

Speaker 1: Tracking everything.

Gonzalo Bearman: Okay. So I'm Gonzalo Bearman, and I'm an Infectious Diseases Specialist at VCU Medical Center. And today's date is 9-13-2019, correct?

Speaker 1: Perfect.

Laura: So Gonzalo, can you start off by telling us something about how and where you grew up, your family? Just take us up into adulthood.

Gonzalo Bearman: Okay. So I had the good fortune of kind of being brought up in two cultures. I was born, partially raised in Argentina and then came to the United States. So I've had my feet almost in both cultures. I've spent time in both countries, speak both languages, and have two passports. But I did a lot of my formal schooling ... we're talking high school, college, medical school, medical training ... in the United States in New York state. I went to Colgate for college, the University of Buffalo for medical school, trained in internal medicine at the University of Buffalo, was the chief resident there, and then I went to New York City to train in infectious diseases and public health at Cornell and Columbia University there.

Patricia: And by the time you did that, we were well into the AIDS epidemic. Well, well into it. So tell us about how you first heard about HIV and AIDS.

Gonzalo Bearman: I remember in the 80s, right around the mid-80s, hearing about it just by watching the news. My dad's a doctor. He's a pediatrician and wasn't dealing with HIV/AIDS patients, but I remember him talking about that. And that certainly wasn't the forefront in the mid to late-80s. But I think the most memorable part for me was kind of a really important year, which is 1995 and '96. So I was a clinical [inaudible 00:01:36] or medical student at the University of Buffalo. And one year, I was a medical student, and they still had not ... The big HIV medicines known as the protease inhibitors had not quite come out. So the internal medicine floor was essentially a huge AIDS ward where the patients had advanced HIV/AIDS with complications such as thrush, pneumocystis pneumonia, cryptococcal meningitis, PTIP, which is a kind of meningitis infection. And you could really see the long-term massive consequences of the virus at that time.

And you fast forward another year when you have the arrival of the protease inhibitors, which was a kind of breakthrough HIV medication which allowed people to go from living and dying with HIV/AIDS to living and then getting better and then potentially surviving with HIV and not having AIDS or getting out of that AIDS category. So that was a huge time, a huge transition, which happened rather quick from '96, '97 onwards. So by the time I was already an intern, which was 1997, those medications were available and really starting to see the turnaround in the people once they got treated. That doesn't mean that the epidemic was over, but we actually had some ... It was no longer kind of a

death now. It still has some stigma and all that attached with it, of course, but we had treatments that were actually helpful and useful and could reverse the course of much of the disease.

Laura: So what led to your decision to work with patients with HIV? To make that your focus.

Gonzalo Bearman: So my focus is really infectious disease, but if you practice infectious disease in a major university such as this one, then you have to, by default, know and understand HIV. So I didn't choose HIV in particular. I just chose infectious diseases knowing that HIV would be a significant chunk of it. Now if you were to go to our West 3 Infectious Disease Clinic here, it's about 70% HIV and 30% every other kind of infectious disease. So you can't escape it if you want to be an infectious disease specialist. I will say that when I was a medical student, second year when I went to the lectures, the infectious disease lectures, I thought, were the coolest because the doctors were presenting unique things. Bacterial infections, parasitic infections, HIV, etc. etc. And I found it really fascinating, the interplay of human beings with microbes and viruses and parasites and the way we treat them. That was really the genesis for me to get involved in infectious disease. Public health came much later, though.

Patricia: Did you see any difference between working at Cornell there in the infectious section and then coming here in Richmond? Was there any difference, and specifically in terms of thinking about the HIV or AIDS?

Gonzalo Bearman: So I wouldn't say the patient demographics are that different. What was really quite striking or unique about the Cornell experience was being in New York City and Manhattan, that's a huge, huge, huge, huge population. And the Cornell center was really quite storied and goes back really to the beginning of the epidemic. So Cornell really had two HIV centers. There was one up on 71st Avenue in New York, which is where kind of mothership is for the Cornell University Medical Center. And there's the Chelsea Clinic, which Chelsea is historically a very LGBT-friendly neighborhood. And they actually embedded the Cornell Center for Special Studies ... That's what it was called instead of just HIV Clinic ... embedded it within the Gay Men's Health Crisis Center. And that's where I was sent for three years. "You're going to go there every Monday and just see patients." I'm like, "Okay. That sounds good to me."

It was a wonderful experience in terms of seeing a really diversity of patients. The only thing I didn't see much there ... And this, I don't think is a terrible detriment, but it's certainly something that was lacking is you didn't see that many women. That's a problem. If you train at the VA all the time, you see a lot of men. You learn a lot from that, of course, but you don't see as many women. So I think that would have been one of the shortcomings of my training was I didn't see as many women with HIV. Although the treatments are largely the same, there are some nuances that you need to know. You kind of pick that up later on in life.

Well, for example, a nuance would be certainly the cervical cancer screening things that you're not going to do on men. We worry about that, about osteoporosis, also, being more accelerated both in men, but also in women. Those are the concerns or the discussions that you have to have with women. Also, vertical transmission. If they're HIV-positive and become pregnant, the risk of vertical transmission to the child ... The way you mitigate that risk, really quite effectively, actually, by taking HIV meds. And I didn't have the opportunity to have all those discussions and those kind of cases working in the Gay Men's Health Crisis Center. I think I had one woman as a patient. They wouldn't turn you away if you were a female, of course, but it was just mostly gay men.

Patricia: Absolutely. Absolutely.

Gonzalo Bearman: [inaudible 00:06:45] Gay Men's Health Crisis Center. Yeah.

Patricia: Were women going other places?

Gonzalo Bearman: Oh, of course. There were multiple clinics in New York City. There's no shortage of clinics, actually. It just happened to be where I was assigned for those three years. There was, I don't want to say a label, but it certainly was a population. And we were within the Gay Men's Health Crisis Center, so it was quite obvious what we were going to expect.

Laura: So you're in New York for three years. You're kind of in the belly of the beast. And then you come to Richmond. So tell us about that. Tell us about that experience and how it is being here in a much smaller city and in a city which has a very different history, especially when it comes to HIV.

Gonzalo Bearman: Yes. So it's true, this is a much smaller city. However, the burden of HIV disease here is not insignificant given its population size. So maybe the absolute number of cases isn't as much here, but given the proportion, it's going to be significant given the city's population. And I think one thing that I didn't sense as much in New York City as I do here is the sense that we're the only game in town. So if you live in Manhattan or any burroughs ... You can go to St. Barnabas. You can go to New York Hospital. You can go to Columbia. You can go to NYU. You get the point. There's a lot of different institutions you could seek medical care in. Here, there's very few private infectious disease specialists in Richmond, Virginia. A handful. They take private insurance only, so if you're not insured through private mechanisms, you're not going to get attention there.

So we're basically the safety net for all HIV-positive patients. We turn away no one. We take all patients regardless of your income or lack thereof and your insurance, and then we work through our systems to get them health insurance through either Ryan White funding or Virginia Coordinated Care. And now we have Medicaid expansion, so that kind of different component to it. I saw us here being much more a safety net than what I was doing at the Gay Men's

Health Crisis Center. Although that was also a safety net, people there have many more options.

Laura: It's interesting. Talking to Sarah Monroe, I got the impression that VCU wasn't necessarily super welcoming to an HIV clinic. And it sounds like that's really changed and evolved over the years.

Gonzalo Bearman: She's probably right about that because she's spent many more years in the institution than I have. I arrived in 2003, so the clinic was well-established. What I can say that upon arriving in 2003, we had an already storied, established clinic who was very proud of the services that they were providing. And the institution is recognized thus and recognizes the value that we have not only for the immediate city of Richmond, but really for the county. And I think we're seen with ... We always want more support. Who doesn't want more support? But we are given support and recognition, and that's very positive.

Patricia: Good, good. So what are the changes that you've seen over the time since you got here in 2003, both in the landscape of HIV in Richmond and more generally?

Gonzalo Bearman: So in the landscape of HIV, I think what's a little bit discouraging, you're seeing a lot more young men being diagnoses. But really, it's a bit paradoxical. You think that with the knowledge we have now and that people are on antiretrovirals and there's greater awareness, etc. etc. there should be less stigma. There's still some stigma. People feel that. There should be less. There should be fewer incident cases. And unfortunately, that's not the case. And I think what we're seeing is kind of an uptake or an increase in risky behavior. This is a very unscientific kind of assessment of it, but I get a sense that there's less of a fear of HIV than there used to be. Way back when, you're HIV-positive, it's almost as if it was a death sentence. Terrible things were happening or are going to happen to you with respect to your health and your well-being. Now it's like, "Well, if I'm HIV-positive, I'll just go to the clinic. You can take one pill once a day." Majority of people can do that. It's almost like taking a big vitamin pill, and that controls the disease.

And it's too bad that we've kind of gone away a little bit from that fear of getting infected to like, "Oh, I'll just manage it if or when I get it." So that's a bit concerning. There's another thing I want to mention that may or may not be the most politically correct for some people. But I think that it's a bit shameful that we don't have comprehensive sexual education in the Commonwealth of Virginia. The public health evidence is really, really, really strong in support of comprehensive sexual education, condom use, all those things. In other countries and even other regions in the United States where they have better public health messages or sexual education messages in the junior high school and high school level. That's really a hindrance for public health. Not only for HIV, but also sexually transmitted infections such as gonorrhea, chlamydia, trichomoniasis, herpes, those kind of things. And [inaudible 00:11:46].

- Patricia: When we started our class, we asked them, "What was your experience?" And those that came from Virginia, especially, said they-
- Laura: They were very ignorant.
- Patricia: -were ignorant about what HIV or AIDS, the impact of it. But that's not only true for Virginia. I think that's true for a lot of the communities that are not targeted communities. They seem to not really focus on the issue.
- Gonzalo Bearman: And I'm not involved in the health department. I'm not an educator in Richmond City Schools, but I don't think there's a comprehensive education program that talks about, "These are the STIs."
- Laura: Oh, not at all.
- Gonzalo Bearman: "This is how you prevent them." Yes, abstinence is one way. But there's also condoms, and there's a lot of things that could be discussed.
- Laura: No, they have abstinence rallies in the public high schools here.
- Gonzalo Bearman: Okay. So the abstinence rallies, I guess my message of that is it's probably not working very well because we're not seeing any down-trending of these infections. We're seeing a plateau or an increase in some infections. I mean, as of the last couple of years, we've actually seen an increase in syphilis. It's been like, "Well, syphilis has been plaguing mankind since [inaudible 00:12:52], so that's not necessarily new." But here in 2019, 2020, we're on the verge to see more syphilis cases increasing. And that's coming from many things. Once again, unsafe sex behavior. But now more than ever, you can apparently hook up and link up with people online through Twitter. There's basically anonymous sex meet-up groups, and we're seeing the aftermath of that. And it's not just HIV seroconversions. It's also with syphilis.
- Laura: It's interesting. It's like the bathhouses all over again.
- Gonzalo Bearman: Right. So that bathhouses have gone from being the brick and mortar bathhouse to the virtual bathhouse.
- Laura: The virtual bathhouse.
- Gonzalo Bearman: So that could be something that we could explore is the virtual bathhouse and where people meet up for sexual encounters. And I think if you're not prudish and you can actually talk to your patients about this ... So you ask them quite frankly, "Do you have more than one partner? Men, women, or both? Use condoms sometimes, never, all the times?" You kind of get a better sense of what's going on out there. You say, "How do you meet these people?" You just ask them that. There's certain meet-up-

- Patricia: Apps.
- Gonzalo Bearman: You're right. Apps or website. It's amazing what you learn by just a couple of questions.
- Patricia: Well, the interesting thing we learned working with the women at St. Paul's, many of them are grandmothers or great-grandmothers, and many of them were only diagnosed in the last couple of years. Because they're not using condoms. They explain to us, "We're not part of the condom generation." Are you seeing lots of elderly people or older people who are getting newly diagnosed?
- Gonzalo Bearman: I'm seeing some, not as many as the young. What I have seen and I had for a while, a small cohort of elderly women for years who were secondarily infected because of their husbands who had either ... they were living on the down-low lifestyle, if you're familiar with that terminology. It generally ended up being down-low, not necessarily other women. It was an interesting phenomenon. I would see their spouses later on with HIV, being HIV-positive. But in terms of new seroconversions for elderly or older folks, I'm seeing fewer of those.
- Patricia: Are younger people coming? So we're trying to also get an idea of who are the demographics that are coming in to get-
- Gonzalo Bearman: So in my practice and much of what we see in the clinic, we're seeing a lot of young folks between the ages 18 to 30, 35.
- Laura: Okay. And mostly men?
- Gonzalo Bearman: Yes, mostly men. Not all, but mostly men. In fact, most of my patients are men still.
- Laura: So what are some of the biggest challenges you've faced providing HIV care?
- Gonzalo Bearman: Well, the challenges are multiple. I think the first challenge is getting someone diagnosed and getting them into care. Okay. So we're getting more aggressive. Medical practice is more aggressive trying to diagnose people earlier. It used to be this way back when, you would HIV test people based on risk factors. You'd ask them a set of questions. "Okay. You have enough of these risk factors. It's time for HIV testing." Now it's like, "Have you been HIV tested? Okay. We'll HIV test you. Yes or no. If it's yes and you're negative or positive, we know what to do. If it's no, you've not been HIV tested, then we go ahead and test." So it's basically universal testing. We just offer it. It's not a mandatory test. You can't force it upon someone. But American College of Physicians now requests that people be tested or screened yearly or more frequently if there are risk factors up until I think it was age 64 or 65. I don't remember the exact age. So that's the first hurdle is recognize it and get it diagnosed and then refer for treatment.

Now one way to increase that is to have community testing fairs, also, to have rapid and easy access, free testings so people can get tested if they're concerned. So this is the first hurdle. The second hurdle is when they come to clinic. And that would be connecting them with the clinic, but making sure they have the appropriate support and eligibility through either Ryan White programs or insurance if they don't have insurance so they can get the treatment. And then last, but not least, is actually keeping them on the treatment. And keeping them on the treatment is 30 to 40% will do very well and take it and not have any problems. Others take it for a while and drop off for multiple reasons, which include drug and alcohol abuse, social issues, mental or psychological issues that need to be addressed. And there's that 20 or 30% that seem to be refractory to almost everything you do. You try to help them. You try to get them to counselors. But they still don't connect with care.

There's that kind of 20% or 30% of those who are HIV-positive and know it that are still having difficulty not only staying in care, but taking their medicines and also becoming viral load suppressed. And that's the goal is to get them viral load suppressed. Because viral load undetectable is believed to be non-transmissible.

Patricia: So Rodney Loftin, if you know him, at Diversity Richmond told us that he was working with a client who had literally decided to die of HIV, although he had a clinic across the street from him, because he couldn't face the stigma of people knowing. Do you see a lot of that still?

Gonzalo Bearman: I see less and less of it, but I have seen those situations in which people, there's such a stigma for them to come to the clinic to be identified with being HIV-positive they either do two things: they don't come, or they come to the clinic, but they hide the fact that they're HIV-positive and their medicine's from everyone else around them. So essentially, they're living in isolation with respect to that problem. That's one of the things we've learned is that the more social support or support you have around you ... family, friends, significant others ... the better you're going to do. By hiding that and living in isolation, being all alone with respect to your diagnosis, that'll make it much tougher for the long-term management.

Laura: Yeah. It seems like a very complex issue, and also very complex here in Richmond where we have such extremes of wealth and poverty and such a concentration of poverty. Can you talk some about our extraordinarily rate of new infection here in Richmond and what you think is responsible for that?

Gonzalo Bearman: I think various things. I think number one, it would certainly be the poverty, the low education or not finishing high school, of course, the access to drugs and street drugs. And obviously, the opioid crisis doesn't help with that. We don't have needle exchange programs, which is a real problem. The absence of comprehensive sexual education's another major problem. So you put all that together, and you have yourself kind of a really, really tinderbox of potential infectious disease outbreaks.



- Laura: Are you seeing a lot of new cases as a result of the opioid epidemic?
- Gonzalo Bearman: Yes. We're seeing not only just an infectious disease with HIV, but we also saw the uptake in hepatitis C infections going along with that, also.
- Patricia: I'm trying to think about if you see ... How does that look like, I'm thinking globally? We have students in our class who are from Ethiopia, and so I'm wondering is there any similarities in Argentina? Or is what is your experience there or perspective there with HIV or AIDS?
- Gonzalo Bearman: So there are similarities in Argentina that you have lower socio-economic classes who will have a higher uptake or higher incidence of HIV infections. And they don't have needle exchange programs, so drug addicts in Argentina are going to have similar problems. The sexual education is not going to be comprehensive, and for many reasons. One, because of resource. It's kind of a middle income country. It's just not super poor. It's middle income. But you can't kind of dissolve entirely the influence of the Catholic church in a big place, in a country such as Argentina where Catholicism, at least in spirit, is there, if not in practice all the time. Don't quote me on that. They'll send that to the pope.
- Patricia: Well, I mean, I think that's interesting that you brought that up because the people that we've connected with the most are those connected with the church. So we've connected with the founder of the NIA program, and they're specifically targeting African-American youth, really trying to kind of work with the community there. But it's connected to a church, and so there are very few programs-
- Laura: And a conservative church, in many cases.
- Gonzalo Bearman: Well, and I guess kudos to them for trying to do something like that to try to promote awareness and assistance. It's a shame that you can't really have open discussions and be accepting of people who maybe don't walk this great line all the time, as we say. That's a major, major roadblock for us, I think, is getting past our cultural prejudices and how we address these things. There's maybe not a lock on the truth. I don't mean to be philosophical here, but maybe that's not the only way to do things, try to be comprehensive and use a multi-modal approach to addressing a public health concern. By multiple studies now, by increasing sexual education awareness, condom use, needle exchange programs, you're going to decrease the transmission of these particular infections. But many would argue, "No, you got to deal with that core root, that aberrant behavior that would lead to that." But that's not necessarily practical.
- Patricia: So you're still hearing that a lot.
- Gonzalo Bearman: Yeah, of course. Of course. I mean, I don't think you need to leave the city of Richmond to hear that. There's conservative voices here. There's conservative



politicians in this state and across the country that will speak that way, which is too bad because you're basically letting your own kind of, I would say, faith and/or beliefs overcome what's been empirically proven through science and epidemiology and observation and assessment and etc. etc. You can actually impact these negative outcomes by modifying or nudging or changing certain behaviors with certain interruptions or certain ... I wouldn't say interruptions. I would say with certain interventions. I'm sorry. Whether it's needle exchange programs, comprehensive sexual education in schools.

Laura: Well, we talked to Elaine Martin over at the health department, and of course, she's come up with all kinds of innovative ways to reach people through their cell phones and their apps and everything else. But we hear the same thing all over the place, that given the conservatism of the political climate here, it is very difficult to treat diseases which primarily hit people engaged in what conservatives think of as aberrant behavior.

Gonzalo Bearman: Right. So if you think, the perception of disease is very different. So if you have hepatitis C, hepatitis B maybe, syphilis, gonorrhea, chlamydia, etc. etc. those are all seen as undesirable diseases secondary to aberrant or unacceptable behavior or immoral behavior. But if you were, say ... Let's take the example of Lyme disease. There's a huge public outcry for that because it's happening to people at no fault of their own. Maybe they get bit by a tick when they're out gardening or going for a nice walk in the woods or whatever, and it's not considered aberrant behavior or immoral. There's a lot of sympathy for people who suffer from Lyme disease or get West Nile Virus or get Dengue on their Caribbean vacation. They have a lot more sympathy for that. I don't see it that way. I see it as all people suffering from the consequences of some sort of infectious disease, and we're here to treat them regardless of how they got it. And we can prevent all those kind of infectious diseases with common sense, empiric studied interventions. Prevent or minimize not only incidents, but also the aftermath of it. And we don't tend to do that.

Patricia: So how do you reach those 20 or 30% of patients that you have who fall off, who stop coming to the clinic or can't quite take that single pill every day?

Gonzalo Bearman: Yeah. So there's the active and there's the passive. The active is that we employ entire teams of the clinic and Ryan White programs to have case managers, social workers, mental health counselors, pharmacists who can continue ... So let's say it's not only the infectious disease specialists or infectious disease nurse practitioner that's interacting with the patient. It's that along with the rest of the team to try to keep that person engaged with care with text messages for follow-up to clinic, making sure their medications are refilled, getting them the appropriate rides to clinic, bus passes, fares, things that will make it easier to come to clinic. That's all the active interventions. The passive are the ones ... And this is much softer, but it's still important is that we let them know the door here is always open to you. Let's say you slink off for six months or a year, even two years. We'll always take you back.

So we have virtually very, very, very high threshold to shut the door on anyone in the clinic. I mean, the only way you'll get the door shut to you in the clinic is if you have such bad behavior and violent behavior that you're a danger to any of the clinic staff. And that's a different kettle of fish, obviously. So we try. But even with those interventions, you're still going to have a chunk, 10, 20%, of that cohort of patients who don't achieve that persistent viral load reduction.

Laura: It's interesting. I talked to Jihad Abdulmumit, if you know him. He's an AIDS educator from Health Brigade who works in the prison system. And he talked about how people in the prison system, which of course has five times the HIV rate of the general population, that they have all of these services provided to them. But if you have diabetes or hepatitis or some other long-term illness, you're out of luck.

Gonzalo Bearman: This is true. I have to say that one of our public health interventions that works the best is actually treating HIV-positive patients in the clinic. So I have an entire cohort of HIV-positive prison patients, or Department of Corrections patients, I should say, that I see sometimes in the clinic, but most of the time, through the telemedicine service. And I've been doing this since 2003, telemedicine. And of the cohorts, let's say I have two cohorts of patients. There's the telemedicine Department of Corrections and everyone else. The telemedicine Department of Corrections are almost always on their meds and almost always undetectable. They have their medications served up to them every day. It's like the directly-observed therapy that you maybe have heard about for TB control, tuberculosis. The department gives you your meds. They watch you take it. So you finish your nine months of treatment. Well, this is somewhat analogous to that. You're in the Department of Corrections. You get in line for your pills, and they give you your pills. And that cohort always does really, really well.

Now where I see the change is when they go from the DoC back to private citizen, when they come back to the clinic. And they show up for a while, and then after a year, we're like, "Where's Mr. So and So? He hasn't showed up to clinic in a while." He fell off the wagon. So he's not coming to clinic anymore, and then you think he's lost to follow up. And unfortunately, because of the high recidivism rate, back in the Department of Corrections. And that's where you connect with them again.

Patricia: Interesting. Interesting.

Gonzalo Bearman: I see that play out time and time again in the last 17 years.

Patricia: So you've talked about the demographics in terms of men. Can you talk about in terms of race and ethnicity? How does that look like?

Gonzalo Bearman: So here at our clinic, here at City Center, most of my patients are African-American. The HIV-positive patients are African-American. Most are men, although not all. Probably about 20% women. But of the women, almost all are

African-American, also. So it's very much an inner city, and of course, the Latin-Americans or Central-Americans, which are fewer in this clinic, I see a lot of them just because I'm bilingual and I can speak Spanish to them. And those tend to be men. It's not the most diverse group I have. This is actually very interesting. For the non-HIV patients that I see here ... and I see a fair chunk still. 30% of my practice will be non-HIV ... those are most commonly Caucasians that are community referrals that I get from community or private doctors. It's like, "Oh, this person's got something unusual or a fever or maybe Lyme disease or some sort of pulmonary infection." It's a little unusual. Those get referred to us.

Laura: And I know this would probably be crossing all kinds of lines, but do you think you might have any Latinx patients who would be interested in talking to us and becoming part of the exhibition?

Gonzalo Bearman: Let me think about that. I might be able to find a patient. You know what would be helpful is if you wanted to contact me, send me an email with this question. I could go back with my clinic team and look back at the roster of patients and say, "Oh, yes, I forgot about him or her. We should inquire about that." So I can't think of someone off the top of my head, but we could probably mechanize it.

Patricia: We don't have any Latinx. Nothing.

Gonzalo Bearman: Okay. I'm sure I can find-

Laura: Yeah. That would be great. And of course, Patricia's fluent in Spanish.

Patricia: Yeah. Yeah. Yeah, yeah.

Gonzalo Bearman: Perfect. I have one really good patient for years, but I think he moved back to Miami. In fact, I know we did. He has a mother that lives here, so maybe he pops in and out. We might be able to get ahold of him.

Patricia: But there might be someone else.

Laura: Yeah. I mean, that's been our biggest gap so far.

Patricia: We've been asking around for a while.

Gonzalo Bearman: I can think of one gentlemen, actually, who I think would be thrilled. I think he's from Nicaragua or [inaudible 00:30:28]. I can't remember. One of the two.

Patricia: That would be fantastic.

Gonzalo Bearman: He was a particularly interesting case because this is a guy who ... I mean, talk about grit. And this guy still works full-time as a roofer here. You know that's

hard work. We got to meet him in the hospital here because he came in completely emaciated and underweight with night sweats, fever, and basically tuberculosis-like infection coming out of his right armpit or right axilla. And we saw him and like, "This gentleman has AIDS and TB," just by looking at him. We were right. We treated him. He's finished the TB treatment. He is now getting the HIV retroviral treatment. He's doing very well.

Laura: He would be fantastic.

Gonzalo Bearman: I have two of them, actually, like that. One had pulmonary TB, and something was coming out of his chest. He had a hole in his chest [inaudible 00:31:18]. So these were immigrants. Both were undocumented or are undocumented and have an amazing kind of life story, illness story, and a kind of story of perseverance and grit and rebounding. Pretty impressive.

Laura: I mean, we could use fake names for that if that would be helpful. I mean, we did one of our exhibitions a couple of years ago was about the Latinx population in Richmond. We did that at the Valentine.

Patricia: [inaudible 00:31:46] at the Valentine. Yeah. On undocumented.

Gonzalo Bearman: Yeah. I can think of two right off the top of my head. So if you could send me an inquiry about that, I can make it happen.

Laura: That's great.

Patricia: Definitely.

Gonzalo Bearman: At least we can ask him.

Patricia: Yes. Exactly.

Gonzalo Bearman: I don't want to oversell here.

Patricia: No, no, no. We would need their permission.

Laura: So how has your understanding of HIV or your views on the epidemic, how have they changed over time?

Gonzalo Bearman: So I think that what I'm going to tell you probably isn't unique to me. It's probably something that you would see with any physician who actually spends time taking care of patients, if it's HIV or not, particularly when you're dealing with chronic illnesses. And what I've learned about chronic illnesses, whether it's infectious disease like HIV, lupus, rheumatoid arthritis, some kind of chronic smoldering cancer ... I mean, you get the point ... is that you can almost never really predict how people will respond to that. It's amazing how resilient some

people can be and how not resilient others can be. Same disease. Different response in terms of psychological. And I think that's what's been most fascinating to me over the years is, "Yes, you have HIV, but I can treat that. It's not a problem. Here's the one or two pills you have to take." That's the easy part. It's really trying to understand how they are experiencing that. Do they just see it as something that they have which is managed and therefore don't suffer? Or are they actually suffering because of other things? Psychosocial, those kind of things.

Remember, suffering and pain are two different things. It took me a while to figure that out, also, as a young doctor and kind of learning the skill and art and practice of medicine. If I break my arm, I'm in a lot of pain. Yeah, I might suffer for a little while. You get in a cast, and you realize it's going to heal, etc. etc. But that's not really suffering for the long term. Whereas you can suffer by being given a diagnosis of HIV/AIDS, and you can recover if you understand that you can be treated and you'll be well, etc. etc. But others don't recover that way mentally. It has a lot of stigma for them, the way they see. So the experience of disease or illness differs by person to person, and it's more than just a physical sensation. It's a psychological, psychosomatic, psychosocial sensation and experience.

- Laura: We certainly saw that a lot with the support group at St. Paul's where some women in the group would just shut themselves in their bedrooms for a year, essentially, and be prepared to die. And then eventually, someone was able to break through. A family member or a fellow-
- Patricia: A friend.
- Laura: Yeah. A friend or someone from their church. And then they could start to rejoin the land of the living.
- Gonzalo Bearman: Right. So that's one response. And the other response I've seen is like, "Yeah, I'm sick, but people are counting on me. So I've got to get through this." I've seen that. "Give me my meds, doc. I'll figure it out. Can I go back to work?" Give yourself a month or something. They want to go right back, and they have this tremendous amount of grit. I think our ability to understand and cope with illness is a function of many things. And you really see, also, the grit that some people have in these situations. It's really amazing. And you can't always predict who's going to be the gritty ones, either. It's amazing. You'll see the old frail grandma's actually got more grit than some 25-year-old.
- Patricia: So tell us about some patients that you've treated over the years who really stand out in your mind one way or the other when it comes to the way they've chosen to or been able to deal with their diagnosis.
- Gonzalo Bearman: Well, some are the ideal patients. "I understand how I got this, doc. I'm just going to do whatever you tell me, if it's reasonable. I take my meds. I show up

every six months or every nine months." And you're doing well. Never complain. They understand they need to take care of themselves. They quit smoking and lose some weight, do some exercise. They become model patients. That's a chunk. Another chunk is like you'll love them and hate them at the same time. Do you know what I mean? So that would be like they're really great about taking their HIV meds. I have this one guy I've been knowing for 17 years. He's like, "Doc, you're the only person I listen to," he tells me, which sounds great. "I take my HIV meds every day. I take my GENVOYA every day. To hell with everything else you say. I'm going to drink and smoke as much as I want. I'm not going to have my colonoscopy. I mean, everything else you tell me to do," he doesn't do. So they're still drinking a six-pack and a half. I mean, the guy's an amazing biological specimen that he can live through all that, all the drinking and smoking and partying. But he shows up like clockwork for every appointment. His viral load has been undetectable for 13 years.

Laura: That's fascinating.

Gonzalo Bearman: He takes his one pill once a day. He once told me ... This was five years ago. His New Years Resolution was to actually do everything I tell him, try to follow my recommendations for a year. That lasted for a month. He's like, "Ah, I can't do it." So that's another group. And then there's the other group that really frustrates you to not avail, and you almost feel at times that maybe you're the one failing. But it's really not because they are recalcitrant to the treatments. They don't want to take them or they don't show up to clinic. Or they show up to clinic once and miss for two years straight and show up again. Despite the fact that you've made yourself available. More importantly, you've made your team available, your nurses, your social workers, your mental health counselors, your pharmacies, and try to communicate and keep in touch with these patients. They still don't show.

And I think that's where we have a certain frustration. And what's been helpful for me is kind of almost to adopt a stoic-like approach to it, like, "Listen. I've tried everything I can. You just have to accept it. We've tried to connect all the dots within our armamentarium." And at the risk of sounding slightly conservative, which I'm not, there's got to be a little bit of personal responsibility. Just a little bit. It's like, "We give you the meds pretty much free. We set up appointments for you. We have mental health counselors calling you. We have a case worker, social worker helping with everything you need. You got to at least show up. You got to show up to the clinic at least two or three times a year. That's all we're asking."

Laura: So what is it like to work with an 18-year-old who's just been told that he's got HIV? [inaudible 00:38:14]

Gonzalo Bearman: My experience with 18-year-olds who've been recently diagnosed have been mostly frustrating because it's kind of like the young ... You hear the paradigm of the young teenager that's diagnosed with Type I diabetes, and they're not

having any part of it. They're not going to do their insulin. They're going to go live their lives like every other kid, etc. etc. And I see that frequently with 18-year-olds being diagnosed with HIV, like, "Okay. I was diagnosed. I'm not that sick. I feel fine." They don't show up again for a while.

And then what usually happens is you need some sort of life-altering or some sort of event that knocks them back into the reality, like, "Hey, yeah, I know I was here three years ago. Well, my immune system went from here to here, and now I feel terrible and I have no energy and I've lost a lot of weight. I have thrush in my mouth." And that frequently, but not always, that frequently is the motivator to get them on therapy. All is not lost. You can still recover and do very well. I can only think of one gentleman who was young at diagnosed, been excellent about always taking his meds. The rest kind of hop on and off. They eventually come around when they hit their late 20s or 30s, a little more mature.

Laura: So if they've been off their meds for years, can they also get to the point where their viral load is undetectable and where there's no huge consequence to pay for the years of kind of screwing around?

Gonzalo Bearman: There's a very small proportion of people who are called chronic non-progressors who are HIV-positive. But for whatever reason, with their immune systems and other genetics, the HIV doesn't really progress as much in them and they have low-level virus and the CD4 drops, but it's somewhat steady. So that's the gross minority, though.

Patricia: We've met a couple of those. Yeah.

Gonzalo Bearman: It's a minority. The majority will have progressive disease with no treatment.

Patricia: I guess what I'm asking about is say your 18-year-old says, "Screw you. I'm going to go party for three years." He comes back. He feels terrible. He starts on his treatment. Can he get back up to the level that he was before?

Gonzalo Bearman: Generally, there's a good chance. It's called immune reconstitution so you can have improvement. It may not go back to what's normal, though. But that's not the most important thing. The most important thing is that the viral load be suppressed. Go from whatever thousands [inaudible 00:40:38] per drop of blood to undetectable. And that can be done.

Patricia: And are you seeing a lot of that? Are you seeing a lot of success with that?

Gonzalo Bearman: Oh, yes. Definitely. Definitely. But the secret to success is someone has to come to clinic. They've got to take their medicines. And it's gotten easier than ever. It's usually one pill once a day. At the beginning, you see them every three months for a handful of times and maybe every six months for a year. And then after that, you can start spacing it out to every nine months, maybe. Twice a



year, you come see the doctor. Once a year or once every 18 months. Not so bad.

Laura: Yeah. Sarah Monroe said, "You know, we could really eliminate AIDS tomorrow. We have every tool that we need, and yet it's not going to happen."

Gonzalo Bearman: Well, I'm not sure who I'm quoting here, but if you're trying to ... This is something like in infection prevention and safety, which I spend a lot of time doing in this institution. And we're at a kind of an "analogy or a paradigm" here. But if you had to choose between altering human behavior or going with a gizmo that gives you the outcome you want, go with the gizmo every time. Because changing human behavior's really hard. Really hard to do, really hard to maintain. So Sarah Monroe is right in theory, but changing human behavior is really tough.

Laura: So let's talk about PrEP, the fact that, in New Zealand, they've got tremendous success with getting people who need to take PrEP to take PrEP. And here, it's much, much spottier.

Gonzalo Bearman: It's a bit of a mixed bag here. It's not because it doesn't work to prevent seroconversion. It's just fewer people are coming to get PrEP.

Laura: Well, that's what I mean. Yeah. So how do you work to get people who need to get onto PrEP onto PrEP?

Gonzalo Bearman: I think a major point to move that forward is really two things: access through insurance companies, which isn't bad. Most private insurance will pay for it. I've never had a private insurance company not pay for someone's PrEP. So that's number one. Number two, and this is really important, is really raising awareness with family doctors and general internists, general practitioners out there to refer patients to specialists such as myself or the infectious disease service here at VCU to do that. There are a lot of patients that finally come to me. They basically find me through the virtual phone book, which is Google, and find out who's the ID doctors in Richmond and they email you. They would say, "I went to my family doctor, and they're like, 'I don't know anything about that.'" Or I've heard some say, "My family doctor said, 'I don't know anything about that, and I don't agree with that kind of behavior. So I can't help you.'" Well, that is already infusing your morals into the doctor/patient relationship, and it makes it really difficult to have a substantive discussion. You've already kind of tainted it with that kind of comment. I've heard a handful of those comments coming from my patients.

Patricia: We've heard that from people living with HIV.

Gonzalo Bearman: Yeah, of course.

- Patricia: We've heard from people who said that their family doctors never ask them to get tested. It just wasn't ever part of their discussion. And we've also heard from patients who had a lot of symptoms that, even to people who are not medical, really sound like AIDS. And their GPs just-
- Patricia: They deny that the testing. They said no.
- Gonzalo Bearman: Yeah, so that's a bit sad and tragic to hear that we're not being aggressive with testing or referring. If we're not comfortable, then just refer them and leave it at that. We do have people here on PrEP, though. It's not as big as I thought it would be, though. My panel's not that big for PrEP.
- Patricia: Interesting. And when you say access, we know that the price for PrEP is tremendous, right? So when you say access, does it mean that other insurances are not taking on PrEP? Is it-
- Gonzalo Bearman: So a public insurance ... Let's take an example like VCU's Ryan White, which is great. But you have to be HIV-positive. You're not going to go there and say, "I'm HIV-negative. I want PrEP." And Ryan White, to my knowledge, isn't covering that yet. So that's a problem.
- Patricia: That's a huge catch-22.
- Gonzalo Bearman: So here's the phenotype of your average PrEP patient that I have. Greater than 25 years old. Usually 25 to 40. Almost always Caucasian. Almost always college-educated and then some. And gay or may have sex with men. That's the phenotype. I'm not getting discordant couples who are man and women, a heterosexual couple. I don't get dems for PrEP at all, like one's positive, one's negative. It's usually what I've told you. It's the gay, educated, greater than 25, white, has a nice office job, lives in suburbia, and/or works downtown in one of these banks and comes up and sees me every three to six months for his PrEP follow-up.
- Patricia: That's fascinating. Yeah.
- Laura: So given that the profile of your HIV patients tends to be black and I'm guessing poor-
- Gonzalo Bearman: Urban. Yes.
- Laura: Urban. But PrEP is all white, middle-class.
- Gonzalo Bearman: It's a different demographic.
- Laura: So how do you think you could start reaching the black inner city patients without a lot of financial resources and get them to take PrEP?

Gonzalo Bearman: I think you'd really have to leverage ... There's really two versions. To reach them, you've got to really leverage public health services. It has to come through health departments, like major public health campaigns, which isn't happening at all. You don't see that many public health campaigns about getting tested for HIV. You don't see that plastered on the side of the poles or the buses. You don't see those messages. That's number one. But number two is those people who are frequently the underinsured or the uninsured, what mechanisms will exist to pay for that? Will the Medicaid expansion pay for all that? Will there be a pool of funds? Can you get PrEP at a public health clinic? Can you go to a BDH clinic and get PrEP. That's different.

Patricia: Yeah. It's very different.

Gonzalo Bearman: It's very different. It's like going for an STI clinic or an STD clinic where you don't pay for anything, really. You've got vaginal discharge, penile discharge, "You've got gonorrhea. We confirmed it. Here's your shot. You're out of here. Use some condoms, those kind of things." We don't have the analogous version of that for PrEP in public health clinics.

Laura: It's a surprising gap.

Gonzalo Bearman: I mean, I guess it is ... Maybe it's not as surprising. If you've been around public health long enough, you realize that some things just don't resonate with the public. And frequently, public programs have to respond to the legislatures, which respond to the people who vote. I guess you've heard this before. A budget's just a reflection of values. So what we budget money means that's what you value. And what you're not budgeting means it's of low value to you. And I think that's the way we see it with Virginia legislature, which I think has been a historically rather conservative lot.

Laura: So if you could say one thing to the general public about HIV, what would it be?

Gonzalo Bearman: It's still very real. It's still very real, and there's a still significant risk of HIV transmission, and much more in certain populations and certainly in men who have sex with men and anonymous meet-ups. That's really high-risk behavior. You have much higher risk. So what I would say is that's one. And number two, certainly use condoms. And last, get tested. Get tested if you're having multiple partners. If you don't know the status of the partners, if you're having unprotected sexual activities, get tested. And you can get tested at health departments.

Laura: That's interesting. All of our class wants to get tested, and one student very urgently. Where should we take them?

Gonzalo Bearman: Well, for the super urgent testing, the emergency departments can do that. They don't necessarily like that. They see that as not their role.

Laura: I don't think she is urgent like it has to happen today, but she's feeling some urgency.

Gonzalo Bearman: So the urgency, there's the free clinics. There's the Health Brigade. There's also the Crossover Clinic.

Laura: Well, we're taking a field trip to Health Brigade.

Patricia: Next week.

Laura: Next week. So they can do that there even if these are kids with private insurance?

Gonzalo Bearman: I believe so. I don't think they turn anyone away. Now I used to be on the board of directors there, but that was a while ago. It was seven years ago or eight years ago. But I don't think they turn away anyone. I mean, they would prefer if you have private insurance that you go to a private doctor. That's why you're insured. So it's not particularly the resources or that institution.

Patricia: Yeah. We don't like doing that. But at the same time-

Gonzalo Bearman: So you can do that. The health department, the STD clinics will do that for you, too. The testing.

Patricia: It's interesting they don't have it at the University of Richmond.

Gonzalo Bearman: You have to wonder why. You have to wonder why. I know you can get it here at Student Health if you're a student here.

Patricia: But you have that different demographic. You have to ask for it, so that's a big barrier.

Gonzalo Bearman: At Student Health?

Patricia: Not at VCU. At U of R. Student has to explicitly ask for HIV. It's not something that is given for free, like if you wanted to get a CI test.

Gonzalo Bearman: Oh, I see. But is there a charge for it? Do you know?

Patricia: I'm not sure. They have days where it's free, so they say where the testing is free. Because we were looking for it when she requested it.

Gonzalo Bearman: The general idea here is that the testing should be universally offered, but not mandated. You don't want to mandate it, saying, "You must get tested now." That's a bit like [inaudible 00:50:09]. Doesn't sound so good there.

Patricia: We are reading The Secret Epidemic of AIDS, and it's really focusing on young women who give birth to children with AIDS.

Gonzalo Bearman: [inaudible 00:50:24].

Patricia: Yeah. So do you see those types of patients here? I know that we focus-

Gonzalo Bearman: We do. The pediatric infectious disease doctors do that. And they manage all the post-partum transmissions right on up through adulthood. So they're the ones who really become the doctors for life for these patients. Fortunately, vertical transmissions, which is mother to child, is becoming less and less because of the treatments, because of the awareness. Certainly any pregnant woman ... I think you're mandated by law if you're pregnant-

Patricia: Yeah, yeah. I had to get HIV tested when I had kids.

Gonzalo Bearman: You have to get HIV tested. Exactly. And if you're HIV-positive, you're strongly encouraged to start therapy right away if you're not already started. But even if you have it at the peri-partum right when you go into labor, they can do the intravenous [inaudible 00:51:09] and treatments. That will greatly, greatly, greatly decrease the risk of transmission to the baby.

Laura: What do you think the biggest misconceptions that the general public has about HIV today are?

Gonzalo Bearman: That it's exclusively a disease of just poor people or exclusively gay men. It's not exclusively that. Yes, there's a preponderance of it, but it's an equal opportunity disease if you're involved in those kind of behaviors. And those kind of behaviors are multiple sexual partners, sharing needles, those kind of things.

Laura: Why do you think that the high rate of HIV transmission is so little discussed or known in Richmond? Because we do community projects 24/7, and until Meg Hughes asked me to start doing HIV interviews and I began digging around, I had no idea that we were number 17 in the nation at that point.

Gonzalo Bearman: It's probably some conservative undertones and unwilling to discuss these kind of things with a general reticence across the population. There's stigma in some groups, particularly in African-American men who happen to be gay and young. There's a lot of stigma there to say you identify with being gay or HIV-positive. A lot of them are still in the proverbial closets, so to speak, and that's a problem. If you're hiding these things and you're not going to ... Obviously, there won't be the awareness and there won't be the response if necessary. It's a big deal. It's a big deal. I mean, I have some patients who ... I'm just going to think of one or two who are HIV-positive, gay men who work full-time for some Baptist mega-churches around here. I ask them out of a conversation, "Do you ever discuss that you're gay or HIV-positive with any of the congregants or your employer?" And it's always, "No, no, no. Can't talk about that." That's amazing. I mean, I

understand it's private that you're ... All of it's private, but the thought that that discussion, maybe being gay, within that environment would be so unwelcomed ... yet you work there. And you're part of it, and you identify with it. It's important. It's very difficult. It should be easy.

Patricia: No. You have to divide yourself.

Gonzalo Bearman: You have to divide yourself. You have to almost live two lives.

Laura: But at St. Paul's Baptist now, it's fascinating. I mean, they started distributing condoms to their congregants in 1995. Very unusual. And several members of the group have talked about getting up in front of the whole 3000 or 6000-person congregation and saying, "I'm HIV-positive." And the knowledge that by that afternoon, 60,000 people will have heard the news.

Gonzalo Bearman: Well, I hope that that was well-received and encouraged.

Patricia: Yeah, it was. Yeah.

Gonzalo Bearman: I hope the message was a positive one.

Patricia: Yeah. We just read that story yesterday. Was it yesterday or two days ago? And they still remembered it so vividly because they knew the risk. They knew what it meant to say, "I'm HIV-positive," in front of the community would also mean they might completely outcast them.

Gonzalo Bearman: It seems like it'd be a very defining moment for them.

Patricia: Yes. Absolutely. Now we've come across a lot of those very profound moments.

Gonzalo Bearman: Yeah. Absolutely. I can imagine. I can certainly imagine. I've heard a lot of them over the years, too.

Laura: So for you, was there any one moment where the before was different from the after, kind of a watershed moment for you in your career treating HIV?

Gonzalo Bearman: Well, I think that the arrival of the protease inhibitors and those newer medications in 1996, '97 was a big change. Because again, you're no longer looking at just treating a disease that had almost a fatal prognosis with terrible complications. It's one that you can actually treat and people get a lot better, and they become your chronic patients. Rheumatologists have people with lupus and rheumatoid arthritis, and now we have HIV-positive patients that I've been seeing for 17 years here. They become your extended family of people you know and care about. So that was a big deal, I think. And the other one, I think, is just having a better understanding. This just comes with experience and spending time in the same clinic for years and how better understanding of how

people deal with chronic disease and difficulty in disability. And it's really quite striking how resilient or not resilient sometimes people can be. It's understanding that and being patient with people. [inaudible 00:55:30]

Patricia: So is there anything that we haven't asked you that you would like to talk about?

Gonzalo Bearman: No. I guess I would just say that we are ... And this is a shameless plug for our program here, so I apologize. But we are proud of the services we offer. We are the biggest HIV center still in the Commonwealth of Virginia, the only HIV center really in Richmond. And we're proud of being comprehensive in our approach and being all-inclusive. And last but not least, we really try to have an atmosphere where people feel that they're not just coming to see the doctor, but they're coming to see a clinic that really cares about their well-being. And not just at the time of the doctor/patient relationship. It includes everything else that goes along with it: the social services, the follow-up, the mental health counseling for those who need it, the pharmacy follow-up, those kind of things. And the support groups. I didn't mention that, but there are good support groups here at VCU that we have for people who are living with HIV either alone or with a significant other, etc. etc.

Laura: Well, thank you.

Patricia: Thank you so much.

Gonzalo Bearman: I hope that's been somewhat informative.

Patricia: Yes, it has been great.

Speaker 1: No, it's been wonderful.

Patricia: Thank you so much. Let's see.

Gonzalo Bearman: It's nice.