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News Coverage

HIV/AIDS: 20 Years and Counting

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[NYU Physician](#)

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Twenty years ago, baffling symptoms of what would prove to be a deadly new syndrome began to appear in urban America, largely among young gay men. At first, only a handful of people in health care and government took notice. But before long this mysterious malady would have a name: Acquired Immune Deficiency Syndrome (AIDS).

By the end of the 1980's, it would turn out to be one of the worst health epidemics in history—a scourge that would fundamentally alter the social, sexual, scientific, and political landscapes of not only America, but the entire world.

For infectious disease specialists of the day, the emergence of AIDS was a rude awakening. After all, polio was a distant memory, smallpox had just been vanquished, and tuberculosis was on the wane. With continued progress in the development of antibiotics, antivirals, and vaccines, there was every reason to expect that diseases ranging from malaria to the common cold would soon be tamed, if not conquered.

But then scientists found themselves facing an alarming trend. Formerly defeated foes like TB began to resurface, while others that were once easily treatable, such as pneumonia, grew ever more resistant to antibiotics. Most ominously, new diseases— notably AIDS and Lyme disease— seemed to emerge overnight, offering a sobering reminder that nature still holds the upper hand.

To be sure, medicine has made significant progress in the battle against AIDS. The swift discovery of its cause and its means of transmission, as well as the development of therapies to fight opportunistic infections and the virus itself, have been nothing short of remarkable. But with an estimated 40 million infected people worldwide, the epidemic is far from over. AIDS remains a monumental challenge for this generation of physicians and researchers and likely the next.

To commemorate the somber occasion of the 20th anniversary of the first diagnosed case of HIV/AIDS, the editors of NYU Physician present perspectives from two infectious disease specialists affiliated with the School of Medicine. Appropriately, they represent two different generations— the one that pioneered the research and treatment of AIDS, and the one that will carry this mission well into the 21st century. Jeffrey B. Greene, M.D., was among the first doctors in the U.S. to treat a patient with AIDS, an experience that has shaped his entire medical career. His colleague, Sibtain Rahim, M.D., is a member of the first generation of medical professionals to come of age during the era of this tragic epidemic.

In The Beginning

Dr. Greene, Clinical Professor of Medicine, will never forget this first patient with AIDS. The place: Bellevue Hospital. The time: late 1980. "It was a totally mesmerizing but confusing case," says Dr. Greene, who had just begun a fellowship in infectious diseases. "The patient

had three concurrent opportunistic diseases and Kaposi's sarcoma. I had never seen any one of these diseases, let alone all four, in one patient. My mentors were also perplexed.

The patient died, leaving few clues as to the origin of his ailments, only that he was gay and had used recreational drugs. Over the next few months, Bellevue's infectious disease specialists would encounter three similar cases. "That was shocking," says Dr. Greene. "At that point, we called the Centers for Disease Control (CDC) and asked them to investigate. They basically pooh-poohed us." This was the first the agency had heard of the new syndrome. "We recognized something strange was going on," Dr. Green recalls, "but it was not clear how widespread this epidemic was going to be."

A chilling realization came to light in early 1981 at the monthly rounds of infectious disease groups from the city's public hospitals. As usual, the doctors were showcasing difficult, confounding cases in the hope of challenging their colleagues and gaining insights. "Someone presented the case of a man with pneumocystis [a rare form of pneumonia now recognized as a common complication of AIDS]," recalls Dr. Greene. "I stood up and said 'We've seen five cases,' and then someone from St. Vincent's said, 'We've seen two.' All sudden, the whole room was abuzz." Soon, the whole world would be, too.

The trajectory of Dr. Green's career was now set. In the months that followed, he would co-author some of the seminal papers on HIV/AIDS and open a private practice, increasingly devoted to people with HIV. "It was very difficult," he says of those first years in practice. "At the beginning, when I didn't have any medicinal tools, I still felt I was doing something positive. I was enabling people to live fruitfully in the time they had left, and I was helping them deal with the final stages of the disease. It showed me a part of medicine that I had intended to explore, and it is something I would not give up now."

"It was a life-changing experience to be on the front lines," adds Dr. Greene. "I felt I was in a trench with my fellow soldiers dying all around me, and the only thing I could give them was a morphine pack and a shoulder to cry on. That changed relatively soon. Even before AZT came out in 1986, we became very good at preventing and managing opportunistic infections, adding as much as a year or two to people's lives." (Up until that time, the average AIDS patient died seven months after diagnosis.)

Still, scores of his patients were dying. "I never really stopped to think about the impact it was having on me," says Dr. Greene. "Once, I had an almost religious experience. When I was moving into my current office, I began cleaning an old storage room, getting rid of charts that were more than seven years old. It was a hot, dank, dusty room with no windows. As I started to look at the charts, I realized I was looking at 500 or so dead people. I had all these images of people whom I had erased from my memory. I felt like I was raiding a tomb, that I was disturbing the dead. That's the only time I felt overwhelmed by the tragedy this disease has wrought."

Dr. Green's contributions to the AIDS community have extended well beyond his role as a clinician. Early in the course of the epidemic he noticed that patients who had lost their jobs seemed to give up hope and swiftly succumbed to the disease. Work, he came to realize, was as vital a therapy as any other. Thus, in 1986, with the late Linda Laubenstein, M.D., then a faculty member at the School, Dr. Greene established Mobilizing Talents and Skills (MTS), a job-training and placement program for people with HIV. MTS now operates under the umbrella of Village Care of New York.

More recently, Dr. Greene assumed the directorship of the AIDS Healthcare Foundation, a national organization dedicated to bringing specialized care to people with HIV, regardless of their ability to pay. "I'm feeling an activism welling up in me," he explains. "I will continue to see private patients, but I feel I can do a lot more by propagating this foundation's care rather than by working one-on-one."

Although Dr. Green is encouraged by the decline in new cases of HIV among certain groups, he fears that the epidemic will get worse before it gets better. "A sense of complacency is

returning in the HIV at-risk population," he says. "I guess part of it is the mindset that there are these wonderful treatments and the disease must be controllable or preventable. It is real tragedy."

Equally tragic, he believes, is the country's myopic view of the epidemic. "We all live in or community," says Dr. Greene. "To ignore what is going on in culturally or sexually diverse communities in New York and other urban centers, or what is going on in Africa, is just fooling ourselves."

The Next Generation

By the time Sibtain Rahim, M.D., a Fellow in infectious disease at NYU, came of age, AIDS had already begun to spread around the world. The initial hysteria had subsided, and as medications like AZT came to market, hope had started to grow. "AIDS has always been accepted part of my generation's life," he says. "It is something we have to live with, something we have to be careful about."

Dr. Rahim brings an unusual perspective. Born to parents of Indian ancestry, he is a native Kenya. "It was a very different disease in Africa," he says. "While the United States was dealing with AIDS as a disease predominantly of gay people and IV drug users, in Africa crossed all lines of sexual orientation, race, and social status. The rhetoric coming from religious groups, government, and the medical establishment in the U.S., who treated people with HIV as social pariahs, wasn't comprehensible to people in other parts of the world."

"It is interesting," he adds, "that even up to this day many physicians in the U.S. have difficulty grappling with issues around HIV. They still think of risk factors in very archaic terms- being gay or an IV drug user. Most people have shifted from that paradigm to talk more about the sexual practices themselves, so that a risk factor is not being a part of so kind of group but the actual practice- for example, having unprotected sex or using dirty needles. The problem with identifying risk groups is that it makes other people outside the groups feel invincible."

According to Dr. Rahim, Kenya's program for responding to the AIDS epidemic was impressive, though far from perfect. "Kenya, at least initially, was one of the countries that the numbers," he explains. "But there was always public education about HIV, and I am thankful for that. It was certainly one of the first African countries to face the issue head-

Dr. Rahim left Kenya to attend college in the United States. He then enrolled at McGill University in Canada to study medicine. From the beginning, he knew he would become AIDS specialist. He made that decision after he read 'And the Band Played On', Randy Shilts's critically acclaimed expose about the mishandling of the epidemic. "It was a very touching book," he recalls. "It elicited a lot of anger toward institutions that were put in place to help people, but failed, at least with respect to AIDS. It is a shame that groups such as Gay Men's Health Crisis had to mobilize their communities and raise money to get care for people who were ill and dying- which is what the government and the medical establishment should have done."

Dr. Rahim chose NYU for his residency not only because he wanted to be in New York City but because he wanted to be at Bellevue Hospital. "I wanted to be in a big public hospital have a significant degree of responsibility and independence in managing my patients," he says. "And Bellevue has a big population of HIV-infected patients."

He is a now second-year fellow in infectious diseases at NYU, dividing his time between clinical care and research. In the coming months he will be working in the laboratory of M. J. Blaser, M.D., the Frederick H. King Professor of Internal Medicine. His work will focus on characterizing the skin flora of people (both those who are healthy and those with various dermatological diseases), using a new technique called 16S rDNA fingerprinting. "I would ultimately like to see if this technique can be used to identify opportunistic infections in patients with AIDS," he says, "particularly those with fevers of unknown origin."

Dr. Rahim's experience at Bellevue has served to strengthen his resolve to help people with HIV, particularly those who have difficulty gaining access to care. "My ideal job," he explains, "would be to do a little bit of everything- clinical care, research, and teaching."

As for the future of HIV/AIDS, Dr. Rahim is both optimistic and pessimistic. "On the one hand," he notes, "we now have medications we can offer our patients. We feel we can be physicians again. On the other hand, it feels more and more that HIV/AIDS is here to stay. There is no cure in sight. The new medications, while beneficial, don't work for everyone, in many individuals lose their effectiveness over time."

Like Dr. Greene, Dr. Rahim is also troubled by the rise in the rate of new infections among certain populations. "Either people are tired of caring or being careful about HIV or about education. There needs to be a renaissance in HIV/AIDS education, and physicians need to be involved, not just community groups, because people look to us as role models," he says.

Dr. Rahim remains critical of the same institutions that were slow to respond to AIDS at the beginning of the crisis. "It is a huge pandemic," he says, "and it saddens me the way they are dealing with HIV/AIDS around the world. This has profound implications for HIV and other diseases."



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