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# IAPAC

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## AIDS, arts, and responsibilities

## An interview with Edmund White

August 2005

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234

## AIDS, arts, and responsibilities: An interview with Edmund White

*Mark Mascolini*

Edmund White—the esteemed gay novelist, biographer, and social critic—may not seem the most likely font of advice on weighing the HIV risk in your patients. But what he has to say on that topic (and of course on AIDS literature) is worth reading.

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battling complacency
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REPORT FROM THE PRESIDENT

# From vision to reality

*José M. Zuniga*

*"IAPAC has begun work with an international panel of member physicians and educators to establish the foundation for a global HIV medicine certification process. [T]he goal is to make reality a vision of the world in which HIV-positive men, women, and children may obtain the best health care available provided by physicians and allied health care professionals armed with cutting-edge clinical expertise."*

With those words published in the June 2000 issue of the *IAPAC Monthly*, the International Association of Physicians in AIDS Care (IAPAC) announced its first steps in the creation of a unique and much-needed credentialing process that will help improve the quality of health care provided to HIV-positive people in the developing world. We have traversed rocky terrain, overcome overwhelming challenges, and persevered through numerous setbacks to advance our commitment to the education of physicians in the provision of improved care for the millions who rely on overburdened and strained health care systems for their care and support.

I am proud to report this month that five years later, on the anniversary of my June 2000 announcement, nine South African physicians passed our GALEN Certification Examination with a score of 70% or higher, thus becoming the first HIV/AIDS-treating physicians in the world to be certified, however informally, in the field of HIV medicine.

IAPAC pursued this course of action for two very basic reasons: 1) our members identified certification as a priority; and 2) we believe that such a process will enhance and support the development of clinical care "best practices" in HIV medicine, leading to corresponding improvements in the health of HIV-affected communities.

Photo: Jaz Hughes

Nokukhanya Mdlalose, a South African family practitioner, writes the GALEN Certification Examination during its June 9, 2005, administration in Durban, South Africa.

Certification in the medical disciplines is viewed as a form of self-regulation that implies the development of standards. In the certification process, a certifying organization convenes a group of experts in a particular discipline to define standards of acceptable knowledge and/or performance, and to measure competence by means of those standards. Among several common attributes of certification programs are:

- incorporation of a formal, systematic, and highly structured process for standards development and review;
- voluntary enrollment, typically through a volunteer-driven process;
- involvement of some form of peer review, where groups of experts are called upon to determine acceptable levels of competence and/or performance;
- a primary goal of protecting the public or enhancing the quality of a service provided to the public; and
- establishment of clinical "best practices" through an expert consensus process.

GALEN builds upon all of these components. In the creation of GALEN, IAPAC acted on the certain knowledge that provision of suboptimal care for HIV-positive patients causes the development of antiretroviral drug resistance, as well as unnecessary morbidity and mortality. As antiretroviral therapy scale-up efforts bear results and allow for greater availability in resource-limited settings, the ability of health care professionals to optimally administer therapy is essential from multiple perspectives—among them the humanitarian, economic, and clinical perspectives. The decision was made to offer a certification examination to physicians who would volunteer to write the examination based on their desire to provide care consistent with best practices in HIV medicine.

The GALEN Certification Committee is a panel of world-class HIV thought-leaders from developed and developing countries that crafted the examination based on their combined knowledge of best practices in HIV/AIDS care delivery in resource-limited settings. The committee's parameter for acceptable performance on the 200-question examination was based on the high level of knowledge derived from the 13-module GALEN course in HIV medicine, which covers clinical management issues along a continuum of HIV/AIDS care—from prevention to palliative care, with a heavy emphasis on antiretroviral therapy. Physicians who elect to write the examination test their knowledge against an HIV medicine knowledge base unsurpassed in the world.

*Continued on page 240*

# 2001 TOP 10

# 10 Most Important Developments in HIV Medicine

1. After years of denial, Chinese AIDS experts stated that China was in the midst of what could become a serious epidemic of HIV infection. Researchers estimated that approximately 600,000 people were infected, and the number of people found to be infected was growing by 30% per year.
2. The US Food and Drug Administration (FDA) issued approval of tenofovir (TDF), the first nucleotide analog approved for HIV-1 treatment.
3. Thirty-nine pharmaceutical companies withdrew their case attempting to block legislation passed by the South African government that would allow generic substitution and parallel importing.
4. AIDS activists filed suit against the South African health ministry, attempting to force the government to supply antiretroviral drugs for prevention of mother-to-child transmission (PMTCT) of HIV. In December, the South African High Court ruled that the government must supply nevirapine (NVP) to pregnant women for PMTCT.

5. According to a US Centers for Disease Control and Prevention (CDC) study, 30% of young gay black men in six US cities were infected with HIV. The CDC also reported that AIDS was the leading cause of death for African Americans between the ages of 25 and 44.
6. The Indian drug company Cipla offered to sell antiretroviral drugs to Médecins sans Frontières (MSF) for less than US$1 per day, adding to the pressure on multinational pharmaceutical companies to reduce their prices for developing nations.
7. At the African Summit on HIV/AIDS, Tuberculosis, and Other Infectious Diseases, United Nations (UN) Secretary-General Kofi Annan called for annual spending of US$7 billion to US$10 billion on AIDS in developing countries, up from spending of US$1 billion. The creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria was announced; initial commitments amounted to only US$1.6 billion.
8. The year 2001 marked the 20th anniversary of the first published report describing the disease that would eventually be named AIDS.

9. Kofi Annan convened the UN General Assembly Special Session on HIV/AIDS, the first such meeting entirely devoted to a public health issue.
10. A study was presented at the Transplant 2001 conference showing that liver transplants can be successfully performed in some people with HIV. The transplants had previously been avoided due to the fear that the immunosuppressive drugs taken following an organ transplant would harm the immune systems of people with HIV.

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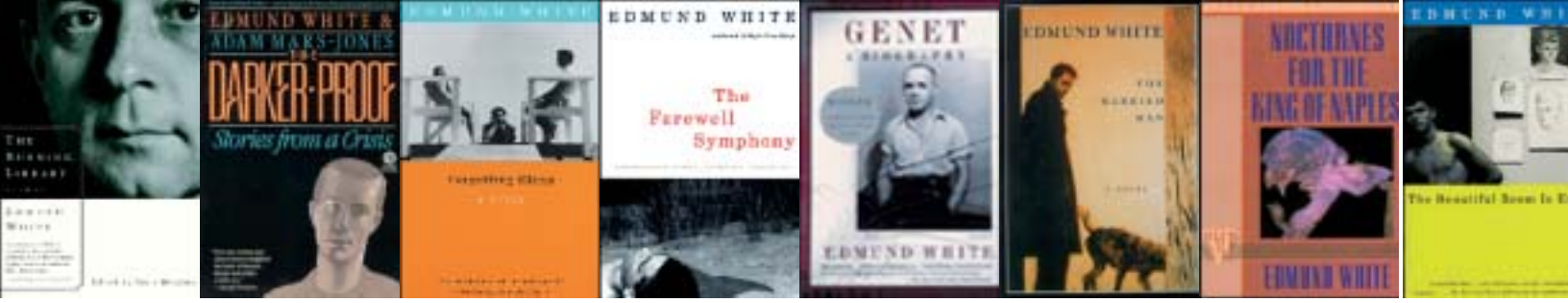
# AIDS, arts, and responsibilities

## An interview with Edmund White




*Mark Mascolini*

For gay men of a certain age—this reporter's age, for example—you could not live in New York in the 1970s and consider yourself cool without reading Edmund White's two novels. Nabokov[1] raved. Sontag[2] cheered. But for us *Forgetting Elena* and *Nocturnes for the King of Naples* meant more than high art by a heretofore unknown. They meant smart, deep, probative prose by an avowed homosexual who had no time for guilt, remorse, or maudlin maunderings toward self-awareness.

White went on to map the ins and outs of gay sex (in *The Joy of Gay Sex* with Charles Silverstein[3]), to map the routes of gay travel (in *States of Desire*), and to snag a National Book Critics Circle Award for his landmark biography of gay lit's ur-rebel, Jean Genet.[4] But White's four autobiographical novels—starting with the breakthrough *A Boy's Own Story*—define his legacy.

For many gay men White's nameless hero holds a flawless mirror to our lives, yet one that is sharper, subtler, droller than our own nonfictive bios. We follow that hero through the years of gay repression, gay rebellion, gay liberation, and inevitably AIDS. Like many gay men who thrived in the 70s, White picked up HIV himself and watched his friends die ugly deaths. Unlike most, he wrote about it beautifully from hard experience. He lost his best friend, a cherished editor, and his lover to AIDS.

Since White just finished his *real* autobiography, *My Lives*, it seemed a good time to ask him to reflect on AIDS, gays, prose, and prospects for gay culture in the age of HIV—and even to ask for some clinical pointers. Not that he has retired to the armchair of graybeard reflection. After he launches *My Lives*, White will continue work on a novel about Stephen Crane[5] and fine-tune his play *Terre Haute* at the Sundance Theater Workshop.

The third novel in his tetralogy, *The Farewell Symphony*, takes its name from the Haydn[6] opus in which the entire orchestra vacates the stage one by one, leaving only a lonely violin to carry the tune. The novel tapped it as a rueful image of an AIDS survivor—not unlike White. But one may also see Haydn's solitary concertmaster as the image of a dauntless artist, fiddling furiously.

***IAPAC Monthly:*** You've written a great deal, and you don't seem to be slowing down. Would you have written with less urgency if you hadn't been infected by a deadly virus?

***Edmund White:*** I found out I was positive in 1985, though I'm sure I was positive for five years at that point because most of my contemporaries were. My initial response was depression and not working. I just pulled the covers over my head for a year and didn't do anything.

I had a Swiss lover when I was living in Paris and we took the HIV test together. I said to him, "I'm a good enough novelist to know what's going to happen—you're going to be negative, I'm going to be positive, and you're going to drop me." That's just what happened, although we're still good friends. But he was afraid of me.

So it was all very depressing and I didn't work well at all initially. Then I began to work on this mammoth project, the Genet biography,[7] which took seven years.

Photo © Robert Giard

Edmund White in 1984 while visiting his friend, the critic David Kalstone,[8] who died of AIDS shortly thereafter.

And I kept thinking, "this is the height of folly if I only have two years to live." But I didn't know then that I would be a slow progressor.

I'm not a nonprogressor. My T cells have drifted down over the last 20 years from 700 to 600 to 500 to 400. Pretty soon I guess I'll have to go on meds; my doctor wants me to go on now.


But because some of the meds are hard on your heart and I have some heart problems, it's kind of a toss-up about what to do as long as I remain asymptomatic.

Only when I thought—"Gee, I guess I'm not going to die right away"—did I come out of my depression and begin to write at this feverish pitch. The first two novels I wrote after I learned I had HIV—*The Farewell Symphony*[9] and *The Married Man*[10]—and my book of short stories, *Skinned Alive*,[11] all dealt with AIDS. And I did write them with some urgency, partly because I was living in France where, at that time, there wasn't much of an AIDS community.

I felt isolated there. In New York I'd been one of the founders of the Gay Men's Health Crisis [GMHC] and I'd known people involved in AIDS activism early on. But I left New York in 1983, so that was still early days. I was in on the early meetings of the French counterpart to Gay Men's Health Crisis, *AIDES*, because after Michel Foucault[12] died in 1984 his lover Daniel Defert[13] asked me to help him with the first meetings.

When I finally got around to writing those novels and the short stories I did feel an urgency—but for my own sake, not for anybody else's—to communicate with people about what it was like to be positive and what it was like to live this way.

***IAPAC Monthly:*** You confront AIDS head-on in *The Married Man*, but AIDS is more a shadow hanging over *The Farewell Symphony* until that last sad chapter. How do you decide how tightly to focus on AIDS in your fiction?

***Edmund White:*** It's like trying to get a child to swallow cod liver oil. Nobody wants to read about AIDS. People who have it don't want to read about it because it's depressing. People who don't have it but are susceptible to HIV don't want to read about it because it's bad news. The only thing people want to read about AIDS is the headline that says they've found a cure. You can walk into bookstores and see piles of AIDS book remainders: Nobody wants to read them.

So anyone writing about HIV faces a commercial and technical problem. The commercial problem is that we have to sell enough copies to stay in business and get another contract to write another book. The technical problem is how to lure people into a novel that seems innocent and then get them to think about AIDS. For instance, *The Farewell Symphony* certainly announces from the title on that it's going to be a downer, but the epidemic doesn't arrive until late in the book.

After I'd written *A Boy's Own Story*,[14] my original plan was to write two more stories—one about the sex-mad 70s, then one about AIDS. The trouble was I waited so long because of the Genet biography that when I finally got around to this I thought it would be intolerable to write a book about everyone having fun and fucking each other, then a few years later to publish another book in which everybody dies of AIDS.

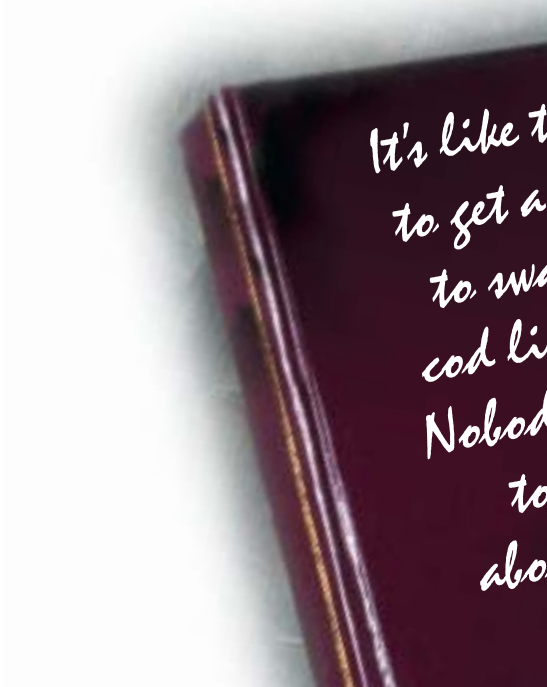
People wouldn't want to read *either* book. They'd see the first one as totally irresponsible and cuckoo and the second one as a total downer. So I thought I'd fuse them and write a much longer single volume than I'd intended, and that became *The Farewell Symphony*. I thought foreshadowing AIDS and talking about the good old days at the same time was a strategy that would make people read on.

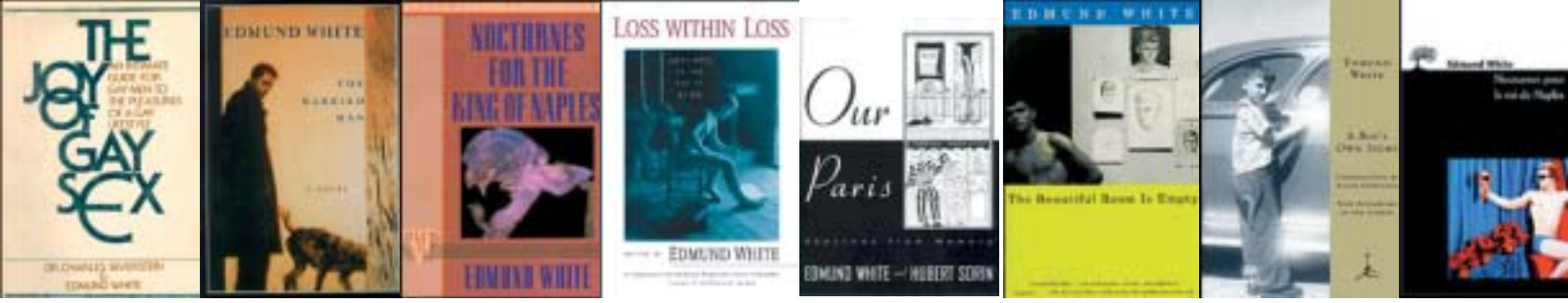
***IAPAC Monthly:*** I'm surprised there's that much premeditation in planning a novel.

***Edmund White:*** I'm very reader oriented. The only kind of criticism I like is reader-response theory, developed by Wolfgang Iser.[15] To me it's as though the writer is playing the piano and the piano is the reader. You're trying to get sounds out of it; you're trying to get responsiveness—to please and entertain him enough to keep him reading—then also to force him a little to deal with hard issues.

***IAPAC Monthly:*** What other works of fiction, drama, or poetry do you esteem for the way they address the epidemic?

***Edmund White:*** I like quite a few French books. For example, I am a big admirer of Hervé Guibert,[16] as I explained in my essay "Sade in Jeans."[17] What I like about Guibert is that he was tough.






It seems to me that in the English-speaking world the problem in AIDS writing has been sentimentality—a tearful, victimized, medicalized approach to AIDS and not enough defiance, anger, gutsiness. I don't want to name names, but we've had everything from AIDS deathbed weddings to angels descending.

Of course this has been vastly admired by most people, and I feel like a cad not liking it. But I don't like its sentimentality. It's not that different from the death of Little Nell[18] in Dickens. I think people living through AIDS probably get a lot of consolation from that kind of writing. But I think, as literature, it's dubious.

Among writers in English, I'm a big fan of Alan Hollinghurst.[19] I feel he's dealt with AIDS extremely well. It's a real factor in his most recent book, *The Line of Beauty*, although it's not center stage. But again I think that's a good tactic for getting people to read. And I think that by taking that approach he was able to win the Man Booker Prize, which I don't think a straight AIDS novel could ever win.

In Hollinghurst's second book, *The Folding Star*, a character named Dawn is dying of AIDS. And it's all miraculously well written. I think he's one of the greatest writers alive.


Photo © Barbara Confino

Edmund White in 2000, the year he published the last of his four autobiographical novels, *The Married Man*, which unflinchingly examines how AIDS affects a gay couple.

***IAPAC Monthly:*** Several years ago on my way to an HIV neurology meeting I picked up *The Man With Night Sweats*, a book of poems by Thom Gunn[20]—quite by chance because I'd never heard of him. When I wrote about the meeting I quoted from Gunn's poem "Lament," which has a few lines that I thought might strike a chord with neurologists:

*You tried to stay the man that you had been,*
*Treating each symptom as a mere mishap*
*Without import. But then the spinal tap.*[21]

And a few neurologists who went to that meeting and read the article wrote to me, asking about Gunn and asking for a copy of the whole poem. Experiences like that make me wonder whether HIV doctors can *learn* from the AIDS literature. And that makes me wonder whether *people with AIDS* learn from the AIDS literature.

***Edmund White:*** I think people do—but not in great numbers. The first thing I ever wrote about AIDS was *The Darker Proof*[22] with Adam Mars-Jones,[23] an English writer who's been a friend of mine forever. We decided we'd do a paperback original of stories about AIDS that would come out quickly. And it did come out fairly early, in 1987, which was early for AIDS literature.

Our idea was that because it was paperback we could get it in print right away, and it would be cheap to buy. We felt that the only people talking about AIDS in the 1980s were doctors and that problems gays had faced for a hundred years were that they were a subject of medical enquiry and they were considered a medical category. The whole discourse had been medicalized.

One of the many tasks of gay liberation, starting with Stonewall in 1969,[24] was to reverse that way of thinking and declassify homosexuality as a medical condition by the American Psychiatric Association and the American Psychological Association. We succeeded in those battles. But AIDS seemed to push everything backwards to an age when the only ones who were talking about male homosexuals were doctors who weren't gay or didn't identify as gays. They were discussing us in a very clinical way as though we were guinea pigs—"subjects."


Adam and I both felt it was important to show the inner life of people dealing with AIDS. Either they were caretakers or they had the disease themselves or were worrying about it. I don't think that book sold many copies but it caused quite a stir in England. I incorporated my stories into *Skinned Alive*.

But I don't think you have to write specifically about AIDS to foster deeper thinking about gay culture and our response to this disease. When Larry Kramer[25] discovered I was writing the Genet biography in 1987, he flew into a rage in print, saying the only thing anyone who's gay should write about is AIDS—and how dare Edmund White (who's supposed to be a good writer) take on this ridiculous historical subject that's totally irrelevant to our concerns?

My feeling was that if we're in danger of being reduced to a single issue, AIDS, and if we're in danger of being seen mainly as victims of a fatal medical condition, then it's part of my AIDS work to write about a great cultural figure who stood outside of the whole AIDS discourse. I thought it was important to write about this towering literary figure to remind people of all these great cultural accomplishments achieved by gays that had nothing to do with AIDS—and to remind them that we'd get back to that.

***IAPAC Monthly:*** Your essay on AIDS writing, "Journals of the Plague Years,"[26] ends with a series of questions about where HIV literature is headed now that people of means can take effective regimens. So let me read those questions, which you posed in 1997, and ask if you think any of them has been answered:

- Will all those people who died be forgotten?
- Because lesbians and gays seldom hand their sexual identity down to their children, will what we are suffering be lost?
- Will we continue our fight to help the poor suffering from AIDS here and abroad?
- Or will we succumb to instant amnesia, pop an Ecstasy and return to the dance floor?

***Edmund White:*** Pretty good questions, huh? Oh, God. What do you think?

***IAPAC Monthly:*** You worked as a journalist—you know the interviewer never answers questions.

***Edmund White:*** Oh, right. I think the truth is that even for people who can afford the drugs, there are still a lot of inconveniences in taking them. Everybody knows someone who's just had some implant in his face because of wasting or the guy upstairs who's dealing with a hump on his back. For such a body-oriented culture, it's very dismaying.

I always felt that the next generation of ads warning people against unsafe sex should concentrate on those things. What people learned about the antismoking campaign is that if you mentioned death people didn't read on, because a little curtain comes down to protect them from the idea of death. You needed to mention things like smelly breath, hacking cough, burning holes in your clothes and sofa—those were things people could register and react to. But death, no.

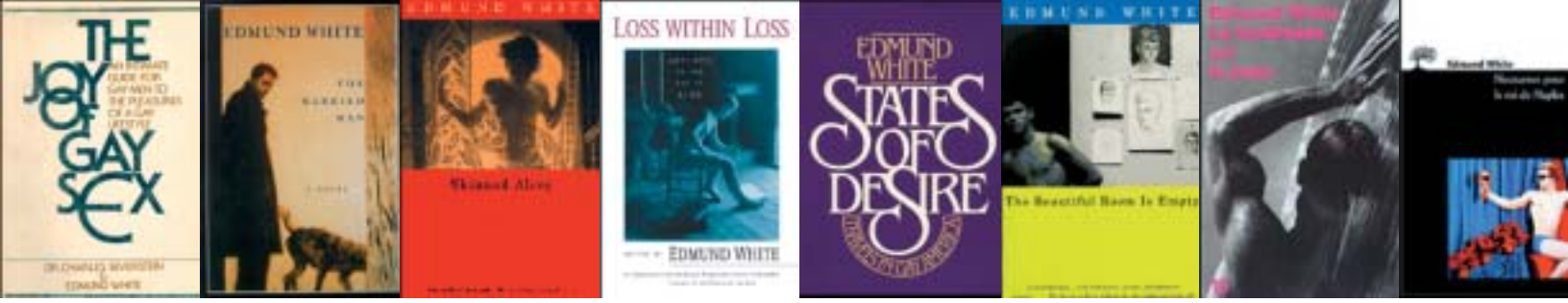
By the same token good anti-AIDS advertisements now should emphasize things like lipodystrophy—not death.

***IAPAC Monthly:*** The narrator of your autobiographical novels battles a dialectic familiar to many gay men—hedonistic adventure versus "true love"—meaning monogamous love. At least that was true of many gay men I knew when I was young, but I wonder if young gay men feel that way today.

***Edmund White:*** I think they definitely do. At least the official rhetoric is that they should get a partner, and they oftentimes do, perhaps planning to be faithful as a way to avoid HIV. If they're both tested and both negative, they can have "unsafe sex" together. But that puts tremendous pressure on them to be honest, and they can't always live up to that. Then the consequences can be fatal.

My own feeling is that it's better to go into a back room and have safe sex with 20 unknown people than to have unsafe sex with your lover—because you can't *really* believe what he says.

I know of one highly successful gay scholar who "married" his lover in a formal ceremony. Though they pledged eternal fidelity to each other, neither of them was



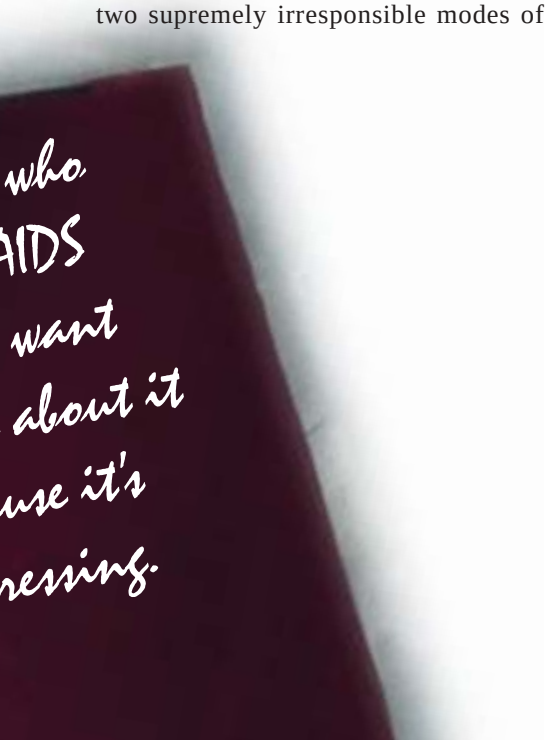

faithful. But they could never bring themselves to admit they weren't faithful. So one of them picked up HIV and transmitted it to the other. They both died. But they never admitted they had AIDS because that would have blown their cover as this ideal faithful couple.

I think there are an awful lot of young people who have a lover but are also cruising on the Internet. I cruise on the Internet and it's just *clogged* with thousands and thousands of people. There's an extraordinary amount of activity of every variety.

***IAPAC Monthly:*** Do young gays ask you questions about sexuality?

***Edmund White:*** No, they don't. Most young people don't even know who I am because they don't read me. If you look in *Gaydar* or other places where people are asked to list their favorite author, it's never me. (It's always David Sedaris.[27]) Maybe my work is too sad, or too unpleasant, or too literate. But when I was young I didn't ask anyone questions about sex either.

***IAPAC Monthly:*** In an essay on the photographer Robert Mapplethorpe,[28] you wrote that "art and passion are the two supremely irresponsible modes of experience." Do you regard your autobiographical novels—which span gay repression, liberation, and AIDS—as either responsible or irresponsible?




***Edmund White:*** I think they're more responsible than not. Even though I was criticized for "glamorizing" sexual promiscuity in *The Farewell Symphony*, my own feeling is—wait a minute: everyone dies in the book. So it's not denying or ignoring the consequences of unsafe sex. But I also am a romantic, and people who think sex is worth dying for—or that art is worth dying for—have all my sympathy. I understand what they're talking about.

There's been a weird natural selection whereby the people with my beliefs tend to have died. And the people who are kind of cautious and prudish and pleasure-phobic are the ones who survived, so you hear a lot from them. They preach to everybody and give a lot of lessons.

I feel there's always been a strong moral strain in my writing. The single best essay about me appeared in the *Times Literary Supplement* and was written by a straight English critic who compared me to [Ralph Waldo] Emerson.[29] I loved that because I feel, first of all, that I am a great American writer and, secondly, that I have that moral preoccupation that somebody like Emerson had.

Yes, I'm very pro-pleasure, but I don't think that makes me irresponsible.

***IAPAC Monthly:*** Through *The Joy of Gay Sex*,[30] *States of Desire*,[31] your novels, your essays, you've defined gay culture and behavior for lots of gay men. You did for me. Do you see yourself as a definer—or would you prefer some other word to describe your legacy?

***Edmund White:*** "Definer" is fine. I hope it's true. I mean it's a very optimistic view of my work.

One thing that people forget when they frame categories like that is that the person himself probably wasn't aspiring toward any such thing. There may be a tendency to say, "White set himself up as an authority on gay culture, and look at all the mistakes he made—A, B, and C." But the truth lies somewhere else. JD Salinger[32] probably thinks he's a fairly minor writer, yet he was crowned then dethroned.

We do that a lot in this country. Even in a minor way with a writer like me there's a tendency to set someone up as an authority, which he himself never claimed to be. Or if he puts himself in the running, he's very happy if lots of other people have their own ideas and publish them.

I think at a certain moment I was sort of prominent, and some people tend to imagine that I set myself up as an authority. For instance, people blame me for encouraging gay people to have sex in *The Joy of Gay Sex*, but that was written in 1976. When AIDS struck, Charles Silverstein and I tried to withdraw the book instantly, but the publisher wouldn't listen to us. Finally we were able to publish a revised AIDS-conscious version. It took too long, but that wasn't our fault.

Anything that touches on gay sexuality is very fraught now because of AIDS. People tend to be ahistorical in thinking of past books as being somehow guilty of promoting something that happened five years later.

***IAPAC Monthly:*** You turned up at some of the watershed events in recent gay history—the Stonewall riot, the founding of the Violet Quill[33] and GMHC—and you wrote the archetypal coming-out novel. I won't ask about the worst memories these events left, but what was the best?

***Edmund White:*** The odd thing is that I've never seen myself as a team member in gay life. I feel that I never repeated anything. I would go to Fire Island in the 60s and 70s, then I stopped going. I would go to back rooms and baths, but then I'd stop it. In other words I feel that I've never been one to acquire habits or persist in something very much. In my writing I feel that I've tried to avoid doing the same book over and over. My most recent book, *Fanny*,[34] was a straight historical novel. So I don't want to present myself as someone who identified with the gay movement and was there to crow over its triumphs, because I don't think I did that much.

Stonewall I sort of stumbled into. I was walking with a friend past the Stonewall at the time it was raided. We got involved and very excited by the demonstration. But it wasn't as though we were in the bar when the police raided it.

I don't think any of us took Violet Quill very seriously. We met only eight times. It was mainly about who could prepare the best dessert. But it's remembered because people like movements and because historians like to write about movements more than they like to write about individuals—and because it did actually coincide with a triumph of gay culture.

Somebody should write a book about the 70s in New York—straight and gay—but it would turn out to be mainly a gay story. I feel that was one of the high points in human culture. There were all these great people—Jasper Johns[35] in painting, John Ashbery[36] in poetry, [George] Balanchine's[37] last years in ballet, many great novelists—there was a tremendous amount of activity and a New York aesthetic that was very powerful.

***IAPAC Monthly:*** Lots of HIV clinicians read this journal. Do you have anything to say to them?

***Edmund White:*** I would say don't have too rigid a notion of who the at-risk groups are. As I've gotten older and moved out of the prime gay category to resemble more the family dentist, I've found that I have sex with all kinds of people who wouldn't want to have sex with "a gay man." I have a tremendous repertoire of people in my address book who are married, bisexual, discreet, in their 50s, 60s, 20s, 30s, who have a dread of the gay culture.

I always practice safe sex, but what if I didn't? I could have infected a whole bunch of people by now. Because they don't think of me as being gay or likely to have HIV infection, they're comfortable having sex with me.

So on the basis of my own experience I believe there's a tremendous underground of people having gay sex—often unprotected sex—whom a clinician would never identify as being gay. Maybe it would be useful for more clinicians to be a little more alert to how fluid and open human sexuality is. ■

*Mark Mascolini writes about HIV infection (markmascolini@earthlink.net).*

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# From vision to reality

*Continued from page 230*

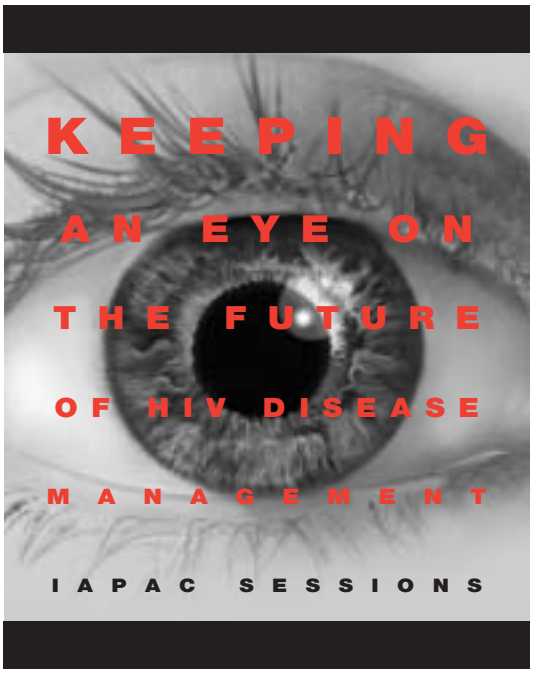
Those physicians who passed the examination during its inaugural administration in Durban, South Africa, can feel justifiably proud of their accomplishment; those who did not pass will have time to hone their skills and another opportunity in the future to demonstrate improvement.

GALEN would not be possible without the dedication and hard work of the GALEN Curriculum and Certification Committees as well as GALEN training module authors, whose talent and dedication have been an inspiration to all. In addition, various IAPAC staff members have spent innumerable hours and devoted their considerable skills in helping create a sustainable program unique in its ability to both improve and measure the skills of participating physicians.

I sincerely hope that IAPAC members share a sense of pride in the accomplishment of this important task. As GALEN continues to advance and improve, it does so only through the support of IAPAC's membership, whose volunteer time is invaluable, as well as through institutional support from various organizations, including the American International Health Alliance (AIHA) and the Pan American Health Organization (PAHO). As we look forward to new challenges, ever-present in our fight against the AIDS pandemic, we should allow ourselves a moment of satisfaction as we contemplate the achievement of this milestone. ■

*José M. Zuniga is President/CEO of the International Association of Physicians in AIDS Care (IAPAC), and Editor-in-Chief of the* IAPAC Monthly.

# HIV MEETING ANNOUNCED!

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# ABSTRACTS

*Sexually Transmitted Infections*

## The psychosocial impact of serological herpes simplex type 2 testing in an urban HIV clinic

*Meyer JL, Crosby RA, Whittington WL, et al.*

*BACKGROUND/OBJECTIVES:* Herpes simplex virus type 2 (HSV-2) is a common infection among HIV-infected people. Herpes simplex virus type-specific serologies permit the diagnosis of previously unrecognized HSV-2 infection. While substantial psychosocial morbidity has been associated with a clinical diagnosis of genital herpes, the burden associated with a serological diagnosis of HSV-2 is unclear. This study prospectively measured the psychosocial response to a new serological HSV-2 diagnosis in patients receiving care at an urban HIV clinic. *METHODS:* At entry, sera were tested for HSV-1 and HSV-2 antibodies by Western blot. Participants completed a 90-item psychosocial and life quality questionnaire at enrollment, and at two weeks, three months, and six months after receiving test results. *RESULTS:* Of 248 HIV-infected participants, 172 (69.4%) were HSV-2 seropositive and 116 (67.4%) seropositive people did not have a previous history of genital herpes. After correction for multiple comparisons, no statistically significant differences were detected on the psychosocial and life-quality scales between those who received a new HSV-2 serological diagnosis compared with those who were HSV-2 seropositive with a history of genital herpes, or those who tested HSV-2 seronegative. Additionally, no significant changes in scores were observed during follow-up. *CONCLUSIONS:* Herpes simplex virus type 2 was a common but often unrecognized infection in this urban HIV clinic and participants coped well with a positive HSV-2 result. Concerns about psychosocial burden should not deter serological testing for HSV-2. Given the epidemiological and clinical interaction between HSV-2 and HIV, these data support routine HSV-2 testing of HIV-infected people.

*Sex Transm Infect. 2005;81(4):309-315.*

*American Journal of Psychiatry*

## Effects of methamphetamine dependence and HIV infection on cerebral morphology

*Jernigan TL, Gamst AC, Archibald SL, et al.*

*OBJECTIVE:* The authors examined the separate and combined effects of methamphetamine dependence and HIV infection on brain morphology. *METHOD:* Morphometric measures obtained from magnetic resonance imaging of methamphetamine-dependent and/or HIV-positive participants and their appropriate age- and education-matched comparison groups were analyzed. Main effects of age, HIV infection, methamphetamine dependence, and the interactions of these factors were examined in analyses of cerebral gray matter structure volumes. *RESULTS:* Independent of the effect of age, HIV infection was associated with reduced volumes of cortical, limbic, and striatal structures. There was also some evidence of an interaction between age and HIV infection such that older HIV-positive participants suffered disproportionate loss. Methamphetamine dependence was surprisingly associated with basal ganglia and parietal cortex volume increases, and in one of these structures—the nucleus accumbens—there appeared to be a larger effect in younger methamphetamine abusers. Neurocognitive impairment was associated with decreased cortical volumes in HIV-positive participants but with increased cortical volumes in methamphetamine-dependent participants. *CONCLUSIONS:* These results suggest significant brain structure alterations associated with both HIV infection and methamphetamine dependence. The regional patterns of the changes associated with these factors were distinct but overlapping, and the effects on brain volumes were opposing. Although the results of the present study provide little information about the specific mechanisms leading to the unexpected methamphetamine effects, they may be related to glial activation or neuritic growth, both of which have been associated with methamphetamine exposure in animal studies. These results have implications for the interpretation of brain morphological findings in methamphetamine-dependent, HIV-positive individuals, a group whose numbers are unfortunately increasing.

*Am J Psychiatry. 2005;162(8):1461-1472.*

*Tropical Medicine and International Health*

## Efficacy and safety of two dosages of cotrimoxazole as preventive treatment for HIV-infected Malawian adults with new smear-positive tuberculosis

*Boeree MJ, Sauvageot D, Banda HT, et al.*

*SUMMARY OBJECTIVE:* To assess the efficacy and safety of two different dosages of cotrimoxazole (CTX) in prophylaxis in HIV-positive new smear-positive pulmonary tuberculosis (TB) patients in Blantyre, Malawi. *METHOD:* Randomized, double-blind trial using 480 mg and 960 mg of CTX given to new TB patients, who were followed up until the end of the tuberculosis treatment. The primary outcome was survival. The outcome in the two groups was also compared with an unselected cohort of similar patients registered in Zomba, Malawi in 1995, and new smear-positive patients registered in the National Tuberculosis Programme in 1999. The secondary outcome was the occurrence of (opportunistic) events, especially bacterial pneumonia. *RESULTS:* There were no statistically significant differences in mortality and bacterial pneumonia between the groups receiving the two different dosages. The case fatality rate at the end of the TB treatment was 15.4% in the 480 mg group and 14.0% in the 960 mg group. This was lower than the case fatality rate in the Zomba cohort (19.2%, $P = 0.10$) and lower than the case fatality rate in the national program (21.0%, $P < 0.001$). Cotrimoxazole was well tolerated. Compliance was fair. *CONCLUSIONS:* Cotrimoxazole prophylaxis may have a beneficial effect on mortality and morbidity in HIV-infected smear-positive tuberculosis patients in Malawi. The efficacy of both dosages is not significantly different. The intervention is cheap and easy to implement. These results would support implementation of CTX in this patient group until better strategies are available or evidence is convincingly presented to suggest that its benefit is marginal.

*Trop Med Int Health. 2005;10(8):723-733.*

*Journal of Acquired Immune Deficiency Syndromes*

## Effects of hepatitis C virus coinfection on survival in veterans with HIV treated with highly active antiretroviral therapy

*Backus LI, Phillips BR, Boothroyd DB, et al.*

*BACKGROUND:* With highly active antiretroviral therapy (HAART) available for patients with HIV, hepatitis C virus (HCV) infection has emerged as a potentially important cause of mortality in coinfected patients. Several studies have investigated the effect of coinfection on mortality, with conflicting results. *METHODS:* The study cohort consisted of HIV-infected veterans on HAART receiving care at US Department of Veterans Affairs facilities. Inclusion was based on first HAART prescription between January 1997 and February 2003, HCV antibody test result, and baseline CD4 and HIV viral load results within one year of starting HAART. We fitted Cox proportional hazards models to study the effect of HCV serostatus on survival time from HAART initiation, controlling for patient demographic and clinical characteristics, facility characteristics, HAART exposure, HAART response, and HCV treatment. *RESULTS:* Of 12,216 patients in the study cohort, 38% were HCV-seropositive. During an observation time averaging 3.5 years, 2,087 patients died. The adjusted hazard ratio for HCV-seropositive patients was 1.56 (95% confidence interval [CI] 1.42-1.70; $P < 0.0001$) without a HAART exposure measure and 1.38 (95% CI 1.26-1.51; $P < 0.0001$) with the measure. We obtained similar results in analyses also controlling for HAART response. *CONCLUSIONS:* Hepatitis C virus seropositivity was independently associated with increased risk of death in a large cohort of HAART-treated HIV-infected veterans. Given the success of HAART in extending the lives of HIV patients, HCV has become an important predictor of their mortality.

*J Acquir Immune Defic Syndr. 2005;39(5):613-619.*

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# Improving anemia in HIV/HCV-coinfected patients

Guidelines for HIV/hepatitis C virus (HCV)-coinfected patients recommend HCV treatment with pegylated interferon-alfa (PEG-IFN) plus ribavirin (RBV). The adverse effects of IFN/RBV, particularly anemia, may be more common among HIV/HCV-coinfected than HCV-monoinfected patients, and are often associated with decreased health-related quality of life (HRQOL), as well as with discontinuation or dose reduction of RBV.

The HIV/HCV Coinfection Study Group evaluated the effectiveness of once-weekly epoetin alfa compared with standard of care (SOC) in correcting anemia, improving HRQOL, and minimizing RBV dose reductions in HIV/HCV-coinfected patients receiving IFN/RBV therapy.

This was a 16-week, open-label, randomized, parallel-group, multicenter study in anemic patients with HIV/HCV coinfection receiving IFN/RBV therapy for an anticipated period of ≥16 additional weeks. Key inclusion criteria included patient age of 18 to 75 years and hemoglobin (Hb) ≤12 g/dL or a ≥2-g/dL decrease in Hb after IFN/RBV initiation. Key exclusion criteria included a history of uncontrolled hypertension or seizure disorder, anemia attributable to another cause, and exposure to any epoetin within three months.

The primary endpoint was to compare the mean change in Hb from baseline (ie, first dose of study drug in epoetin alfa group, day one in SOC group) to week 16 in the epoetin alfa group with that in the SOC group. Secondary endpoints were mean change in RBV dosage, HRQOL scores, physical and mental health components, and transfusion. Patients were required to complete HRQOL assessments before each visit. Safety assessments included monitoring vital signs, adverse events, alanine aminotransferase (ALT) levels, CD4 counts, HIV viral load, and HCV viral load.

***Editor's Note:*** *Reprinted with permission from www.hivandhepatitis.com (first e-published July 22, 2005).*

## Results

- Sixty-six patients were randomized (34 to the epoetin alfa group and 32 to the SOC group). Baseline characteristics were comparable between the two groups.
- Immediately after randomization (day one/week zero), 14 patients (four epoetin alfa and 10 SOC) dropped out of the study without baseline or follow-up assessments.
- Thirty epoetin alfa patients and 22 SOC patients were included in the modified intent-to-treat (MITT) analysis.
- Twenty (63%) SOC patients and 11 (32%) epoetin alfa patients dropped out during the 16-week study period.
- Mean baseline Hb (± standard error [SE]) was 11.1 ± 0.3 g/dL in the epoetin alfa group and 11.5 ± 0.3 g/dL in the SOC group ($P = 0.33$), and mean increases in Hb from baseline to week 16 were 2.6 ± 0.3 g/dL and 0.2 ± 0.3 g/dL, respectively ($P < 0.001$).
- No patient had epoetin alfa withheld because of reaching the upper limit of Hb.
- Patients receiving epoetin alfa and zidovudine (ZDV) had a greater mean increase in Hb from baseline to week 16 than those not receiving ZDV [$n = 17$];
- For SOC patients, the mean change in Hb was similar in ZDV users and nonusers.
- No transfusions occurred.
- Mean RBV doses at initiation of IFN/RBV and at baseline, respectively, were 1,047 and 973 mg/d in the epoetin alfa group and 1,027 and 982 mg/d in the SOC group. At week 16, 67% of epoetin alfa patients and 45% of SOC patients were receiving RBV doses ≥10.6 mg/kg/d ($P = 0.09$).
- Epoetin alfa was well tolerated, with most adverse events mild to moderate in severity.
- Patients treated with epoetin alfa had significantly less fatigue ($n = 3$ [10%]) compared with those in the SOC arm ($n = 9$ [38%]) ($P = 0.02$); there was no other significant difference between groups in the incidence of common adverse events.
- Four serious adverse events were reported: one in the epoetin alfa group (constipation, which was considered unrelated to epoetin alfa) and three in the SOC group (chest pain, myocardial infarction, and psychosis).
- There were no reports of thrombovascular events or anti-erythropoietin antibodies related to epoetin alfa.

## Discussion

According to the authors, in this randomized study epoetin alfa effectively corrected anemia in HIV/HCV-coinfected patients treated with IFN/RBV, including those taking ZDV. The magnitude of Hb increase in coinfected patients was similar to that previously observed in IFN/RBV-related anemia in patients with HCV monoinfection.

In contrast to studies in patients with HCV monoinfection, no effect of epoetin on RBV dose was observed. A significant number of SOC patients dropped out after randomization (10 patients) and before week 16 (20 patients), however, substantially limiting our ability to assess the secondary endpoint of RBV dose, because patients and investigators may have selectively discontinued study participation in those SOC patients with worse outcomes.

Improvements in HRQOL scores were greater in patients receiving epoetin alfa, but the small sample size precluded definitive conclusions. ■

## Reference

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# An ounce of prevention ...

**Counsel your HIV-positive patients about safer sex. An ounce of prevention is worth everyone's effort!**

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# Patrick Tranmer

For more than three years the *IAPAC Monthly* has featured members of the International Association of Physicians in AIDS Care (IAPAC), who are asked to bare their souls by answering a series of questions similar in nature to those asked in the famous *Proust Questionnaire*.

This month, *IAPAC Monthly* is proud to feature Patrick Tranmer, Department Head and Professor of Clinical Family Medicine in the Department of Family Medicine at the University of Illinois at Chicago.

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**What proverb, colloquial expression, or quote best describes how you view the world and yourself in it?**
"But you are, Blanche, you are in a wheelchair!"—Bette Davis to Joan Crawford in *What Ever Happened to Baby Jane*? In other words, do the best you can with what you have at that very moment. As we know, Blanche comes out on top!

**What activities, avocations, or hobbies interest you? Do you have a hidden talent?**
Activities: Exercise, as able, and professional reading. Avocations: My partner and our two children. Hobbies: Hardware stores, movies. Hidden talent: Writing.

**If you could live anywhere in the world, where would it be?**
San Francisco. I fell in love with the city on first arrival in 1972. It was like going to Oz. But I've never lived there for family reasons.

**Who are your mentors or real life heroes?**
My mother, because she taught me how to love unconditionally; and my father, because he instilled in me the love of work and education.

**Who are your favorite authors, painters, and/or composers?**
Authors: Anaïs Nin, Eudora Welty. Painters: Wassily Kandinsky, Jackson Pollack. Composers: Aaron Copland, Giuseppe Verdi.

**If you could have chosen to live during any time period in human history, which would it be?**
Now. It's been a "long," strange trip. The people I've met in life are mostly remarkable.

**If you did not have the option of becoming a physician, what would you have likely become, given the opportunity?**
An actor.

**In your opinion, what are the greatest achievements and failures of humanity?**
Achievements: Potable water, vaccines, art. Failures: Religions, guns, tribalism.

**What is your prediction as to the future of our planet one full decade from present day?**
Greater economic disparity and overall reduction in quality of life for the majority of the planet's inhabitants; a doubling or tripling of AIDS-related deaths; the imminent creation of an effective HIV vaccine; a much more defensive world due to *governments*; and overall, there will be more global tolerance among *people*. ■

## SAY ANYTHING

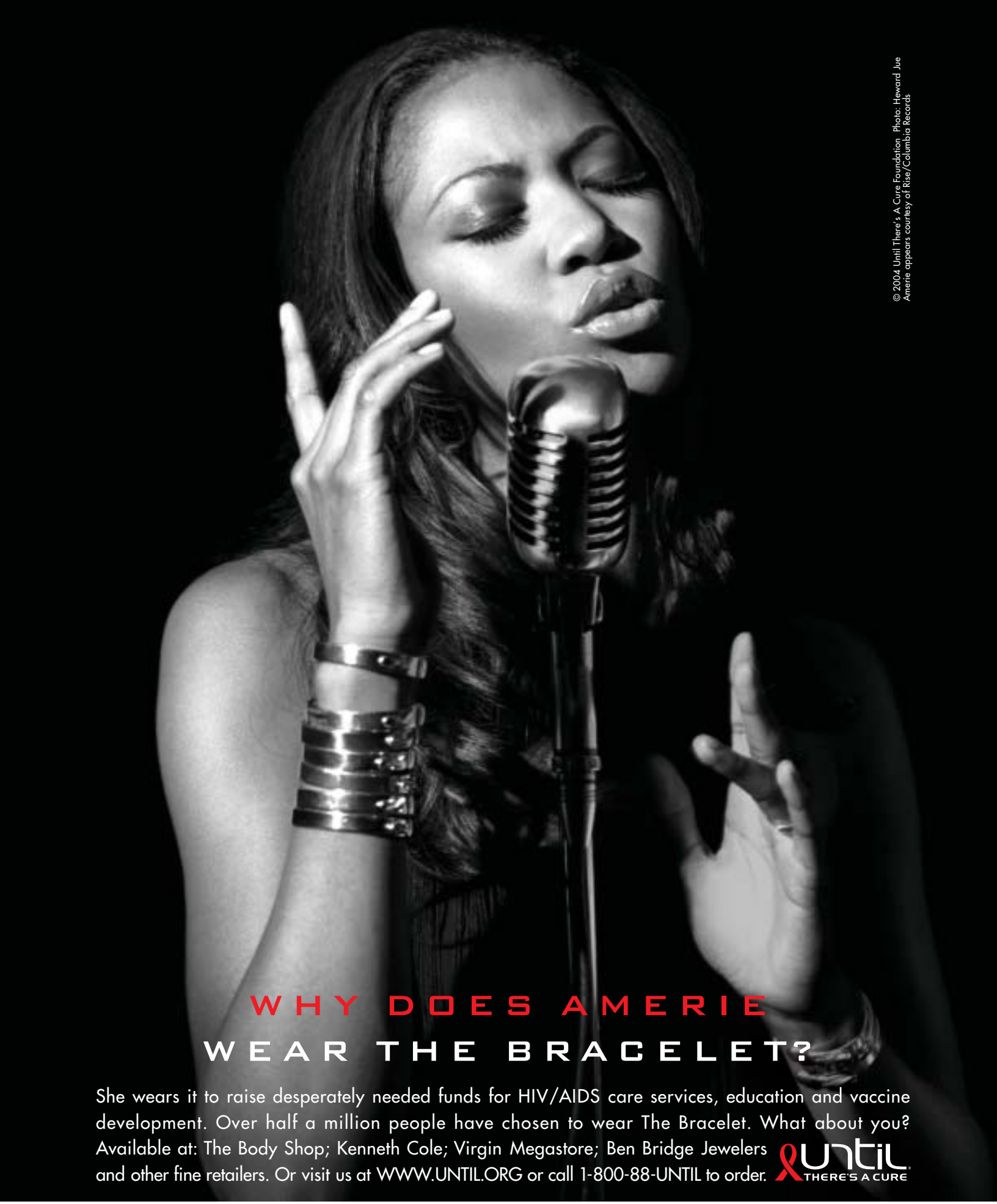
**People were dying because of the delays.**
*Hetherwick Ntabe, Health Minister of Malawi, in a July 8, 2005,* Financial Times *article discussing the reasons Malawi may begin producing its own antiretroviral drugs (ARVs). Malawi began distributing antiretroviral drugs free of charge to its citizens in 2004, through a program supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria. Most of the drugs were manufactured by two Indian companies, which have been affected by tighter patent legislation in India, and one of which has de-registered its ARVs due to questions from the WHO regarding its procedures. Malawi was not able to re-order the drugs for up to three months, and is now considering alternative methods of providing the drugs to its citizens.*

**The process of a compulsory license is still ongoing and breaking the patent has not been discarded as a final alternative.**
*José Saraiva Felipe, Health Minister of Brazil, in a July 14, 2005, Associated Press report discussing Brazil's options in providing Kaletra, a fixed-dose combination antiretroviral drug containing the protease inhibitors lopinavir and ritonavir, to its citizens. Though the government had announced an agreement with the drug's maker, Abbott Laboratories, less than a week earlier, when Felipe began his term as Health Minister the same day, he found that nothing had as yet been signed. The agreement announced by the government would reduce the price of Kaletra from US$1.17 per pill to US$0.99 per pill (with a further reduction to US$0.72 by 2010), which was far short of the government's goal of US$0.68 per pill. Felipe is continuing negotiations with Abbott Laboratories, and has stated that all legal methods of obtaining the drug at an affordable price will be considered.*

**In the project, what was very interesting was that transgender and [gay and bisexual] male recruiters had smaller networks—about two to three people, on average—but we have found they were very good at identifying those in their social networks who had undiagnosed HIV.**
*Lisa Kimbrough of the US Centers for Disease Control and Prevention (CDC), speaking in a July 8, 2005, article in the* Washington Blade *about the social network project for the CDC she directed in which HIV-positive and at-risk HIV-negative people were trained to encourage their peers to be tested for HIV. The two-year project aimed to reach at-risk populations that may not be receiving other messages regarding the benefits of testing, counseling, and referral. People who were tested as a result of the program were found to be five times more likely to test positive for HIV than patients who presented at more traditional settings. In the first year of the project, 814 people were convinced by 133 recruiters to be tested for HIV; 46 people (6%) tested positive.*

**It's a human tragedy that so many people are still not heeding the safer sex message. People need to realize that HIV is not exclusive to gay men or to people who live in sub-Saharan Africa. It is a threat to anyone who indulges in risky sexual behavior.**
*Qutub Syed, Director of Health Protection Agency North West in the United Kingdom, in July 14, 2005, article in the* Manchester Evening News, *responding to statistics showing that the number of HIV cases in greater Manchester in Northwest England increased by 96% from 2001 to 2004. The greatest number of new cases was among heterosexuals; three quarters of those cases were diagnosed in people who acquired the virus outside of England, for instance in tourists or businessmen who engaged in casual sex in other countries. The city also recorded its greatest one-year increase; from 2003 to 2004 the number of HIV cases rose by 22%. Other groups adding to the increased total of HIV cases included migrant workers, asylum seekers, foreign students, or temporary visitors who are not citizens of the United Kingdom.*

**We can get you the medicine you need and do the same for other countries in Africa, but the most important barrier to scaling up the treatment of ARV [antiretroviral drugs] is the lack of well-trained people in every country.**
*Former US President Bill Clinton, addressing an audience in Tanzania, as reported in a July 20, 2005, Reuters report. Clinton spoke at the launch of a program that aims to train 30 health care workers every year to practice in rural Africa. "If it is going to save people's lives, the medicine must be accompanied by instructions, monitoring, by follow-up, and changing the medicine if necessary," Clinton commented. Africa has the lowest proportion of physicians to patients in the world, averaging 12.5 doctors per 100,000 people in sub-Saharan Africa, and the highest prevalence of diseases such as HIV, malaria, and tuberculosis. The William J. Clinton Foundation will spend approximately US$10 million on programs for HIV-infected children, mainly in rural Africa.*

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