

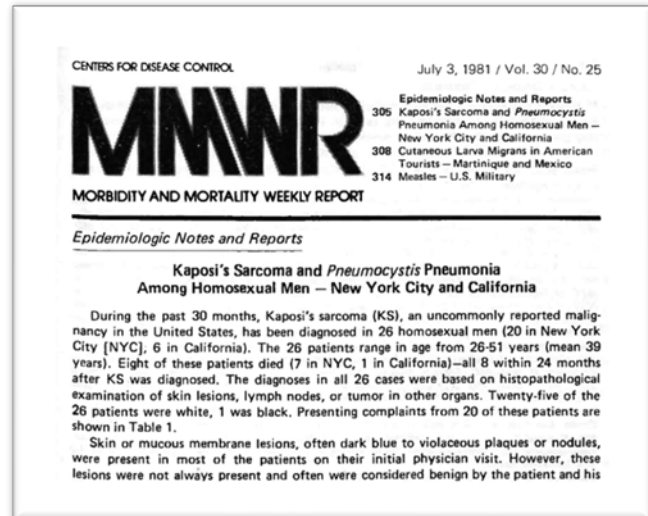
Physician Assistant Involvement with the AIDS Epidemic, 1980s-1990s

by Reginald Carter, PhD, PA

R. Peter Nyquist, a physicians' [sic] assistant and administrator of the AIDS Team at Bronx Municipal Hospital Center, died of complications of AIDS on Jan. 9 [1990] at Montefiore Medical Center in the Bronx. He was 31 years old and lived in Manhattan. Before becoming administrator of the AIDS Team three and a half years ago, Mr. Nyquist coordinated AIDS programs at the central office of the New York City Health and Hospitals Corporation. He was a 1980 graduate of Harvard University and a 1985 graduate of Duke University. - [Obituary] New York Times, 17 Jan 1990.¹

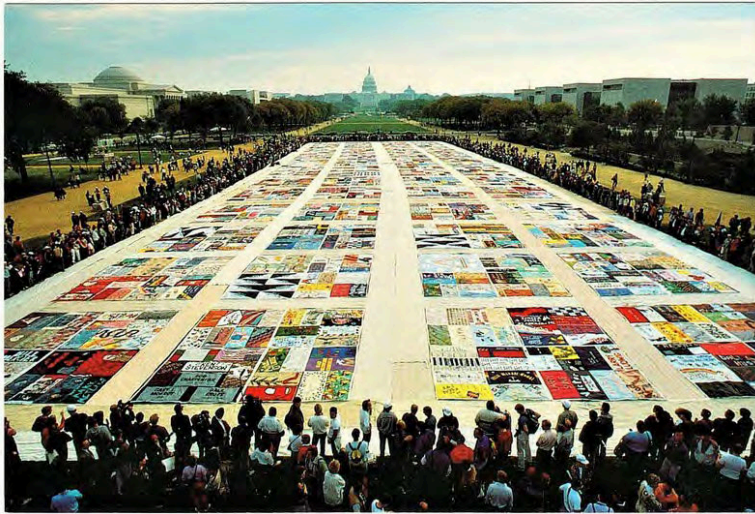
Introduction: Peter Nyquist personified the commitment, sacrifice, and collective and individual struggles of physician assistants (PAs) to combat the acquired immunodeficiency syndrome/human immunodeficiency virus (AIDS/HIV) epidemic during the 1980s and 1990s. The AAPA LGBT Caucus was formed in part to sensitize and provide AAPA members with continuing medical education (CME) resources to improve healthcare for LGBTQ+ patients and patients suffering from HIV/AIDS. This article provides a brief overview of the social and political impact of the HIV/AIDS epidemic in the USA during the 1980s and 1990s and the founding of the AAPA LGBT PA Caucus and its role in educating PAs to the needs of infected HIV patients. It also provides a historic perspective of PAs who were involved in the battle against HIV/AIDS during the early years of the pandemic and PAs who continue to serve the LGBTQ+ community, especially HIV-infected patients.

HIV/AIDS Epidemic Emergence in USA: According to an article that appeared in the *New York Times* on July 3, 1981, something unusual was happening in the gay male community that was of concern to two doctors, one located in New York and the other in California. They had diagnosed among gay men 41 cases of a rare and often rapidly fatal form of cancer (Kaposi's sarcoma) with eight of the victims dying in less than 24 months of diagnoses. Dr. James Curran said there was no apparent danger to "non-homosexuals" since no cases had been reported to date outside the gay male community or in gay women. Dr. Friedman-Kien tested nine of the victims and found severe defects in their immunological systems. The patients had defects in T and B cell lymphocytes, which played important roles in fighting infections and cancer. He was not sure if this was the underlying problem or secondary to previous infections or drug use.² That same day the Centers for Disease Control (CDC) released a report given statistical and demographic details of the growing numbers of cases of Kaposi's sarcoma and pneumocystis among gay men. The report noted that physicians "should be alert for Kaposi's sarcoma, pneumocystis pneumonia, and other opportunistic infections associated with immunosuppression in homosexual men."³ It was discovered in 1983 by doctors from the Montefiore



Hospital and the Albert Einstein College of Medicine in Bronx, NY, that HIV/AIDS could affect both sexes and could also be spread through heterosexual activity and intravenous drug use.⁴

According to a 1986 report published by the National Academy of Sciences (NAS), Institute of Medicine (IOM) the increasing need of patients with AIDS and other associated HIV conditions posed a complicated public health and ethical challenge for the USA. The two billion dollars being proposed to study and educate citizens about AIDS represented only a small fraction of the billions of dollars that the epidemic would cost in care of infected patients. The report noted that “The optimal organization of care has only begun in a few cities ... but some evidence is emerging to support community-oriented and minimal hospitalization. The provision of such care should be designed to guarantee equity of access...”⁵ With 40,000 dead from AIDS and the epidemic spreading across the country, US President Ronald Reagan appointed a Commission on the Human Immunodeficiency Virus Epidemic in the summer of 1987; later renamed the Watkins Commission, after its chair. Several of the members on the commission were openly hostile to the LGBTQ+ community believing that it was “purely a result of [their] immoral behavior.” The



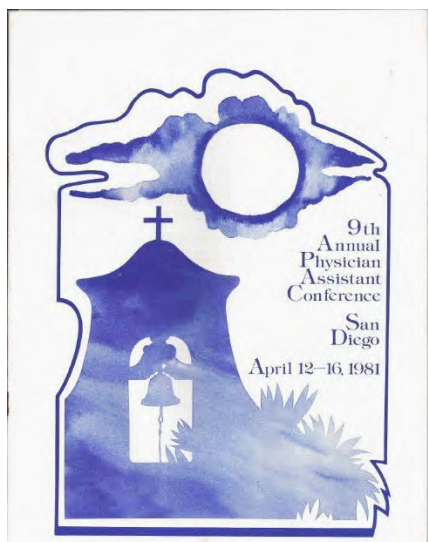
homophobia vocalized by religious and political leaders and the federal government’s inactivity spurred AIDS activists to create the AIDS Coalition to Unleash Power (ACT UP) in 1987.⁶ During the National March on Washington, DC for Lesbian and Gay Rights held on October 11, 1987, the AIDS Memorial Quilt was displayed for the first time on the National Mall. It was larger than a football field and included 1,920 panels. As sections of the Quilt were unfolded, volunteers read aloud the 1,920 names of the people represented in the Quilt. It is estimated that half a million people visited the Quilt that weekend.

From 1981 through 1990, 100,777 deaths among persons with AIDS were reported to the CDC with AIDS emerging as a leading cause of death among young adults in the United States. In 1991, the CDC estimated that one million Americans were infected with HIV; of these, an estimated 165,000-215,000 would die during 1991-1993. The impact of HIV/AIDS on mortality in the mid-1990s through the early 2000s would depend on present efforts to prevent and treat HIV infection.⁷

History of the AAPA LBGT PA Caucus’ Advocacy and the AAPA’s HIV/AIDS Policy and Education:

On May 19, 1979, Clover Jacobson, Ron Vachon and PA student Mark Behar, while attending a National Gay Health Conference in New York, were inspired to form a Lesbian & Gay PA group within the AAPA. The goals of the group would be to offer professional and social support to LGBTQ+ PAs and a chance to educate the entire PA profession on health issues affecting the LGBTQ+ community, such as STIs, HIV/AIDS, etc. At the 1980 AAPA annual meeting held in New Orleans, the House of Delegates (HOD) was asked to establish the LGPA organization as a Special Interest Caucus (SIC) within the Academy. The resolution passed the HOD, and 20-25 people attended the first meeting of the LGPA SIC a couple of days later. The following year, at the 1981 AAPA annual conference held in San Diego, CA, the HOD passed a resolution to have the LGPA SIC become a bonified Caucus of the AAPA. Some HOD delegates voiced

“moral” objections, while others tried to get the vote tabled. However, with the support of HOD delegates from New York, New Jersey, Massachusetts, and California, the resolution passed by a vote of 87 to 70. An attempt to abolish the LGPA Caucus the following year failed to gain support and the Caucus’ Exhibit Hall booth, “Heterosexuality: Can It Be Cured?” was well received and helped many PAs rethink their preconceived notions about their LGBTQ+ peers and patients.⁸



At the 1981 AAPA Conference in San Diego, Mark Behar presented the Academy’s first talk on AIDS (“Report on the acquired immunodeficiency syndrome: A New Sexually Transmitted Disease?”). Behar provided another update on AIDS at the 1983 AAPA annual conference held in St. Louis, MO. Although Behar’s presentation was well received, a resolution to have the AAPA educate PAs about AIDS and to support legislation to increase AIDS research funding was tabled indefinitely by the HOD.⁹ A survey of PA programs by the LGPA Caucus in 1984 found that programs were giving more attention to LGBTQ+ sexuality because of the “AIDS era.”⁸ At the 1985 AAPA annual conference held in San Antonio, TX, LGPA members attended the Memorial Day AIDS Candlelight Vigil at the Alamo and sponsored a CME lecture on AIDS by David Lyman, MD. The following year at the AAPA annual conference in Boston, MA, the LGPA Caucus endorsed a HOD resolution supporting Human

T-lymphotropic virus (HTLV) testing with suggested modifications to test all pregnant women exposed to the virus. Another Memorial Day AIDS Candlelight Vigil parade was held in Boston the following year. Throughout the remaining 1980s and early 1990s, the LGPA Caucus continued to provide CME and educational materials to PAs attending AAPA annual conferences. Members of the Caucus helped develop the Academy’s AIDS Policy Paper that was presented and accepted by the House of Delegates in 1989.⁸ The AAPA revised its AIDS Policy Paper in 1990 and 1992 and in 1994 approved an addendum supporting needle/syringe exchange programs as one method of preventing further spread of HIV.¹⁰ The Academy’s HOD policy paper stated that “Physician Assistants are ethically required to be knowledgeable about the risks, problems, pre- and post-test counseling and appropriate treatments associated with caring for HIV-infected patients, regardless of the incidence of HIV infection among their patient population.”¹¹ The Academy encouraged PAs to provide nondiscriminatory care to those suffering from AIDS and AIDS-related conditions; the denial of appropriate care for any reason was unethical. In 1995, the LGPA Caucus was reinstated with the addition of B for “bisexual” to become the LBGPA Caucus (later to become the LBGT PA Caucus with the addition of T for “transgender”).



Epilogue: In 1987, the antiretroviral drug azidothymidine (AZT) helped extend the lives of HIV victims and prevent mother-to-child transmission of the virus if taken during pregnancy. Other combination therapies were offered in the early-to-mid 1990s that were more effective at limiting the amount of the

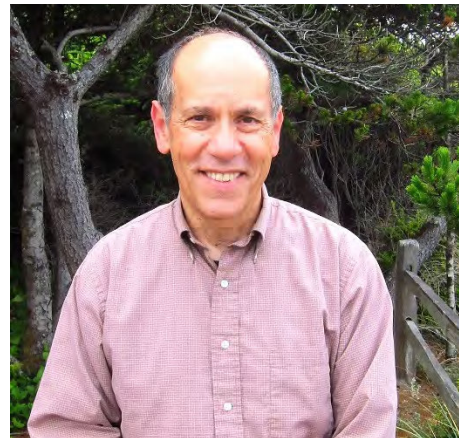
virus in the body, but often had unwanted side effects. In 1996, a new class of antiretrovirals called protease inhibitors were combined with other multiple drugs to create a highly active antiretroviral therapy (HAART) which became the standard of care in the US. The following year, AIDS-related deaths declined by 47%. Testing also continued to improve over the years, with the first oral test approved in 1994, the first at-home testing kit approved in 1996, and the first rapid test approved in 2002.¹²

Like other healthcare providers during the 1980s and 1990s, PAs had to grapple with the issues that were entangled with the HIV/AIDS pandemic, made even more difficult by the lack of scientific and clinical research data needed to provide optimum care to HIV patients and their families. The AAPA LGBT PA Caucus acted as a catalyst to help educate and change the perception of the profession, not only about the treatment of HIV/AIDS, but about the healthcare needs of the LGBTQ+ community in general. There are many stories that remain untold by those who lived through those first two-decades of the HIV/AIDS pandemic and who are still joining in the fight against HIV/AIDS today. Their stories and the lives they touch are an integral part of our professional history; a history that all PAs should embrace and learn from as they face the new challenges that are on the horizon.

Historic Perspectives: PAs and the Battle Against HIV/AIDS

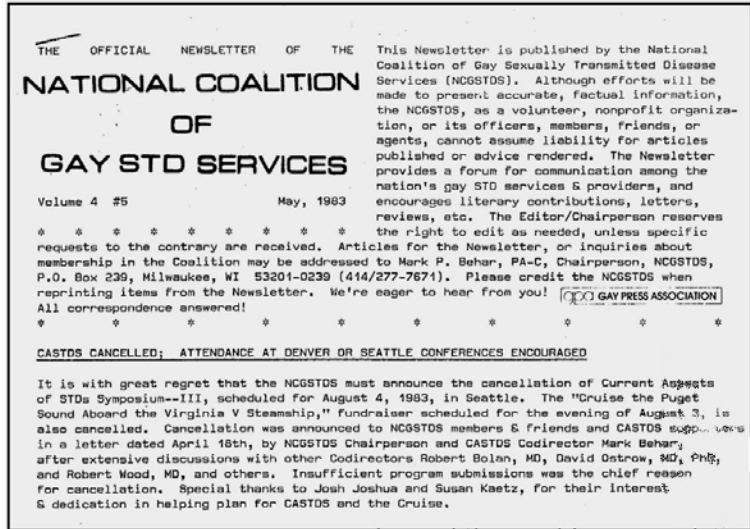
[Eric Schuman, PA¹³](#)

Schuman recalls reading a 1981 Morbidity and Mortality Weekly Report that mentioned that a gay man in San Francisco was diagnosed with Kaposi's sarcoma which was unusual for someone of his age and who had no risk factors for the disease. When it became apparent that this was happening mostly in gay men, Schuman joined a gay physician who also worked in Topeka, Kansas to begin publishing and distributing literature on HIV/AIDS (HTLV-3) and speaking to various gay organizations in their region of Kansas. They also spoke to gay student groups at the University of Kansas and Kansas State University.



Schuman's first AIDS patient was a good friend, Toby, who became ill after a trip to Indonesia in 1985. After Schuman ruled out a tropical disease as cause for the illness, and based on his knowledge about AIDS, he ordered a CD4 count and tested Toby for antigenicity to determine if he was immune compromised. This was before antibody tests for HIV were available. Toby had AIDS. Soon thereafter, a group of clinicians, social workers and activists in the gay community founded the Topeka AIDS Project. The Project provided round-the-clock care for Toby and eventually evolved to provide group support, education, outreach and home care to HIV infected patients. The Topeka AIDS Project became a member of the National AIDS Network founded in the late 1970s. The organization was based in Washington, did a lot of federal lobbying and helped inform state governments, especially health departments, about the spread of AIDS. Because Toby wanted to be forthcoming about his illness and prevent others from becoming infected, he allowed Schuman to interview him for an article that was published in a national circulated church periodical. About this time, Mark Behar was approached by McGraw Hill publishers to write a clinical article about HIV for PAs. Behar talked Schuman into writing a case study based on Toby's illness. The article was published in the winter 1985 issue of the PA Journal. Toby died a few weeks after publication. Meanwhile, Mark Behar published the National

Coalition of Gay STD Services Newsletter that was distributed monthly to STD Clinics throughout the US. The newsletter averaged 20 pages and was thoroughly researched with the latest information on diagnosis and treatment of HIV infected patients. Behar published the newsletter for many years.



Schuman recalls the social stigma and unfounded anxiety that AIDS caused among healthcare workers and the public. He recounts a story that Toby told him while he was rounding at the hospital. Toby had used the call button to request a phone book so he could look up a number. Soon after, an attendant opened his door two inches and said “here is your phone book” leaving it outside the door on the floor in the hallway. The attendant was too afraid to enter the room. Schuman also recalls eating breakfast at a McDonald’s restaurant in the early 1980s when he overheard people at an adjacent table say how despicable AIDS patients were. Angrily, Schuman confronted them saying that his friend was dying of AIDS and that he resented their remarks. In response, they said they might have less disdain for his friend depending on “how he got it.” Schuman believes this was probably the way most Americans felt at that time.

Initially, physicians in Kansas had little interest in AIDS viewing it as a bicoastal problem affecting mostly gay men and drug addicts. However, the Kansas Regional AIDS Conferences held annually at the Topeka VA Medical Center attracted increasing numbers of health workers with well-known speakers from the CDC and prestigious research universities. Notable presenters at the Annual National Lesbian and Gay Health Conferences included James “Jim” Curran, MD, MPH, who led the taskforce on HIV/AIDS for the Center of Disease Control, and Anthony “Tony” Fauci, MD, who at the time was the director of the National Institute of Allergy and Infectious Diseases.

[Karen Newell, MMSc, PA-C, DFAAPA¹⁴](#)



Newell’s first experience with an HIV positive patient occurred while a student in the Emory University PA Program. It was her second clinical rotation. The patient was admitted to the Atlanta Veteran Administration Hospital and was going blind and had other health-related complications. She remembers this patient well because she performed her first supervised lumbar puncture on him. Because he was HIV positive, she realized that it was important not to get a finger stick from the needle being used for the procedure. The patient underwent a series of operations but eventually died. AZT was the only treatment at the time and the high dosages made patients ill from side effects. Grady Hospital opened an infectious disease clinic in a small room which

eventually grew to become its own large complex. It was frustrating dealing with patients who came to be tested for HIV infections but did not want to use their own names or insurance because they were afraid others would find out. The stigma attached to HIV/AIDS prohibited many patients from getting timely and appropriate healthcare. Newell believes that given all the negatives associated with the HIV/AIDS epidemic, one positive thing did occur. As testing and treatment plans improved, patients became more involved in the decision-making process, becoming active participants in their own healthcare. This has become a standard practice in healthcare today.

When Newell attended her first AAPA LBG PA caucus, it was mostly for social contact. This was before the Caucus had much political clout. She recalls that the Caucus had two lists of members, those that were “out” and those that were not. These lists were used for communication via postal mailings and phone calls based upon the individual’s openness about their sexual orientation. She did not tell her faculty colleagues at Emory about being gay until 1998, not sure of how they would react. They told her that it did not matter, she was “a member of the family and was safe.” Eventually, she became a role model and mentor for LGBTQ+ students at Emory.

Blaine Paxton Hall BS, MHS-CL, PA-C Emeritus, DFAAPA¹⁵

Hall’s first experience with HIV/AIDs was a co-worker at Central Piedmont College, Charlotte, NC. This was during the early days of the epidemic and prior to Hall becoming a PA. His co-worker developed the typical Kaposi’s purplish lesions on the backs of his hands and became sick and wasted away. After PA school, Hall’s first job was with the Buncombe County Public Health Department where he saw many patients with AIDS in the adult HIV/AIDS, STI and OBGYN clinics. Later, when he worked in nephrology, his role was to provide emergency dialysis for patients in acute or chronic end-stage renal failure. One of his tasks was to insert femoral venous catheters into patients, not only in the dialysis unit but in other Intensive Care Units within the hospital. He stuck himself twice, both patients were HIV positive and in the Medical Intensive Care Unit (MICU); one also had hepatitis C. Both patients died in the MICU from their advanced diseases. Hall had to take the post-exposure prophylaxis treatment which consisted of taking three pills several times a day, for four to six weeks. The medication made him exceedingly nauseated, but he continued to work. Blood work was done routinely throughout the course of treatment including a one year follow up for hepatitis C. Understandably, Hall was anxious throughout the entire testing period, though in the end he would ultimately test negative both times.



When Hall graduated PA school in 1991, the death toll from AIDS was still on the rise, peaking in 1995 and gradually decreasing over time. Patients had to take many pills throughout the day and experienced toxicity side effects and drug resistance. Hall recalls that about 25 medications were used to treat AIDS before developing today’s modern approach. Patients now take 1-2 pills a day. Antiretrovirals are given upon diagnosis and especially if diagnosed early, their life expectancy is about the same as the non-HIV infected population.

[Peter I. Bergé, JD, MPA, PA-C Emeritus¹⁶](#)



In 1985, Bergé decided to collect information and teach himself about the emerging AIDS problem. As the newly appointed senior PA of student health services at the University of California-Santa Cruz, Bergé realized that the academic community was unaware of AIDS risk-factors. So, he started the first HIV/AIDS Education Program for students, staff and faculty. He later began providing CME lectures on AIDS for the health center’s medical staff. Being located near San Francisco, an epicenter of the epidemic, information was being collected and reported routinely about AIDS. Concurrently, fellow PA Mark Behar began compiling and sending additional information about AIDS to PA colleagues and other providers. In 1985, the first antibody test was licensed, and the term HIV was introduced into the vocabulary.

Bergé left California for New York City in August 1987 to work specifically in an AIDS clinic. The clinic was at the Kings County Hospital Center which was in a medically underserved section of the city. The clinic provided fulltime HIV/AIDS care. Because of the strain, Bergé lasted there for only 10 months. AZT (zidovudine) was the only antiretroviral treatment - which in Bergé words, “really didn’t work”. Patients were diagnosed primarily by having a major opportunistic infection. Most patients had advanced medical problems and suffered even more from the adverse effects of the AZT treatments. Bergé burned out quickly emotionally and took a position at the New York Blood Center where he notified and counseled patients who had tested HIV positive. He became involved in epidemiological research to determine who was at most risk for infection, and why they donated blood knowing their risks. He also participated in programs notifying donors of exposure to hepatitis C and human T-lymphotropic virus type I/II (HTLV-1/2). Given his knowledge and background, Bergé wrote a book chapter on the psychosocial implications of HIV antibody testing and counselling.

After a year of epidemiological research, Bergé began working with Dr. Donna Mildvan, a infectious-disease specialist and pioneer in HIV/AIDS research in New York, performing clinical trials on HIV infected patients. During the seven years he was there, he also provided primary care to patients enrolled in the clinical trial studies, helping them get needed services such as blood transfusions. From 1989 to 1996, most of the clinical trials involved the use of the original nucleoside reverse transcriptase inhibitors such as ddi (didanosine), ddC (zalcitabine), d4T (stavudine), and 3TC (lamivudine) as monotherapy; they didn’t work. Most of the patients died. This was a “very difficult time to work in HIV clinics”. The worst part was when patients started to slide and their CD4 count became less than 100 making them vulnerable to catastrophic opportunistic diseases and a wasting syndrome. Bergé described this advent “as when the glue began coming undone” for the patients and treatment no longer worked since there was no immune system left – very difficult times indeed. From 1994 to 1995, clinical trials began evaluating the effectiveness of “triple cocktails” using nucleoside reverse transcriptase inhibitors (RTIs) such as ddi (didanosine), ddC (zalcitabine), d4T (stavudine), 3TC (lamivudine), and non-nucleoside RTIs such as nevirapine (Viramune) and efavirenz



(Sustiva) with protease inhibitors, the last “ingredient”. The FDA approved the first one, Invirase (saquinavir), in late 1995.

Bergé remembers a clinical trials patient that he had developed a close working relationship with for over a year. The patient’s CD4 count fell below 50 and he was blind in one eye due to CMV retinitis, but otherwise healthy. According to Bergé, “He was essentially a ticking timebomb. He had never seen a CD4 count returned after being that low and it would not be long until some deadly opportunistic condition would take hold. Bergé recalls starting him on the first triple cocktail trials and his CD4 count rose dramatically to over 200. The patient was out of danger of developing a lethal condition. The ability to negate the effects of HIV, changed Bergé’s life as a clinician. With the incredible advances in HIV/AIDS treatment over the past 25 years, fewer clinicians now specialize in HIV as treatment now takes place in other clinical settings. Dosages have been reduced to one pill daily and new IM injections can be administered once a month or every two months. Today there are fewer side effects and less drug resistance to the medications used to treat HIV.

Mark P. Behar, PA-C¹²

In 1974, Behar helped create a local STI clinic in Milwaukee known as the Gay People’s Union VD Testing Clinic, which later evolved into the Brady East STD Clinic. Since there were other similar clinics in Milwaukee, Behar convinced these clinics to collaborate and share information to help improve healthcare to all their constituents. Working as an EMT provided him free time to explore other avenues for gathering information about STIs. Medical friends told him about the American Public Health Association’s taskforce comprised of gay and lesbian healthcare workers. Behar attended meetings of the taskforce where he

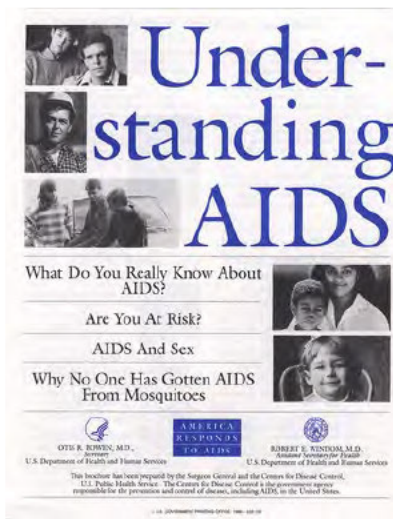
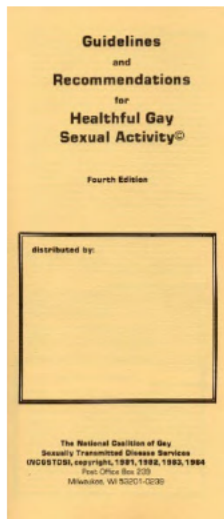


met nurses, social workers, physicians, and two physician assistants: Ron Vachon and Clover Jacobson. It was at one of these meetings that Jacobson, Vachon and Behar formulated a plan to establish the AAPA’s LBG Caucus.

In 1979, healthcare workers in STI clinics decided to improve communications between each other by creating a group called the National Coalition of Gay STD Services. The Coalition would share information through a regularly published newsletter about a variety of topics, such as risk factors, treatment modalities, funding, and political issues. Behar became chair of the Coalition and editor of the newsletter, which was published from 1979 to 1988.

Early on, there were discussions within the Coalition about the heightened risk of gay men contracting an unknown type of sexually transmitted disease. In 1981, the premonition became reality when the first cases of gay related immunodeficiencies (GRID) were reported. (GRID would later become known as AIDS.) Some speculated that the underlying cause of GRID was an infection while others thought it could be environmental or caused by sexual enhancement drugs, such as “nitrite poppers.” The Coalition believed the best way to prevent the transmission of STIs, including GRID, was to develop a risk

assessment tool that could predict an individual's chances of acquiring a STI. The risk assessment tool was field tested, modified and went through four renditions. STI clinics began using the risk reduction guidelines almost immediately. The guidelines were cited in an informational brochure titled



“Understanding AIDS” prepared for C. Everett Koop, Surgeon General of the United States, and sent to every American household in 1988. According to Behar, the guidelines were good, but not based on “evidenced-based medicine.” The reason for the lack of research was political. The federal government forbade the CDC or other federal grantees from studying “gay activities.” This was openly discriminatory. So, the Guidelines had to depend on the best expert advice available.

Behar attended his first AAPA annual meeting in 1982, where he submitted a paper on HIV (HTLV-3) to present which was accepted. He expected a small attendance but over 1,000 PAs came to the presentation - the first HIV/AIDS lecture delivered at an AAPA annual meeting. Behar provided an overview that was not overly clinical but more of a “heads up.” He did this for several years until others who had more clinical experience treating HIV/AIDS began speaking at the annual meetings.

As more of the LGBT Caucus’ members became involved in providing direct patient care in HIV/AIDS clinics, clinical information became more readily available. The Caucus played a vital role in distributing this first-hand information to Caucus members and fellow PA colleagues. The LGBT Caucus continues to play an important role in sensitizing PAs to the issues and inequities of healthcare in the LGBTQ+ community.

[Kirsten Gipson, PA-C, DFAAPA¹⁸](#)

Prior to becoming a PA, Gipson worked in the Veterans Administration Hospital (VAH) in San Francisco. She recalls several of her coworkers contracting HIV and dying quickly. She does not recall HIV infected patients being treated badly nor being stigmatized against, as was the case in other cities. Her contact with PAs at the VAH motivated her to enroll and graduate from the Emory University PA Program in 1989. In 1990, she moved from Atlanta, GA, back to California to complete a postgraduate emergency medicine residency at the Los Angeles (LA) County Hospital. During her one-year residency in LA, she did not encounter any prejudice against gay HIV infected patients.



In 1990, Gipson returned to the east coast to work in an emergency room (ER) in Washington, DC. She spent five years there. The ER she worked in was located near one of the Washington DC airports. She remembers passengers coming to the 1993 LGBT March on Washington from Europe and the west coast who became sick on their flights. When they showed up at the ER, some nurses were afraid to touch them. Unless dealing with body fluids, Gipson knew these patients were not contagious and, to set an example, did not wear gloves when examining potentially HIV infected patients. She remembers how

elated she was when President Bill Clinton mentioned the word “AIDS” in his 1993 inaugural address. His predecessor, George H. W. Bush, never mentioned HIV or AIDS the entire time he was in office. “Politicians never said the ‘A’ word, only the CDC or Public Health Service”, she remarks. (Note: President Bill Clinton convened the first White House Conference on HIV and AIDS on December 6, 1995.)

Postscript: In addition to the above PAs, there are others who had similar experiences combating the HIV/AIDS epidemic during the late 1980s through the mid-1990s. [F. J. Gino Gianola, MA, PA, DFAAPA](#), was the first PA to work at the National Cancer Institute in Bethesda, MD. He recalls the medical staff’s first encounter with a young male patient with Kaposi’s sarcoma who was also immune deficient. Consequently, he began working with Dr. Anthony Fauci, who at the time was director of the National Institute of Allergies and Infectious Diseases, to find out if a virus was involved. [Grace Landel, MEd, PA-C, DFAAPA](#), worked for a year in HIV intervention project at the King County Public Health Department in Seattle, Washington. [Jamilah Ali Alexander, PA-C, MPH](#), worked in a clinic providing healthcare to homeless individuals, many of whom had HIV/AIDS. [Heidi Miller, PA-C](#), was first exposed to HIV/AIDS patients when she did a one-year postgraduate residency in emergency medicine at the LA County Hospital. If you are a PA and have first-hand experience working with HIV/AIDS patients, please [contact us](#) if you would like to share your personal story.

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Useful Resource Links:

[The AIDS Epidemic: 1981-1987 \(nytimes.com\)](#)

[Confronting AIDS: Directions for Public Health, Health Care, and Research - ProQuest](#)

[World AIDS Day: Remembering what Reagan AIDS Commission member Richard DeVos had to say about AIDS and the Gay Community | Grand Rapids Institute for Information Democracy \(griid.org\)](#)

[1987 AIDS Quilt the Names Project on National Mall | Etsy UK](#) and [Aids Project Quilt Washington DC 1987 Postcard | eBay](#)