HIV/AIDS: TWENTY-TWO YEARS AND COUNTING: WHERE ARE WE?

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Thank you for inviting me to lead off what looks like an outstanding day. Some of the future speakers today are friends of mine, professional colleagues and people I’ve heard of but have never heard speak. It’s really a pleasure to be able to set the tone for the day—to begin to describe to you some of the global themes in HIV. In order to do that, I will describe some things that have happened in America and where we are at clinically with the HIV epidemic.

I start with a personal note—Kirsahn and Hirav. They are both nine years old and living in India where they were born. Not only are they among the approximately fourteen million AIDS orphans in the world today,1 they have lost both parents to AIDS and both have AIDS themselves. They were dropped off together, literally, at the steps of New Delhi’s largest AIDS service, which is actually the only major AIDS service organization in New Delhi.2 The surviving family members who dropped them off said: “Take care of them. We just can’t do it.” For a year, my family actually tried to adopt one, as well as the other—or just get them to the United States in some way—but was unable to do so. We finally gave up in frustration. So, they live, both in good health right now, fortunately; but I usually think about them throughout the course of the day. I remind you of something Neil Schram, a fellow Kaiser physician, said in the early days of the epidemic—there is enough epidemic for everyone. Whatever it is that you like to do, whether it’s write a check, give a speech, educate, read or go to a food bank, there is plenty for all of us to do.

In 2003, there are some things that are pretty much the same. We know how HIV is transmitted and how it is not.3 Testing modalities are pretty much the same.4 Three-drug therapy has become the mainstay for the past seven years.5 We know how to prevent and how to treat most of the opportunistic infections and complications. In the last few years though, there are some strange threads, if you will, that are different. More attention is being paid to global issues and inequities, of course, that is one of the reasons we are here today. A new assay for testing of HIV, which would give a result immediately in fifteen minutes instead of several hours to several days, has tremendous implications for inner city

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populations, people with poor access to health care, etc.\textsuperscript{6} Issues on when to start therapy, more options to use, simpler regimens and treatment interruptions are all topics that I’ll cover in the course of my remarks.

Speaking to people involved in the law is really exciting for me because I think about you every day. A day does not pass that I either need a lawyer or wish I had a lawyer because everything that we do in HIV connects inextricably to what you do as lawyers. We are continually trying to define AIDS, figure out who is to be tested for HIV, determine if specialists are needed to take care of people with HIV, as California did decree last year,\textsuperscript{7} decide what services are to be made available, even decide how to treat HIV and its complications, and regulate costs while ensuring access.

Although only a partial list, these are all examples of where we need you. For instance, last year California confronted the issue of who should take care of a person with HIV in the managed care climate today, and decided that anyone in the State of California with HIV should not have to jump through hoops but can have immediate access to an HIV Specialist.\textsuperscript{8} However, the regulation didn’t define an HIV Specialist.\textsuperscript{9} And so, we’ve had a series of scrambling and political lobbying, but we are finally in a place to define who in California is an HIV Specialist, and who is not.


\textsuperscript{8} \textit{Id.}

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