

How Public Hospitals Set the Bar for Early AIDS Care

By Alexandra Greeley

When the devastating illness known as Acquired Immune Deficiency Syndrome (AIDS) became generally recognized in the United States in the early 1980s, scientists and health care professionals had no idea what caused the disease nor how to treat it. But it quickly became evident that they were seeing the onset of an overwhelming epidemic that would require a dramatic shift in traditional patient care.

Many public hospitals nationwide were in the forefront of responding to the epidemic, says Mervyn Silverman, MD, former public health director of San Francisco and former President of the American Foundation for AIDS Research (AmFAR). Among the first of these was San Francisco General Hospital, reacting to a health crisis that left the city and its gay community reeling: 99 percent of the infected were gay, middle-class men.

“Our hospital contributed to HIV care . . . and the people who took on the care took it on as a mission, a passion.”

San Francisco General’s model of compassionate care became extensively followed worldwide. “We took the time to work with the community; our work was academically based, and we provided a comprehensive program for patients,” explains Paul Volberding, MD, professor and vice-chairman of the department of medicine, UCSF, co-director of UCSF-GIVI Center for AIDS Research, and formerly director of the AIDS clinic at San Francisco General.

In addition, San Francisco General Hospital was among the earliest places that used experimental treatments to improve patient outcomes, says Volberding: “This was also the first hospital in the world that had a dedicated

AIDS clinic, which opened in 1983, and the first to have a dedicated inpatient unit.” Because of its outstanding levels of care, people who could have gone to private hospitals chose San Francisco General instead, according to Silverman.

AIDS was a different epidemic in different parts of the country, and in New York City, it became a mosaic of affected populations, reports Gerald Friedland, MD, director of the AIDS program at Yale School of Medicine, Yale-New Haven Hospital in Connecticut. At the onset of the epidemic, Friedland worked at North Central Bronx Hospital in New York City. Because of its different geographic neighborhoods, New York represented a complex cross-section of people, from the middle-class gay white men who lived in Greenwich Village to the mainly working-class and poor population in the Bronx and Brooklyn where the majority of AIDS patients were injection drug users and their heterosexual partners, he says.

Like his colleagues in San Francisco, Friedland and associates drew up plans for an HIV program based on the principles of comprehensive care, continuity of care, compassion, competence, and cost effectiveness but with elements necessary to address the challenging needs of this marginalized population. That meant not only developing outpatient clinics, support groups, and provisions for death and dying, but also accessing and providing mental health and substance abuse services and finding ways to involve family members, who often included spouses, parents, and children.

In Miami, public hospitals were faced

DEMIC ERGINING

with a different challenge, says Arthur Fournier, MD, associate dean for community health, University of Miami Miller School of Medicine. “The first HIV patient with what we now call AIDS walked into my life in 1979,” he says. By 1980, it was clear that AIDS was having a major impact in Miami, particularly among the poor in the Haitian community. “Because the epidemic in Miami singled out the poor, they came to our public hospital for care,” he says. “Ironically, if they had gone into a community hospital, there would not have been enough academic and research resources to provide compassionate, comprehensive care to the earliest victims, to figure out the various opportunistic infections and learn about the epidemic.”

Because Miami’s Jackson Memorial Hospital is a teaching hospital, the house staff is on call around the clock, providing the comprehensive care needed. When a patient succumbed to AIDS, they could request an immediate autopsy. “It was only when the pathologists started doing autopsies that they realized patients had overwhelming pneumocystis pneumonia and toxoplasmosis,” he says. “The pathologists played a major role in understanding the disease.”

“Now, thanks to the Comprehensive AIDS Program, some of the major research is done here,” says Fournier. “We had the first clinical trials of AZT. The first women with HIV were identified here. The first children with HIV were diagnosed here.”

When the HIV/AIDS epidemic first began, patients in Chicago were treated at Cook County hospital, and AIDS patients were representative of the hospital’s overall patient population — namely minorities and the working poor, explains Mardge Cohen, MD, director of HIV research at the Ruth M. Rothstein CORE Center, an affiliate of the Cook County Bureau of Health Services. “The county was providing an enormous amount of care for people with no health insurance, and for people who might have had the insurance but who were undesirable at the very few private settings where HIV was being addressed,” she says. “Our hospital contributed to HIV care in Chicago, and the people who took on the care took it on as a mission, a passion.”

Because the numbers of infected seeking care continually increased, by 1983 Cook County expanded its HIV program, and opened its own AIDS clinic, the Sable-Sheer

clinic. At that time few women were diagnosed with HIV, but the women — who may have been intravenous drug users or partners of users — were vocal in asking for care; they had nowhere else to go.

Consequently, the hospital initiated a successful program for women and children. “Our program was unique,” says Cohen. “It was a family-centered comprehensive model; we thought of women and children as a unit.... We were able to get funding to provide a specialized setting for women and children, and that helped to keep money coming in for other programs. So we got many ancillary services, too, including mental health providers, pastoral care, case managers, and volunteers. We became a model for other hospitals in the city and nationwide.”

And like the AIDS care programs at other public hospitals, the Cook County effort continues to make an impact today. Since 2000, there have been no mother-to-child transmissions of HIV for women in care at the CORE Center. ■