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Responding to the Patient With AIDS
Alan Gregg Lecture
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It had been three days since I had last spoken on AIDS to a public audience.

This was the Alan Gregg Lecture, an annual affair of the Association of American Medical Colleges. Dr. Gregg was prominent in medical education and especially the work of the association and it was an honor to be able to recall his memory at the time of the delivery of this lecture.

I acknowledged the honor afforded me in the 30th year that the Gregg Lecture has been part of the annual meeting and noted that I had shared the stage with two good friends Dr. Petersdorf and Dr. Fauci. I also thanked the association for their special effort over the past year in the development and publication of the "Policy Guidelines" in reference to AIDS

My hat was tipped to another personal friend and colleague, Dr. Jay Sanford, the President and Dean of the Uniformed Services University of the Health Sciences, who chaired the committee of this association on AIDS. I included a fellow pediatrician and colleague from my days at the University of Pennsylvania and Children's Hospital of Philadelphia, Dr. Festus Adebonojo of Meharry Medical College, who was responsible for the specific wording of the report.

The major thrust of this presentation – although the wording is different – is that made on 10/20/88, and 11/10/88 in reference to working with persons with AIDS. This group was the cream of academic medicine and I did not have to be as detailed about some of the things I talked about to the previous two audiences, many of whom, although health related, were not physicians.

To this audience, I added some things I had not said in the two previous lectures with the same general thrust, and I presented them in answer to a question, "What, then, is left to be done?" I focused on something I called, the "professional will to respond". Our leaders and our professional journals have been scrupulous about guaranteeing prominent coverage of all the issues. At the level of the individual physician, however, we must ask if he or she was demonstrating the professional will to respond to the challenges, as they had been spelled out. I noted that we needed to support that individual physician, whether he or she was in graduate or post-graduate training or already in practice and provide that person with specific guidance for

his or her personal and professional behavior. I referred them back to their own report, especially appendix A, which suggested that our colleagues, "address and cope with their fears and prejudices in treating HIV-infected patients."

The practitioner -- at the local level – has to devise the appropriate, specific answer that both works in that practice environment and that also fits with the practitioner's own sense of what is at stake...morally, ethically, personally, and professionally.

As usual, I expressed my fear that we were seeing presidential commissions and state courts trading theories and opinions, but asked if we were seeing physicians relegated to a sideline role as these important matters were debated and adjudicated elsewhere in our society. I counted it as not a good sign, which in this case, the confidential nature of the physician/patient relationship was left to the electorate to decide. To this group, it seemed appropriate to suggest that this meant that the public was frustrated by a perceived lack of leadership – real or imagined – on the part of the medical profession.

I repeated my often-expressed belief that the great majority of our colleagues were indeed providing quality, compassionate care to persons with AIDS and that where there had been some instances of patients being turned away, they were clearly exceptions to the rule of professional behavior.

I closed congratulating this group on their own published report.

Anything that appears in this speech that did not appear in the two mentioned above has been included in this introduction. For that reason, no index is included.