) Those who suffered from such diseases were to avoid sexual intercourse (Ket. 77b).

In the Talmudic period, individuals so afflicted were considered akin to the dead (Ned. 64b). In the *New Testament* some such diseased individuals called to Jesus from a distance as they were obviously prohibited from approaching anyone in the community (Luke 17.12).

Discussions in the *Talmud* and the later responsa literature which dealt with other epidemic diseases usually were less drastic; they suggested that a fast be decreed as the pestilence was thought to be the result of community sins (*M.* Avot 5.12; Ta-anit 3.4, 19b). Jews in the Middle Ages like the rest of the population often fled whenever a plague or epidemic threatened. An epidemic existed if a smaller city suffered three deaths from a known disease on three consecutive days, or nine deaths in three days in a larger city [one which could provide 1500 young men as soldiers] (Ta-anit 21b).

The Jewish medical works of the seventeenth century contain regulations which govern epidemic diseases. As the garments of the sick were considered to provide a source of contagion, they were to be avoided until thoroughly aired. All drinking water was to be purified as a preventive against the epidemic (Tobiah Hakohen *Ma-aseh Tuvyah*, Frankfurt, A. M., 1707, in Max Grunwald's *Die Hygiene der Juden*, p. 262). Dr. Leon Elias Hirschel suggested a number of ways of fighting smallpox; they included quarantine and washing with vinegar by those who came in contact with the ill ("Abhandlung von den Vorbauungs - und Vorbereitungsmitteln bei den Pocken," Berlin, 1770, *Ibid.* p. 265). Israel Salanter took a humane and courageous

approach to a cholera epidemic in Vilna during his lifetime as he urged the community to assist the victims (D. Katz *Tenu-ot Hamusar*, Vol. I, pp. 156 ff).

It is clear from all this that our forefathers sought to protect themselves through whatever ways were available from epidemics. The avenues of quarantine and flight were used.

In the current situation as we deal with AIDS, we should begin by following the advice of the medical community. The current medical opinion suggests that the disease is spread through sexual contact (homosexual or heterosexual), intimate contact and blood transfusions. Little is yet known, however, and there is no cure or preventive vaccine for AIDS, nor is anything known about its incubation period.

The fear and anxiety of employers, parents and others, therefore, can be understood. It is our duty to calm that fear and counteract the pressure of the media. In some instances quarantine or other measures may be appropriate, but they should not be undertaken lightly.

We should do whatever we can to minimize the suffering of the victims of this disease and help them and their families adjust to its tragic consequences. We should follow the advice of public health authorities in our attitude to employees and school-aged children.

November 1985

83. QUALITY OF LIFE AND EUTHANASIA*

QUESTION: Does Jewish tradition recognize the "quality of life" as a factor in determining medical and general care to preserve and prolong life? I have four specific cases in mind. In the first the patient is in a coma, resides in a nursing home and has not recognized anyone for several years. In the second, the patient is in a nursing home, completely paralyzed and can not speak or make his wishes known in any way. The third is a victim of a stroke, sees no hope for recovery or even major improvement, wishes to die and expresses this wish constantly to anyone who visits. The fourth is slowly dying of cancer, is in great pain and wants a prescription which will relieve her of pain but will probably also slightly hasten death. All of these patients are in their early eighties; none is receiving any unusual medical attention. Should we hope for a new medical discovery which will help them? (Rabbi R. H. Lehman, New York, NY)

ANSWER: The considerations which govern euthanasia have been discussed by the Committee in a recent responsa (W. Jacob, *American Reform Responsa*, #79, 1980). The conclusion of that responsum stated:

> "We would not endorse any positive steps leading toward death. We would recommend pain-killing drugs which would ease the remaining days of a patient's life.
>
> "We would reject any general endorsement of euthanasia, but where all 'independent life' has ceased and where the above-mentioned criteria of death have been met, further medical support systems need not be continued."

The question here goes somewhat further as we are not dealing with life threatening situations, but with the general question of prolonging life when its quality may be questionable. In none of these situations has any current extraordinary medical attention been provided. In two of the cases the cognitive and/or communicative ability seems to have ended. In the third there is a strong wish for death. In the fourth, the primary concern is relief from pain. Let us look at each of these cases individually.

For the patient in a coma and the one completely paralyzed and unable to communicate, a segment of the brain which provides intelligence seems to be damaged beyond repair. Judaism does not define human life only in terms of mental activity. Every person has been created in the image of God (Gen. 1.26), and so even those individuals who may be defective, i.e. the retarded, the blind, the deaf, the mute, etc., have always been considered as equally created in the image of God; their life is as precious as any other. It is necessary to guard their life and protect it just as any other human life. This is also true of an elderly individual who has now lost some of her mental ability or power of communication. In fact, we owe a special duty toward these individuals who are weak and more likely to be neglected by society just as to the orphan, the widow and the poor (Deut. 14.29, 27.13, Jer 7.6; Is. 1.17; Shab. 133b; Meg. 31a; San 74a; Yoma 82b).

Let us turn to the individual who seeks death and constantly reiterates his wish to die. Although some rabbinic authorities feel that neither an individual nor his family may pray for his death (Hain Palagi *Hiskei Lev*, Vol. I, Yoreh Deah #50), most of our tradition would agree that a person may ask God to be relieved of suffering. The decision, of course, lies with God. A servant of Judah Hanasi prayed for his release (Ket. 104a). Other ancient authorities pointed to simila examples (Ned 40a and Commentaries). We would, however, discour

enough to them to risk sharing his anger and frustration. Since there is often expectation that love within family will remain constant no matter what, family may be the only safe "target" for these feelings.

18) Encourage families to provide support without being over-protective. In this way, the loved one does not give in to the sense of helplessness and passivity that is common. He should be encouraged to maintain as much control as possible in those areas he can. Helping him to do things he can do himself is not help. The patient can't be rescued from the disease but he can be comforted by a shoulder to cry on.

19) Most important of all is to help families be there for their loved ones. Families should not abandon the ill person because of their own difficulties in dealing with the diagnosis. It's not important to say "the right thing" or do something exceptional. Touching and smiling can convey much affection and reassurance. All their loved one wants to know is that this illness has not altered their feelings of love and affection.

This pamphlet was created by Leila Bender Laitman, M.D., a member of the Union of American Hebrew Congregations' Committee on AIDS, with the assistance of other members of the committee.

SUGGESTED GUIDELINES FOR

COUNSELLING FAMILY MEMBERS OF PEOPLE WITH AIDS

While you may not be personally asked to counsel a person with AIDS, you might very well have contact with parents, siblings, lovers or friends of people with AIDS in your congregation who need your support very much. The following thoughts and suggestions might prove helpful in dealing with them.

1) Be open to discussion of homosexuality or drug abuse which may have been revealed for the first time to family due to the dignosis of AIDS. To learn this news while coping with the fatal prognosis can be overwhelming. People do not know what to tell friends and neighbors. They may even be afraid to speak to you about it fearing your disapproval or some moral judgment. Help them deal with shock, embarrassment, hurt, and anger.

2) Avoid judgmental pronouncements regarding the person with AIDS and his life style. Your goal is to help the family be as open as possible in discussing things with you and be as accepting and supportive as possible in dealing with their loved one.

3) Encourage them to get to know their loved one's friends and close relationships as these might be people whom family can turn to especially for assistance in household chores, bedside care, transportation, orientation to an unfamiliar city and answers about available services. In addition, they may be able to share the emotional burdens as well.

4) Sometimes family members must make decisions about their loved one's medical care such as whether to institute life support machines in an emergency situation when the patient himself cannot say what to do. Be open to discussion of ethical issues involved. Encourage family members to include the person with AIDS in decision making in advance so the loved one's feelings are clear and he has a feeling of control. Remind family that their loved one's lover, care partner or roommate should be part of the decision process.

5) Realize that conflict may develop over the person with AIDS feeling that his lover or friends are also his family. Encourage family members to respect this and to lend support to the lover, care partner or roommate as they may also be suffering. Care partners may also need a small break from the illness from time to time just as family members do. They may wish to be included in all decisions made as they may know the patient better than the family and act as an advocate for his wishes.

6) Stress that the single most important thing a family can offer their loved one is a willingness to go through this experience with him.

7) Help them acknowledge their worries and fears for their own health and well being (even though there is no danger of contracting AIDS through ordinary contact). At an appropriate time, the fears can be discussed with the loved one as part of going through the experience together.

8) Encourage them not to set aside their own needs all the time. It is important to the person with AIDS and other loved ones that family members maintain good health themselves.

9) Help correct misinformation about AIDS. Reassert that there has been no reason to believe that AIDs is spread by casual household contact and that the person with AIDS is the one who is more at risk in having to combat even common viruses and infections like colds, coughs and flu with an impaired immune system. If family members or friends do not feel well themselves, they should visit by telephone.

10) Be open to discussing fear of losing a loved one. This fear can sometimes block expressions of understanding and affection from family members which AIDS patients desperately need for support.

11) Help family members realize they must try to relax and not insist the loved one eat more or sleep more or do *anything* to get better. Try and step back from the immediacy of situations and gain beneficial perspective.

12) A sense of humor is important to encourage in family members when dealing with the emotional trials of AIDS.

13) Encourage family to help the loved one celebrate Jewish and other holidays by decorating home or hospital room or bringing flowers and including him in holiday festivities.

14) Help family members realize that there are little things that they can do to make life for their loved one more pleasant like take him for a walk or outing; help answer correspondence with which he may have difficulty dealing; shop for him; bring books, periodicals, taped music, a poster for the wall, home-baked cookies or delicacies to share with visitors. Always keep promises that are made. Encourage old friends or long lost family to visit if he wants them to.

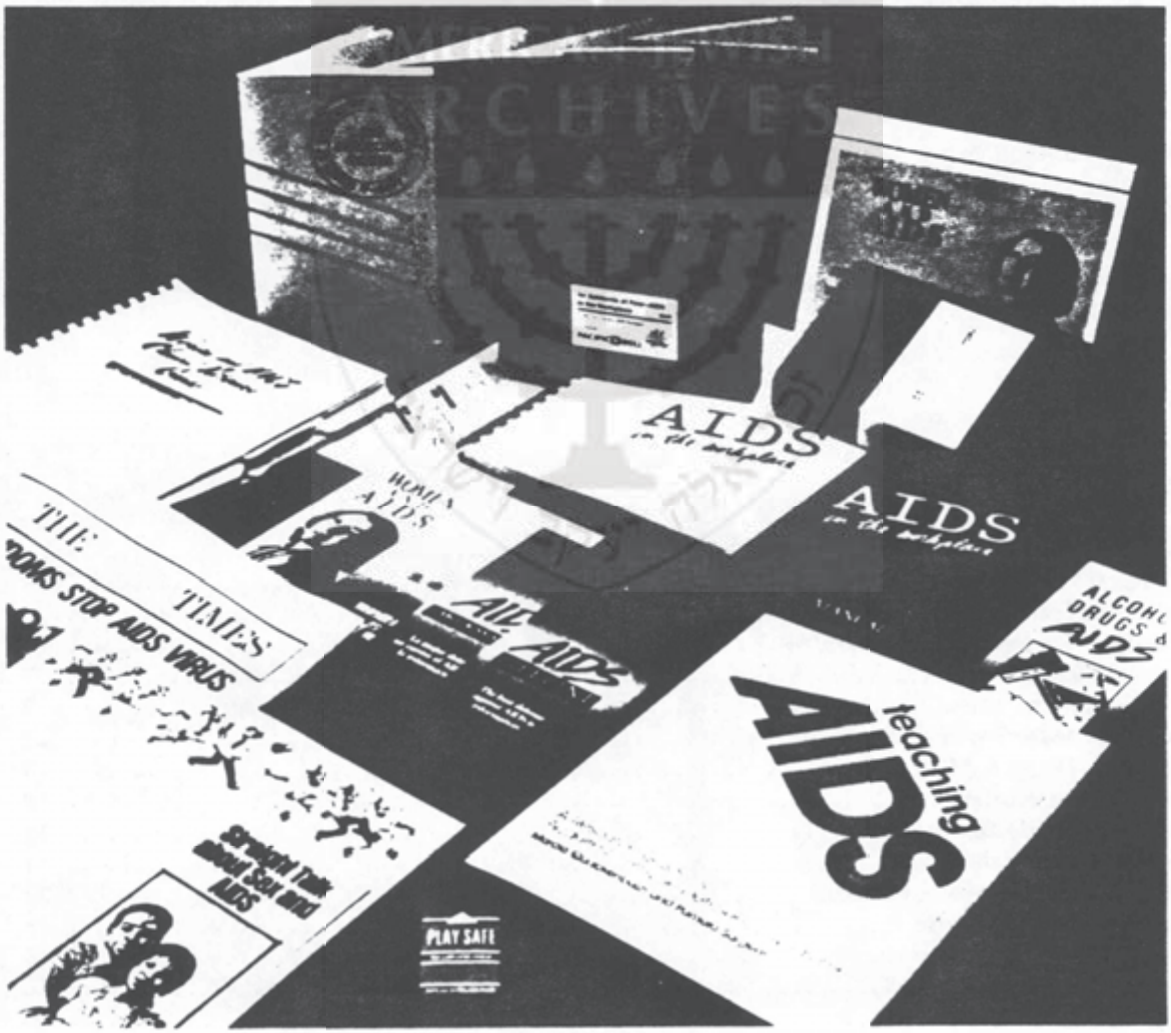
15) Be aware that the strain of serious illness in one family member can cause problems in other relationships both at home and at work for the rest of the family. Be willing to talk about these problems too and not just center on talking about the relationship with the AIDS victim himself. Perhaps it would be helpful to ask how things are going apart from dealing with the sick loved one.

16) Help family members make sure that their loved one's personal affairs are in order such as knowing about current wills, bank accounts, charge accounts, outstanding loans. Family members might want to enlist your help in making funeral arrangements for a proper Jewish burial.

17) Help family members tolerate anger that may be projected toward them by their loved one. Let them realize they've done nothing wrong and should feel no guilt. They should feel flattered that he is close

AIDS EDUCATOR

San Francisco AIDS Foundation Publications Catalog Spring 1987 No. 1



San Francisco AIDS Foundation
333 Valencia Street
Fourth Floor
San Francisco, CA 94103
415-864-4376

Dear Friend:

Since 1982, the San Francisco AIDS Foundation has been a pioneer in the field of AIDS education. During that time, we have provided quality AIDS education materials to thousands of health professionals and social service providers like yourself. We're proud to have assisted you, and we want to continue to meet your AIDS information needs — quickly and efficiently.

In this catalog you'll find the widest variety of materials with which to address your AIDS education needs. Our materials are internationally recognized as models for effective AIDS education. They have proved successful in the education and social service programs conducted by the Foundation. Programs that have earned the Foundation the 1987 Edward R. Loveland Memorial Award from the American College of Physicians, honoring a lay organization "...for distinguished contributions in the health field."

We are also pleased to offer resources produced by other AIDS educators. These materials have been reviewed by our health educators and have been chosen for their outstanding educational features.

I invite your comments on our materials and suggestions for new titles. I am very interested in providing you with only the most effective and useful materials.

Please read and enjoy your new catalog. We look forward to serving your AIDS education needs.

Sincerely,

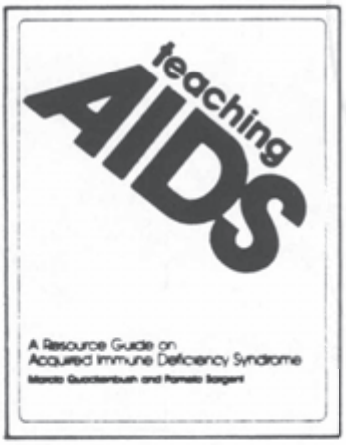
Thomas E. White
Marketing Manager

CONTENTS:

AIDS EDUCATOR is published quarterly by the San Francisco AIDS Foundation and distributed free of charge.

Initial funding for development of this catalog was provided by a grant from the Richard and Rhoda Goldman Fund and the Columbia Foundation.

NEW ITEMS!



"AIDS is no longer the concern of any one segment of society; it is the concern of us all."

— U.S. Surgeon General's *Report on AIDS*, 1986

GENERAL POPULATION

For brochure pricing and shipping information see page 18.

AIDS Lifeline

The Best Defense Against AIDS is Information

One of our most popular brochures, this highly informative publication explains basic facts about AIDS: prevention, cause, risk, transmission, symptoms, treatment and diagnosis. Over 250,000 copies distributed in its first year.

English-Spanish-Chinese (Braille in English only)

Co-produced with KPIX-TV

(1985) 8½ × 11"/2 folds/2 colors

Straight Talk About Sex and AIDS

Very much in demand, this pamphlet is aimed at sexually active heterosexual adults and teens. An easy-to-read guide, it promotes open communication between partners about sexual history and drug use, and encourages condom use to prevent transmission of the AIDS virus.

English-Spanish

Produced in conjunction with the SF Dept. of Public Health

(1986) 8¼ × 11¾"/2 folds/2 colors

Women & AIDS

Our primary educational brochure for women, this nationally recognized publication presents current guidelines on AIDS prevention for women. It describes the specific circumstances when women risk infection and how they can protect themselves. It also addresses concerns about pregnancy, breastfeeding and artificial insemination.

Text by Women & AIDS Network

(1986) 8½ × 14"/3 folds/2 colors

BONUS!
FIGHT THE FEAR WITH THE FACTS! FREE POSTER!
See page 14 for details

You have two easy ways to order materials: Use the convenient order form on page 19, or call our Materials Distribution Office at 415/861-3397. Also use that number for inquiries or additional information.

Your Child & AIDS

This important brochure answers parents' questions about the risk of contracting AIDS through bites, cuts, bruises or contact with other children who have AIDS. Guidelines established by the National Centers for Disease Control are reproduced here. Straightforward and credible.

Co-produced with the SF Medical Society, SF Department of Public Health and SF Unified School District. Partially funded by the SF Dept. of Public Health and the California Dept. of Public Health Services.

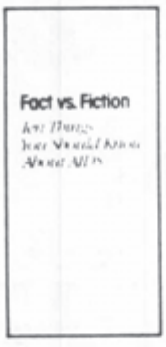
(1986) 8½ × 11"/2 folds/2 colors

When A Friend Has AIDS

Sensitive and practical, this brochure provides suggestions for friends, family or loved ones of people with AIDS or ARC. It presents specific ways to communicate, consider, listen and touch, and encourages the reader to find positive ways to meet his or her own needs.

Originally developed by Chelsea Psychotherapy Associates of New York. This version created with permission from Chelsea by the SF Community Partnership on AIDS.

(1985) 8½ × 11"/2 folds/2 colors



Fact vs Fiction

Ten Things You Should Know About AIDS

This easy-to-read brochure lists ten 'true' or 'false' statements about AIDS transmission, diagnosis, and who can get the disease. It encourages the reader to find out more about what can be done to help and emphasizes the importance of financial support. Most appropriate as part of a fund-raising campaign.

(1986) 8½ × 7"/1 fold/2 colors

"The best defense against AIDS is information."
— AIDS Lifeline

(See p. 18 for all brochure prices)

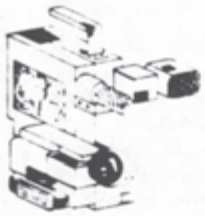
WOMEN, TEENS, & CHILDREN

Women & AIDS Clinical Resource Guide

This comprehensive manual provides up-to-date information on risk, transmission, diagnosis, prevention, infection control, program development, children, teens, psychosocial issues, and substance abuse. An invaluable tool for health care workers and social service providers concerned about women and AIDS. *Prepared by Women's Health Outreach*
(1986) 367 pgs, photocopied $40.00

Model Programs for Women's AIDS Education and Services

A critical report on the transmission and demographics of women with AIDS. Includes a thorough overview of networks, forums, research efforts, medical and support services currently being offered in the San Francisco Bay Area.
Written by Nancy Shaw, Ph.D.
(1985) 28 pgs $5.00



NEW! AIDS & The Women's Community

VIDEO

This video provides an in-depth view of the critical impact the AIDS epidemic has had on the lesbian community. It includes presentations by a physician, a therapist, and an attorney. Topics include risk factors, transmission, safe sex, emotional issues, job discrimination, and political aspects.
Co-produced with Bay Area Career Women
(1986) 44 min. Purchase $45.00 Rental $25.00 Preview $15.00

Brochures:
Lesbians & AIDS: What's the Connection?

Highly informative, this publication discusses the emotional and political impact of AIDS, as well as possible AIDS risk factors for lesbians. It presents information on donor insemination, substance abuse, and safe sex.
Prepared by Women's AIDS Network (See p. 18 for prices)
(1986) 8½ × 11"/2 folds/2 colors

For our **WOMEN & AIDS, YOUR CHILD & AIDS,** and **STRAIGHT TALK ABOUT SEX AND AIDS** brochure descriptions, see page 4.

Women & AIDS Clinical Resource Package

This package includes the **Women & AIDS Clinical Resource Guide, Model Programs for Women's AIDS Education and Services**, and the video, **AIDS & the Women's Community**, and 200 different brochures (your choice: up to 4 different titles) $115.00

Safe Sex Guidelines for Women at Risk for AIDS Transmission

This fact sheet lists safe and unsafe activities and presents information on the use of condoms, spermicides, latex or rubber gloves and barriers. Sexually explicit. *Compiled by Women's AIDS Network, Coyote, Project Aware, and Lesbian Insemination Project* (1986) 8½ × 11" 10¢

Women & AIDS

A Referral Manual for Women with Concerns about AIDS
An exhaustive listing of agencies in the San Francisco Bay area serving women and people with AIDS/ARC.
(1985) Second Edition, 31 pgs. $5.00

Help us expand our mailing list. If you're reading someone else's catalog and you would like your own copy, send us your name and address. If you have colleagues whom you think should receive this catalog, send us their names and addresses on the coupon on page 16.

BOOKLETS FOR PEOPLE WITH AIDS/ARC

Two easy ways to order: Use the convenient order form on page 19, or call 415/861-3397 between 9 am & 4:30 pm (PST).

AIDS Medical Guide

This booklet provides detailed information about the host of opportunistic infections that affect the AIDS patient. It describes symptoms and available treatments in laymen's language. An invaluable guide for people with AIDS or others who want to understand the medical facts about the disease.

(1986) 5½ × 8½"/21 pgs.

Coping With AIDS

Written by people with AIDS and staff members at San Francisco General Hospital, this booklet provides assistance in coping with the emotional, physical and financial consequences of AIDS. It includes thought-provoking segments by people with AIDS on their personal experiences.

(1984) 5½ × 8½"/10 pgs.

The Family's Guide to AIDS

This booklet addresses the friends and family of people with AIDS, discussing issues like patient advocacy, the hospital environment, insurance forms, sharing medical information, and emotional stress in a concise format. It concludes with local referrals and a short booklist.

(1984) 5½ × 8½"/9 pgs.

Coping With ARC

This comprehensive booklet discusses the most important aspects of AIDS Related Complex. Methods of diagnosis, possible treatments, and the effects of drugs and alcohol on the immune system are examined, along with issues related to confidentiality, employment, sex, and personal support. Two appendices provide a comprehensive definition of ARC and an extensive list of financial benefits and social services in California.

(1986) 5½ × 8½/18 pgs.

Resource Manual For People With AIDS/ARC

This comprehensive guide is an invaluable aid in locating the proper resources for the AIDS & ARC patient, friends, family and care-givers in the SF Bay Area. It contains more than 40 pages of local resource listings, a thorough summary of federal financial and medical benefit programs, along with a glossary of terms related to AIDS and medical care.

(1987) Fourth Edition, 5½ × 8½"/Stapled

All of the booklets in this series were partly funded by the SF Dept. of Public Health and the California Dept. of Health Services.

GUARANTEE

All materials purchased from the San Francisco AIDS Foundation are guaranteed. If for any reason you are not completely satisfied, contact our office within 30 days and arrange to return the purchased materials in original condition for a full refund or credit.

Infection Precautions For People With AIDS Living in the Community

This fact sheet provides simple, specific common sense hygienic measures for people with AIDS who are able to care for themselves at home.

(1984) 8½ × 11"/2-sided 10¢

Booklet Prices

For our Aids Medical Guide, Coping with AIDS, the Family's Guide to AIDS, Coping with ARC, Resource Manual for People with AIDS/ARC and AIDS & Your Legal Rights (see p. 7):

25-499	90¢	1500-4999	75¢
500-1499	80¢	5000 & up	70¢

We request a minimum order of 25 booklets. Up to six booklets may be requested as free samples.

LEGAL ISSUES & AIDS

Getting Your Affairs In Order

This two-paged publication enables the reader to compile information concerning financial matters and legal records. It enables a lover or family member to locate and settle the sick person's affairs. Includes listing of SF Resources.

Co-produced with Bay Area Lawyers for Individual Freedom. Partly funded by the SF Dept. of Public Health and the California Dept. of Health Services.
(1983) 8½ × 11"/2 folds/color

NEW! AIDS and Your Legal Rights

Detailed and comprehensive, this ten-page booklet answers 25 vital questions on the effect of the AIDS epidemic on civil rights for patients, employees, gay or bisexual males, etc. Specific questions related to antibody testing, insurance, job discrimination, government programs, and wills are included.

Produced by National Gay Rights Advocates.
(1986) 8½ × 7"/1 fold/8 pgs.
See p. 18 for brochure prices.

Need sample copies? Fill out the coupon on page 16. Or order our sampler pack for $4.

NEW! Wills Give You Power

Offering much needed information on the protection a will offers, "Wills . . ." covers important questions on probate, joint ownership, creating your own will, etc. Specifically designed to address issues unique to gays & lesbians.

Produced by National Gay Rights Advocates.
(1985) 8½ × 11"/2 folds/1 color

NEW! AIDS Practice Manual: A Legal & Education Guide

An extensive guide to the legal and financial concerns facing a person with AIDS or ARC, this publication enables the reader to prepare someone for incapacity and terminal illness. It summarizes the medical and psychological issues involved, and provides detailed information on estate planning, conservatorships, durable powers of attorney, wills, directives to physicians, trusts and obtaining public benefits.

Produced by National Gay Rights Advocates.
(1986) 8½ × 11"/99 pgs., photocopied.
$25.00

ETHNIC COMMUNITIES

Information for People of Color

This publication presents information on how AIDS has affected different ethnic communities. It describes various methods of transmission in clear detail and lists specific symptoms associated with AIDS. Lists resources specific to the SF Bay area.

Written by the Third World Advisory Task Force.
(1985) 8½ × 11"/2 folds/4 colors
(See p. 18 for prices)

Reaching Ethnic Communities in the Fight Against AIDS

This timely report summarizes findings from attitudinal research conducted with leaders from San Francisco's Black, Asian and Latino communities on AIDS risk reduction. It begins with an assessment of current levels of awareness and risky behavior, and concludes with ways to communicate most effectively to minority groups. Appropriate for most urban communities.

Prepared by Communication Technologies and Research & Decisions Corporation
(1986) 16 pgs.
$5.00

See p. 17 for Brochures & Cards in other languages.

AIDS IS STRIKING PEOPLE OF COLOR. "It is not limited to gay white men. In fact two out of five Americans with AIDS are Black, Latino, Asian, American Indian and other People of Color. Among women with AIDS, half are Black and one in five are Latina. More than four out of five U.S. children with AIDS are from People of color."

— Information for People of Color

SAFE SEX MATERIALS FOR GAY/BISEXUAL MEN

Several titles are available in Spanish. See page 17 for listing.

Guidelines For AIDS Risk Reduction

This popular and effective brochure provides an in-depth discussion of AIDS symptoms, transmission and risk reduction. It includes a detailed discussion of safe sex. Sexually explicit.

English-Spanish

Written by the Scientific Affairs Committee of the Bay Area Physicians for Human Rights.

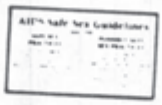
(1984) 8½ × 14"/2 folds/1 color (see p. 18 for prices)

Can We Talk?

This colorful, lively brochure uses cartoons and direct language to explain safe and unsafe sex practices for gay and bisexual men. Sexually explicit. *(For bulk orders of more than 100 pieces outside Northern California, please write to the Harvey Milk Lesbian/Gay Democratic Club, POB 14368, San Francisco, CA 94114.)*

(1985) 5½ × 24"/5 folds/2 colors (see p. 18 for prices)

Safe Sex Cards



A wallet-sized card that outlines safe and unsafe sex practices. Great for easy reference; easy to pass out at street fairs and other events.

English-Spanish

Written by Bay Area Physicians for Human Rights.

(1985) 1 × 3"/2 sided 5¢

Can You Pass the Safe Sex Test?

A factual chart of safe and unsafe sex practices. Sexually explicit.

AIDS Safe Sex Guidelines

For sexually active men and women, this poster provides basic information on safe and unsafe practices. Explicit language.

(1985) 8½ × 11" 10¢ each

The Hot 'N Healthy Times

This 4-page newspaper is designed to eroticize condom use for gay men. Lively articles cover all of the issues related to condoms: how safe they are; how to overcome resistance to condoms (your own or a partner's); how to choose between brands; and how to make condom use pleasurable. Graphic center spread shows exactly how to put condoms on. Contains sexually explicit language and nudity. *Erotic us Publications*

(1985) 11 × 17" or bulk rates

Lifeguard: The Safe Sex Video

VIDEO

A full-length video featuring well-known gay porn stars, this video shows sensuous safe sex in full color. It also includes a brief presentation of safe sex guidelines by Dr. Robert K. Bolan, past president of the SF AIDS Foundation's Board of Directors. Includes one copy of "Guidelines for AIDS Risk Reduction." *Produced by HIS Video/VCA Labs*

(1986) (74 min.) $39.95

Condom Commercials

VIDEO

This full-color video uses humorous sketches to encourage viewers to use condoms. It contains two 60-second and two 30-second spots. Use it in bars, bathhouses, or other meeting places. Suitable for any gay male gathering place. Not sexually explicit.

VHS or Beta $20.00 ¾" Master $40.00

"Play Safe" Condoms NEW!

A matchbook-sized package containing one lubricated condom and graphic directions on proper use. Can be customed-printed with local resource referrals. Call for price

Free materials are available for conferences, workshops, training events and classes. We will be happy to provide you with:

- **SF AIDS Foundation catalogs**

Informational Fliers on:

- **Women and AIDS Educational Resources**
- **AIDS and the Workplace — Educational Program and Consulting Services**
- **AIDS: Care Beyond the Hospital Videotape**
- **Sex, Drugs and AIDS — 18-minute videotape**
- **Lifeguard: Safe Sex Video for Gay Men**

Let us know what you need, how many, and when. There is no charge for materials, except for rush service.

Send your order at least 5 weeks in advance, and include complete shipping information. For further information, or to receive display copies of selected titles, call us at 415/861-3397.

ALCOHOL, DRUGS & NEEDLE USE

Alcohol, Drugs & AIDS

This brochure discusses links between the use of alcohol and drugs, damage to the immune system and increased susceptibility to the AIDS virus. It describes the biological effects of alcohol, amphetamines, marijuana and poppers.

English on one side; Spanish on the reverse.

Written by the Committee on Substance Abuse and AIDS, SF. Funded partly by SF Dept. of Public Health and California Dept. of Health Services.

(1986) 8½ × 17"/4 folds/2 colors

Shooting Up & Your Health

This pamphlet discusses the major health risks associated with intravenous drug use and the three most deadly infections which may be contracted by sharing needles: AIDS, hepatitis-B, and endocarditis. Emphasizes the need for clean works and not sharing needles. Lists SF Bay area resources.

English-Spanish

Prepared by the Haight-Ashbury Free Medical Clinic.

(1985) 8½ × 11"/2 fold/2 colors

Poppers

Your Health & AIDS . . .Can You Afford the Risk?

Shaped like a bottle of poppers, this publication discusses the possible link between poppers and susceptibility to the AIDS virus and Kaposi's Sarcoma.

Prepared by the Substance Abuse and AIDS Task Force with the Committee to Monitor Poppers. Partially funded by the SF Dept. of Public Health.

(1985) 11¼ × 6¾"/3 folds/2 colors

"Of the women who have gotten AIDS, over half have been I.V. drug users."
— Women and AIDS

VIDEO

NEW! Sex, Drugs & AIDS

This lively 19-minute film speaks frankly to teenagers in their own language. The first segment dispels myths about AIDS casual contagion; the second explains exactly how AIDS is transmitted (through sex and I.V. needle use) and describes how people can protect themselves from infection.

The film also strongly emphasizes compassion for people with AIDS, who are portrayed here as a gay man, a straight woman, a Black teenage mother, and a blood recipient. Highly recommended. Some sexually explicit language.

Hosted by movie and television star Rae Dawn Chong.

Includes discussion guide and current student fact sheet.

(1986) *Produced by ODN Productions. Funded in part by the New York City Board of Education and the Maurice Falk Medical Fund.*

Video	
Preview	$ 20.00
Purchase	$325.00
Rental (5 days)	$ 75.00
Film (16mm)	
Purchase	$400.00

NEW! This Bottle Could Save Your Life

A clear, graphic representation of how to clean hypodermic needles with bleach and water. Effective for use in treatment centers and public areas. Also useful as a handout.

(1986) 8½ × 11"/4 colors 25¢

NEW! Needle Use & AIDS

A wallet-size card that gives clear directions on cleaning needles to avoid exposure to the AIDS virus. Emphasizes not sharing needles as the best form of prevention.

(1987) Call for prices.

For brochure and booklet pricing and shipping information see page 18.

The more brochures or booklets you order, the lower your unit cost.

AIDS IN THE WORKPLACE

1986
CINE
Film Award
Winner!

Our **AIDS in the Workplace** package is a comprehensive multi-media education program suitable for any workplace. Developed with the assistance of top business leaders, this package is invaluable for employees at any level, as well as health educators employed in the workplace.

Less than a year after its release, this package has set an internationally-recognized standard for the corporate response to AIDS.

The five-part program consists of:

VIDEO

- **An Epidemic of Fear: AIDS in the Workplace** This widely acclaimed 23-minute videotape uses real-life situations to educate managers and employees about AIDS. Includes interviews with medical experts, corporate managers, employees with AIDS and their co-workers.
- **An Educational Guide for Managers** A 68-page how-to guide that tells decision-makers what they need to know about AIDS and provides a model for educating employees. Also includes answers to common workplace-related questions about AIDS and a list of educational resources. Arranged in a premium quality 3-ring binder.
- **Strategy Manual** This 53-page manual is based on the experience of companies which have successfully dealt with AIDS in the workplace. It provides hands-on suggestions for the development of policies and guidelines for responding to AIDS in the work environment.
- **Strategy Manual Appendix** A comprehensive collection of resource materials, including samples of actual corporate policies and guidelines, newsletter articles and other valuable information.
- **Brochures: AIDS In The Workplace: A Guide for Employees** This pamphlet answers questions about AIDS transmission and casual contagion in the workplace. Each package includes ten sample copies. Other brochures provided are: **AIDS Lifeline**, **When A Friend Has AIDS** & **AIDS Antibody Testing at Alternative Test Sites.** (5 copies each) *See Index on p. 17 to locate brochure descriptions.*

"Offices, factories, and other work sites should have a plan in operation for education of the work force and accommodation of AIDS or ARC patients before the first such case appears at the work site."
— U.S. Surgeon General's Report on AIDS

This award-winning program was developed in cooperation with the Business Leadership Task Force of the San Francisco Bay Area. Members of the Task Force include Levi Strauss & Co., Pacific Bell, Mervyn's, Bank of America, Wells Fargo Bank, AT&T and Chevron Corp. These businesses and their associated foundations also funded the development and production of our **AIDS in the Workplace** *materials.*

PRICE SCHEDULE FOR AIDS IN THE WORKPLACE

Total package	$398.00
Videotape & Leadership Guide	$275.00
Strategy Guide & Appendix	$125.00
Videotape alone	$195.00
Leadership Guide	$125.00

Employee Brochures

1-9	45¢
10-99	35¢
100-499	30¢
500-4999	28¢
5000-& up	25¢

Nonprofit AIDS agencies are eligible for special discounts on **AIDS in the Workplace**.
Call for more information: (415) 861-3397.

AIDS ANTIBODY TESTING

AIDS Antibody Testing At Alternative Test Sites

VIDEO

Video: A full-color, 11-minute educational presentation on the pros and cons of the AIDS antibody (HIV) test. The video uses sophisticated graphics to describe how the test determines the presence of antibodies to the AIDS virus, and includes group discussions on the social, psychological and medical issues surrounding the test. Designed to help individuals make their own decisions about whether or not to take the test.

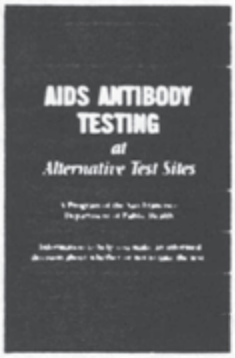
Version 1: contains references to San Francisco program.

Version 2: for any location with anonymous testing program.

Customizing available. Call for details.

(1985) VHS or Beta. Purchase or preview only.

Preview	$ 20.00
Single copies	$300.00
AIDS agency	$200.00



AIDS Antibody Alternative Testing at Test Sites

A decision-making guide for those considering the AIDS antibody test. Useful for answering questions on test procedures, personal concerns and the meaning of test results.

English-Spanish

Prepared with assistance of the SF Dept. of Public Health

(1985) 8½ x 22"/3 folds/2 colors

(See p. 18 for brochure prices.)

Personalize brochures with your agency's resource information. **See page 17 for more information.**

Research Paper

A summary of findings from the Researcher's Conference on the Psychological and behavioral consequences of AIDS Antibody Testing. (1986) 8½ x 11"/9 pgs. $2.00

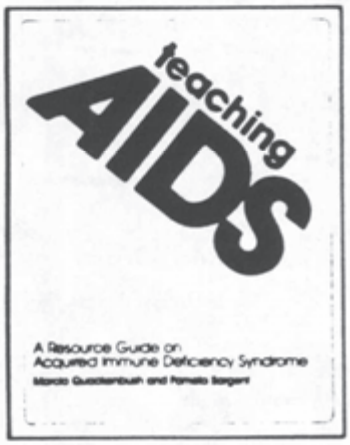
TRAINING MATERIALS

AIDS Hotline Training Manual

This comprehensive, clearly written, and up-to-date manual provides everything you need to train volunteers on an AIDS hotline. A valuable resource for all AIDS educators. It includes:

- an in-depth AIDS education program
- active listening techniques
- appropriate language and phone responses
- how to handle crisis calls
- using TDDs to communicate with deaf callers
- hotline rules and regulations
- an appendix of AIDS reference materials

Available in February, 1987. Call for price.



Teaching AIDS

This resource guide offers a comprehensive curriculum on AIDS for teachers, youth leaders and health educators. Written in language appropriate for teenagers, junior college students and community education, the curriculum is clear and exact. Not sexually explicit. In addition to the curriculum, **Teaching AIDS** includes these useful features:

- sample lecture and guidelines
- seven teaching plans for single-session classes
- six exercise worksheets for soliciting student responses
- a 10-question test on AIDS transmission and prevention

Developed in conjunction with the Youth and AIDS Prevention Program/AIDS Health Project of the University of California, SF. Written by Marcia Quakenbush and Pamela Sargent. Published by Network Publications.

1-9 copies	$14.95
10+ copies	$11.95

"Because of their sexual behavior and drug-use patterns, teenagers are certainly at risk . . . 50% of teenage women have had sexual intercourse, with some 16% reporting 4 or more partners."

Teaching AIDS, Network Publications

HEALTH CARE & HOSPICE PERSONNEL

VIDEO

NEW!
Exploring the Heart of Healing with Stephen Levine & Ram Dass

This three-hour video presents an in-depth exploration of self-healing within the context of a community living and dying with AIDS. Part I explores healing the body and soul, opening out of separateness, life as an opportunity for growth, cultivating spiritual practice, a message to grieving parents, and audience questions & answers. Part I is most appropriate for those personally involved with AIDS and other life-threatening diseases.

Part II includes segments on symbolic overload and AIDS, supporting ourselves and others in the living/dying process, providing skillful service and dealing with burn-out. It captures the essence of Ram Dass' most recent book, "How Can I Help?", and is most appropriate for care-givers. The second half closes with a 15-minute healing meditation.

Both tapes provide excellent training material for volunteers, students, professionals, people with AIDS and their loved ones.

Part I: Two hours	$ 75.00
Part II: One hour	$ 75.00
Both tapes:	$125.00
Preview (5 days) each tape:	$ 20.00

(1986) *Produced by the Access Group, Novato, California*

"AIDS: Care Beyond the Hospital is an excellent educational resource for home care providers. Nurses, social workers, attendants, and volunteers will benefit from this sensitive and professional approach to home care for persons with AIDS."

— Jeannee Parker Martin, RN, MPH, Director, AIDS Home Care & Hospice Program, Hospice of San Francisco

VIDEO

AIDS: Care Beyond the Hospital

This videotape is designed as a teaching tool for health care providers who will be working with people with AIDS in the home. It discusses the psychosocial impact of AIDS on the patient, the range of social responses, the common physical problems caused by AIDS-related infections and malignancies, and the home care needs of a person with AIDS. It is an excellent source of help in developing a case management plan for a chronically or terminally ill patient.

There are two versions of the tape. The 45-minute Case Management version is directed toward nurses, social workers, discharge planners, and physicians. The 30-minute Attendant Care version omits the case management section and outlines basic home hygiene techniques. It is intended for home health aides, attendants, and volunteers. (The video presentation is not to be shown to general audiences, lay people, or to groups of gay men not providing services to people with AIDS or any mass media.) Free descriptive brochure available.

Specify Case Management or Attendant Care version.

½" VHS $ 75.00 ¾" $115.00

Previews are $20 for each version, for a period of one week.

Rentals are $25 for one week. Please specify date needed. Slide show format available as rental in Northern California only.

HEALTH CARE & HOSPICE PERSONNEL

NEW!
AIDS Home Care and Hospice Manual

This exciting publication is a training guide for home health agencies and hospice programs in the care of persons diagnosed with AIDS. Based on the first AIDS Home Care and Hospice program at VNA of San Francisco, it provides educational guidelines and resources for administrators, staff and volunteers. Includes an overview of AIDS and ARC, the epidemiology of the disease, infection control requirements, physical and psychosocial interventions, easy reference tools for field staff, local, state and national resources, and examples of documentation used for reimbursement.

For-profit corporation: $195 Nonprofit agency: $ 95
Individual clinician: $ 50

AIDS & The Health Care Worker

Graphically illustrated, this brochure addresses health care workers' fears about AIDS. It describes specific methods of infection control to ensure both worker and patient safety, and provides current information on people at risk.

Produced by Service Employees International Union, Washington, DC.

(1986) 8½ × 14"/3 folds/2 colors (See p. 18 for prices.)

Medical Evaluation of Persons At Risk for Acquired Immune Deficiency Syndrome

Designed for physicians, this manual presents an in-depth discussion of the most common symptoms associated with AIDS, including fever, lymphadenopathy, pulmonary problems, gastrointestinal syndromes, neurological complaints and dermatological manifestations. Guidelines for evaluating the worried well are provided, along with safe sex guidelines for people at risk. Covers history-taking, physical exam, laboratory tests and suggested treatments.

Prepared by the Scientific Affairs Committee of the Bay Area Physicians for Human Rights, SF. Co-editors: J.M. Campbell, M.D. and W.L. Warner, M.D.

(1985) 40 pgs., photocopied $10.00

All revenues from sales of materials go towards fulfilling the San Francisco AIDS Foundation's nonprofit educational and social service goals.

How Infections Are Transmitted

This fact sheet presents general information on infection, contagion, germs, immunity, and certain illnesses such as diarrhea in simple language. It includes specific infection control guidelines for health care workers or anyone who is likely to come into contact with blood and other bodily fluids.

(1984) 8½ × 11"/5 pages photocopied 50¢

EDUCATIONAL CAMPAIGNS

Order all your AIDS information needs at one time. You'll save money with our quantity discounts.

Designing an Effective AIDS Prevention Campaign Strategy

This is a series of four public opinion surveys, three conducted among San Francisco's gay and bisexual male population, and one devoted to heterosexual men and women with multiple sexual partners.

The first three studies, conducted at one-year intervals, provided data critical to the development of our risk reduction education campaign aimed at gay and bisexual men. The fourth study was designed to provide data on the potential size and composition of the risk groups in the heterosexual segment of the population. All four studies provide detailed information about attitudes toward and awareness of AIDS, risky behavior, and safe sex among the populations studied.

(a) Results from the First Probability Sample of an Urban Gay Male Community (1984) Specify #1
(b) Results from the Second Probability Sample of an Urban Gay Male Community (1985) Specify #2
(c) Results from the Third Probability Sample of an Urban Gay Male Community (1986) Specify #3
(d) Results from the first Probability Sample of Multiple/High-Risk Partner Heterosexual Adults (1986) Specify #4

All the above reports were prepared by Research & Decisions Corporation $25.00 each

Health Education Planning for AIDS Risk Reduction in the Gay/Bisexual Male Community: The Precede Framework

Detailed and thorough, this report presents the basic principles of developing AIDS risk reduction strategies for gay and bisexual men. The *PRECEDE* framework helps health educators "identify critical non-behavioral factors which affect risky behavior but which must be addressed by social agencies, community organizations, or social action groups . . ." The appendix includes four examples of AIDS risk reduction display advertisements.

1985. *Prepared by Robert K. Bolan, M.D.* $4.00

FREE BONUS!

NEW!
Some People Think You Can Catch AIDS from a Glass

This two-color poster, suitable for general display, depicts a drinking glass. The brief text explains how AIDS is and is not transmitted. California toll-free hotline numbers are provided. Bulk quantitites are available for free only in California. Shipping and handling charges do apply. Poster can be personalized with your local Hotline number. Call for estimate.

Celebrity Public Service Announcements

The first national AIDS PSA's are now available directly to individuals and organizations. 46 prime-time TV stars and other well-known personalities educate the public about various aspects of the fight against AIDS on one videotape.

The PSA's, 64 altogether, have already been distributed nationwide to 650 radio and TV stations. Now you can get Ron Reagan Jr., Eva Gabor and Joe Namath to speak to audiences in your area who aren't reached by local media. Space is provided at the end of each 30-second spot for organizations to add their local resource information.

Production coordinated by the San Francisco AIDS Foundation; co-produced by KPIX-TV San Francisco and Chen Sam Associates, New York. Production funded by KPIX-TV, AIDS Project Los Angeles, American Foundation for AIDS Research, and the U.S. Public Health Service. Initial distribution assisted by the National AIDS Network.

Tapes are available for purchase at minimal cost. For further information contact Mary McFadden, Highland Labs, 840 Battery Street, San Francisco, CA 94111 415/981-5010. Reference "KPIX AIDS PSA's"

SAN FRANCISCO AIDS FOUNDATION SERVICES

San Francisco AIDS Foundation
333 Valencia Street
Fourth Floor
San Francisco, CA 94103
415-864-4376

Educational Services

The Education Department

- **Telephone Services**
  Well-trained and supervised volunteers staff the AIDS Hotline Monday-Friday 9-9 and weekends 11-5.
- **Educational Events**
  Speakers are provided to diverse audiences requesting AIDS information; forums are organized to address specific areas of concern; and in-depth seminars are held for health care professionals.
- **Media Relations & Advertising**
  Educational messages are developed and placed in various advertising media to increase AIDS awareness locally and nationally. We disseminate accurate AIDS-related information to media professionals.
- **Materials Development and Distribution**
  Literature and audiovisual materials are designed to address specific target audiences and are distributed nationally and abroad.

Direct Services for People with AIDS/ARC

The Social Services Department

- **Social Services Program**
  The Social Services Program meets critical social service needs of people with AIDS or ARC. Social workers assist clients with disability benefits, housing, and employment concerns.
- **Emergency Housing Program**
  The Emergency Housing Program is a short-term housing program serving people with AIDS/ARC.
- **Food Bank**
  The Food Bank is a privately funded, community-supported program which assists low-income people with AIDS/ARC with additional groceries and other necessities.

Northern California Educational Services

The Northern California Service Department

- **800 Toll-Free AIDS Information and Referral Hotline**
  This volunteer-staffed Hotline serves 44 counties in Northern California.
- **Direct Educational Services in Counties without Education Programs**
  Staff provide forums, literature, media education and media advertising to health care providers, people at risk and the general population in specified counties where no such services exist.
- **Program Assistance**
  In order to foster resource-sharing among AIDS agencies and other local departments of public health, staff consult on program development, forums, materials development and distribution, media relations and advertising in specified counties in Northern California.

1987 Award Recipient! The San Francisco AIDS Foundation is the recipient of the Edward R. Loveland Memorial Award from the American College of Physicians — "to honor a lay organization for distinguished contributions in the health field."

For People With AIDS, ARC and Their Families

We do urge people with AIDS, ARC and their families who live in Northern California to call our local hotline numbers to receive free literature suitable to their individual needs. In San Francisco, that number is 863-AIDS. In Northern California, it's (800) FOR-AIDS. Outside California, please call 1-800-342-AIDS.

Hotline: (415) 863-AIDS (800) FOR-AIDS (No. Calif.)

ITEMS TO COME!

- **Dental Patient Management and Office Procedures Resource Manual**
- **A Guide for Living with AIDS** *(Comic Book)*
- **AIDS 101: A Primer of Medical Information on AIDS** *(Booklet)*
- **Safe Sex Information Targeted for Inmates at Correctional Facilities and low literacy populations** *(Low Literacy Brochures and Cards)*
- **Infection Control at Home for People with AIDS and ARC** *(Brochure)*
- **After the AIDS Antibody Test — What's Next?** *(Brochure)*

Posters: AIDS Education in Correctional Facilities

Four posters that clearly communicate basic AIDS risk information to correctional inmates and staff. Each poster uses a focused, textual message and limited graphics. Posters 1 and 2 advise readers to contact their medical officer or counselor. The text in posters 3 and 4 is pertinent for posting in any location.

Developed by the San Francisco Forensic AIDS Task Force

Poster 1: **"The Ultimate Point — Shooting up and sharing needles puts you at risk for AIDS. This fact may save your life!"**

Poster 2: **"The Best Life Insurance Against AIDS is Information — Learn how to prevent the spread of AIDS"**

Poster 3: **"You Cannot Get AIDS From: foods; eating utensils; shaking hands; the air; toilet seats; sneezing and coughing"**

Poster 4: **"AIDS Prevention — Don't share tattoo kits"**

(1985) 17" × 22" **Prices:** 1-10: $3.00 10-100: $2.50 100+: $1.75

All revenues from sales of materials in this catalog go towards supporting the educational and social service goals of the San Francisco AIDS Foundation.

Reader Service Coupon

Name _____

Title _____ Date _____

Organization _____

Address _____

City _____ State _____ Zip _____

Telephone _____

Please send review copies of the following six brochures and/or six booklets:

1: _____ 2: _____

3: _____ 4: _____

5: _____ 6: _____

7: _____ 8: _____

9: _____ 10: _____

11: _____ 12: _____

Do you have any comments about our publications or services? _____

Do you have suggestions for new titles? _____

Names of colleagues who should receive our catalog:

Name: _____ Name: _____

Title: _____ Title: _____

Organization: _____ Organization: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

☐ Please send a **Sampler Packet** for $4 (Includes over 25 brochures & our safe sex card)

PERSONALIZING YOUR BROCHURES

Most of the brochures in this catalog can be personalized with your agency's logo and/or local AIDS resource information. This assures that each brochure is doubly effective in assisting your community's fight against AIDS.

Personalizing can be done in two ways:

1. Printing your logo and/or information on the exposed back panel only. Your information would appear beside existing San Francisco resource information, where space permits. Copy dimensions for this type of personalizing is 1¼" (h) × 3" (w). Imprint is in black. Minimum quantity: 5,000.
2. Removing all or most references to San Francisco resources, wherever they appear in the brochure, and substituting your message(s). This gives you more room to describe your services. And it's especially helpful for brochures that have no space available for personalizing. Copy length varies by brochure. Minimum quantity: 10,000.

	STANDARD RATE	NONPROFIT AIDS AGENCY	QUANTITY
Option 1:	$0.20	$0.15	5,000+
Option 2:	$0.26	$0.20	10,000+

Please enclose clear, complete instructions with your order. If you have a logo or special typeface, please enclose camera-ready artwork. Fifty percent deposit required on all orders.

Call for information on lower rates for quantities of 25,000 or more.

Don't forget that you can combine different brochures to qualify for quantity discounts.

Brochures & Cards Available in Other Languages

	Spanish
AIDS Lifeline	AIDS Cable de Salvamento (also in Chinese) 4
Guidelines for AIDS Risk Reduction	Normas Para Reducir el Riesgo de Contraer AIDS (Chinese, Tagalog, Japanese also) 8
Straight Talk About Sex & AIDS	Información a las Parejas Sobre AIDS/SIDA 4
Safe Sex Cards	Prácticas Sexuales Sanas 8
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ORDERING INFORMATION

Mail Orders

Please use the order form on the inside back cover. It will speed the processing of your order. If the order form is missing, please be sure to include the following information with your order.

TITLE	QUANTITY	UNIT PRICE	TOTAL
		SUBTOTAL	
		SALES TAX (CA 6%, SF 6.5%)	
		SHIPPING & HANDLING (See chart below)	
		GRAND TOTAL	

Agencies/institutions should include purchase order information. Mail your order to:

San Francisco AIDS Foundation
Materials Distribution Dept.
333 Valencia Street, 4th floor
San Francisco, CA 94103

Payment

Please make checks or money orders payable to the **San Francisco AIDS Foundation**. Foreign or Canadian orders must be paid in U.S. dollars.

Phone Orders

You may order by phone between 9 AM and 4:30 PM (PST). Call (415) 861-3397. Please give us the name and quantity of each item when you place your order.

Discount Policy

Nonprofit agencies who serve AIDS, ARC, antibody-positive and predominantly high-risk clients are eligible for a 25% discount on all materials produced by the San Francisco AIDS Foundation. Services provided to these groups should include one or more of the following: housing, medical, legal, education, or counseling. *This discount is intended to assist agencies who would not otherwise be able to purchase educational materials.* Certain items are *not* eligible for the discount: **Teaching AIDS, Exploring the Heart of Healing, Sex, Drugs & AIDS, AIDS in the Workplace,** and the **AIDS Home Care and Hospice Manual.**

Shipping Information

Please allow 4-6 weeks for delivery from the date we receive your order. If you need your order sooner, please specify the date you need to receive it. However, you can be sure of your item's availability by calling ahead. All reasonable efforts will be made to fill your request. We normally ship via UPS. We must have a **street** address for UPS delivery (no P.O. Box addresses).

Partial Shipments

If certain items are out of stock, partial shipments will be made. Your request will be kept on file until those items not yet available can be shipped. Please allow 2-4 weeks for items back ordered.

Bulk Rates

Any combination of brochures, except for **AIDS in the Workplace** brochures, will count toward the quantity necessary to receive the bulk rate. The same holds true for booklets.

Customer Service

We want your order to arrive in good condition and to be exactly what you ordered. If you receive damaged goods, or if there are any problems with your order, please don't hesitate to contact us. Call (415) 861-3397 between 9 AM and 4:30 PM (PST).

Guarantee

All materials purchased from the San Francisco AIDS Foundation are guaranteed. If for any reason you are not satisfied, simply contact our office within 30 days and arrange to return the purchased materials in their original condition for a full and prompt refund or credit.

Pricing

The following schedule is for the purchase and shipment of bulk quantities of brochures, booklets and our tabloid, **Hot 'N' Healthy Times**. The purchase price for manuals, reports, videos, fact sheets, cards and posters are listed inside the catalog with each item description. Shipping charges for each type of item are described below.

Brochures		AIDS in the Workplace Brochures		Booklets		Hot 'n' Healthy Times	
25-99	30¢	1-9	45¢	25-499	90¢	1-9	$2
100-499	20¢	10-99	35¢	500-1499	80¢	10-99	$1
500-999	17¢	100-499	30¢	1500-4999	75¢	100-999	50¢
1000-9999	15¢	500-4999	28¢	5000 & up	70¢	1000 & up	25¢
10,000 – call for quote		5000 & up	25¢				

Shipping

Charges are calculated according to the actual weight of the item, and include a small handling fee.

All Brochures		Booklets	Hot 'n' Healthy		Other Items	
25-499	$ 5.00	Add $5 for every 100	1-249	$ 2.50	Manuals & Reports	$3.00
500-999	10.00	Large orders may require individual estimate.	250	5.00	Videos	2.00
1000-1499	15.00		500-1000	10.00	AIDS in the Workplace pkg	10.00
1500-1999	20.00		Add $10 for every 1000 copies		Women & AIDS pkg	5.00
2000-2500	25.00					

Please add $5 for every 500 brochures

San Francisco AIDS Foundation
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PLEASE PRINT CLEARLY

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Name: _____

Title: _____

Organization: _____

Street: _____

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Telephone: _____ Purchase Order No. (if applicable): _____

If order destination is different from address above, please enclose shipping instructions.

Payment options.

- ☐ I've enclosed payment.
- ☐ Bill my organization. (Terms: Net 30 days.)
- ☐ I've enclosed purchase order # _____

Please send _____ additional copies of this catalog.

Brochures

Quantity	Title (Please Print)	Specify Language	Unit Cost
	TOTAL number of brochures		¢
	AIDS In The Workplace Brochures		¢

IMPORTANT:

Personalization instructions are:
☐ enclosed

(Be sure to enclose instructions.)

Price entered below is for
☐ personalized
☐ non-personalized brochures

→ _____ Total Brochure Cost

→ _____ Total AWP Cost

Booklets

Quantity	Title (Please Print)	Unit Cost
	TOTAL number of booklets at	¢

→ _____ Total Booklet Cost

Other Items

Quantity	Title (Please Print)	Unit Cost
	TOTAL number of other items TOTAL cost	

→ _____ Total of Other Items

☐ Please send these materials labelled "Educational Materials" without listing "SF AIDS Foundation" in return address.

* We are required to collect sales tax on all orders
- SF residents 6½%
- Other California residents 6%

SB7

SUBTOTAL	=	$
Less 2% discount (see p. 18)	=	$
SUBTOTAL	=	$
Add applicable sales tax*	=	$
Shipping & Handling (see p. 18)	=	$
ORDER TOTAL	=	$

SF AIDS FOUNDATION
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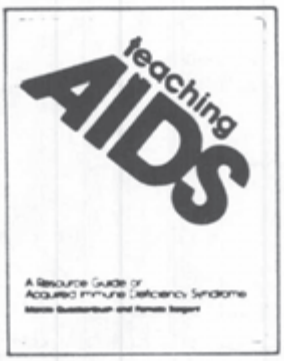

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AIDS education and training materials for:

- Substance Abuse Counselors
- Health Educators
- Health Care Professionals
- AIDS Agencies
- Hospices
- Corporate Managers and Employees
- Teachers

San Francisco AIDS Foundation . . . internationally recognized for effective AIDS education materials.

Mind Games

Problems are a pastime for San Francisco's Brain Exchange

BY GREGG LEVOY

Vyvyn Lazonga is a San Francisco tattoo artist who had a business problem. She needed to find ways to promote her line of tattoo cosmetics, which can be used to disguise scars, apply permanent eyeliner or even out the color of blotchy skin. Part of her problem, however, was that she didn't know of any professional groups to which a tattooist could go for peer advice.

Enter the Brain Exchange, a San Francisco-based group that brainstorms with people to help them find solutions to their entrepreneurial, career, creative or personal problems.

When Lazonga went to her first BE meeting in an uptown office building, she encountered several dozen people from all walks of life, ready to discuss any problems that group members presented. Lazonga readily volunteered to go first, and the response was overwhelming. For 15 minutes, she scribbled frantically as the group stormed her with ideas and possible solutions. Their suggestions ranged from the sublime to the ridiculous, from the practical to the practically insane.

"I got great ideas, though," she says, "even if it was hard not to be overwhelmed by the sheer number. Some of those ideas have really helped me fine tune my professional presentation. I'm making up a brochure and business cards, getting a business wardrobe together, calling on doctors, hospitals, beauty salons and plastic surgeons, and learning how to tap into the clientele I want.

"It really helps to get ideas from outside sources, especially for people who, like me, work alone," Lazonga says. "It's also helpful for people who, again like me, work in fields that others frown upon. The Brain Exchange is so open, positive and non-judgmental. No one frowns. They just want to give away ideas. I've never seen anything like it."

Neither have a lot of people in locales up and down the West Coast—Los Angeles, San Francisco, Sacramento, Seattle and Vancouver Island, British Columbia—where BE now holds meetings in private homes, in corporate boardrooms like that of Merrill Lynch and even over the radio. The organization's current mailing list includes some 800 people, from corporate executives to chiropractors to street performers. All of these individuals have at least one thing in common: They want to take the curse off the word "problem."

Gathering in groups sometimes as large as 50 or 75 people, they demonstrate what can happen when the withering effect of premature criticism is removed from problem solving. The typical BE meeting is spirited, prolific, cathartic and positive.

The Brain Exchange, according to co-director Lee Glickstein, a humor writer and owner of a word-processing service, is "a playful think tank." It is also an antidote to what he calls "the 98 percent blues." Many of us, he submits, "have inherited the unexamined assumption that 98 percent of all possible ideas in the world have been conceived and executed, that 98 percent of all ventures and inventions have been ventured and invented, 98 percent of all creative solutions to finding satisfying work

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Gregg Levoy lives in San Anselmo, California.

have been attempted, and 98 percent of them don't work anyway. Which would leave 98 percent of us gifted children scrounging and competing for the 2 percent supply of available new ideas and avenues.

"The Brain Exchange is dedicated to proving the scarcity-of-possibilities assumption false," he says. "We believe that most of the creative contingencies in our future are unknown to us now. We nurture a stimulating, supportive environment receptive to that knowledge."

In San Francisco, the BE's weekly meetings begin with a go-round introduction during which an average of 50 attendees disclose their "hidden agendas," says co-director Joy-Lily, a textile artist and humor writer. If you're there in hopes of finding a business partner or a baby-sitter, you say that. If you have a service to offer, you offer it. If you have a project in the works, a reigning passion or a problem that needs solving, you tell about it. This is the networking portion of the show, where valuable business connections often are made.

The go-round also reveals that the evening's brainstorming team is composed of people in diverse fields. This is a distinct advantage, according to BE officials, because supposed "experts" in your field often seem to know only what *can't* be done. Thus, exchange devotees contend that the naive often have the best ideas.

"Sometimes you're just too close to a problem," says Byron Mandel, owner of a San Francisco marketing development company. He originally went to the Brain Exchange to mine ideas on how to help a client market a new pizza product. "Sometimes it helps to have input from people who don't see the limitations you do."

Today, this is what brainstorming is all about—putting heads together for the sharing of ideas. That's quite an enlightened concept to attach to a word that was originally coined during a 1907 murder trial to describe a fit of temporary insanity. In fact, it wasn't until the 1940s that Madison Avenue adman Alex Osborn popularized brainstorming as a term for corporate problem-solving sessions.

"I just go to give out ideas. I'm a real idea person and I need somewhere to put them, without worrying if they're practical."

By the end of the '50s, the concept, also referred to as buzz sessions, idearamas and imagineering, already was employed by several of America's top corporations—IBM, General Motors, U.S. Steel, General Electric—as well as the U.S. Army. GE, for example, found that the flow of ideas increased up to 300 percent during

brainstorming sessions, and Osborn's BBD&O ad agency found the process so valuable that it named a vice president in charge of brainstorming. The vice president subsequently held all meetings in a yellow room because yellow was considered conducive to thought.

Studies done during Osborn's era suggested that 6 percent to 10 percent of all ideas generated during corporate brainstorming meetings were practical: Sometimes, more than 100 ideas were proposed in a single half-hour session.

The BBD&O ad agency found the process so valuable that it named a vice president in charge of brainstorming.

Brain Exchange participants may not go home with 100 ideas, but they certainly will get enough input to grease their wheels. Such was the experience of Rebecca Searles, a San Francisco street musician who came to a BE meeting last year in hopes of finding ways to get her name "out there." First off, the group helped her get her problem into proper brainstorming shape; that is, they couched it in terms of an answerable question. In Searles's case, the question ended up being "How many names can I come up with for my street music business?"

Within seconds of asking the group, she was busy scrawling down a barrage of possible names: Drum Schtiks, Duet in the Road, Treble in the Streets, Music for Sewer-Sides, Band on the Run, De-Composer, Keys West, Half Note Will Travel, Music without a Pitch, Concert-ed Efforts, Band in San Francisco.

A grin spread across Searles's face as she struggled to keep up with the flood of ideas. "My head is spinning," she said when it was over.

Other meetings are no less prolific. At one, the problem was, "How many ways can I market my quilt art?" The group's solutions were: Sell quilts to women executives for their offices; make a quilt design for consideration as a postage stamp; make miniature quilts for dollhouses; sell huge quilts to corporate art buyers for bank lobbies and atriums.

Another question was of a more personal nature: "How can I move out of a temporary depression?" Some of the ideas: Find a trampoline to help you bounce back; count your blessings; sing "Poor Poor Pitiful Me"; write the Pope and include a self-addressed stamped envelope; don't read any self-help books; do something new.

At the Brain Exchange, all brainstorming ideas are stated in the imperative. No one says "What about this?" or "Have you tried that?" Glickstein says, because such phrasing can invite excuses for why an idea won't work. ▷

Acquired Immune Deficiency Syndrome (AIDS): An acquired defect in immune system function which reduces the affected person's resistance to certain types of infections and cancers. To qualify as AIDS, the malfunctioning of the immune system must not be linked to genetic disorder, chemotherapy, malnutrition, or deliberately induced medical treatments (as in organ transplant recipients). Although the cause is unknown for certain, it is thought to be a virus (HIV) which is transmitted through intimate sexual contact or exposure to infected blood or blood products. Once immune-depressed, an individual becomes susceptible to a number of opportunistic diseases.

AIDS-Related Complex (ARC): At present, ARC has no "official" definition. Simply stated, ARC is a lesser disease response to the AIDS virus. Some individuals develop a few or many of the symptoms of AIDS, such as swollen lymph glands, night sweats, diarrhea, and fatigue, but do not necessarily go on to develop one of the life-threatening diseases that meet the requirements for an AIDS diagnosis. This makes ARC a very broad catch-all category.

Antibody: A substance formed by the body as a reaction to a foreign agent or antigen. The antibody formed works only against that particular antigen.

ELISA Test: A blood test which indicates the presence of antibodies to the AIDS virus. (Various ELISA tests are used to detect other infections as well.) The HIV ELISA test does not detect the disease AIDS but only indicates if viral infection has occurred. The test is used to screen blood supplies, is used in certain research projects, and has also been used in specific health-care situations.

Helper/Suppressor T-cells: T-cells are lymphocytes (white blood cells) that are formed in the thymus and are part of the immune system, which has been found to be abnormal in people with AIDS. The normal ratio of helper T-cells to suppressor T-cells is approximately 2:1. This becomes inverted in people with AIDS but may also be temporarily abnormal in people for many other reasons.

HTLV-3/LAV/ARV: The three names previously given for the virus which causes AIDS. Respectively, the three names stand for Human T-cell Lymphotropic Virus-Type Three, Lymphadenopathy Associated Virus, and AIDS-Related Virus. The virus is now called HIV (see below).

Human Immunodeficiency Virus (HIV): The name chosen by a scientific panel of virologists and other researchers for the AIDS virus. The name was chosen as a generic description to help ease the controversy over different researchers giving the AIDS virus different names.

Person with AIDS (PWA): A term developed by individuals diagnosed with AIDS to counteract the more negative term "AIDS victim" and the less assertive "AIDS patient."

Pneumocystis Carinii Pneumonia: A lung infection seen in immunocompromised people. It is caused by a protozoan present almost everywhere but which is normally destroyed by healthy immune systems. By the age of four years, 70 percent of healthy children have evidence of past exposure. The protozoan is airborne, but cannot be transmitted this way to unaffected individuals. Once a person develops PCP, they are susceptible to recurrence of the disease, and the outcome may be fatal.

Seropositive: A condition in which antibodies to a particular disease-producing organism are found in the blood. The presence of antibodies indicates that a person has been exposed to the organism but does not distinguish between an active infection and a past infection.

Western Blot Test: A blood test used to detect antibodies to the AIDS virus. Compared to the ELISA test, the western blot is more specific and more expensive. It can be used to confirm the results of the ELISA test.

From AIDS: A Self-Care Manual (AIDS Project Los Angeles), Edited by BettyClare Moffat, et al., IBS Press, 1987, pp. 257 ff.

What is the "AIDS test" that is done in blood banks? It is simply a test for the AIDS antibody. The method used is called an "enzyme-linked immunoabsorbent assay" (ELISA). In general it is a very good test. To put it simply, we stick the AIDS virus at the bottom of a test well, adding serum for testing antibodies to the virus. If there is an antibody to the virus, it will stick to the virus because they interlock. Then the well is washed. Another antibody made in a goat recognizes human antibody. So if the blood specimen being tested has an antibody to the AIDS virus, this goat antibody will stick to the human antibody. Attached to the goat antibody is an enzyme. When the substrate of that enzyme is added to the well, a color change occurs. A spectrophotometer reads the color change, produces a value which is then scored as either positive or negative.

There are a number of places where there might be some error, but in general, the test is 99 percent accurate. That means 1 percent are going to be inaccurate....So one percent of those is 110,000 units of blood that need to be discarded because they are read as positive for the AIDS virus, even though, in fact, they are not. Regardless of the uncertainty this information implies, 110,000 people must be told they have been infected with the AIDS virus--even though this is not true.

To avoid these false positives, we do what is called a "confirmatory test." The western blot is another technique available for detecting antibodies to the AIDS virus....

...Again, it isn't the antibodies to the virus that cause the disease. At this time, we do not know the natural history of people who are antibody positive. We don't know if all of them are going to get AIDS twenty years down the line, or if some of them will never have any problem again and just always remain positive to the antibody. It is the virus which causes disease. And the disease is diagnosed clinically, quite easily, without necessarily obtaining a blood test for antibodies. AIDS is a clinical diagnosis. A positive antibody test is not a diagnosis of AIDS.

From AIDS: A Self-Care Manual (AIDS Project Los Angeles), Edited by BettyClare Moffat, et al., IBS Press, 1987, pp. 257 ff.

Before people take the test, we ask them to think about the difference between assuming that they are positive and knowing that they are positive. On one hand, if a person makes the assumption, because he or she has been involved in risky behavior, that he or she is positive, then perhaps that person does not need to take the test, which can be a traumatic experience. On the other hand, some people are engaged in compulsive sexual behavior, and for them taking the test can be a sort of confrontation. Being told in fact, "Yes, you are positive," has helped a number of people to make behavioral changes....

In pretest groups, we notice that people do not know what to expect the test to answer, and they want it to answer things it cannot answer, specifically, "Will I get AIDS?" "Will I live a long life?" "Will I live a happy life?" We cannot stress enough that the test will not tell if one is going to die of AIDS. Nor could any counseling give definitive answers about one's longevity or well-being....

People are given a list of resources for the two-week waiting period, which, for many, is a very difficult time. Upon returning, they meet with a counselor privately. Again, only the number is exchanged--no names are used. At that point the result is given. People are helped to understand the test result, and appropriate referrals are made to resources in the community. A follow-up videotape and resource list are also given. At the end of the session we offer to those who are seropositive or seronegative the opportunity to see a follow-up counselor for a free hour consultation to consider questions or help with problems in adjustment. Few people find this extra session necessary....

Intervention has three goals. The first is to help the person absorb the news and cope with the results, to be able to walk out on the street again. The second is to connect the person to resources. No matter how good the counseling, many do not really hear much of what goes on because they are in shock. Even with negative results, the situation is very complicated. If someone is all geared up for a positive test result, and gets a negative, his or her whole world is turned upside down....

Giving the results is divided into four parts: establishing rapport quickly with the person; giving results as clearly and straightforwardly as possible; working on emotional and cognitive integration, the heart of the interview; and finally, developing a plan....

Informing others is a big issue. We discuss with the person whom to tell, whom not to tell, how to tell them, what that would be like. Telling a lover could result in violent conflict, perhaps a breakup, or it could make the two feel closer. That subject alone could require about ten hours of counseling, so much is involved.

We make sure that at least the person walks out with a resource list and a referral to a counselor. Most people will have a delayed reaction. People are often numb, which is why that resource list is so critical.

We have a plan for potential suicides. We are in touch with the emergency rooms and psychiatric units. It's must more likely, however, that any kind of an emergency reaction will be subacute, necessitating only a walk-in clinic. Here are a few issues that come up during the counseling sessions: sutstance abuse, fear of sex or sex-phobias (many people report being celibate), sexual addiction, sexual identity problems, relationship conflicts, grief over loss or anticipated loss of friends or lovers, general health concerns, excessive anxiety or hypochondriasis or extreme anxiety responses, whom and how to tell, coming out, quality of life, continuing risky behaviors, unwillingness to change sexual behaviors, unwillingness to alter behaviors around cofactors (such as drug use or nutrition), stress reduction, establishing and utilizing a support network, fears of intimacy, health education, health planning, transmission, parenting, and fear of illness or death. There's an awful lot to deal with in a half-hour to an hour....

In settings other than the alternative sites, people receive the results in brief telephone calls from, for example, a health worker. We have heard some fairly bad stories, such as getting positive results from doctor's offices, and then at the time of the next physical examination noting the doctors and nurses putting on gloves. Right after giving results that just does not work. People feel pretty bad anyway. In the initial feedback session when one gets results, a supportive session is most helpful, although very little information can be imparted at this point.

Group members have reported a progression of psychological reactions over time. Days one to three constitute a kind of psychological shock. The first emotion that people report is anger rather than denial: anger at the medical community, anger at the government, anger at various agents, often a projection--questions like "Who did this to me?"

From three days to three months there are waves of depression, with accompanying sleep, eating, and mood disturbances, a sense of isolation and alienation, as well as impotence and a decrease in libidinal drives. Many body image questions come up--feelings of being diseased, feelings of being impotent in the face of this disease, and feelings of being contagious. Sex in a way becomes deadly, sex becomes evil...

Awareness of being seropositive for HIV can promote a sense of weakness of the body, of the self. The knowledge that antibodies cannot fight off the virus, in fact, leads to a certain sense of a weakening of the self, into which the whole question of the will enters, a fundamental kind of psychological problem. Since one cannot do anything, one feels hopeless and impotent. In psychological terms, a positive HIV result can lead to a breaking down of the defense structure....

Psychodynamically, inadequacy, nurturance, and trust themes emerge, the nurturance and trust themes coming from a sense of being affected by the nurturing object. In this case, the nurturing object of sexual affection leads to a disease; in HIV transmission, the person who has it becomes that diseased object and passes it on. That is why a very supportive, nurturing environment is essential to encourage the development of new defenses....

We encourage people not to talk to others outside the group about their test results for a while, until those defenses come back and are a little stronger. Participants have related stories about their experiences, for example, longtime roommates who have moved out, one physician telling a man that he should not live with his children whom he then shipped away to his mother's house....

People are very anxious to hang onto anything you can offer, like a plan to protect their health. Legal plans also come up a lot. People have concerns about what will happen when they die--they equate seropositivity with dying. Psychological advice of the very simplest kind is well taken. Sex is often a question, and along with this of course the emotional release that people need....

Rephrasing the situation into a positive experience is immensely helpful. The positive HIV result is useful for carrying on one's life, facing up to major existential questions. This result can bring a certain immanence to life. It may be time for bibliotherapy--to go back and read that old philosophy that didn't make too much sense when you were in college but may make a lot of sense now, about what it means to be alive today.

People who are seropositive are a new group. Potentially, they might live the rest of their lives being contagious, carrying a disease that can kill other people, and yet they might also live fully through their lives....

The presence of the AIDS antibody in one's blood does provoke profound questions, and the sensitive counselor can help the individual consider them in a frank, honest way. What we have found best is clear information presented in a timely fashion after the test has been performed, accompanied by appropriate referral with the added provision of supportive group experiences. AIDS has made all of us face the harder existential issues of life and death. Knowing that this confrontation is difficult and having sensitivity and compassion for those struggling with

it is the basic key to good HIV antibody test counseling.

From What To Do About AIDS, Edited by Leon McKusick, Berkeley and Los Angeles, University of California Press, 1986, PP. 104-110.

negative, while those who test positive need to know the practical implications (see below).

In the clinical setting, an HIV-positive result is useful in that it may lead the physician to include an AIDS-related condition in the differential diagnosis and to take an aggressive approach to the patient's illness if necessary. Individuals who are identified as positive also require careful counseling.[6,41-43]

Interpretation of Test Results

If the ELISA is negative, a Western blot is usually not done. Blood from ELISA-negative individuals who do not belong to any risk groups may be used for transfusion. Individuals from high-risk groups should be notified that a negative ELISA test does not carry the same degree of confidence as in low-risk individuals.

If the ELISA is positive and is confirmed by Western blot or IFA, then the individual has been infected with HIV.

If the ELISA is positive and the Western blot is completely negative, the patient's blood should, nevertheless, *not* be used for transfusion, although re-entry into the blood donor population may be possible in the future. Such a patient (donor) is probably not infected with HIV. If the Western blot and/or IFA is equivocal, the infection status with HIV is unknown and the Western blot should be repeated on a specimen obtained in four to six months.

Counseling

Information to be communicated to patients with antibody to HIV should include at least the following:

1. The infection is persistent, probably for life, and a certain proportion of those affected will develop AIDS. Approximately 35% of HIV antibody-positive individuals developed AIDS over six to eight years,[44] but having a positive antibody test does not mean that the patient has AIDS.
2. It is not possible to predict who among seropositive individuals will develop AIDS or show clinical symptoms.
3. Antibody-positive persons are potentially infectious to others by sexual exposure, by sharing drug injection paraphernalia, by childbearing, or by donating blood, semen, or body organs.
4. Antibody-positive persons should practice what has come to be known as "safe sex." In the absence of celibacy, this usually means using a condom routinely when having sexual intercourse. Preventing perinatal HIV infection requires that adequate birth control measures be employed.

Underlying all of the above measures for controlling the spread of HIV infection is notification of all individuals who are HIV antibody-positive, providing them with the above information, and being available to answer questions. Information for counseling seropositive individuals is available through state or local health departments and from a number of AIDS information organizations. Antibody-positive individuals should also be encouraged to notify their sexual partners, so that the risk for further transmission may be reduced. The responsibility to notify known sexual partners may fall to the physician if an antibody-positive person refuses to do so, but this area is extremely complex and unsettled. In some jurisdictions, seropositive individuals must be reported to the health department. The advisability of mandatory screening, as in the prenatal setting or for marriage license application, will continue to be debated. The ultimate purpose of such screening is to reduce the incidence of infection by reducing transmission through changes in behavior.

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3. Gallo RC, Salahuddin M, Popovic M, et al: Frequent detection and isolation of cytopathic retroviruses (HTLV-III) from patients with AIDS and at risk for AIDS. *Science* 1984;224:500-503.
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Table 1

Recommendations to Family, Friends and Household Contacts

1. There is no evidence that AIDS can be transmitted to family, household members or close contacts by routes other than exposure to blood, sex and perinatal transmission.

2. Reasonable precautions should be taken within the household to avoid direct contact with blood and other body fluids. However, these precautions need not interfere with normal interactions.

3. There is no evidence that saliva on household items can transmit infection. Household items may be shared by patients and household members. It is not necessary to have separate dishes and eating utensils for AIDS patients, though they should be washed routinely with hot water and detergent.

4. Razors, toothbrushes or any other items that may be soiled by blood from AIDS patients should not be shared.

5. Blood and other body fluids (urine, feces or items soiled by blood and body fluids) should be handled with care. Disposable gloves should be used and hands should be washed thoroughly with soap and water. Soiled surfaces should be cleaned with a solution of household bleach diluted 1:10 in water.

6. Bathroom facilities (toilet, bathtub and shower) can be used by all household members. Facilities should be kept clean and soilage by body fluids should be cleaned with household bleach diluted 1:10. Blood and other body fluids can be flushed down the toilet.

7. Soiled clothes or linen should be washed with a detergent and/or bleach.

8. Sharp objects used in the home care of patients should be handled carefully to avoid accidental injury and disposed of in impervious sealed containers.

Table 2

Guidelines for the General Public

1. HIV is transmitted by sexual intercourse, the transfusion of blood or sharing of needles contaminated with blood and by perinatal exposure. There is no evidence that other person-to-person interaction among workers, consumers, clients or school children poses a risk for transmission of HIV.

2. Persons with AIDS or HIV infection should not be restricted from work, school or personal interactions. Telephones, office and school equipment, toilets, showers, eating facilities and water fountains can be used safely.

3. Sexual relations with persons at increased risk for HIV infection can result in HIV transmission. The risk increases with increasing numbers of sexual partners. The use of condoms may reduce the risk of HIV transmission.

4. The use of intravenous drugs with the sharing of needles and syringes can result in HIV infection.

5. Persons at risk for HIV infection should not donate blood, semen or organs.

6. Women of child-bearing age who are at risk for HIV infection should determine their HIV antibody status before conception or defer pregnancy by use of barrier contraception.

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AIDS: A Jewish View

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Introduction:

The acquired immunodeficiency syndrome (AIDS) has been described as this century's greatest health peril. Thousands have already died from the disease and there is no cure in sight. The emotional toll on patients with AIDS, their families and their caregivers needs to be actively and aggressively addressed. The public hysteria should be alleviated by a well planned, coordinated and implemented educational program involving not only health professionals but the mass media and press which have in part fueled the public fear about AIDS. Prudent practices in the health care and private industry work places have been suggested and should be followed. Governmental involvement in terms of increased AIDS treatment and research funding is sorely needed. Finally, public policy decisions need to be made with compassion and understanding and the conviction that this disease can be tamed and eventually overcome by a concerted effort of all parties concerned.

Homosexuality and Drug Abuse in Judaism

Ninety per cent of all patients with AIDS are homosexuals or intravenous drug abusers. The Torah labels homosexual intercourse as an abomination[1] and ordains capital punishment for both transgressors,[2] though minors under thirteen years of age are exempt from this as from any other penalty[3]. This biblical directive is codified by Rambam:[4]

> In the case of a man who lies with a male, or causes a male to have connection with him, once sexual contact has been initiated, the rule is as follows: If both are adults, they are punishable by stoning, as it is said, "Thou shalt not lie with a male", i.e., whether he is the active or the passive participant in the act.

The prohibition of homosexuality proper is omitted from the *Shulchan Aruch*, which omission reflects the virtual absence of homosexuality among Jews rather than any difference of views of the criminality of these acts.[5] The Torah only refers to incidents involving homosexuality in regard to the sinful city of Sodom[6] and in regard to the conduct of a group of Benjaminites in Gibeah, leading to a disastrous civil war.[7] Isolated cases are also described in the Talmud.[8]

Rabbi Jakobovits cites rabbinic sources for the strict ban on homosexuality which is included among the seven commandments of the sons of Noah.[9] It is an unnatural perversion debasing the dignity of man, it frustrates the procreative purpose of sex, and it damages family life. He concludes that Jewish law rejects the view that homosexuality is merely a disease or morally neutral.

In an earlier issue of this Journal, Rabbi Barry Freundel posited that Jewish law views the homosexual or drug addict as no different than a Sabbath desecrator or an adulterer.[10] He has no greater or lesser rights or obligations and deserves no special treatment or concessions. The term "homosexual," says Freundel, is inappropriate. We should refer to this individual as a person engaged in homosexual activity. The term is not a noun but an adjective. The Jewish community should, therefore, deal with the practitioner of homosexuality as a full-fledged Jew, albeit a sinner; he should be counselled and treated and be the concern of outreach and proper education.

The use of consciousness-expanding drugs such as LSD or other addictive substances is generally considered to be proscribed by the halacha. According to Rabbi Moshe Feinstein, the harmful effects of marijuana is one of the reasons to prohibit its use.[11] The same can be said about smoking in Judaism.[12] Certainly the abuse of narcotics and other substances by the intravenous and other routes is detrimental to one's health and, therefore, prohibited in Judaism, for the Torah instructs us not to intentionally place ourselves in danger: "Take heed to thyself, and take care of thy life"[13] and "take good care of your lives."[14] The avoidance of danger is exemplified in the biblical commandment to make a parapet for one's roof so that no one fall therefrom.[15] Hence, the smoking of marijuana and the abuse of intravenous narcotics, which constitute a definite danger and hazard to life, are considered pernicious habits and should be prohibited. The subterfuge of "it is no concern of others if I endanger myself" is specifically disallowed by Rambam[16] and the *Shulchan Aruch*.[17]

Jewish Legal Questions Relating to AIDS

Not only is the intentional endangerment of one's health or life by the use of intravenous drugs prohibited in Jewish law, but wounding oneself without fatal intent is also disallowed in the Talmud[18] and the Codes of Maimonides[19] and Rav Yosef Karo.[20] Since most patients with AIDS are homosexuals and/or drug addicts, they are considered sinners, thereby raising a variety of

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1. Leviticus 18:22
2. *Ibid* 20:13
3. *Sanhedrin* 54a
4. *Mishneh Torah, Hilchot Issurei Biah* 1:14.
5. Jakobovitz, I. *Encyclopedia Judaica*, Jerusalem, Keter, 1972, volume 8, pp. 961-962.
6. Genesis 19:5.
7. Judges 19-20
8. *Sotah* 13b and Jerusalem Talmud *Sanhedrin* 6 a, 23c.
9. *Sanhedrin* 57b – 58a
10. "Homosexuality and Judaism," *Journal of Halacha and Contemporary Society*, No II Spring 1986, pp. 70-87.
11. *Iggerot Moshe, Yoreh Deah*, Section 3 #35
12. Rosner, F. *Modern Medicine and Jewish Ethics*, Hoboken, N.J. and New York, N.Y., Ktav and Yeshiva Univ. Press, 1986, pp. 363-375
13. Deuteronomy 4:9
14. *Ibid*. 4:15
15. *Ibid*. 22:8
16. *Mishneh Torah, Hilchot Rotze'ach* 11:4 ff.
17. *Shulchan Aruch, Choshen Mishpat* 427 and *Yoreh Deah* 116
18. *Baba Kamma* 91b
19. *Mishneh Torah, Hilchot Chovel Umazik* 5:1
20. *Shulchan Aruch, Choshen Mishpat* 420:31 and *Orach Chayim* 571.

Jewish legal questions. Should a Jewish drug addict who develops AIDS as a result of sinful activity be treated any differently than any other patient? Should the Jewish homosexual who develops AIDS as a result of "abominable" behavior be treated? Does Judaism teach compassion for all who suffer illness irrespective of whether or not the illness is the result of practices which Judaism abhors and prohibits? Should every effort be made to heal these patients or at least alleviate their pain and suffering? Is a physician or nurse or other health worker obligated to treat a patient with AIDS or other contagious disease if there is a risk that they may contract the illness from the patient? Should the Jewish community expend resources for AIDS research and treatment since most such patients are sinners? Should not the resources better be allocated to the health of law-abiding citizens? Can patients with AIDS be counted in a quorum of ten men (*minyan*)? Can they serve as cantors or Torah readers? Should they be given honors in the synagogue? Can a *kohen* with AIDS go up to the *duchan* and offer the priestly blessing? Can a patient with AIDS serve as a witness in a Jewish legal proceeding? Is a patient with AIDS to be given all the usual burial rites? Is mourning to be observed for such a patient? These and other halachic questions pertaining not ony to AIDS patients but to sinners in general were addressed in two separate discourses delivered by Rabbi Hershel Schachter and Rabbi Moshe Tendler, both senior faculty members at Yeshiva University. The following discussion is based in part on those discourses.

Obligation of the Physician to Heal a Sinner

The physician's license to heal is based on the biblical phrase "and heal he shall heal"[21] from which the talmudic Sages[22] deduce that divine authorization is given to the human physician to heal. In his biblical commentary, Rabbi Moses Nachmanides, known as Ramban, states than since the physician may inadvertently harm his patient, divine permissibility to heal was necessary to absolve the physician of responsibility for any poor medical outcome, provided he was not negligent. Other commentaries assert that since sickness is divinely inflicted as punishment for sin, divine permission to heal is required to allow a human physician to intervene and provide healing.

Maimonides expands the permissibility for the human physician to heal into an obligation or mandate based on the biblical commandment for restoring a lost object to its rightful owner[23] — if a physician is able to restore a patient's lost health, he is obligated to do so. If a patient dies as a result of a physician's refusal to heal him, the physician is guilty of shedding blood for having stood idly by.[24] A detailed discussion of the physician's obligation to heal in Judaism can be found elsewhere.[25]

G-d cherishes the life of every human being and therefore requires all biblical and rabbinic commandments except idolatry, incest, and murder to be waived in order to save the life of a person in danger (*pikuach nefesh*). The Sabbath must be desecrated to save a human life.[26] But is the desecration of the Sabbath allowed and/or mandated to save the life of a sinner who is guilty of a crime such as homosexuality for which the death penalty might be imposed?

The Talmud[27] permits the killing of a pursuer (*rodef*) to prevent him from killing the person he is pursuing; the one who kills him has no sin because the pursuer is considered to be legally (halachically) like a dead man (*gavra ketila*). For the same reason, one may *not* desecrate the Sabbath to save the life of the pursuer if a building collapses on him and his life is in danger. The same is true of a person sentenced to death by the court (Beth Din) in that one may not desecrate the Sabbath on his behalf if his life is in danger because he, too, is halachically considered like a dead man. However, a sinner who has not been sentenced by the Beth Din is considered as a live human being. As a result, although he is a transgressor, all biblical and rabbinic commandments must be suspended to save his life. Therefore, it seems clear that patients with AIDS should be treated medically and psychosocially no differently than other patients, and physicians and other medical personnel are obligated to heal patients with AIDS. The Talmud[28] clearly states that every life is worth saving without distinction as to whether the person whose life is in danger is a criminal or transgressor or law-abiding citizen. In fact, the Talmud requires that one expend money from one's own pocket to provide whatever is necessary to save another's life.

Some contemporary writers[29] raise the issue of the difference between a provocative sinner (*mumar lehachis*) and a lustful sinner (*mumar lete'avon*). The Talmud rules[30] that a provocative sinner is not to be helped but actually hindered (*moridin velo ma'alin*). The commentary of Rashi there and the code of Maimonides[31] interpret a provocative sinner to refer to one who habitually and willfully sins. On the other hand, one who only occasionally sins out of lust or appetite is considered like one whose life and property are to be protected and carefully treated.[32] It would seem therefore that physicians and other health personnel have an obligation to care for patients with AIDS no differently than for other patients.

Danger to Medical Personnel Treating Patients with AIDS

Jewish law requires that if one sees his neighbor drowning or mauled by beasts or attacked by robbers, he is bound to save him.[33] Elsewhere the *Shulchan Aruch*[34] rules that if one observes a ship sinking with Jews on board, or a river flooding over its banks thereby endangering lives, or a pursued person whose life is in danger, one is obligated to desecrate the Sabbath to save them. The commentaries of *Mishnah Berurah*[35] and *Pitchei Teshuvah*[36] add that if there is danger involved to the rescuer, he is not obligated to endanger his life because his life takes precedence over that of his fellow man. If there is only a doubtful risk (*sofek sakanah*) to the rescuer, he should carefully evaluate the small risk or the potential danger to himself and act accordingly.

What should a physician do if his patient is suffering from a contagious disease which the physician might contract? Is the physician allowed to refuse to treat the patient because of the risk or the fear by the physician of contracting the disease? What if the risk is very small? What is the definition of *sofek sakanah*? If there is a 50% chance of the physician contracting the disease from his patient, halacha would certainly agree that such odds are more than doubtful and the physician would not be obligated to care for that patient without taking precautionary measures to protect himself. If he wishes to do so in spite of the risk, his act is considered to be a pious act (*midat chasidut*) by some writers, and folly (*chasid shoteh*)[37] by others. But if the risk is very remote, the physician must care for that patient because "the Lord preserveth the

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21. Exodus 21:19.
22. *Baba Kamma* 85a.
23. Deuteronomy 22:2.
24. *Mishneh Torah, Hilchot Rotze'ach* 1:14.
25. Rosner, F. *Modern Medicine and Jewish Ethics* pp. 9-13.
26. *Shulchan Aruch, Orach Chayim* 328:2.
27. *Sanhedrin* 27b.
28. *Ibid.* 73a.
29. Noval, D. personal communication.
30. *Avodah Zarah* 26b.
31. *Mishneh Torah, Hilchot Rotze'ach* 10:12.
32. Commentary of Tosafot, *Avodah Zarah* 26b s.v. *ein*, Maimonides' *Mishnah* Commentary on *Nedarim* 4:4, *Shulchan Aruch, Choshen Mishpat* 425:5.
33. *Sanhedrin* 73a. *Shulchan Aruch, Choshen Mishpat* 426:1. *Shulchan Aruch, Orach Chayim* 329:8.
34. *Shulchan Aruch, Orach Chayim* 329:8.
35. *Mishnah Berurah* 329:19.
36. *Pitchei Teshuvah, Chushen Mishpat* 426:2.
37. *Mishnah Berurah* 328.

simpletons."[38] This phrase is invoked in the Talmud[39] in relation to the remote danger of conception in a minor child and discussed in great detail by Rabbi Moshe Feinstein[40] in a lengthy responsum concerning the use of a contraceptive device by a woman in whom pregnancy would constitute a danger to her life. Contraception, states Rabbi Feinstein, is permissible for *sofek sakanah* but not where the risk is extremely small. Rabbi Shneur Zalman of Lublin[41] and Rabbi Chayim Ozer Grodzensky[42] respectively discuss whether the above biblical phrase is invoked for a minor risk (less than 50%) or for a very remote and rare risk.

Rabbi Yitzchok Zilberstein[43] discusses the case of a female physician in her first trimester of pregnancy who is called to see a seriously ill patient with rubella (German measles). The physician is at 50% risk of acquiring rubella and possibly giving birth to a seriously defective baby (blind, deaf, or mentally retarded) or she may abort or have a stillbirth. Although there are no fetal indications in halacha which would allow abortion, Rabbi Zilberstein posits that halacha considers miscarriage to be a situation of *pikuach nefesh* and rules therefore that the female physician is not obligated to care for a patient with rubella.

The question as to whether or not a person is obligated to subject himself to a risk in order to save another person's life is discussed in great detail in several recent articles[44] and briefly summarized by Professor A.S. Abraham[45] in an article on human experimentation. The matter is related to the well-known difference of opinion recorded in the two Talmuds. The Jerusalem Talmud[46] posits that a person is obligated to potentially endanger his life (*sofek sakanah*) to save the life of his fellow man from certain danger (*vadai sakanah*). This position is supported by Rabbi Meir Hacohen[47] as cited by Rav Yosef[48] and by Rav Karo himself.[49] On the other hand, the Babylonian Talmud[50] voices the opinion that a person is not obligated to endanger his life to save that of another even if the risk is small (*sofek sakanah*). The ruling from the Jerusalem Talmud is omitted from the Codes of Rif, Rambam, Rosh, *Tur*, and Ramo.

The prevailing opinion among the various rabbinic sources seems to be the one cited by the Radvaz:[51] If there is great danger to the rescuer, he is not allowed to attempt to save his fellow man; if he nevertheless does so, he is called a pious fool. If the danger to the rescuer is small and the danger to his fellow man very great, the rescuer is allowed but not obligated to attempt the rescue, and if he does so his act is called an act of loving kindness (*midat chasidut*). If there is no risk at all to the rescuer or if the risk is very small or remote, he is obligated to try to save his fellow man. If he refuses to do so, he is guilty of transgressing the commandment "thou shalt not stand idly by the blood of thy fellow man."[52] This approach is also adopted by recent rabbinic decisors including Rabbi Moshe Feinstein[53] and Rabbi Eliezer Yehudah Waldenberg.[54] Since the risk to physicians and other health personnel in caring for AIDS patients is infinitessimally small (less than a fraction of one per cent), it follows that a physician is obligated under Jewish law to care for such patients.

The same logic is used to allow but not require healthy people to donate a kidney to save the life of a close relative dying of kidney failure. Most rabbis, including Rabbi Ovadiah Yosef,[55] Rabbi Jacob Joseph Weiss,[56] Rabbi Eliezer Waldenberg,[57] and others[58] support this halachic position.

Visiting Patients with Infectious Diseases such as AIDS

It is a duty incumbent upon everyone to visit the sick, for G-d visits the sick[59] and we must emulate Him.[60] Rabbi Jakobovits[61] points out that the question whether the duty to visit the sick extends to visiting patients suffering from an infectious or contagious disease was already answered with a qualified affirmative by the Ramo[62] against the view of some later authorities who questioned the need to expose oneself to the hazard of contagion in the fulfillment of this precept. Ramo holds that there is no distinction in respect of visiting the sick between ordinary and infectious diseases, with the sole exception of leprosy. A recent re-examination of this question, continues Rabbi Jakobovits, leads one to the conclusion, based on several talmudic narratives,[63] that the ruling of Ramo applies only to an infection which would not endanger the life of the visitor even if he caught it, but that one is not required to risk one's life for the sake of fulfilling merely the rabbinic precept of visiting the sick, nor can anyone be compelled to serve such patients. Elsewhere[64] Rabbi Jakobovits asserts that in practice, the view of Ramo did not prevail and approval was expressed for the custom not to assign visitations of plague-stricken patients to anyone except specially-appointed persons who were highly paid for their perilous work. Rabbi Jakobovits also cites the seventeenth century records of the Portuguese Congregation in Hamburg[65] which indicate that even the communal doctors and nurses were exempt from the obligation to attend to infectious cases and that the required services were rendered by volunteers entitled to special remuneration.

Rabbi Yekuthiel Yehudah Greenwald[63] states that if there is hope to heal the patient from his illness, one is obligated to visit and serve him even if there is a risk of contracting the disease because, according to the Jerusalem Talmud, one is obligated to accept a small risk in order to save one's fellow man from a definite danger. However, if there is no chance of saving the patient, one should not endanger one's own life by visiting the patient.[66]

The Talmud states[67] that those sent to perform a religious duty do not suffer harm (*shiluchei mitzvah aynon nizakin*). This rule is also codified in Jewish law[68] but only where there is no danger involved to the person performing the precept. Where there is prevalent danger (*hezekey matzui*), the rule may not apply and the person may be foolhardy to risk his life to perform the precept (*chasid shoteh*). However, if the risk is infinitessimally small such as one in a thousand or less, the person should fulfill the precept.

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38. Psalms 116:6.
39. *Yevamot* 12b.
40. *Iggerot Moshe, Even Haezer* #63.
41. *Torat Chesed, Even Haezer* #44.
42. *Achiezer*, part 1 #23.
43. Zilberstein, Y. *Assia* (Jerusalem), Vol 11 #11 (Nissan 5746), May 1986, pp. 5-11.
44. Hershler, M. *Halacha Urefuah*, Jerusalem, Regensburg Inst., Vol. 2, 1981, pp. 52-57, Sloshitz, M.Y., *Halacha Urefuah*, Vol. 3, 1983, pp 158-163, Metzger, A. *Harefuah Le'or HaHalachah*, Jerusalem, Vol 4, 1985, pp. 10-34; Abraham, A.S. *Hamayan*, Nissan 5742, pp. 31 ff.
45. Abraham, A.S. *Assia* (Jerusalem) Vol. 5 1986, pp 18-23.
46. *Terumot*, end of chapter 8, according to *Ha'amek She'elah, She'iltot* 147:1.
47. Known as *Hagahot Maimuni*.
48. *Keseph Mishneh* Commentary on *Hikhot Rotze'ach* 1:14.
49. *Bet Yoseph, Tur Shulchan Aruch, Choshen Mishpat* 426.
50. *Sanhedrin* 73a, according to *Agudat Aizov, Derushim* folio 3b and *Hashmatot* folio 38b.
51. *Raduaz*, Part 5 (Part 2 in *Leshonot HaRambam*, section 1, 582), *Raduaz*, Part 3 #627, and *Sheilot Raduaz* 1:52.
52. Leviticus 19:16
53. *Iggerot Moshe, Yoreh Deah*, Part 2, #174:4.
54. *Tzitz Eliezer*, Vol. 10 #25:7.

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55. Yosef, O. *Halachah Urefuah*, Vol. 3, 1983, pp. 61-63
56. Weiss, J.J. Responsa *Minchat Yitzchok*, Part 6 #103.2
57. *Tzitz Eliezer*, Vol 10 #25.7
58. Meneleman, M. *Halachah Urefuah*, Vol 2, 1981, pp 114-121 Hershler, M. *Halachah Urefuah*, Vol 2, 1981, pp 122-127
59. Genesis 18.1
60. Sotah 14a
61. Jakobovits, I. *Journal of a Rabbi*, New York, Living Books, 1966, p 156
62. Responsa *Ramo* #19 (end)
63. *Nedarim* 39b, *Berachot* 22b, and Rashi in *Shabbat* 30a
64. Jakobovits, I. *Jewish Medical Ethics*, New York, Bloch, 1959, pp 108-109.
65. Cassuto, J. *Jahrbuch der Juedisch-Literarischen Gesellschaft*, Vol 10,1912, pp 252 and 280 (in minutes dated 1664 and 1666)
66. *Mishneh Torah, Hikhot Shemirat Hanefesh* 1.7.
67. *Pesachim* 8b
68. *Turei Zahav* (Taz) on *Shulchan Aruch, Orach Chayim* 455 3

The risk of contracting AIDS by visiting or touching the patient seems to be nil. No case of AIDS has yet been contracted by casual contact with an AIDS patient. The virus is only transmitted through the blood and by sexual contact. Hence, physicians are obligated to care for patients with AIDS and everyone is obligated to visit patients sick with AIDS. The only precaution one need take is to avoid sticking oneself with a needle used to draw blood from or given as an injection to an AIDS patient.

Allocation of Resources for AIDS Research and Treatment

Some people claim that governmental and societal resources should not be devoted to AIDS research because the disease is self-inflicted. This approach is obviously invalid because some patients acquire AIDS through no fault of their own, i.e., through blood transfusions as in hemophiliacs, or transplacentally as in infants born of AIDS mothers. Even if a disease occurs only in sinners, society is still obligated to expend resources to try and conquer the disease, and physicians are obligated to heal patients suffering from that disease. The Talmud[69] clearly states that every life is worth saving without distinction as to whether the person whose life is in danger is a criminal or law-abiding citizen.

The problem of the allocation of the resources of society when money for health care and medical research is limited is discussed in greater detail elsewhere.[70] Similarly, physicians have to allocate their time and energy among their various patients, raising halachic questions such as the permissibility (or prohibition) for a physician to leave one patient to care for another much sicker patient. This topic, however, is beyond the scope of this essay.

Can Patients With AIDS Be Counted As Part of A Minyan?

May patients with AIDS who are homosexuals and/or drug addicts be counted as part of a quorum of ten men (*minyan*)? The *Shulchan Aruch*[71] states that a sinner who transgressed the decrees of the Jewish community or who committed a biblical or rabbinic transgression can be counted as part of a *minyan* as long as he was not excommunicated. Even if he was excommunicated and cannot be counted as part of a *minyan*, a sinner is allowed to pray in the synagogue unless the congregants strongly object.[72] The *Mishnah Berurah*[73] cites the *Pri Megadim*, who says that this rule applies only if the sinner is one who sins occasionally out of lust or appetite (*mumar le-te'avon*), but a provocative sinner (*mumar le-hachis*) or one who worships idols or who publicly desecrates the Sabbath is judged like a non-Jew and cannot be counted for a *minyan*.

Rabbi Yechiel Weinberg[74] quotes earlier Hungarian rabbis who say that today no Jew is excommunicated and, therefore, all Jews, even sinners, can be counted as part of a *minyan*. However, he continues, other rabbis say that if a person is worthy of being excommunicated by virtue of transgressions he has committed, he cannot be counted as part of a *minyan* even though he is not actually excommunicated." The clarification of this rabbinic disagreement is important, for homosexuality is a sin for which the transgressor is worthy of being excommunicated. Nevertheless, this responsum of Rabbi Weinberg is difficult to understand in view of the clear statement in *Shulchan Aruch* that unless the sinner is actually excommunicated, he may be counted as part of a *minyan*.

Can Patients With AIDS Lead Synagogue Services?

The question has been raised as to whether or not a patient with AIDS can lead services in the synagogue as a cantor (*shaliach tzibur*) or Torah reader. Jewish law requires[75] that the cantor be worthy, be free of sins, and not have a bad name even when he was younger. Moreover, he should be humble and desired by the congregants, have a sweet voice, and study Torah regularly. Rabbi Moshe Isserles[76] asserts that if someone transgressed unintentionally (*beshogeg*) and repented, he is allowed to serve as a *shaliach tzibur*, but not if he sinned intentionally (*bemayzid*) because he had a bad name before he repented. The *Mishnah Berurah*[77] cites *Magen Avraham*, who quotes many rabbinic decisors that even if one sinned intentionally, he can serve as a *shaliach tzibur* if he repented. However, on fast days and on the High Holy Days, one should not appoint him as a cantor, although once appointed he should not be removed.

For the High Holy Days, one should seek out a cantor who is most worthy, most learned in Torah, who has performed many meritorious deeds, who is married, and over thirty years of age.[78] The *Mishnah Berurah*[79] adds that the cantor and the one who blows the *shofar* should have fully repented from their sins, although one who begins as a cantor or *shofar* blower should not be removed. It thus seems that if an AIDS patient has repented from his sins, including the sin of homosexuality, and if he meets the above qualifications and is acceptable to the congregation, it is permissible to have him lead synagogue services or blow the *shofar* or read from the Torah.

Should a kohen with AIDS Recite the Priestly Blessing?

Is it permissible for a *kohen* to offer the priestly benediction (go up to the *duchan*) if he has AIDS related to homosexuality or drug addiction? The *Shulchan Aruch*[80] states that if a *kohen* killed someone even unintentionally he should not offer the priestly blessing even if he repented. Ramo adds, in the name of many rabbinic decisors: "If he repented, he is allowed to recite the priestly blessing and this is the practice which one should follow."

The *Shulchan Aruch*[81] also asserts that if the *kohen* is an apostate he should not recite the priestly blessing although some rabbis allow him to do so if he repented. If a *kohen* is intoxicated, he should not recite the priestly blessing.[82] So, too, if he married a divorced woman.[83]

However, continues Rav Karo,[84] if none of the above circumstances which prevent a *kohen* from reciting the priestly blessing are present, even if he is not careful about the observance of other commandments, he is allowed to recite the blessing. The *Mishnah Berurah*[85] explains that such commandments include even serious prohibitions such as forbidden sexual relationships (*arayot*). It would appear, therefore, that a *kohen* with AIDS is permitted to offer the priestly benediction. *Mishnah Berurah*,[86] quoting the *Zohar*, adds that if the *kohen* is despised by the congregation, he should not recite the priestly blessing. The reason why even a *kohen* who has sinned is allowed to offer the priestly blessing is that one should not prevent him from performing the positive commandment of blessing the people, thus adding to his sins by not allowing him to fulfill this and other commandments.[87]

Someone might ask: what good is his blessing if he is a sinner? The answer is that the *kohen* only recites the words but the actual blessing comes from G-d, as it is written: "and I will bless them."[88]

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69. *Sanhedrin* 73a.
70. Rosner, F. *Modern Medicine and Jewish Ethics*, pp. 339-354.
71. *Shulchan Aruch, Orach Chayim* 55:11.
72. Ibid. 55:12.
73. *Mishnah berurah* 55:11.46.
74. Responsa *Seridei Aish*, Part 2 86.
75. *Shulchan Aruch, Orach Chayim* 53:4.
76. *Ramo on Orach Chayim* 53:5.
77. *Mishnah Berurah* 53:5.22.
78. *Ramo on Orach Chayim* 581:1.
79. *Mishnah Berurah* 581:1.11.
80. *Shulchan Aruch, Orach Chayim* 128:35.
81. *Ibid* 128:37.
82. *Ibid* 128:36.
83. *Ibid* 128:40.
84. *Ibid* 128:39.
85. *Mishnah Berurah* 128:39,143.
86. *Ibid* 128:10,37.
87. *Havaget of Rawal*, Jerusalem 5744, (1984), *Hilchot Nesiyat Kapayim* 15:6.
88. Numbers 6:27.

Should a Patient With AIDS Be Honored in the Synagogue?

The Talmud[89] states that it is prohibited to flatter the wicked in this world because it encourages them to believe that they are not doing anything wrong. Furthermore, if a homosexual AIDS patient is honored in the synagogue by being called up to the Torah, people may be misled into thinking that his behavior is acceptable. Thus honoring a sinner might constitute transgression of the negative precept of "not placing a stumbling block before the blind."[90] The same question arises when a person who publicly violates biblical commandments is honored at a testimonial dinner. Is not the bestowing of such an honor prohibited because it misleads the sinner and the public into believing that the person's violations are being condoned?

Rabbi Feinstein[91] discusses the case of a very philanthropic and charitable Jewish physician who performs many deeds of loving kindness but is married to a non-Jewish woman. Ordinarily, one should not give this physician any honors in the synagogue because of "the stumbling block that is being placed before the blind" in that such honors might mislead him into believing that his marriage to a non-Jew is not wrong. However, if the honor might lead the sinner to repent, or if one tells him that what he is doing is wrong, it is permissible to give him the honor. In the case under discussion, Rav Feinstein concludes that it is permissible to have the physician open and close the holy ark and remove and subsequently return the Torah to the ark because all the congregants know that he is being honored because of his philanthropy and good deeds, thus the honor does not represent acquiescence to his wrong-doing. Furthermore, the public is in need of his services (*rabim tzerichim loh*) because of his expertise as a physician and he may, therefore, be accorded the aforementioned honor.

However, the *Chatam Sofer*[92] rules that one should not call a sinner to the Torah for a portion of the Torah reading (*aliyah*) because of the aforementioned possibility of misleading the sinner and/or the public into believing that the sin is being condoned.

Can a Patient With AIDS Serve as a Witness?

Maimonides[93] lists ten classes of individuals who are ineligible to attest or testify before a Jewish court: women, slaves, minors, the mentally deficient, deaf-mutes, the blind, transgressors, the contemptible, relatives and interested parties. Transgressors are ineligible as witnesses by biblical law, for it is written: "Put not thy hand with the wicked to be an uprighteous witness"[94] which is interpreted as "accept not the wicked as a witness."[95] Maimonides then enumerates the various types of transgressors, including those who are liable to be flogged, thieves, robbers, tricksters, gamblers, usurers, as well as idlers and vagabonds who are suspected of spending their leisure time in criminal activity.[96]

How should one classify the transgressions of homosexuality and drug addiction, the most common risk factors for the development of AIDS? Those who sin unintentionally are eligible to serve as witnesses, but AIDS patients who are homosexuals know what they are doing. Perhaps such patients can be considered to lack self-control over their strong desire; Jewish law states that a person who sins under compulsion is divinely exempted from punishment (*onus rachamanah patrey*). Support for this position can be found in the talmudic commentary known as Tosafot[97] who quote the passage[98] which states that one who is suspected of adultery is nevertheless eligible as a witness.

Burial, Funeral Rites and Mourning For an AIDS Patient

Two cases known to this writer involved AIDS patients who died, where the members of the burial society (*chevra kadisha*) refused to perform the ritual purification of the deceased (*taharah*) because of their fear of contracting AIDS. It is now known that one cannot acquire AIDS by casual contact and their fear was unfounded. However, the problem arises with deceased individuals who had a real contagious disease vis-a-vis the ritual purification for the dead. If the members of the burial society can take precautions such as wearing masks, gloves, and gowns, they should do so. If they cannot or will not do so out of fear, they are not obligated to perform the *taharah* because the latter is only a custom and not a law.[99]

Are the laws of mourning (*avelut*) to be observed for a homosexual patient who died of AIDS? Jewish law states[102] that there is no mourning for those who cast off the yoke of commandments and act like apostates. However, if they repent, mourning is observed for them. Rabbi Abraham Sofer[103] distinguishes between a sinner who suffers for weeks, months or years before his death and one who died suddenly. The former probably repented, the latter did not. Therefore, AIDS patients who suffer for variable periods of time before their death should probably be mourned on the assumption that they repented.

It is certainly not proper to honor an AIDS patient after death by naming a school or playground after him. The Talmud[104] interprets the biblical phrase, "But the name of the wicked shall rot,"[105] to mean that rottenness enters their names in that none name their children after them. If it is public knowledge that the AIDS patient was a sinner, he should not be honored after death by having a person or thing named after him. It is also a punishment for the wicked not to honor them after death.

Use of the Ritualiarium (Mikvah) by Women Fearful of Contracting AIDS

The Talmud states[106] that if wine or olive sap falls into a ritual bath or ritualarium (mikvah) and changes its color, it becomes invalid. Based on this ruling, some rabbis prohibit the addition of chlorine to a mikvah because the color of the water is changed to green. As a result of this prohibition, some women are afraid of using such a mikvah for fear of contracting AIDS from the water used by other women whose husbands may have AIDS. However, this fear is totally unfounded since AIDS cannot be transmitted through water but only by sexual contact or through blood or blood products. Secondly, most rabbis do not prohibit the use of chlorine because only a minute amount is used to provide antisepsis of the mikvah water. (Sufficient chlorine to make the water change color to green would be intolerable to humans and produce serious eye irritation and skin burning. The greenish color of some mikvahs is due to the green or blue tiles lining the mikvah.) Furthermore, the rabbis who prohibit the use of chlorine because of the problem of the change in the appearance (*shinuy mareh*) of the water can offer the solution of using chlorine crystals rather than liquid chlorine. The addition of solids such as foods or chemicals, states the talmudic commentary called *Mishnah Acharonah*,[107] does not invalidate a mikvah even if the color of the water is thereby changed.

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89. *Sotah* 41b
90. Leviticus 19:14
91. *Iggerot Moshe, Orach Chayim*, Part 2 #51
92. *Chatam Sofer, Orach Chayim* #15
93. *Mishneh Torah, Hilchot Eydut* 9.1.
94. Exodus 23.1.
95. *Mishneh Torah, Hilchot Eydut* 10.1
96. *Ibid* 10.2-5.
97. Tosafot on *Sanhedrin* 9b s.v. *lretzono*.
98. *Sanhedrin* 26b.
99. *Chochmat Adam*, beginning of the customs of the *chevra kadisha*
102. *Shulchan Aruch, Yoreh Deah* 345.5.
103. *Responsa Ketav Sofer, Yoreh Deah* #171.
104. *Yoma* 38b
105. Proverbs 10.7
106. *Mikva'ot* 7.3
107. *Ibid*

Circumcision of a Baby with AIDS

The AIDS virus can be transmitted through the placenta from an AIDS-suffering woman, usually a drug addict or sexual partner of an AIDS man, to her unborn fetus. AIDS in newborns or infants is a rare but well-recognized disorder. Is it permissible or mandatory to perform a ritual circumcision (*brit milah*) on such a male infant on the eighth day of life? Must it be postponed until the child recovers from the illness? But there is no cure for AIDS! How does one perform the *metzitzah*, or sucking, which is part of the ritual circumcision? May *metzitzah* be omitted in cases of AIDS?

In a lengthy article, Dr. Abraham Steinberg[108] discusses medical-halachic considerations in the performance of *brit milah*. He reviews the reasons for this divine commandment and the various medical conditions for which the circumcision may or must be postponed. Steinberg cites numerous rabbinic responsa which address these issues. The rules on these matters can be found in the classic codes of Maimonides[109] and Rav Yosef Karo.[110]

If an infant has a generalized illness from which he is not expected to recover, but the physicians state that circumcision would not in any way endanger the infant nor add to the illness, *brit milah* should be performed, preferably on the eighth day.[111] Some rabbis rule[112] that a baby who cannot live for twelve months should be circumcised on a weekday but not on the Sabbath. The *Chatam Sofer*[113] gave a similar ruling in the case of a baby who was not expected to live three months.

On the other hand, Rabbi Bakshi-Doron[114] refused to allow a baby with spina bifida and paraplegia to be circumcised in spite of the medical testimony that the baby had no feeling in the lower half of his body and would not be harmed medically by a *brit milah*. This rabbi and others rule that circumcision should be postponed in any baby with a generalized illness "until it recovers". Most infants with AIDS are critically ill, and circumcision is usually medically and therefore halachically contraindicated.

Conclusion

At the same time that we condemn homosexuality as an immoral act characterized in the Torah as an abomination, we are nevertheless duty bound to defend the basic rights to which homosexuals are entitled. The Torah teaches that even one who is tried, convicted and executed for a capital crime is still entitled to the respect due to any human being created in the image of G-d. Thus, his corpse may not go unburied overnight.[115] The plight of Jewish AIDS victims doomed to almost certain death should arouse our compassion.

In Judaism, the value of human life is infinite. Whether a person is a homosexual or not, we are obligated to give him proper care if he is sick, charity if he is needy, food if he is hungry, and a burial after death. If he breaks a law of the Torah, he will be punished according to the transgression. Even if AIDS is a punishment by G-d for the sin of homosexuality, Jewish tradition teaches us that such a divine affliction may serve as an atonement for that sin or the patient may repent while ill, making the AIDS victim even more deserving of our mercy and loving kindness as a fellow Jew.

The compassion of Jewish law in requiring treatment for AIDS patients, however, should not be confused with acquiescence of the behavior of homosexuals who develop AIDS. Under no circumstances does Judaism condone homosexuality, which we characterize as an abomination. Nevertheless, the patient with AIDS should be treated and his life saved. To stand idly by and see the homosexual die without trying to help him is prohibited.[116] Evil should be banned but the evildoers should be helped to repent.[117]

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108. Steinberg, A. *Assia* (Jerusalem) 5743 (1983) Vol. 4, pp. 207-228
109. *Mishneh Torah, Hilchot Milah* 1:1ff
110. *Shulchan Aruch, Yoreh Deah* 260 ff
111. *Minchat Yitzchak*, Vol. 5 §11
112. *Maharam Schick, Yoreh Deah* §243
113. *Chatam Sofer* §64.
114. Bakshi-Doron, E. *Halachah Urefuah*, Vol. 2, 1981, pp. 268-272
115. Deuteronomy 21:23.
116. Leviticus 19:16
117. Psalms 104:35

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mistake be made? They believed that they could define right and wrong on the basis of their own knowledge.

Torah precludes the possibility of such an error. It forces us to constantly measure our behavior against an objective standard. The Shulchan Aruch has laws and guiding principles that relate to the totality of our behavior. If it prohibits a certain action, a Jew is forbidden to perform it, regardless of all reasons and explanations to the contrary. If it requires the performance of a particular deed, then there is no way a Jew can free himself from that obligation.

A similar concept is demonstrated through the Ten Commandments. They were given in two tablets. The first contained the first five commandments, the laws that pertain primarily to the relationship between man and G-d. The second, containing the second five, dealt essentially with relations between man and man. Both were given as a single entity, thus demonstrating that the two services cannot be separated. The connection between man and G-d must be extended to the point where we relate to G-d not only as a transcendent spiritual being, but recognize and relate to Him as He is manifest in the physical creation and particularly in our fellow man. Also, our relationship with our fellow man must be preceded by a relationship with G-d. There can be no consistent moral approach to dealing with other people without the prior acceptance of G-d and a willingness to follow His will. Without this prerequisite, there will constantly be times when our selfishness and personal desires will cause us, even unknowingly, to ignore and mistreat our fellow man.

Adapted from Likutei Sichos, Vol. II, pgs. 561-562; Sichos Shabbos Parshas Mikeitz, 5731.

RECOMMENDATIONS FOR CHILDREN AND EMPLOYEES WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME/HIV
INFECTION IN THE SYNAGOGUE SETTING*

Recommendations for the Education of Children

Human Immunodeficiency Virus (HIV) is the viral agent responsible for Acquired Immune Deficiency Syndrome (AIDS). Persons who become infected with HIV may develop AIDS, may develop AIDS Related Complex (ARC), or may experience no symptoms of disease. At the present time AIDS is always fatal. ARC is a less severe illness, but may progress to AIDS.

The perinatal spread of HIV infection to infants, who have not reached school age or children who become infected via blood transfusion (prior to the implementation of blood screening), has resulted in questions regarding whether and how these children can be managed or placed in the school setting. Highly charged emotional issues related to HIV infection require that the placement and/or management of these children in the school setting be based on available evidence regarding the risks of transmission of HIV to others in the school setting and the risks to the child with HIV infection of acquiring other infectious agents in the school setting, along with the careful consideration of the confidentiality and legal issues involved.

Based on current evidence, casual person to person contact as would occur among school children poses no risk of transmission of HIV, the viral agent responsible for AIDS. However, a theoretical potential for transmission between young children or neurologically handicapped children who lack control of their body secretions may exist; this theoretical transmission would most likely involve exposure of open skin lesions or mucous membranes of a susceptible person to the blood and possibly other body fluids of an infected person.

Since HIV infections may result in immune deficiency, the infected child may have a greater risk of acquiring infectious agents. Assessment of this risk to the immuno-depressed child is best made by the child's physician who is specifically aware of the individual child's immune status.

The following recommendations apply to all children known to be infected with HIV, regardless of whether or not actual symptoms of disease are present:

1. Decisions regarding the type of educational setting for the HIV infected child should be made on a case-by-case basis taking into account the child's behavior, neurologic development, and physical condition. These decisions are best made using the team approach, including the child's physician, the child's parent or guardian, and personnel from the Synagogue and local health department, and should be reviewed and approved by the Director of Education and Rabbi.

   A. For school-aged children infected with HIV, the benefits of an unrestricted setting in most cases outweigh the risks of their acquiring potentially harmful

infections in the school setting. These children should be allowed to attend school and after school day care in an unrestricted setting. A mechanism for the sharing of information between the child's physician and the school authorities is recommended so that any significant change in the child's medical status can be addressed. In addition, if the school experiences an outbreak of a communicable disease which could be threatening to a child infected with HIV, (e.g. chickenpox, measles), the child should be temporarily excluded by the Educator, pending consultation with the child's physician.

B. HIV infected preschoolers and older children should be considered for exclusion from the classroom if they:

1. lack control of body secretions;

2. exhibit behavioral problems, such as biting;

3. have uncoverable oozing lesions.

Evaluation to assess the continued need for exclusion should be performed regularly.

2. Persons involved in the education of HIV-infected children should respect the child's right to privacy, including maintaining confidential records. The number of personnel who are aware of the child's condition should be kept to the minimum needed to assure proper care of the child and to detect situations where the potential for transmission may increase, e.g., bleeding injury. In individual situations, such people may include the following: Director of Education, Rabbi and the child's teacher(s). Notification should be done by a process that would maximally assist patient confidentiality--ideally, by direct person-to-person contact. It is not necessary to notify parents of other school children regarding the HIV status of any school child.

3. Screening for HIV infection as a condition for school entry is not warranted based on available data.

4. All schools should adopt routine procedures to minimize the transmission of any communicable diseases. Handwashing (with soap and running water for 15-30 seconds and drying with disposable paper towels) is the single most important technique for preventing the spread of disease and should be done frequently. In addition, specific precautions should be taken whenever there is potential for contact with the blood or body fluids of children:

A. Exposure of open skin lesions or mucous membranes to blood or body fluids should be avoided. If open lesions

are present, disposable gloves should be worn. A disposable apron should be worn if clothing is likely to be soiled by blood/body fluids.

B. Surfaces soiled with blood or body fluids should be immediately and thoroughly cleaned. It is advisable to cover the blood/body fluids with paper towels, flood with a solution of one cup of household bleach in 9 cups of water, and allow it to remain for at least 15 minutes before disposing of paper towels in sealed plastic bags.

C. Disposable materials, e.g. gloves, paper towels, sanitary napkins, should be promptly discarded into sealable plastic bags.

D. Mops and other non-disposable cleaning materials are not recommended, but if used, should be rinsed in the disinfectant.

E. Hands should be washed thoroughly after contact with the blood or body fluids of any child, including after removing disposable gloves.

Recommendations for Synagogue Employees

No evidence supports the spread of AIDS/HIV through casual contact, such as that which occurs in the Synagogue setting. Epidemiologic evidence at this time has only implicated blood, seman and vaginal secretions in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HIV, and it has not been shown to be transmitted by contaminated food or water.

In view of this evidence, the following recommendations are made:

1. Screening for HIV infection as a condition for Synagogue employment is not warranted.

2. Decisions regarding Synagogue employees known to be infected with HIV should be made on a case-by-case basis, utilizing existing mechanisms for employee health in consultation with the local health department.

3. Adequate steps must be taken to protect the confidentiality of the Synagogue employee with HIV infection.

4. Since no known risk of transmission to co-workers or others exists from HIV infected workers in the Synagogue

setting, they should not be restricted from using telephones, office equipment, toilets, showers, eating facilities or drinking fountains. Equipment contaminated with blood or other body fluids of any worker, regardless of HIV infection status, should be cleaned with soap, water, and household bleach as described in the section on recommendations for the education of children.

*Congregations should be advised that federal, state, and local discrimination laws may also affect their employment and school attendance policies. A federal disrict court in California recently held that federal physical handicap laws guaranteed the right of an Atascadero public school boy to attend despite having AIDS. More than twenty states have determined that their physical handicap laws protect persons with AIDS, and a number of cities in California and elsewhere have passed or are considering passing AIDS anti-discrimination laws as well.

Modified from information prepared by the Maryland Department of Health and Mental Hygiene and the Governor's Task Force on AIDS.

C.C.A.R. RESPONSA COMMITTEE
1950 Bathurst Street, Toronto, Ont. M5P 3K9
Tel. (416) 789 3291 Fax (416) 789 9697

Tevet 14, 5750/January 11, 1990

To Rabbi Alexander M. Schindler
838 Fifth Ave., New York, NY 10021, USA

Dear Alex,

enclosed is our *teshuvah* on AIDS. Since I involved all members of the Committee in the process, including one colleague in Israel, the matter has taken a bit longer than anticipated.

Thank you for asking this particular *she'elah*, it has given us a good deal to think about. Incidentally, this is our first effort.

With fond regards from house to house,

Cordially,

Gunther

And thanks again for your kind letter of concern. Elizabeth is fine again, or nearly so.

MEMORANDUM

From Rabbi Alexander M. Schindler

Date January, 1990

To Members, UAHC Executive Committee

Copies

Subject RESPONSA

Some time ago I addressed an inquiry to the Responsa Committee of the CCAR. The answer is enclosed herewith, not only because the specific issue might be of interest to you, but because it is a good example of how Reform Judaism at its best enters into a dialogue with Tradition.

Warm regards.

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

Rabbi Alexander M. Schindler 1/30/90

Rabbi Joseph B. Glaser

Rabbis Samuel Karff & Daniel B. Syme; Albert Vorspan

Thanks for sharing Mike Rankin's letter with me, as well as your own thoughts on the workibeing undertaken by our movement in the area of AIDS. First of all, you should know the use of the term "Commission" is purely Mike's doing...we never created a Commission, we have a Committee on Aids.

Be that as it may, your comments are well taken and I do agree, we should maintain this work under the designation of a Joint Committee. These helps avoid some of the more technical woes you state in your note but provides for a continuation of the important work undertaken by this group under the aegis of both the Union and the Conference.

Warm regards/

Rabbi Joseph B. Glaser

c

1/24/90

Dear Alexander

This AIDs thing is driving me crazy. See Rankin letter now. Then continue my note...

I called Rankin, welcoming his initiative, because I think it's dumb for CCAR to have its own c'tee. The UAHC is doing a good job and there are 13 rabbis on it not including UAHC staff. But there are those in CCAR who want "CCAR presence ... visibility". Rankin says all says a joint Commission is now OK by you and CCAR should worry about travel expense, Rankin assuming there is UAHC money available. Secretaries, I called all and he firmly contradicted this, Rankin obviously misunderstanding. All and I would prefer status quo but call it a "joint Committee" so we don't get into the technicalities and woes of a Commission, letting UAHC continue to run the whole shebang and CCAR will pay for the equal of 5 rabbis travel once a year. They can split it up any which way they want. How's that?

Regards.

Joe

CCAR • 192 Lexington Avenue
New York, New York 10016
(212) 684-4990

cc: Sam Karff, Al Vorspan, Dan Syme

C

Outpatient Clinic

2221 Martin Luther
King Jr Way
Oakland CA 94612

December 26, 1989

Department of Veterans Affairs

Note to Sam Karff - Let's hold up on the C'tee - Joe

In Reply Refer to:

Rabbi Joseph B. Glaser
Executive Vice President, CCAR
192 Lexington Avenue
New York, N.Y.

Dear Rabbi Glaser,

As you may know, we've had a change in the leadership of the UAHC Commission on AIDS. Rabbis Janet Marder and Sandy Seltzer have replaced Rabbi Sternberger as staff coordinators, and I've assumed the chair from Bo O'mansky, who is heading up Local Arrangements for the Baltimore Biennial.

The two rabbis and I spoke recently with Al Vorspan regarding the relationship between the Commission and the CCAR, and it was suggested that I communicate directly with you on the matter.

I know that we in the Union, and you in the CCAR want to do all we can to combat this terrible epidemic. The only question is, how do we do that most effectively? Thus far the Commission has functioned as a UAHC entity, with a number of rabbis serving on it. And Rabbi Moss was recently appointed by the CCAR to serve as its representative on the Commission. We may want to continue that arrangement. But we may also want to consider an alternative whereby the UAHC and the CCAR could work closely together, perhaps as a joint committee. I'm writing to see how that sounds to you and your colleagues in the Conference.

The advantages to the joint committee are several, it seems to me. First, we would avoid duplication of effort that is sure to occur if we have two separate committees. And second, a joint committee might have more "clout" with the congregations and the College-Institute, and with the lay and rabbinic leadership of our movement.

There may also be disadvantages, but I think they could be overcome. The Commission does not make UAHC policy, of course--only the Board of Trustees can do that. But we do suggest policy to the Board, usually as a resolution. There could come a time when the majority of the joint committee wanted to recommend something that was not necessarily supported by the majority of the Conference. I have no idea what that might be, but if such an issue did come before us, I'd hope we could find a satisfactory compromise.

In any case, I'd like to talk with you about all this. Let's both get past the holiday rush, and I'll give you a call in early January. Or, you can call me if you like. My card is enclosed, with both office and home numbers.

Every good wish for a healthy and productive new year.

Sincerely,

Mike Rankin

Robert M. Rankin, M.D.

August 29, 1989
28 Av 5749

The Rev. Leontine Kelly, Bishop
United Methodist Church
and
The Rev. Donald Eastman
Second Vice Moderator
Universal Fellowship of
Metropolitan Community Churches
475 Riverside Drive - 10th floor
New York, NY 10015

Dear Rev. Kelly and Rev. Eastman:

Many thanks for your most gracious invitation to join the Honorary Host Committee for a national consultation on AIDS - The Moral Imperative: A Call to National Leadership. This is a critical gathering and and I am delighted to join with distinguished colleagues as a member of the Honorary Host Committee.

I look forward to further word on this gathering and will do my utmost to participate in the advance planning.

With kindest greetings, I am

Sincerely,

Alexander M. Schindler

AIDS National Interfaith Network

August 25, 1989

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

Dear Rabbi Schindler:

On December 4, 1989, the Carter Presidential Center, with the AIDS National Interfaith Network and Atlanta AIDS Interfaith Network, will host a national consultation entitled, AIDS - The Moral Imperative: A Call to National Leadership. Invited will be approximately 250 elected or appointed religious leaders from metropolitan centers in the nation with the highest reported rates of HIV infection and from selected smaller cities, heads of communions and religious bodies, and national interfaith leaders.

We enclose, for your information, the draft agenda for the consultation. We hope that you will plan to attend the consultation, formal invitations to which will be mailed by the Carter Presidential Center within a few weeks.

We are writing at this time to invite you to serve on the Honorary Host Committee for this important consultation. In addition to being identified on the letter of invitation, members of the Host Committee will have a primary oversight role in the drafting of a consensus statement on religious responses to the AIDS pandemic. The consensus statement will be circulated for endorsement among consultation invitees and other religious leaders in preparation for public presentation on December 4th. Enclosed you will find a listing of persons invited to serve on the Honorary Host Committee.

We anticipate the Honorary Host Committee will need to meet once in late September or early October to

~~132 West 31 Street, 17th Floor, New York, NY 10001 (212) 268-8700~~
475 Riverside Drive, 10th Fl., New York, NY 10115 (212) 870-2100

outline the scope and general content of the consensus statement and to agree upon a process for the writing, review, finalization and circulation of the consensus statement. In addition, some Honorary Host Committee members will participate in presenting the consensus statement at the December 4th consultation.

Since the letter of invitation to the consultation will be sent in early September, a timely response regarding your willingness to serve on the Honorary Host Committee would be much appreciated. We will then be in contact with those willing to serve to arrange a mutually acceptable date and site for the Honorary Host Committee meeting.

If you have questions, please telephone Rev. Don Eastman at (213) 464-5100.

This consultation will provide an important opportunity for leaders of the nation's interfaith community to focus attention upon the moral imperative of responding meaningfully to the many human needs and challenges of the AIDS pandemic. We hope you will join with us in preparing for this historic event.

Most sincerely,

Leontine Kelly

The Rev. Leontine Kelly
Bishop, United Methodist Church

Donald Eastman

The Rev. Donald Eastman
Second Vice Moderator
Universal Fellowship of Metropolitan Community Churches

LK/DE:bj
enclosures

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

May 22, 1989
17 Iyar 5749

Rabbi Yoel H. Kahn
Congregation Sha'ar Zahav
22 Danver at Caselli
San Francisco, CA 94114

Dear Yoel:

I have now seen your letter and I thank you for your most encouraging words. It was good of you to take the time to write and share your reaction to my AIDS address.

I am also grateful for the wonderful cookbook. You should know that I actually purchased a copy when I was at the convention in Monterey. But, we will keep the copy you sent because of the beautiful personalized inscription, which I appreciate very much. The copy we bought will be given to one of our children. I know it will be enjoyed by one and all, for leafing through it is really a delight and there are some fine recipes.

Thank you for the information about Tristano Palermino. I appreciate your thoughtfulness in giving me this information.

With repeated thanks and fondest good wishes, I am

Sincerely,

Alexander M. Schindler

cc: Robin Leonard,
President

Dr. Mike Rankin

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

July 18, 1989
15 Tammuz 5749

Dr. Boris L. O'Mansky
3400 Woodvalley Drive
Pikesville, MD 21208

Dear Bo:

Thank you so much for your letter of July 12th and the enclosures. Your comments will be of help to me.

I may not present the resolution just as you have it, but something will be said along those lines.

All the very, very best. I hope that you, too, have a relaxing Summer, which will renew your strength and spirit.

Fondly,

Alexander M. Schindler

May 17, 1989
12 Iyar 5749

Rabbi Yoel H. Kahn
Congregation Sha'ar Zahav
220 Danvers at Caselli
San Francisco, CA 94114

Dear Rabbi Kahn:

Your letter of April 21 and the exciting cookbook published by Congregation Sha'ar Zahav arrived after Rabbi Schindler had left the office to attend Board meetings of the UAHC, which will be followed by staff meetings. Both of these are to be held out of the city. Thus, he has not as yet had an opportunity to see the book or to read your letter. I know we will be grateful for your very kind comments about his AIDS sermon delivered at the service in Los Angeles. And, I am confident he will want to read your own talk on Silence = Death: A Jewish Response to AIDS.

I will be bringing your letter and the cookbook to the Board meeting tomorrow, but I did not want to leave the city before at least acknowledging receipt of your gracious gift to Rabbi Schindler. I know he will be grateful for the cookbook -- it looks very exciting and just leafing through it I have noted a number of wonderful recipes.

With warm good wishes, I am

Sincerely,

Edith J. Miller
Assistant to the President

Congregation Sha'ar Zahav

שער זהב

Member, Union Of American Hebrew Congregations

Rabbi Yoel H. Kahn

220 Danvers at Caselli San Francisco, California 94114 (415) 861-8932

April 21, 1989
16 Nisan 5749

Rabbi Alexander M. Schindler
President
UAHC
838 Fifth Ave.
New York, New York 10021

Dear Alex;

Mike Rankin, our peripatetic and ever-busy new UAHC national board member, was kind enough to give me a copy of your address at the Jewish Community Service in support of people with AIDS in Los Angeles. Separately, I've received another two or three copies from rabbis and community members who were present.

I cannot express how moved I was to read your words. They came to me truly as <u>nechamta</u> at a time of need for me; they surely were inspiring and uplifting to all who heard them.

Mike informs me that you are planning on printing the text of your remarks in an upcoming issue of <u>Reform Judaism</u>. I heartily support this. I think that this truly prophetic message needs to be circulated as widely as possible in our movement and in the wider community.

At the Regional Biennial in Monterey, you had a brief chat with a member of our congregation, Tristano Palermino. When you asked him about his family, Tristano was too embarrassed to explain that though he is from Palermo, his family is not Jewish. That is why you had never heard of any Italian Jewish families by this name! (Both he and his lover, David Glassberg, member of our Regional AIDS Committee, are living with AIDS.)

I have taken the liberty of including the text of my recent talk, "A Jewish Response to AIDS: Silence = Death," which I delivered at Holy Blossom Temple this February. I thought that you might be interested in the concept of "safe sex as <u>mitzvah</u>" which I discuss at the beginning of the second section.

Our congregation is pleased to have published <u>Out</u>

of Our Kitchen Closets: San Francisco Gay Jewish Cooking. In addition to passing on many nice recipes, $3 from the sale of every book goes to the San Francisco AIDS Foundation Food Bank. We sold out our first printing last year and gave the Food Bank a check for over $7,000; we are now selling the second edition. Please accept the enclosed copy as a gift from our congregation.

Respectfully,

Yoel Kahn

Rabbi Yoel H. Kahn

YHK/jh
cc: Robin Leonard, President
Dr. Mike Rankin

Enclosures

Congregation Sha'ar Zahav שער זהב

Member, Union Of American Hebrew Congregations

Rabbi Yoel H. Kahn

220 Danvers at Caselli San Francisco, California 94114 (415) 861-6932

SILENCE = DEATH: A JEWISH RESPONSE TO AIDS
Holy Blossom Temple, Toronto, Canada
February 17, 1989 Shabbat Tetzaveh

Thank you, Rabbi Moskowitz. It is an honor to speak from the bimah of this congregation and a special pleasure for me to be in Toronto. Although this is the first time I have ever been here, this city has always had a special place in my family's collection of oftold stories - my parents met in 1947 when they were both students at the University of Toronto. I am especially honored to have some of their oldest friends here this evening. I would like to express my thanks to the Rabbis of this Temple for inviting me to speak here and to Chutzpah, Toronto's organization of gay and lesbian Jews, who have made this visit possible under the auspices of the Sheldon Ross Memorial Symposium. I am honored to greet the members of the Ross family here this evening as well.

Over the last two years, a simple statement has become the rallying cry of those organized to seek more attention to AIDS and to those whose lives it has touched. In the United States it was first popularized at the largest civil rights march in history, in October 1987, when more than 600,000 lesbian and gay men, their families and their friends gathered in Washington. Many of the marchers wore a shirt or button which featured a pink triangle on a black background and the slogan Silence = Death. The pink triangle, the Nazis' identifying label for homosexuals (comparable to the yellow star), has become an international symbol of gay pride and resistance. Elie Wiesel, our generation's prophet of memory, has repeatedly reminded us that "Never Again" is more than a call for Jews to resist anti-Semitism; it is a summons to the world to resist all oppression and genocide.

In the United States, there have been more than 80,000 diagnosed cases since 1981. In Canada, there are a reported 2,375 cases (as of Feb. 3rd; source: Health Ministry AIDS Hotline). Worldwide, there have been 140,000 reported cases to date; the real number is without doubt several times higher. Here in Toronto, eighty people are testing positive for HIV-antibodies each week. Since the beginning of the epidemic, the organized Jewish community has been virtually silent on this health emergency. With the exception of our Reform movement, no national Jewish group in the U.S. or Canada has made a public statement about the AIDS epidemic and its social, public policy or religious dimensions. Our silence directly affects the length and quality of the lives of everyone with AIDS, ARC or HIV infection. Since the incubation period for the virus can be as long as five, ten years or more, most of the people who are being diagnosed today probably were infected several years ago. Even if the rate of new infection is slowed, the number of new cases is projected to continue to rise for the foreseeable future. But the further spread of this disease can be stopped - if the silence is broken. Silence about AIDS leads to death. I have come this evening to ask you to break the silence.

I.

Safe sex is a mitzvah (commandment) for our generation. We must teach our children - and ourselves - that safe sex is not only healthy, life-saving and good - but also that it is what God wants of us. Our youth movements and camps are effective at teaching about social justice, from Central America, to the boat people, in the context of traditional Jewish religious values. Yet in the realm of personal moral values and sexual standards, we expect only fundamentalists and the Catholic Church to take a public stand. Surely there is a middle ground in sexual behavior and

standards between unrealistic and unenforceable puritanism and the idealized promiscuity of prime-time TV. Silence in education equals death.

To be effective, our sex education must be explicit. It is insufficient to teach that the HIV virus can be transmitted by "having sex." It is not transmitted by having too many sexual partners. It is not transmitted only through homosexual, as opposed to heterosexual, acts. This virus is far too simple and methodical to make cultural and social distinctions. It is controlled by biological and physiological determinants: the HIV virus' primary route of transmission is through the exchange of body fluids during unprotected vaginal and anal intercourse, when sharing needles to shoot intravenous drugs, and from and infected mother to her foetus. Until we say these words out loud, show pictures, and speak in the language that children, youths and adults use and understand, we are still silent. Safe-sex education belongs in Jewish education in the context of teaching about responsible personal decision making. Sex education in the schools, when it is permitted, is largely limited to the details of plumbing; the mitzvot of responsible sexual behavior in the context of mutually loving respectful and healthful relationships will only be learned if we teach them at home, in our summer camps and youth programs, and in our synagogues.

While gay men have been the hardest hit by this virus, they have also been the most successful in educating each other and changing their own sexual behavior. The rate of new infection among gay men in San Francisco is now effectively zero. This change in sexual behavior is astounding when we consider the other life-threatening circumstances which people have the power to change, yet usually don't - from smoking to not wearing seat-belts. Tragically, most gay men who will develop AIDS were infected before the disease and its methods of transmission were recognized. But new infection among other at-risk populations can be prevented only if we risk speaking out.

II.

For the person diagnosed with AIDS or at risk of diagnosis, silence leads to death. AIDS is not transmitted by casual contact, but the fear of AIDS is. This unfounded fear, coupled with the absence of correct and explicit public information, has created the climate for discrimination, hysteria and violence in which, for instance, the home of three children infected by the virus was firebombed in Arcadia, Florida. Even the Reagan administration, hardly a pro-gay biased source, concluded in a recent study that gays and lesbians are "probably the most frequent victims" of hate crimes [U.S. Justice Dept, Oct. 1987].

Besides the threats of physical assault, there is a more subtle violence which the person with AIDS or HIV infection, or who is at risk, must face. This person must lie at work for fear of losing a job or tenure, be careful of whom to tell for fear of losing an apartment, and carefully decide who to inform among friends, families and acquaintances, lest they all disappear. A young man from my synagogue went home to the town where he grew up, became ill, and unexpectedly spent two months in the hospital. No one visited him during this period outside his immediate family - not his rabbi, nor his high school classmates, nor old family friends. Only when he left the hospital did he learn that his parents had not told anyone he was sick, for fear of the stigma of having a son with AIDS.

Although AIDS is not a gay disease it is impossible to separate the history of this epidemic from the history of oppression and violence against gay and lesbian people. The greatest violence has been the passivity of governments and institutions - national, state, provincial and local - in the face of a disease which only affected "them." The stigmatizing and oppression of gay men and lesbians has in turn kept many people in the closet, reinforcing gay people's invisibility. For

the person who has never come out to parents, spouse or family, the twin secrets of homosexuality and an HIV-infection or illness can be overwhelming. The affected person instead retreats into silence, carrying this tremendous burden alone, perhaps becoming ill and dying cut off from family, friends and community just when they are needed most.

III.

For the mourners who cannot share their pain and therefore do not heal, silence too leads to death. If, as we teach, the enduring power of memory is the key to eternal life, then death is victorious when the survivors never speak for fear of being cut off themselves from their own communities. When the man I described above, who spent months in social isolation in the hospital, was dying in San Francisco, I asked his parents for permission to call their hometown rabbi and inform him of their son's impending death. The mother pleaded with me not to say a word: "Please, I have to go back and live with these people." Do the families touched by HIV disease in this congregation feel safe?

The deep wounds and loss do not heal, but instead become scars on the soul, hidden deep within, self-fulfilling prophecies in which the fear of social death leads to the death of the spirit and a turning away from the healing power of remembrance. Meanwhile, the friend, neighbor, co-worker or fellow synagogue member who has suffered a similar loss also mourns alone, each thinking: "I am the only one."

IV.

Lurking behind the AIDS health crisis is a crisis of faith. Jerry Falwell, together with some isolated Jewish voices, has explained AIDS as a form of punishment. In an August 1987 Gallup poll, forty-two percent of the people surveyed agreed with the statement: "I sometimes think that AIDS is a punishment for the decline in moral standards." [NYT, August 30, 1987] Regardless of our attitude towards homosexuality, the conclusion that a particular disease represents a direct expression of divine displeasure is only possible within a biblical fundamentalist and literalist mindset, which is completely alien to the Jewish tradition and the modern Jewish world-view. AIDS cannot be considered as "divine punishment" visited upon those whose lives it touches, unless we are ready to declare sickle-cell anemia as divine punishment on blacks, Tay-Sachs disease as a punishments on Jews, and the earthquake in Armenia a punishment for the Soviet government's erroneous ways. If AIDS is a punishment for irresponsible actions, and therefore those affected by it are not deserving of our sympathy and support, should not the same conclusion be made about middle-aged men with type-A personalities who suffer heart attacks?

The Jewish religious tradition suggests an alternative explanation through its theology of suffering. The Jewish people has wrestled with the meaning of suffering for hundreds of years. After the expulsion from Spain in 1492, Jews eventually came to interpret their pain and exile not as the will of God but rather as the consequence of shevirat ha-kelim - the incomplete nature of the cosmos. Their pain and anguish was not a punishment from God but instead a reflection of a process within the Godhead itself. There will be inexplicable evil in the world, and pain and suffering will not be eliminated, until the tikkun is complete. We are not so arrogant as to assume that floods or droughts or diseases- great forces of nature - have their genesis in our own private histories.

The AIDS virus is best understood as an evolutionary and natural phenomenon which follows natural laws, just like gravity follows its laws. AIDS derives neither from some satanic source nor from divine judgment. It is a virus which follows the laws of biochemistry. People of faith need to speak out

1against those who, like Job's misguided friends, continually try to blame a victim who has done no wrong. To date, the public theology of AIDS has focused on "AIDS as punishment." Does not our tradition suggest that God is best known as Ha-Rachaman, the loving and Comforting One?

Our rabbis taught that when Israel goes into exile, the Shechinah goes into exile too. When Israel cries, they taught, God sheds a tear. God shares in our pain and God comforts us in our time of sorrow. Where is God in this epidemic? God is beside and supporting those who are ill and those who care for them. As Rabbi Robert Kirschner has taught, God has no hands to heal with but our hands, no voice to comfort with but our voices, no arms to embrace with but our arms. God's presence in this epidemic is found in the reservoirs of strength which volunteers summon up to continue their service despite the hardship and grief, in the continuing attention and devotion of family, friends and lovers who provide care, and in the courage of those who are living with this illness. Over and over again, I have met these heroes of spirit and faith, affirming life in the face of death. Harvey Milk, San Francisco's martyred gay county supervisor once wrote: "We cannot live on hope alone. I know that. The important thing is not that we can live on hope alone but that life is not worth living without it." God as the Source of Hope and Comfort is perhaps a less dramatic figure than the hoary God of Retribution who sends lightning and disease to a sinful world. Until now, we have abandoned the public theological debate-with its attendant influence on public policy debate - to those whose religious and social outlook is most contradictory to our own. Silence cuts off the soul from God and cuts off our community from its own source of healing.

V.

AIDS belongs on the political agenda of the Jewish community. In the United States, reporter Randy Shilts' important book, And the Band Played On, documented in painful detail how the United States government deliberately avoided becoming involved and committing resources to fight this epidemic. The Canadian government, too, has been slow to respond. Through vigorous public education, the life-saving message of safer sex has successfully been transmitted in San Francisco and some other large cities. The AIDS education available in Canada is entirely financed at the provincial level, and the education programs which are being promoted are not targeted to those at greatest risk. Continuing silence today means life-threatening illness tomorrow. The Jewish people, whose slogan is "Never Again" surely recognizes that when a government allows thousands to perish who could be saved, because it considers them unimportant, Jews have a special responsibility to act.

[Many of the political issues raised by the AIDS crisis are, in fact, already on the progressive agenda. Many politicians who oppose federal funding for agencies which "promote homosexuality" by teaching about safe-sex also oppose federal funding for family planning clinics which counsel women about abortion. These are public policy matters in which we can find common ground with our counterparts in other religious communities, along with minority and civil rights organizations. There is an urgent need for a liberal religious coalition to speak out with prophetic courage on public policy.]

VI.

How then can Jews and the Jewish community end the silence? First, it is essential to stop treating AIDS as something totally unfamiliar. It is a tragedy of enormous proportions, but the human needs in this epidemic are the same as in any health emergency. The people who are ill need care, comfort and attention. And the caregivers, both professional and volunteer, along with family members, lovers and friends, are constantly on the edge of burnout. The Jewish tradition is clear on our task.

In the Book of Genesis, we learn that when our parent Abraham was recuperating from illness, they Holy One came to visit him. How did God arrive? In the guise of an angel, one of the three visitors who appear at Abraham's tent. From this story our rabbis derived the mitzvah of bikkur cholim - visiting

and caring for the sick. In virtually every major city in this country, the local AIDS service organizations are in desperate need of volunteers and support. The existing institutions of the Jewish community can open their doors and reach out to the people touched by AIDS and their families. A model which we started in San Francisco and is now being duplicated elsewhere is our Jewish Emergency Assistance Network's AIDS Family Assistance Project. Under the auspices of our Jewish Family and Children's Service, the program has served over 150 Jews with AIDS and their families, with counseling, holiday meals, support groups, home hospitality and care. In addition, thousands of Jews have been educated through the out-reach efforts of the project staff and volunteers. As individuals and through the work of your congregation's AIDS Sub-Committee, you can act, giving of your most precious gift, yourself. A pressing need for people living with any life-threatening illness is to write a will and put their legal affairs in order. I am informed that in Toronto, there are only six attorneys, out of the thousands in practice in the city, who have agreed to help people with AIDS prepare wills and deal with their legal affairs.

It is not always easy for us to care for people touched by this illness. We will not overcome our discomfort until we face our homophobia, our embarrassment about sexuality, and our fear of death. In our culture, we have grown accustomed to making things better, ever confident that with the proper technology or pill or procedure or practitioner, all will be well. In this epidemic many are not getting better. There are good days and there bad days. Many are hanging on; others, despite the best care and a determined spirit, are fading. It is very painful to be a witness. What can we say or do?

Once again, silence only denies the pain. The topic of AIDS cannot remain taboo, spoken of shamefully or in whispers. We need to open ourselves, our families, our synagogues and our communal institutions to the reality of this disease. We need to stop thinking about "them" and start talking about "us." Rabbis must speak about AIDS from their pulpits. The sisterhood and the brotherhood, Hadassah and B'nai Brith, our schools and youth groups, together with the Rotary Club, the Masons, the Scouts and all the other forums where we gather, must put AIDS education on their agenda. Chutzpah, Toronto's organization of gay and lesbian Jews, has been and out of necissity will continue to be on the front line; its members and programs need and deserve your support.

Through the painful lessons of history we have come to know that Silence = Death. Over the last year, a new slogan has appeared. Against the same black background and beneath the same pink triangle appears: "Action = Life." As Jews, we are summoned by our history and by the call of Elohim Chaim, the God of Life: "U'becharta b'chaim... Now therefore choose life."

Yoel Kahn is rabbi of Congregation Sha'ar Zahav in San Francisco.

איחוד
ליהדות
מתקדמת
באמריקה

Union of American Hebrew Congregations

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
Assistant Director

March 15, 1989

Rabbi Alexander M. Schindler
838 Fifth Avenue
New York, NY 10021

Dear Alex,

I am sure that I did not adequately express my thanks to you at the conclusion of Sunday's Service. To tell you the truth, your sermon left me speechless. So let me now tell you how grateful I am for your words. I had expected the sermon to be forceful and eloquent; what I did not anticipate was the deeply personal tone of your remarks. That made your speech extraordinarily moving and set it apart from other "official" statements on AIDS that I have heard. I think that all of us in the sanctuary realized how remarkable it was to hear the national leader of a religious movement declare his solidarity with homosexuals and all those suffering from AIDS. It certainly went far beyond the usual calls for "compassion for AIDS victims." As you said, it crossed the boundary of "otherness."

The hours of thought and struggle you devoted to this issue have truly generated a magnificent statement.

I feel privileged to have witnessed your talk, and honored to be part of the movement you lead.

Sincerely,

Rabbi Janet R. Marder
Assistant Director

JRM/hpr

Union of American Hebrew Congregations

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PACIFIC SOUTHWEST COUNCIL
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Assistant Director

איחוד
ליהדות
מתקדמת
באמריקה

January 13, 1989

Rabbi Alexander Schindler
Union of American Hebrew Congregations
838 Fifth Ave.
New York, N.Y. 10021

Dear Alex,

I hope this letter finds you well. Here are some thoughts about your sermon at the AIDS service on March 12:

First, a couple of things to avoid. It would be better if you did not refer to AIDS "victims" but to "people with AIDS." Because the term "victim" suggests passivity and helplessness, those who are struggling with this disease prefer not to have it applied to them. I would also urge you not to dwell too much on the inevitably fatal nature of the disease, since there will be people there who are fighting to survive and trying desperately to maintain some hope.

On the positive side, I would love to hear you call for the Jewish community to face the truth and recognize that AIDS is in our midst--that it touches nice, white, middle-class Jewish families. It is important that you address the issue of their (often self-imposed) isolation--the intense fear and anxiety that keeps them from coming forward to seek help. It is very common for mothers and fathers to tell no one of their sons's diagnosis with AIDS, and to emphasize that even at the funeral the secret must not slip out. They rarely turn to the Jewish community for help, I believe, because they have no expectation of finding help there--only judgment, gossip, and fear of contamination. Quite often, the assistance they need is basic and concrete: someone to visit, help with cooking, laundry or transportation. We Jews have been concerned about protecting ourselves from AIDS; when will we be ready to go beyond our fear and offer help on this simple, human level? I'd like to see you discuss why we should help and how we can help.

The point to stress is that we can't wait for people affected by AIDS to come to us and ask for help; synagogues must make a conscious effort to reach out to the AIDS community by contributing to the AIDS Project Food Bank, sponsoring blood drives, inviting PWA's to Shabbat meals or Passover Seders at the temple or in homes, offering meeting space to groups serving PWA's and so forth. Synagogue members could volunteer with agencies serving PWA's; those who are professionals (lawyers, accountants, dentists, insurance agents, etc.) could offer their services free or at reduced cost to a PWA. All temple members should continue to learn about AIDS, even though it's depressing, and make an effort to educate those around them, dispelling ignorance and

irrational fears whenever they encounter them.

The most important message that should be conveyed is not pity or compassion for those suffering from AIDS, but a sense of solidarity--a feeling that Jews affected by AIDS are part of us and belong to us. The other day I heard a priest say, "The Church has AIDS," and was much struck by his words.

I also think it's important for you to explain why AIDS is a Jewish issue that needs to be on our agenda, and why we should care about people with AIDS even if they're not Jewish. Most people don't understand the impact that AIDS is having, and will have, on our entire society.

I'd love to hear you make a statement against homophobia, especially in the religious community, and point out how homophobia has contributed to our society's appalling delay in responding to this epidemic. It would be wonderful if you could acknowledge the magnificent work the gay community has done in caring for the sick and dying; they have truly been leaders for all of us. And when you refer to people affected by AIDS, it's very important to mention families, friends and lovers. It would mean a lot for you to acknowledge the existence of loving, courageous gay couples who battle this disease.

I'd also like to see you praise the heroic efforts of nurses, doctors and other caregivers (many of them Jewish) who have devoted to their lives to people with AIDS with extraordinary tenderness, energy and dedication. It would also be appropriate to pay tribute to our own UAHC AIDS Committee.

Finally, I hope you'll make a strong statement of love and acceptance to those individuals, couples and families who are coping with AIDS or mourning the loss of a dear one. They need to feel embraced by their community, and you are the voice of that community.

We want to make this service an affirmation of life, as well as a remembrance of those who have died. We'd like people to leave feeling hopeful and united--a sense that all of us, the sick and the well, stand together against this disease and hold one another up.

I realize that this is a lot to ask for, but I have heard you speak and know that your words will be inspiring. Please feel free to contact me with any reactions to my suggestions. Once again, let me express my deep appreciation to you for taking part in this service. I am very proud to be part of the movement you lead.

B'shalom,

Janet

Rabbi Janet R. Marder
Assistant Director

BB:

Peter-Joseph Avitabite requested that I write to you and share a copy with him...he wants to use my letter to further his work in behalf of the Saint Peter's Momentum Aids Outreach Project which, as you know, he directs.

Have a great Summer.

AMS

July 6, 1988
21 Tammuz 5748

Rabbi Balfour Brickner
Stephen Wise Free Synagogue
30 West 68th Street
New York, NY 10023

Dear Balfour:

I was delighted to learn that the Stephen Wise Free Synagogue has determined to undertake the Momentum Aids Outreach Program patterned after the program presently undertaken by Central Synagogue in cooperation with St. Peter's Church.

On several occasions I have gone over to St. Peter's Church and participated in the preparation and serving of meals for the guests affected by AIDS and their spouses. I have seen the effective impact which this effort has as well as the take-home food baskets which are given to the guests as they leave the Church.

This is a true service of the heart, one which merits replication not just by you but by many other synagogues throughout the land. WC must do everything we humanly can to counter-act the mindless discrimination to which the victims of this dread malady are subjected - that wave of hysteria whose symptoms include ostracism, prejudice and violance. This secondary scourge is as deadly as is the primary affect of the illness itself and must be counteracted by every means at our command.

I salute the members of your congregation undertaking this project, it is in the tradition of a synagogue which has always been known for its concern for the well-being of that community of which it is a part.

Fondly,

Alexander M. Schindler

cc: Peter-Joseph Avitabite, M.A.

(212) 995-2200

Peter - Joseph Avitabile, M.A.

Saint Peter's Momentum Kids Outreach Director

9106 24 A 96
NY C 10010

(212) 689-7166

June 13, 1988
28 Sivan 5748

Rabbi Morley T. Feinstein
Temple Beth-El
305 West Madison Street
South Bend, IN 46601

Dear Morley:

I am simply delighted that the students of Temple Beth-El's Confirmation Class of 1988 and the 8th grade class have contributed their Tzedakah funds to the AIDS Committee of the UAHC. Their thoughtful gift means much to all of us and I hope that you will convey to the 8th grade class the profound appreciation of the Union and the AIDS Committee. Even as I, by means of a copy of this letter to Lauren Sarnat and Marc Rosenthal, ask that they convey to the Confirmation Class our deep felt gratitude.

It is heartening to know that the young people of our congregations are concerned about the scourge of AIDS. Through their generosity our work in seeking to create awareness and education among our congregants will be strengthened.

With warmest good wishes, I am

Sincerely,

Alexander M. Schindler

cc: Mr. Lauren Sarnat
Mr. Marc Rosenthal
Chairpersons of Confirmation
Class tzedakah.

Sonja L. Young June 10, 1988

Mrs. Randi Locke

Please find the enclosed checks (two) and letter from Temple Beth El, South Bend, Indiana. Rabbi Schindler has sent his personal thank you to the students.

Thanks.

sly

TEMPLE BETH-EL
305 WEST MADISON STREET
SOUTH BEND, INDIANA 46601
(219) 234-4402

June 2, 1988

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

Dear Rabbi Schindler:

On behalf of the Confirmation Class of 1988 - 5748, I am pleased to present you with a check for $62.50 in support of the Union of American Hebrew Congregations AIDS Project.

The class selected this as their recipient of tzedakah for the year, and hope that the UAHC will do all it can to promote public education about AIDS and support of people with AIDS.

The 8th grade class also chose to support the AIDS Project, and their check in the amount of $18.50 is enclosed as well.

The Confirmation Class tzedakah chair people were:

Lauren Sarnat
50858 Mercury Drive
Granger, In 46530

Marc Rosenthal
15721 Hunting Ridge Trail
Granger, IN 46530

Many, many thanks, and all best wishes for a wonderful summer.

Shalom,

Morley

Morley T. Feinstein
Rabbi

MTF:jj

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(513) 221-1875

cc Rhea
5/11/89

May 8, 1989

Personal

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

Dear Alex:

Thank you so very much for sending me a copy of your deeply moving address on AIDS. I treasure it especially because of your very thoughtful and much appreciated inscription.

The address, as I experienced when I read your previous draft, affected me profoundly. I felt its wonderful sincerity and inspiring religious message. It made me "wrestle with demons" of my own--and the good Lord knows they are there--and motivated my own confessions.

You have my deep admiratrion for not heeding all of my counsel and expressing your own feelings as your integrity and conscience dictate. I find that when one is called upon to advise another, one is tempted to adopt an institutional perspective and become cautious. This is the danger. I am inordinately pleased that you decided to say it as it is. May you go from strength to strength.

As ever,

Eugene Mihaly

EM:pg

or rather as it should be!

AMS

from: Rabbi Joe Edelheit

Working Draft

THE RABBI AND THE ABYSS OF AIDS

The story is told of one of the disciples of Rebbe Barukh. The disciple had followed the dangerous path leading to darkness. They say he had read forbidden books, played with perilous thoughts, and looked into hidden areas which only the chosen may approach. Now the disciple stood on the edge of the abyss, tempted by damnation. The storyteller of our time, Elie Wiesel, explains that Rebbe Barukh finally decided to go and see his disciple who had strayed from the path of righteousness. Without telling anyone, the Rebbe journeyed to the far away town to confront his disciple. Before the young man could collect his thoughts and utter a word, the Rebbe spoke to him, "You are surprised to see me here in your room. You shouldn't be--I can read your thoughts. I know your innermost secrets. You are alone and trying to go deeper into your loneliness; you have already passed through one after the other. All but the last of the 50 gates of knowledge and doubt. And I know how you did it. You began with one question and explored it in depth to discover the first answer, which then allowed you to open the first gate. You crossed that gate and found yourself confronted by a new question. You worked on its solution and found the second gate, and the third, and the fourth, and the tenth. One leads to the other, one is a key to the other, and now you stand before the 50th gate.

Look--it is open, and you are frightened, aren't you? The open gate fills you with fear because if you walk through it, you will face a question to which there is no human answer, and if you try, you will fall into the abyss, and you will be lost forever. You didn't know that, but I did, but now you also know."

"What am I to do?" cried the disciple. "What can I do? Go back to the beginning, back to the first gate?"

"Impossible," said Rebbe Barukh. "A human being can never go back. It is too late. What is done cannot be undone."

There was a long silence. Suddenly the young disciple began to tremble. "Please, Rebbe, please, Rebbe, help me. Protect me. What is there left for me to do? Where can I go from here?"

"Look," said Rebbe Barukh, "look in front of you, beyond the gate, what keeps a human being from running, dashing over its threshold, what keeps a human being from falling--faith. Yes, beyond the 50th gate there is not only the abyss, but also faith, and they are next to one another" (Somewhere a Master, Elie Wiesel, pp. 73-74).

This story, as told by Elie Wiesel, has always moved me a great deal. One can certainly read it as an anti-enlightenment story, a story that warns about the reading of secular books and thinking of secular thoughts, but like so many Hasidic tales recovered within our own time, its value is more than merely that of a closed

religious piety. I now read the story and tell the story and understand myself to be in the story; because of my work with AIDS, I have been transformed and the story carries a different set of nuances. The 50 gates are opened by 50 questions which are not from radical secular books, nor do they destroy my faith in God or separate me from the Jewish people. These questions which have led me to the edge of this abyss come from human beings who have touched my life, the lives which make up the essential third dimension of the oft reported statistics of the AIDS epidemic.

Mary Catherine Bateson and Richard Goldsby, in Thinking AIDS, note, "AIDS will cause psychological and social reactions that may change the character of human social life....This kind of danger to the way that society is organized is the basic threat of the AIDS epidemic (p. 120). For some these words are merely an intellectual or social critique of a disease and contemporary crisis, but [redacted] Bateson and Goldsby illuminate the transformative character of AIDS and the sobering awareness that once transformed, one stands on the edge of the abyss, because you have walked through the 50 gates--opened by the 50 questions which can only come from the lives touched by AIDS.

These present reflections are stimulated by a review of these questions that have led me and others to a place we did not expect to be. These reflections are not meant to be an indictment, though they are judgmental. This essay is

an autobiographical touchstone, woven through a series of questions that must be asked again and again and ultimately answered, even if we have to wait for the Messiah for the answer. Some of these questions shatter previous answers to previous questions. Mine is but a small voice in a growing chorus of those who are aware that life is completely different; our work with AIDS has transformed us. This awareness opens us to the reality that we are living through a caesura, a rupture in history, in which our behaviors, attitudes, and beliefs, will change. How we learn to live with these changes will determine what we do when we look beyond the 50th gate and realize that we stand on the edge of the abyss.

(add Berkowitz - wrestling with God in Hell)

The first question which led to the first gate still rings in my ear. The young woman called on behalf of her brother who was gravely ill in the hospital with PCP, pneumocystic carinii, the pneumonia most related to the HIV virus. He had wanted to see a rabbi and could I please visit him. I asked, Were they affiliated, Did they have a rabbi? I did not want to infringe unethically on someone else's congregant.

I was told that the man's rabbi had rejected him shortly after he had been diagnosed with AIDS, saying that there was no place in Judaism for him. I refused to accept that statement, it was impossible--no rabbi could possibly say that, no rabbi could have done that. I didn't want to

believe it. Already the questions beyond the first question were opening gates beyond gates which I could never have imagined. Without knowing what the implications were, I walked beyond each gate, and reflected on each question. With each new gate, and each new question, there was new learning which tested my credulity, and slowly but perceptibly, I accepted new insights, and I struggled with an awareness of a new suffering. I ask myself again, I ask anyone who will listen, Can a rabbi help rekindle a soul which has been smashed by another rabbi's callous homophobia? Can rabbis be homophobic? To the degree that rabbis in American today are like anyone else, they are like everybody else, with their fears, their prejudices, and their ignorance. If rabbis are ignorant and sometimes homophobic, who will reach out to those Jews who have turned away because of callous silence? Are there enough rabbis and laypersons who will hear the call of those in need? This was the first PWA to teach me by his patience and his extraordinary courage. He held his hand out to me, and I tentatively and fearfully reached back. Month laters I held his hand as he died, and I faced a new set of questions. His mother told me in the hospital room that she could not tell the school at which she was a nurse that her son died of AIDS; therefore there could be nothing in the eulogy about her son's illness or about his gay Jewish identity. New questions are asked about how you deliver eulogies in euphemisms. And how do you help

Jewish customs and the Halachic interpretation of rituals. Does one include a homosexual lover as an avel (mourner)? Does one give a kriah ribbon to a lover? A gay Jewish man, at the funeral of a Jewish PWA, asked me whether he should say kaddish. Was kaddish an obligation, not an option for a homosexual lover as for a spouse? I quickly reviewed in my mind all of the laws about those who are categorized Halachically as mourners, but none of tradition had anything to do with this question at this moment. I said, "Yes, you are obligated to say kaddish." Had I abused my rabbinic authority, had I misinterpreted the law? Each question like this which is "radically" new is always raw, but the gates always open so quickly.

There have been more funerals and more PWAs and more questions. What does one do about the embalming of a PWA--when the state requires a steel casket liner without embalming? How does one explain to a Jewish funeral director that it is ignorance and prejudice which stigmatize a family, when the director says that a PWA's remains will infect those in the chapel without a steel casket liner? What does one do for the Methodist lover of a Jew who has died from AIDS, and after his death, asks for a memorial service in the synagogue? Who is "the rabbi" for a gay Jew who died from AIDS who was so alienated from the Jewish community that he had not affiliated for 25 years? Should

a rabbi facilitate a memorial service in a Methodist church because there is no synagogue which is open because he was unaffiliated? I answered the question by leading the services and then did a service at the cemetery crypt for his ashes. I continue to ask the question now--what does the statement from Isaiah--"My house shall be a house of prayer for all peoples" really mean? Should we read that statement with an exclusion of PWAs, gays, lesbians?

The first time I preached on AIDS was on Erev Rosh Hashanah and there were all of those "professional" questions about rabbinic sensitivity to politically controversial issues. Can you use as a sermonic foil the Unesaneh Tokef because as a prayer of providential theology it now sounds harsh and cruel as if God were using AIDS as a punishment? I shared with the congregation my own introduction to AIDS and how it had already changed me, and I beseeched them to look into their hearts and confront their own prejudice and fear and ignorance. There was some shock, incredulity, and even anger. Then more questions--how could you do this on this Erev Rosh Hashanah? The questions were always a "mild" form of chastisement. Should a rabbi's pulpit take the leadership on issues which go beyond merely reading the Torah? Had I abusively tampered with a sensitive medieval piyyut (poetic prayer) of the High Holy Day liturgy when I rewrote the Unesaneh Tokef? The sermon was the "tangible" experience of recognition that there were already too many

questions behind me, too many gates now closed to go back. I was beginning to understand that there is a difference between being a rabbi "before" and "after" AIDS. Randy Shilts is correct in The Band Played On: there is a "before" and an "after"; most of us just don't realize we are already living in the "after."

There was the Board of Trustees meeting at the synagogue at which someone got up and challenged me, asking me whether I wanted all of the homosexuals in Chicago to join our Congregation. Wouldn't the Congregation change, and didn't I know that homosexuality was a sin in the Torah? The questions conveyed such contempt, and I stood alone, and the board was so silent. I answered: Yes, Leviticus 18:22 does refer to homosexuality as an abomination, but Deuteronomy 22:5 says that a woman wearing a man's clothing is an abomination, too. Your wife and daughters wear slacks--are they an abomination? Then I was asked: If I cared so much about gays, would I start "marrying" them? That is a question that I had not heard before asked in that way, though I would hear it again and again, and for the first time, I listened to it differently.

All rabbis must ask, especially those who become involved in caring for the dying and who bury the dead and who care for the grieving, How shall we relate differently to the living, when the living are gay men and lesbian women? Can we ever read Leviticus 18:22 in the same way? Can we ethically refuse to read it, expurgating it from the text of Torah? What shall we do, when that weekly portion comes again? What is the

imperative regarding he or she who reads from the Torah and what they read? What they believe?

The first time I went on a TV show about AIDS and the Jewish community, I tried to explain why there was confusion, apathy, and fear. The question from the interviewer which one hears again and again and again was: "Why is AIDS a Jewish problem and not merely a human problem?" One can answer the question in terms of the lives of Jews as PWAs, as lovers, as parents, as grandparents, as sisters and brothers. And then another question: "But how many Jews are we talking about? Five percent? Ten percent?" How does one answer that question? Why is AIDS a Jewish problem? Because there are Jews dying of it, Jews living with it, and Jews grieving over it. All of this is obvious. Why is any problem a Jewish problem? Did we ask how many Jews were being discriminated against in the South in the 50's and 60's for civil rights to be a Jewish problem? Did we ask how many Jews were dying in Viet Nam for that to be a Jewish problem? Do we ask how many Jews are homeless when we proclaim that homelessness and poverty are a Jewish problem? I have been asked why AIDS is a Jewish problem more than 50 times that have opened more than 50 gates.

Should a rabbi be obligated to teach in the Religious School about AIDS when the students are learning about it in public school? One enraged mother argued, Why should you take time away from teaching Torah by teaching about AIDS? [redacted] then she took her child out of the school. Should a rabbi, a

Jewish educator, and a Jewish school, be responsible for teaching about sexuality with an emphasis on celibacy and with an equal emphasis on condoms? Does this also include teaching "safer sex" about homosexuality? Is it a Jewish problem if there is a sakanah--a danger, in which someone has information which can prevent harm for themselves or someone else? Must there be pasuk--a verse, in the Torah which defines the problem as Jewish for it to be a Jewish problem? Must 10% of those touched by AIDS be Jews for us to recognize a new reality? Should rabbis and Jewish leaders only be concerned about Jewish problems?

In Illinois ~~it~~ the reporting requirement in AIDS became a ~~felony~~ when every premarital couple was required to take an HIV Antibodies blood test. Educating other clergypersons, especially rabbis, I wondered why clergy seem so ill-equipped as clergy to deal with issues beyond the scope of simple seminary pastoral counseling. How does a rabbi handle a young male who turns to his fiancee and says, "I guess you ought to know before we have the HIV test that ~~there was~~ he had had a chance bi-sexual encounter. What does a rabbi do when a young man calls crying three days after an initial premarital sessions and admits that he had joined his fraternity brothers in going to a whorehouse and obviously had had high risk exposure? Is the rabbi obligated to tell the fiancee, and what if either had tested positive? Should I, as a rabbi who requires Tay-Sachs testing, require the HIV test before conception? Nothing in the Torah, the Talmud, on in the Shulchan Aruch, or in any of the commentaries to these texts,

answers these questions. No professor in the Seminary ever taught me anything about this. Yet there are people who come to me, whose eyes glisten with tears, and whose hearts race as I try to explain that the HIV Antibodies Test is not an AIDS test, and that they should go to a doctor they trust and not a street clinic. I explain what an ELISA test is and what the Western blot confirmatory test is. I worry each time I speak to a premarital couple about their emotional strength as individuals and as a couple when their sexual behavior of the past ten years is tested.

How do rabbis teach other rabbis about AIDS? We rarely talk together about sexuality and IV drug use and certainly not with such graphic vocabulary. Is there an impropriety of z'nut (immodesty) which impedes rabbis from opening themselves to these worldly matters? When one is trying to achieve a communal rabbinic support for an AIDS education program, should ideological differences compromise rabbinic integrity? Can there be an AIDS program which does not emphasize the use of condoms when premarital sexuality is not recognized by the traditional rabbinate? Should the organized Jewish community through the Federation support AIDS education programs which ignore homosexual behavior in order to achieve Orthodox support? Was it appropriate to change the title "rabbi" to "doctor" in order to teach a group of Orthodox rabbis about AIDS and premarital counseling? Should anyone be forced to argue with a journal editor that an article on HIV antibodies must be accepted because the first reader who rejected it was homophobic

rather than a critical scholar? Is it significant that major rabbinic organizations seem to find time to discuss almost every other priority issues in the Jewish and secular world except AIDS?

How does a rabbi answer the questions about becoming involved in community task forces on AIDS? Should a rabbi try to set up a Jewish communal or interfaith coalition on AIDS? Should rabbis spend outside-non congregational time involved in such community organizations? Why are there been so few rabbis consistently involved in this? Most rabbis honestly are facing the crush of several pressing issues. Besides, some rabbis will admit--as long as one rabbi is so involved, why is it necesasry for more rabbis to press the issue? Some rabbis have suggested AIDS is too controversial, and besides, it only involves them intellectually--they haven't seen any PWA's. Some rabbis simply never respond to the many letters and calls. There are too many AIDS meetings, yet there are not enough meetings for all of the problems that AIDS brings us. Sometimes those who have been through the gates and have been transformed feel lonely, angry, and resentful that they are carrying the burden of AIDS for others.

There are a lot of other issues like Israel, mixed marriage, outreach, the homeless, and Jewish education, as well as the primary context of our own congregational needs which require a rabbi's personal profession time + energy. Surely there must be other rabbis among the voices who find the time and the words to speak on so many of these other issues; yet many of my otherwise courageous colleagues and many of the

otherwise outstanding lay leaders remain ignorant and thus so very silent.

Dennis Altman, in his provocative essay, "Legitimation Through Disaster," in AIDS: Burdens in History, has noted that paradoxically the gay community has been legitimated through the epidemic of AIDS more than at any time prior in history. Thus, even though we have all tried to separate AIDS from the gay community, those of us who have done AIDS work are necessarily drawn closer and closer to the homosexual community. Will the Jewish community's leaders have any choice but to confront the valid claims of the gay and lesbian community? Are we ready to move beyond the mere rhetoric of supporting synagogues with special outreach to the gay and lesbian Jewish community? How will we respond to the needs of the gay and lesbian rabbis? What will we eventually do with the liturgies for life cycle events as they pertain to the gay and lesbian Jewish community?

We cannot stop asking these quetions merely because they aren't questions within Jewish tradition. We cannot merely say, Homosexuality is an "abomination" and therefore we cannot ask. Because of the transformative nature of AIDS, we must be able to begin to talk about these questions, recognizing that we cannot go back to living as if AIDS were not going to be our reality for the foreseeable future.

Rabbis, educators, and Jewish lay leaders are like everyone else. We weren't more ready than anycne else for AIDS, and for many, there may be an intuitive sense that AIDS,

with all of its ramifications, is bigger than some people can handle politically, morally, emotionally, and psychologically. ~~AIDS is a hole that does not seem to have a bottom~~. AIDS is the abyss at which I and others stand after going through the 50 gates, provoked by 50 different questions asked 50 times over.

We may ~~well~~ be experiencing what ~~only~~ a vanguard ~~handful~~ of people experienced in 1955, '56, and '57, before civil rights became the tidal wave that changed America socially, economically, and emotionally.

Those same kind of changes are on the horizon as the pressures of the AIDS epidemic provide the crucible within which the foundations of the twenty-first century are forged. Is it merely coincidental that neither of the presidential candidates spoke at all about AIDS? Is it coincidental that a presidential commision delivered its report, but the most significant finding of the report--anti-discrimination legislation--has not been acted upon?* Is it coincidental that we are all still dealing with a disease which is so complex that its name is acronyms--AIDS and HIV. We do not have any referential categories which explain it. We do not know how to evaluate the daily, weekly, and monthly statistics. How many are dead from AIDS does not even begin to explain how we are coping with those who are living with AIDS. ~~[redacted]~~ How will we help those who will die--die with dignity, whether they are gay, an IV drug user, a hemophiliac, a person of color, or a Jew?

* Will the war on drugs be won by conceding the war on AIDS in the Communities of Color?

Those of us who have been transformed by the work we have already done with AIDS know that we cannot go backwards through the fifty gates and deny the fifty questions. The complexities of AIDS and all of its ramifications are overwhelming to many people. In these first few years of the epidemic, the extraordinary and completely transformative nature of AIDS is still not fully accessible to a lot of people. It took more than twenty years for most of the Jewish community to accept the foundational role of the Holocaust/Shoah in Jewish identity. Learning to deal with death, survival, hatred, fear, and the ignorance of others is still a primary goal of Jewish leadership. AIDS is no less a challenge in scope and influence. We must all be more patient with one another, especially if we have walked through the gates of transformation. We must be willing to reduce our expectations of rabbinic and lay involvement. In the short term we must simply look to a smaller group that will eventually bring AIDS to a larger group.

Like Rebbe Barukh's disciple, caught in a grip of terrible fear and simultaneous hope--we who have been transformed through our work with AIDS look to others with a sense of desperate need: How do we translate our desperation, our own fears, our anger, and our sense of urgency? In time, AIDS will have an impact on more and more people, who having gone through experiences of each question, will go beyond each gate and eventually become aware that they stand at the edge of the abyss, and then--like the Hasidic tale--each

will peer beyond the 50th gate, knowing in their heart of hearts, that alongside the abyss of AIDS, which has no bottom, there is faith. Like the [redacted] people who preceded me, and knowing in my heart of hearts that there will be others who follow me, I now pass through the 50th gate, and closing my eyes and feeling the presence of God at my side, I leap.

Joseph A. Edelheit

Rabbi, Emanuel Congregation

UAHC Committee on AIDS

AIDS Pastoral Care Network Board

Co-Chair, UAHC-CARR AIDS Task Force

March 22, 1988
4 Nisan 5748

Dr. Boris L. O'Mansky
Valley Pediatric Associates, PA
9199 Reisterstown Road
Owings Mills, MD 21117

Dear Bo:

Thank you for enlightening me on the College-Institutees problem in regard to the Aids Conference. The news is not happy, but at least I don't live in blissful ignorance.

With warm regards and every good wish, Iaam

Sincerely,

Alexander M. Schindler

Rabbi Alexander M. Schindler

Mr. Albert Vorspan

March 22, 1988
4 Nisan 5748

Enclosed is a letter from Bo O'Mansky. Were you aware of this situation? What can or should be done?

VALLEY PEDIATRIC ASSOCIATES, P.A.

M. Larrie Blue, M.D.
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9199 Reisterstown Road
Owings Mills, Maryland 21117
(301) 363-6380

March 13, 1988

Rabbi Alexander M. Schindler
Union of American Hebrew Congregations
838 FifthAvenue
New York, NY 10021

Dear Rabbi Schindler,

I have just received a copy of your letter to Chuck Rothschild concerning the HUC-JIR program on AIDS. Unfortunately, I cannot report that this is a harmonious joint program.

Last summer Rabbi Kerry Olitzky contacted Dick Sternberger and asked if we would meet with him concerning having the UAHC Committee on AIDS develop an all day program on AIDS for the New York Campus of HUC-JIR. He asked that we bring a suggested program. I offered to stay in New York when I was there for a meeting in the Fall, and Dick and I met with Rabbi Olitzky and his assistant, and presented the program we had prepared. Rabbi Olitzky was quite pleased, so we selected a date, and Dick and I left the meeting with the understanding that we should flush out the language of the program and send it to them, and then recruit the speakers. We had been asked if we could help fund the program, and explained this was not possiblewith our budget, but that we would try to recruit speakers from our committee who would donate their time.

We submitted the final program and hearing nothing, I began lining up speakers. Dick then received a call from Rabbi Olitzky to check on our progress and expressed some dissatisfaction with our speakers. Dick suggested he call me, but Rabbi Olitzky stated that lay people didn't have to be involved, and that the professionals could handle it. Dick called me and I tried to reach Rabbi Olitzky and finally spoke with his assistant. She told me there should be no problem with our speakers, but I continued trying to reack Rabbi Olitzky andfinally was successful. He then rejected all of our speakers for various reasons. He asked if I would help him find other speakers, and I explained I had nocontacts in New York beyond ourcommittee. Hethen asked if our committee would continue to co-sponsor the program and I said we would. When he asked me to agree to help cover any overages in expenses, I once more explained we had no funds for this. He then withdrew the invitation to co-sponsor.

It is of interest that the HUC-JIR has decided to use our program, as the first half of the program is exactly as we presented it, word for word. We proposed three workshops, and they combined these into two. They even kept our logo in the title, "Confronting the AIDS Crisis".

We thought we were originally approached because of the expertise of our committee. In the two years of our existence, whenever we have been asked to develop a program, we have assumed full responsibility for program and speakers. We were never led to believe that Rabbi Olitzky wanted the right to veto everything.

We have gone through a most distasteful experience with Rabbi Olitzky. We wonder if the primary reason we were asked to be involved was so that we would help pay for the program. In conversations with several members of the UAHC staff, they expressed no surprise that we had problems with Rabbi Olitzky.

I'm sorry I couldn't give a positive response to your inquiry. In summary, the HUC-JIR is using our program, but providing their own speakers. If you have further questions, I'll be happy to answer them.

Sincerely,

Bo

Bo O'Mansky

cc: Mr. Charles J. Rothschild, Jr.