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THE IMPACT OF AIDS: A MODERN DAY PLAGUE

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Not many days after their arrival in Attica the plague first began to show itself among the Athenians. It was said that it had broken out in many places previously in the neighborhood of Lemnos and elsewhere; but a pestilence of such extent and mortality was nowhere remembered. Neither were the physicians at first of any service, ignorant as they were of the proper way to treat it, but they died themselves the most thickly, as they visited the sick most often; nor did any human art succeed any better. . . . The end of it was that Hagnon returned with his ships to Athens, having lost one thousand and fifty out of four thousand heavy infantry in about forty days¹

Pestilence was not a novelty to our forefathers, but not within recent history, never mind the recent memories of those alive today, have we had to cope with a disease that has aroused as much fear, hysteria, gloom, and panic as has AIDS (acquired immunodeficiency syndrome). It has produced almost insoluble health delivery problems, ethical dilemmas, and internal frictions within the medical delivery system, as well as within society as a whole, which have no recent precedents. Despite an extensive past experience with the epidemiology of major contagious diseases, there have been many who have been willing to prognosticate without data, ignore the likely evolution of the disease, and utilize the fear induced by AIDS to promote political or economic programs to satisfy selfish agendas that have nothing to do with the health problems created by this epidemic.

The disease began to be recognized about seven years ago,² and was first described in gay men. It was subsequently recognized in Haitians, and in intravenous drug abusers, and it still remains prevalent in those populations. It was thought to have been spread to Haitians by the combination of poor sanitation and frequent use of Haiti by vacationing gay men. Unfortunately, there are also a number of victims who have no other risk factors for the disease, but who acquired AIDS from a blood transfusion. At higher risk, then, are frequent blood users—such as hemophiliacs, although this will hopefully change with the new methods of sterilizing and obtaining blood and blood products.³

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1. Thucydides, *The Peloponnesian War*, in 6 GREAT BOOKS OF THE WESTERN WORLD, 399, 402 (R. Hutchins ed. 1977).

2. *Pneumocystis Pneumonia*, 30 MORBIDITY AND MORTALITY WEEKLY REPORT 250 (1981); *Kaposi's Sarcoma and Pneumocystis Pneumonia Among Homosexual Men*, 30 MORBIDITY AND MORTALITY WEEKLY REPORT 305 (1981).

3. Hilgartner, *Aids and Hemophilia*, 317 NEW ENG. J. MED. 1153 (1987); Allain,

Since the identification of the causative virus, it has been possible to test for sero-positivity and to diminish the spread of the agent by blood transfusion. Although the disease was first described in 1981, it was not until March of 1985 that a screening test became available with which to make blood and blood products safer. It also has become clear that the disease can be spread by heterosexual sexual transmission, and AIDS is now a major problem in Zaire.⁴ The disease is also unfortunately spread from bisexual males to heterosexual females, and by intravenous drug abusing mothers to their unborn children.

Confounding the issues raised by a disease that has increased relentlessly—approximately 30,395 diagnosed and reported cases as of February 16, 1987,⁵ and over 40,000 nationwide cases as of December 1987⁶—is the lack of information on how many people are HIV seropositive, and of these people, how many will develop the disease. The media, as well as many physicians, have tended to confuse the two groups, and it is useful to remember the natural history of most, if not all, viral diseases. When a population is first exposed to a viral disease, there is a devastating morbidity and mortality.⁷ After the population adapts, or the virus mutates, or perhaps both, there is usually a drop in both morbidity and mortality, with severe cases often affecting only the extremes of age.⁸

Rabies is virtually the only viral disease attacking humans with an almost 100% mortality, but it does behave differently from the HIV virus, being extensively shed in saliva. It has an attack rate of only about 25-30%, but as there are no human populations that have been extensively exposed to the virus, the disease has had no chance to evolve, and thus has continued its high mortality.⁹ It is fortunate that there are immunologic defenses to rabies, but treatment of the developed disease still remains unavailable, and human protection has come more from prevention than cure.

Not every victim who has converted to HIV seropositivity has developed the disease, and the predicted conversion rates are not meaningful since the denominator is not truly known. For example, it is estimated

Laurian, Paul, Verroust, Leuther, Gazengel, Senn, Larriev and Bosser, *Long-Term Evaluation of HIV Antigen and Antibodies to p24 and gp 41 in Patients with Hemophilia*, 317 NEW ENG. J. MED. 1114 (1987).

4. Redfield, Markham, Salahuddin, Wright, Sarngadharan and Gallo, *Heterosexually Acquired HTLV-III/LAV Disease (AIDS-Related Complex and AIDS)*, 254 J. AM. MED. A. 2094 (1985) [hereinafter Redfield]; Piot, Taelman, Minlangu, Mbendi, Ndangi, Kalambayi, Bridts, Quinn, Feinsod, Wobin, Mazebo, Stevens, Mitchell and McCormick, *Acquired Immunodeficiency Syndrome in a Heterosexual Population in Zaire*, 2 THE LANCET 65 (1984).

5. Reinhardt, *AIDS Conference Marks Beginning of Major Dialogue*, INNER-CITY PHYSICIAN 3 (May/June 1987).

6. Weinberg and Murray, *Coping with AIDS; The Special Problems of New York City*, 317 NEW ENG. J. MED. 1469 (1987).

7. One need only recall the devastation of the American Indian population upon their initial exposure to measles.

8. J. FULLER, *FEVER! THE HUNT FOR A NEW KILLER VIRUS* (1979).

9. 2 TOPLEY AND WILSON'S PRINCIPLES OF BACTERIOLOGY AND IMMUNITY, Ch. 87 (G. Wilson and A. Miles ed. 1955); H. MERRITT, A TEXTBOOK OF NEUROLOGY, 96-98 (1963).

that there are 400,000 to 500,000 New Yorkers who carry HIV. This figure is derived from the guess that 50% of New York homosexuals are positive, and that from 50-87% of the 200,000 New York drug-abusers are positive.¹⁰ It has been estimated by 1991 there will be between 25,000 and 40,000 new cases. But if the 70% development rate of AIDS and AIDS related complex¹¹ reported in a select group of high risk gay and bisexual men is accurate,¹² then the epidemic will indeed begin to resemble the black plague, which reportedly erased a third of the population of Europe in the fourteenth century.¹³ Fortunately, all the predictions concerning this disease have to date been wrong, but it does not alleviate the appropriate concerns for how to care for this disease, and it certainly does nothing to ease the general hysteria and paranoia that is inflamed by inaccurate and sensational media reports.

There is much debate about the etiology of the disease, and the purpose of this article is not to debate the scientific merits of the different theories, but rather to discuss the impact of the disease, whatever its causes. The general consensus is that the disease is caused by the virus now called the HTLV-III.¹⁴ What is not known is whether there is a genetic predisposition to the infection; whether there are other circumstances that must exist for the virus to infect,¹⁵ and it does seem to be the case that unless exposed to blood borne virus, there is low risk to the *healthy* general population, and even to the medical profession.

The virus does not appear to be transmitted to others through saliva.¹⁶ Blood borne virus appears to be the principal risk to others, and may well explain the drug abusers high incidence of disease, although one can hardly define this population as normally healthy. There have been few documented cases of health workers being infected,¹⁷ and even of the cases where seropositivity has developed, it does not mean that these workers will evolve the full blown disease.

What then has caused all the panic and hysteria? I believe that it is

10. Weinberg and Murray, *supra* note 6, at 1470.

11. AIDS Related Complex ("ARC") is chronic unexplained lymphadenopathy and persistent depletion of T-helper cells. See Redfield, *supra* note 4.

12. N. Hessel, The Natural History of HIV Infection in a Cohort of Homosexual and Bisexual Men: A Seven Year Prospective Study, Proceeding of the Third International Conference on AIDS (June 1-5, 1987).

13. 2 C. PREVITÉ -ORTON, THE SHORTER CAMBRIDGE MEDIEVAL HISTORY 847 (1952).

14. Gallo, Shearer, Kaplan, Haynes, Palker, Redfield, Oleske, Safai, White, Foster and Markham, *Frequent Detection and Isolation of Cytopathic Retroviruses (HTLV-III) From Patients With AIDS and at Risk for AIDS*, 224 SCIENCE 500 (1984); Safi, Groopman, Popivic, Schupbach, Sarnagadharan, Arnett, Sliski and Gallo, *Seroepidemiological Studies of Human T-Lymphotropic Retrovirus Type III in Acquired Immunodeficiency Syndrome*, 1 THE LANCET 1438 (1984).

15. The virus appears to be of low infectivity. There would appear to be some other source of immune suppression for the virus to become established. Once established, it in turn seems to destroy the immune system. For example, what Haitians, intravenous drug abusers, and certain homosexual gay men seem to have in common, is an exposure to large inocula of bacteria; usually fecal in origin.

16. Friedland and Klein, *Transmission of the Human Immunodeficiency Virus*, 317 NEW ENG. J. MED. 1125 (1987).

17. *Update: Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients*, 36 M.M.W.R. 285 (1987).

due to two main causes: first, the disease appeared to initially be caused by homosexual male deviant sexual practices,¹⁸ and secondly, because when the full-blown disease has occurred, death has always ensued.¹⁹ Thus, not only is there the specter of early, unpleasant, and inevitable death to cause concern, but there is also the social stigma that is almost impossible to measure or eradicate—that if you have the disease, it must be because you have indulged in excessive, deviant, and homosexual sexual practices.

There is the added enigma of how to categorize AIDS related complexes in the general equation. Not only are these particular patients more at risk to develop the full blown disease, but they also are at much greater risk from other more conventional diseases.²⁰ For example, patients who are seropositive for HTLV-III have a five fold greater chance of developing pneumococcal pneumonia,²¹ and the incidence of tuberculosis and endocarditis is rising among seropositive drug abusers.²² Thus, it is hard to calculate the true impact of AIDS as a disease since its path to death can take many different courses.

The sad sequela to our scientific ignorance has been reflected in the confusion and internal strife that has developed within the medical community itself. Unlike the physicians referred to by Thucydides in the plague of Athens, many physicians and other members of the medical team have been unwilling to extend their services to the sufferers of this terrible disease. There have been those who have supported the ethics of this position, maintaining that, except for emergency physicians, others have no ethical obligation to treat HIV positive patients.²³ There are almost never any absolutely right or wrong ethical positions, but to most lay people and many physicians, the unwillingness to treat is an ethical posture that doesn't seem to gibe with the professed mission of

18. The highest risk group yet identified are the gay men whose sexual life can only be described as promiscuous (an average of 12 contacts a night was not unusual for this group).

19. D. Cohen, A. Davidson, K. Penty and F. Judson, Mortality in AIDS in Colorado: Life Table Analysis From AIDS Reporting System, Proceedings of the Third International Conference on AIDS (June 1-5, 1987). In a study of AIDS in Colorado from May 1982 to December 31, 1986, the median survival from the development of the full blown disease is 239 days. There has been some recent extension of this time with AZT treatment, but the reality is still one of dreadful, inexorable downhill course.

20. Weinberg and Murray, *supra* note 6, at 1471; R. Stoneburner, B. Breuer and S. Friedman, Trends in Pneumonia Mortality and Possible Relationship to Acquired Immune Deficiency Syndrome in New York City, Presented at the 33rd Epidemic Intelligence Service Conference (April 9-13, 1984).

21. It is generally forgotten that pneumococcal pneumonia has around a 3% mortality in otherwise healthy patients, but that the mortality rises to around 30% in the bacteremic patient, the extremes of age, and in otherwise debilitated patients. This mortality has not changed since the introduction of penicillin. Brewin, Arango, Hadley and Murray, *High-Dose Penicillin Therapy and Pneumococcal Pneumonia*, 23 J. AM. MED. A. 409 (1974); Annot., 60 ANNALS OF INTERNAL MEDICINE 759-76 (1964).

22. Weinberg and Murray, *supra* note 6, at 1471.

23. Zuger and Miles, *Physicians, AIDS and Occupational Risk: Historic Traditions and Ethical Obligations*, 258 J. AM. MED. A. 1924-28 (1987).

the physician.²⁴ The Board of Directors of Denver Health and Hospitals, the medical staff of Denver Health and Hospitals, and the Directors of Service of Denver Health and Hospitals have all formed committees which have met on numerous occasions to attempt to address the disease from an official policy vantage point. Nevertheless, there are still many puzzling, divisive, and difficult problems to resolve; some ethical, some medical, some economic, and some legal. This article shall attempt to discuss some of these, but always within the context that amidst the attempts to deal with these problems is the necessity to maintain the ongoing mission of the agency, especially at a time when resources are already shrinking.

Perhaps the most significant is the problem of employee hysteria, paranoia, and desire for self-protection. Not all the fear is irrational, since there is still so little known about the true dangers and the real routes of contagion. There have been patients who, when approached by paramedics or the first responders of the fire department, or when being arrested by police officers,²⁵ have announced that they have AIDS. On occasion, they have deliberately spat upon police or medical workers. It is not hard to understand why these workers wish to know how they are to be protected. Even when there has been no such flagrant attempts to frighten or invade police or medical personnel health, there have been exposures to patient blood or other bodily fluids. This is not a unique experience to Denver, but has been mirrored in virtually all large cities. The concerns are also not limited to those areas with large gay male or drug abusing populations, but have been expressed in almost every community no matter its size or makeup.

The Center for Disease Control in Atlanta has issued guidelines for the protection of workers and the prevention of transmission of AIDS.²⁶ Unfortunately, these recommendations are neither practical nor logical. It is neither necessary nor wise to assume that all patients may be contaminated. This attitude leads to fear of patients, and hostility towards them, as well as leading to a refusal of services. The recommendations to immediately screen the patient's blood for HIV seropositivity makes no sense when it is possible to transmit the disease before seroconversion has occurred, when it is not possible to predict who will convert from a single exposure, when it is not possible to prevent the disease, and when there is no therapy. This routine screening for ill advised or thoughtless indications is well documented to lead only to breach of confidentiality and to be accompanied by little or no supportive counsel-

24. Pellegrino, *Altruism, Self-interest, and Medical Ethics*, 258 J. AM. MED. A. 1939 (1987); Dan, *Patients Without Physicians: The New Risk of AIDS*, 258 J. AM. MED. A. 1940 (1987).

25. The most common cause for arrest being driving under the influence of alcohol.

26. *Human Immunodeficiency Virus Infections in Health-Care Workers Exposed to Blood of Infected Patients*, 36 MORBIDITY AND MORTALITY WEEKLY REPORT 285, 285-89 (1987); *Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-agency Recommendations*, 32 MORBIDITY AND MORTALITY WEEKLY REPORT 101, 101-03 (1983); *Provisional Public Health Service Inter-agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome*, 34 MORBIDITY AND MORTALITY WEEKLY REPORT 1-5 (1985).

ing.²⁷ If anyone is to be tested, it makes much more sense to test the employee than the patient, and repeat the employee's test every six months. Even though it is not conclusively known how long the incubation period is after exposure, the evidence seems to indicate that conversion will occur within six months, if it is going to occur. This is the policy adopted by the Employees Medical Clinic of Denver Health and Hospitals, at the advice of the public health and infectious disease specialists at our agency.²⁸ It has provided some comfort to the paramedics and the physicians of the emergency department, but has not satisfied the police or firemen, especially of allied agencies outside the city of Denver.²⁹

The whole issue of HIV testing has achieved a level of meaningless hysteria with a supertone of magic rite, as when the Dallas Cowboys announced in their preseason that they had tested all their players and found no positives. Presumably this made them safe to bite at the line of scrimmage. There are legitimate concerns over the confidentiality of the patient test results, and the sad facts still remain that no one knows what it means to test positive, nor is any therapy available.

Efforts to provide protection are also more magical than real. Even if health workers were to sensibly wear gloves and eyeglasses at all times, and are willing to accept the formidable logistical problems caused by such a policy, there is not a scintilla of evidence that this will provide protection against contamination. We have made goggles and gloves available to all personnel from the field on into the hospital, as this seems to be prudent practice, but we do not have much hope that it will be truly protective.

The reality is that gloves have never stopped surgeons, or other high risk health workers from developing serum hepatitis. It is not widely appreciated that both emergency physicians and surgeons frequently puncture their gloves during the course of normal operations upon patients, and that the puncture may not be perceived until the end of whatever invasive procedure is being performed. One can only imagine the ease of exposure with a slight nick upon a finger, never mind the act of puncturing oneself with a needle or scalpel—an accident that is all too easy to achieve in the press of resuscitation or surgery for major life-threatening injury or disease. It is also not hard to conceive of the difficulties that the field personnel will have in the maintenance of their protective garb as they transport a patient from the field to the hospital.

Thus, it is easy to understand the source of friction among the med-

27. Henry, Maki and Crossley, *Analysis of the Use of HIV Antibody Testing in a Minnesota Hospital*, 259 J. AM. MED. A. 229, 229-33 (1988).

28. Letter from Dr. Robert Beck, Director of Occupational Medicine Employees Health Clinic, to Chief Sponsel of the Denver Fire Department, and Chief Coogan of the Denver Police Department (March 5, 1987).

29. For example, Denver Health and Hospitals serves as the site of major trauma care for the city of Aurora. There, patients are brought from the field by helicopter, and the police and firemen of Aurora feel vulnerable and unsupported because they cannot demand and receive HIV testing on any patient with whom they have had contact, no matter how slight.

ical staff. Those specialties who have to work with emergencies are already exposed to an unknown number of possible inoculations. It should be no surprise that they feel reluctance to increase their own risks by assuming an ever increasing elective burden of HIV patients. On the other hand, those specialties that do not perform invasive procedures, or can avoid close contact with patient blood are more willing to see the hospital population of AIDS patients increase. This is the number one stress upon our institution, and no easy solution to the problem is foreseeable without the development of hospice, a special ward, or even a reopening of special hospitals as was done for tuberculosis and leprosy; or unless all of the predictions about the estimated number of new cases turns out to be fortunate overestimations. A cure or effective immunization procedure would also solve many of these problems, but there do not appear to be any such hopes on the horizon.

One manifestation of this particular problem has been the depressing reality that no private dentists (or at least any that we can find to refer patients to) will provide routine or any dental care to HIV positive patients. As a result of this, there has been an extreme rise in the numbers of such patients applying for treatment to the dental clinic. In hopes of maintaining a workload that would allow the other missions of the dental and oral surgical services to be satisfied, the Director of Dentistry and Oral Maxillofacial Surgery, and I, as Deputy Manager for Clinical Affairs, issued a policy in July of 1987 that all patients with communicable diseases, such as tuberculosis, serum hepatitis, or HIV positivity would receive only emergency dental care. While this was not done because of a desire to exclude such patients from care, it was undertaken because it would have required at least two new full-time positions for which there were absolutely no resources. Other services have not as yet been forced to limit services, but there is serious overcrowding in the AIDS clinic and counseling services, and the laboratory has little added room to undertake and keep pace with its ever increasing workload in HIV testing. To date, no patient has been denied elective surgery, or any urgent or emergent invasive procedure, nor am I aware that the University of Colorado Health Science Center, where open heart surgery is performed for Denver Health and Hospital patients, has restricted or denied services to HIV positive or AIDS patients. Nevertheless, the vast majority of care for these patients is delivered at these two institutions, and if the epidemic produces a workload that even begins to approach the levels of some predictions, there will undoubtedly have to be new resources or rationing of services.

This leads me to a discussion of the next most significant problem concerning this disease, namely the consumption of already tight resources for a disease that would appear to be growing at a rate that can swallow up the entire public delivery system.³⁰ In May of 1987, the Directors of Service at Denver Health and Hospitals and a special Denver General Hospital AIDS task force committee recommended that the

30. Weinberg and Murray, *supra* note 6, at 1471.

drug AZT be made available for selected AIDS patients.³¹ It was estimated that it would require an additional budget expenditure of \$200,000 for this drug alone. It was also recommended that a clear policy statement be made articulating a willingness to care for AIDS patients, but to undertake the implementation of the policy would require an infusion of new dollars and resources. To date, even though both the Manager and the Board of Denver Health and Hospitals agree with the recommendations, there has not only been a lack of new monies or resources allocated, there has been a cut in the amount of money the city is willing to give to the support of the Denver Health and Hospitals mission. One can only hope that the estimated number of new cases will prove to be too high, and that we will somehow manage to integrate whatever patients we must care for into our already full workloads.

A major sequela of the above two problems has been experienced in New York and San Francisco, but fortunately not yet in Denver. That is an exodus of faculty leaders, and a reluctance for new house staff and students to undertake training in those institutions that have major AIDS patient populations. It is estimated that about 30% of the inpatient services at San Francisco General Hospital is given over to the care of AIDS patients. This was once one of the most sought after training sites in the country. Many of the students whom we advise or interview as candidates for residencies here in Denver inform us that they don't wish to go to a program that is so heavily involved with AIDS, not only because they believe this diminishes their educational experience, but also because they fear the unknown levels of personal exposure. Moreover, a number of the leading staff members of San Francisco have left the institution, and it will not be easy to replace their quality.

The other aspect of the problems alluded to above that cannot be minimized is the impact that a single AIDS patient can cause upon the institution. There are special requirements for isolation, not to protect the staff, but to protect the patient and other patients. There are also tremendous psychologic impacts. The staff quickly become tired and depressed in the care of patients whose inevitable death is staring at them no matter how hard they try to prevent it, and who develop one major complication after another. It is also very demoralizing to have long term patients seek alternative locations for their care because they don't wish to be looked after at an institution that cares for AIDS patients. To those patients who have no access to another institution, there is an ever-growing sense of bitterness and hostility to the system and institution that forces them to receive care at a place that they believe not to be safe. It has been years since patients argued against the destination policy of the paramedic division, but it is an ever increasing complaint with which we must deal.

31. Policy Recommendation Statement from the AIDS Task Force Committee to the Manager and the Board of Denver Health and Hospitals (May 4, 1987). Azathioprine ("AZT") is a purine antagonist that interferes with DNA synthesis. It appears to extend life in some AIDS patients.

There are numerous other problems besides those having a major impact, but one that needs discussion still lies in the future. It could be even more devastating and significant to the solution of all the other problems than any we have yet discussed. Moreover, it will more directly introduce legal issues than any of the others. I refer to the problems of workman's compensation for the acquisition of AIDS from the performance of one's job. At present, there is no definition of proof of when the disease is considered to be acquired at work, and additionally there are the stigmata alluded to above that the acquisition is a reflection of one's deviant sexual problems.³² Moreover, there are no ways to predict what this will mean to one's employability elsewhere, not considering what it will mean to insurability, consortium with one's spouse and children, and one's community reputation. In March of 1986, the mayor's AIDS Task Force issued a statement that stated in part "since there is no hazard of transmitting the HTLV-III virus through normal social contact, persons who test positive for the virus or who have AIDS are not a danger to others and may continue their employment without restriction."³³ This admirable policy has not yet been tested, but more important is the question of how the city will adequately compensate someone, like a trauma surgeon or anesthesiologist, for the acquisition of this disease on the job. It is my guess that they will not, and cannot, given the economic problems facing the hospital and the city as a whole.

These, then, are some of the issues facing difficult resolution in dealing with this modern day plague. Although there are ample examples of both heroic and cowardly behavior by physicians in the past, it is my hope and belief that the majority of physicians and other medical workers will rise to this newest challenge to our profession. We have a long tradition of belonging to that group of professionals who, by virtue of special training, skills, and concern, have made themselves available to any member of our society who needs that help. We have not been good about separating that help from the way that we support ourselves, and as a society, we have not been clever or generous about solving the health delivery problems for the indigent. That is especially applicable to AIDS since so many victims are indigent or become so during their inexorable march to death. But in the past, we have always managed somehow to care for the major diseases of our time. Even though there seems to be more fear, denial, false speculation, and distrust of this disease than any other we have had to face, we must remember that this is not an unique experience. We have, within our recent memory, conquered or survived leprosy, tuberculosis, and poliomyelitis. Our responses to our fears of those diseases were not always logical, wise, or humane,³⁴ so it should be no surprise that our initial responses to AIDS

32. See *supra* note 18 and accompanying text.

33. The Mayor of Denver, Colorado, Fredrico Peñ a's AIDS Task Force (March 25, 1986); C. Broderick, *City Adopts AIDS Rules for Workers*, Rocky Mountain News, March 26, 1986, at 8.

34. J. LONDON, *Koolau the Leper, Good-by Jack, and The Sheriff of Kona*, in *STORIES OF HAWAII* (A. Grove Day ed. 1986); T. MANN, *THE MAGIC MOUNTAIN*, (1969).

are not what we idealistically might wish them to be. Nevertheless, I believe that as we learn more, as the doom predictions prove to be inaccurate, and as we settle down to what we know how to do—relieve suffering—we will respond to our challenge, and one day look back upon our fear and hysteria with laughter and a sense of bewilderment as to what was the big fear all about.