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# HOLY CROSS MAGAZINE

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## Features

### "I saw people who were in pain"

One of the country's most visible and admired physicians and the director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health, Anthony S. Fauci, M.D., '62 has led the fight against AIDS and, in the process, won the trust and respect of his one-time opponents.

By Donald N.S. Unger

One of the signal features of AIDS activism in the late 1980s was the vociferous attack mounted against federal agencies, like the Centers for Disease Control (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH). These agencies were accused of doing too little, doing it too late, and often, of handcuffing individual doctors and people with AIDS with medical regulations that were too cumbersome to deal with a fast moving and deadly epidemic.

One of the most frequent accusers in this dialog was writer and activist Larry Kramer, founder of Act Up, the AIDS Coalition to Unleash Power, an organization founded in New York City in March of 1987, with the avowed purpose—as its name implies—of taking a tactical line that might better be described as *uncivil disobedience*.

One of the most frequent targets of Kramer's rhetoric, and of Act Up protests, was Anthony S. Fauci, M.D., '62, the federal government's chief point man in the fight against AIDS, who has headed the National Institute of Allergy and Infectious Diseases (NIAID) at NIH since 1984.

By October of 1992, however, a curious series of things had happened: When the Circle Repertory Company premiered Kramer's play, *The Destiny of Me*, that month at New York's Lucille Lortel Theater as a benefit for Gay Men's Health Crisis—another organization which Kramer founded—Fauci was in the audience.

On stage, most of the play is seen from the point of view of the hospital bed of Kramer's stand-in, the character Ned Weeks, an AIDS patient undergoing experimental treatment, who spends a chunk of his time berating or sparring with his primary caretaker, Nurse Hanniman, or with her husband, Weeks' physician, the hospital administrator, Dr. Anthony Della Vida—*Dr. Life*—and no reasonably informed member of the audience could have failed to identify the model for the character.

These days, Kramer and Fauci describe each other as friends; when Kramer is in Washington, Fauci takes him out for Italian food.

While this rapport might at first seem unlikely, the fact is that AIDS activists and medical researchers—whatever disagreements they had and continue to have about pace, funding or methods—share, and have always shared, a common goal.

Clarifying that, and moving an often sclerotic and stubborn medical establishment—both its public and private arms and its formal and informal practices—has been a key part of what success there has been in fighting AIDS in the United States in the past two decades.

Fauci has been one of a handful of people, in the higher reaches of the medical establishment, at the fulcrum of that change.

#### Brooklyn Born and Bred

Anthony Stephen Fauci was born in New York City on Christmas Eve 1940, the second of Stephen and Eugenia Fauci's two children. His parents, both the children of immigrants, met as students at Brooklyn's New Utrecht High School and married when they were just 18. He grew up in Bensonhurst, Brooklyn, where his father, a Columbia University educated pharmacist, owned a neighborhood drugstore, at 13th Ave. and 83rd St. The family lived in an apartment above the store, and all pitched in when needed—his father in the back, his mother and older sister, Denise, at the register.

"I was delivering prescriptions from the time I was old enough to ride a bike," Fauci recalls.



Routinely cited in recent decades for the length of his work day and the peripatetic nature of his job, Fauci took on these habits early and came to them naturally. He was that kind of kid, too.

He grew up surrounded by disparate influences that he seems to have enjoyed and that seem to have benefited him: There was his pharmacist father, known as “Doc” in the neighborhood—whom he describes as “laid back”—and his mother, also college educated, whom he describes as “goal oriented.” There was an attraction to medicine and science fostered from an early age, and a commitment to the humanities nourished by premedical studies at Holy Cross that also encompassed the study of Latin, Greek and philosophy.

And there is early evidence, as well, that Fauci had a streak in him that was something between puckish and perverse—a stubborn adherence to his own values and interests in the face of local prejudice that had to have been fierce. Growing up in post-war Brooklyn, playing baseball in Dyker Heights Park, on Gravesend Bay, in the era of Jackie Robinson and Pee Wee Reese, Fauci was a Yankees fan. Among his heroes were Joe DiMaggio and Mickey Mantle, which, he says, made him something of a sports outcast among his friends, Brooklyn Dodgers fans all.

If he had been a sports outcast, he was an athletic one. In a 1989 interview with the NIH Historical Office, he remembers, “We used to play basketball from the beginning of basketball season to the end, baseball through the spring and summer, and then basketball and football again in the winter.” When he was younger, he played CYO basketball in the neighborhood; in high school, he captained the basketball team. Today, he’s a daily runner who has completed the New York and Marine Corps marathons.

He attended Regis High School, a Jesuit school on Manhattan’s Upper East Side. And the distance he had to travel to get there is difficult to explain, for reasons of time or geography and also for reasons of culture. Time and geography matter, of course, in multiple ways: the trip took 75 to 80 minutes each way, a bus and three subways during rush hour in both directions. By rough calculation, all the time he spent commuting during his four years at Regis, it cost him more than 70 days. And he didn’t just let the time go: then, as now, he was focused and organized. He was the kid on the subway—packed up against the other passengers, elbows against his body, wrists and forearms folded inward, a book almost on top his face, reading—in his case, probably Ignatius Loyola, at some point or other, and likely in Latin.

Time and geography also matter because Brooklyn was further away from Manhattan in the 1940s and 1950s than it is today, and Bensonhurst is deep Brooklyn, just a short three or four miles—a few stops on what was then the BMT Seabeach local line—from Coney Island and the beach. New York is New York, but it’s also five boroughs and a million neighborhoods. And working class, Italian and Jewish Bensonhurst, might as well have been 15 light years away from Manhattan’s Upper East Side, then, as now, one of the country’s most affluent zip codes.

### **The Nefarious Act of Reading**

In his commencement address this past May, U.S. Poet Laureate Billy Collins ’63—whose time at Holy Cross overlapped with Fauci’s, although they didn’t know each other—spoke with some nostalgia of the 10 o’clock dorm curfew of that era, and how students learned to “black out” their rooms with towels, newspapers and tin foil.

“It was behind these drawn shades,” Collins said, “that we indulged in the nefarious act of reading.”

Fauci came to Holy Cross in the fall of 1958. He played intramural sports when he had the time, but his days of more organized competition were over. He had entertained the vague idea that he might make the basketball team as a walk on, but the competition was fierce, and he didn’t quite have the height. Always a fully engaged student, moreover, he took to his premedical studies with gusto; “the nefarious act of reading” didn’t leave him a lot of spare time.

“There was a certain spirit of scholarship up there,” he remembers, “that was not matched in anything that I’d experienced. The idea of seriousness of purpose—I don’t mean nerdy seriousness of purpose—I mean the importance of personal development, scholarly development and the high standard of integrity and principles that became a part of everyday life at Holy Cross. And that, I think, was passed down from the Jesuits and from the lay faculty to the students.”

The premed program covered enough science to get the students into medical school, but also stressed the humanities—a continuation, in some ways, of what he had been taught in high school. Fauci often credits part of his professional success to the inculcation of Jesuit intellectual rigor that was a core part of his education: an emphasis on organization and logic, on succinctness and clarity of expression. Arguably, the twinning of science and the humanities has proved useful in his dual roles as physician and researcher as well.

Summers, he worked construction in New York, balancing personal and scholarly development with a measure of dust and grit. In the summer of 1961, before returning to Holy Cross for his last year, he was part of a crew working on a new library for the Cornell University Medical College (now the Weill Medical College of Cornell University), about six blocks east and 15 blocks south of his high school *alma mater*. He recounted the following anecdote at the Medical School’s centennial celebration in April of 1998, and it was recently reported in the *Regis Alumni News*:

“One day during lunch break, while the rest of the construction crew was sitting along the sidewalk on York Avenue eating their hero sandwiches and making catcalls at the nurses who were entering and leaving the hospital, I snuck into the auditorium to take a peek. I got goose bumps as I entered, looked around at the

empty room and imagined what it would be like to attend this extraordinary institution ... After a few minutes at the doorway, a guard came and politely told me to leave since my dirty construction boots were soiling the floor. I looked at him and said proudly that I would be attending this institution a year from now. He laughed and said, 'Right kid, and next year I am going to be Police Commissioner.'

Fauci received his M.D. from Cornell in 1966. He was ranked first in his class. There is no record of what sort of footwear he chose for commencement. Howard R. Leary was New York City's Police Commissioner in the spring of 1966. There is no record of his ever having worked security at Cornell.

### **A Professional Lifetime in Public Service: Researcher, Physician, Administrator**

Fauci has spent his entire professional career at the National Institutes of Health. He started as a clinical associate in the Laboratory of Clinical Investigation at the National Institute of Allergy and Infectious Diseases (NIAID) in 1968, after a two-year residency at The New York Hospital-Cornell Medical Center. By 1974, he was head of the clinical physiology section of the lab. In 1980, he became chief of the Laboratory of Immunoregulation (a position he still holds) and since 1984, he has been the director of NIAID.

The lab work that has dominated one major facet of Fauci's professional life isn't necessarily what lay people imagine. On a day-to-day basis, "doing science," as a lot of researchers casually refer to it, encompasses most of the same administrative, and even promotional, frustrations as running a small business. Added to that are the imperatives of academic and scholarly progress: "*publish or perish*."

Dr. Peter Warburton, a molecular biologist who runs a lab at the Mount Sinai School of Medicine in New York, puts it this way, "Running a research lab is supposed to be fun; you're doing science, working hard but focusing on your research, which hopefully you love and find endlessly fascinating. But when you finally become successful enough to get your own lab, reality clicks in, and you find out how much administrative work is required to run a lab, and how little time is left to actually *do* the science. Suddenly, not only do you need to be a scientist, graphic artist, technical author, public speaker and politician, you also need to be a personnel and business manager—and an accountant, usually with a budget of several hundred thousand dollars a year."

For Fauci, of course, the budget numbers are rather larger, as noted below.

At the same time that he has continued to do lab research, however, Fauci has never stopped seeing patients—and he has continued both of those kinds of hands-on work—as his administrative duties have increased, along with their attendant political and media responsibilities. While others have sometimes characterized this as a difficult juggling act, Fauci has always stressed the benefits. Others have noted them, on occasion, as well.

In 1990, for example, journalist Randy Shilts, who would later write an important memoir of the early years of AIDS, *And the Band Played On*, wrote caustically in the *San Francisco Chronicle* of researchers who no longer did research, but singled out Fauci as an exception: "Although the federal government's leading AIDS celebrity, Dr. Anthony Fauci of the National Institutes of Health, actually goes into his immunology lab in Bethesda to work with test tubes, a lot of the people you see quoted on TV as major laboratory researchers don't. They have assistants don white coats and do all that tedious work, even though they're the ones Dan Rather chats with once the results are in."

Politically, Fauci has overseen a huge increase in the budget of NIAID. Figures in *Government Executive Magazine* put the Institute's 1984 budget, at the beginning of his tenure, at about \$357 million per year; the 2003 budget will be approximately \$3.9 billion. In comparative terms, NIAID had moved from taking up 7 percent of NIH's budget to taking 14 percent, and from the sixth highest funded Institute to the second.

While a great deal of attention has been focused on his work on AIDS, Fauci's scope is much broader than that, as evidenced at the beginning of this year when he was one of the most visible of the government officials publicly discussing the threats posed by anthrax and other possible bio-terror weapons. His is the timbre of voice that one wants to hear in that sort of atmosphere: calm, reassuring, but not falsely so. He spoke the facts and had a credible record of speaking the truth under difficult circumstances.

The balancing act that he has accomplished between the various parts of his career is underscored as much by what he has *not* done as by what he has done. Twice, during the presidency of George H. W. Bush, he was offered the position of director of NIH, and twice, he turned the position down; on the second occasion, he did so in the Oval Office.

### **How AIDS Changed Medicine**

It's easy to forget, some 20 years into the AIDS epidemic, both how terrifying and chaotic the early onslaught of the disease was, and how much AIDS activism has percolated through our approach to other diseases, changing in many ways the entire doctor-patient relationship in the United States, and the ways in which drugs are tested and approved and research is funded.

As Fauci describes the pre-AIDS attitude of the medical establishment: "It was not traditional or acceptable for anyone to question what physicians or public health personnel did. 'We knew better; therefore it should be done this way.'" Period.

AIDS changed that, he says.

"With the HIV epidemic came the birth of a certain form of activism that *demanded* participation in the decision making," he says, "particularly when it was dealing with a deadly disease, for which there was no treatment."

But those changes were not instantaneous, of course, nor were they consistent—neither within the clinical practice of medicine, nor within the medical research community. It's easy, in retrospect, to say that "unnecessary" bureaucracy shouldn't hold up the release of "crucial" medication. But what do those terms mean without the words "safe" and "effective"?

The relationship of doctor and patient is similarly complex. Most people would count it as progress that, over the past 20 years, physicians more often have been socialized to *interact with* than to *dictate* to their patients. And the AIDS crisis has been a key part of moving medicine in this direction. At least in the beginning, it leveled the playing field: doctors often knew no more than their patients, who were then motivated to go out and find their own answers. But taken to the extreme, this leveling of the doctor-patient relationship can feel like an abdication of responsibility.

The first wave of the epidemic, in gay enclaves on both coasts—places like Greenwich Village, West Hollywood and San Francisco—was heralded by a mix of patient complaints both esoteric and mundane: a rash of otherwise healthy young men coming down with normally rare diseases like Kaposi's sarcoma and pneumocystis pneumonia, odd yeast infections, suffering inexplicable immunological failures; another group in the same cohort suffered with chronic fevers, night sweats, swollen glands, illnesses sometimes transient, sometimes not, again without good explanations and not responsive to treatment.

This was frightening, first and foremost, of course, to the people suffering from the disease, who, in the beginning, didn't even have a name for what they were going through. That fear and concern quickly spread through the local communities that were hardest hit and into the population at large.

One of the early problems that the disease spawned was discrimination against the people who contracted it, and an early reluctance in some quarters to treat AIDS as "everyone's problem."

As Fauci puts it, "It was and is a combination of a real disease in the classic sense, a huge societal problem with disenfranchised populations, an ethical issue, a social issue, a very charged political issue, with conservatives early on ... not really wanting to recognize that this is something that we should pay attention to—probably because the subjects of the disease were people who were disenfranchised."

Immediately, this put public health officials dead center in an agonizing struggle.

### **Walking Among Them**

Carol Brown Moskowitz, a research nurse and neurological nurse practitioner, recalls running into a group of leather-clad men, many of them body pierced and draped in chains, in the lobby of Washington's Omni Hotel, in the fall of 1988. They looked as if they might be members of a motorcycle gang, but the Omni seemed an unlikely place for a biker convention.

When she asked one of them who they were, he told her that they were members of "Act Up," and that they were going out to make some noise at the FDA about the AIDS epidemic and the lack of funding for research.

Make some noise they did. On Oct. 11, about 1,000 demonstrators descended on the FDA facility in Rockville, Md., for some nine hours and shut it down; there were almost 200 arrests.

A smaller group splintered off and headed out to Bethesda, to the NIH campus.

What Fauci remembers about the demonstration, and the demonstrators themselves, was the sense of layers: theatricality, genuine anger, but also an underlying core of pain.

Like Carol Moskowitz, he mentions their clothing first.

"They were dressed funny; they had all these strange outfits; and they were screaming and cursing and yelling," he recalls. "And I looked at them, and I saw people who were in pain. I didn't see people who were threatening me, I saw people who were in pain. And that's exactly what I saw, and I was very moved by the pain. *Boy, they must really be hurting for them to do this.* And I think I conveyed that to them, and they saw that that's how I was feeling toward them."

Fauci asked the police and the FBI on the NIH campus not to make arrests. He also asked that a handful of the demonstration's leaders be brought to his office.

"That began a relationship over many years that allowed me to walk amongst them," Fauci says. "It was really interesting; they let me into their camp. I went to the gay bath houses and spoke to them. I went to San Francisco, to the Castro District, and I discussed the problems they were having, the degree of suffering that was going on in the community, the need for them to get involved in clinical trials, since there were no other possibilities for them to get access to drugs. And I earned their confidence."

It was in San Francisco, in February of 1989, that he met Terry Sutton, a former school teacher, who was losing his sight to cytomegalovirus, one of the secondary infections then common among AIDS sufferers. The infection, it was already known, could be treated with the antiviral medication ganciclovir, but the FDA had not yet approved the medication for release.

The meeting was arranged by Martin Delany, the founder of San Francisco's Project Inform, which had been on the leading edge of getting both information and medication—often imported illegally from other countries—to people with AIDS at a time when the government approval process was perceived to be too slow.

"I arranged for Tony to come to the Hilton Hotel, to meet some people face to face," Delany remembers. "It was sort of based on the feeling that if people like him would just get in the face of people who were really sick and desperate over some of these regulatory issues, it might change how they felt about them ... That was how he connected to them. And you could see clearly that he was moved emotionally by that."

Less than four months later, in June of 1989, at the 5th International AIDS Conference in Montreal, Fauci publicly spoke out in favor of releasing ganciclovir to people who needed it, and by the end of the month, the FDA had reversed course and done so.

In the face of Fauci's public change in position, they'd had little choice.

Delany also points to the 6th International AIDS Conference in San Francisco the following year as a time that solidified a more positive view of Fauci in the activist community. This was also part of a broader series of moves undertaken by the researchers and public officials fighting the epidemic to take account of the activists and people with AIDS: a number of free passes to the conference were offered to activists, community members and people with AIDS, who couldn't afford the \$550 cost of admission. There were nightly debriefings and question and answer periods held at a local public auditorium for people not attending the conference—one of them run by Fauci. Researchers joined an AIDS rally in downtown San Francisco, where conference organizer and AIDS researcher, Dr. Paul Volberding, told the crowd, "The apparent divisions between us are not real."

Undoubtedly, what Volberding had said was true as a matter of spirit: everyone there was united in a desire to see the disease conquered. What had changed significantly, between Montreal and San Francisco, was the degree to which that process was to be overtly open to patient input. In Montreal, Act Up protesters had seized the stage; in San Francisco, they'd had a place on the stage. Some joked that rioting had now been given an official slot on the program.

This approach was not without its detractors, nor was a loosening of the strictures on the release of new drugs universally seen as a good thing. Many researchers worried that it would now be difficult to get people to enroll in well controlled clinical trials, and that the data from people who did enroll might be contaminated by exposure to a broad variety of untested medications. By managing to walk a line between conflicted constituencies and work at redrawing those lines, often under heavy fire, Fauci has succeeded as an administrator.

### **When to Take a Punch**

Observing the strategic tussles between Kramer and Fauci in the '80s and into the early '90s, one might liken them to the Punch and Judy Show, with Kramer always in the role of Punch—and with a real bat. But this would be to misunderstand what was going on, as, ironically, the dramatist Kramer sometimes seemed to do.

One can see Fauci's awareness of the dynamic of his relationship with Kramer in an article Natalie Angier wrote in *The New York Times* in February of 1994:

And through it all, Dr. Fauci accepts the criticisms, and he accepts that someone must absorb the anger and terror that AIDS has spawned, so why not somebody of strong vertebrae who was raised on the streets of Bensonhurst? "I was on a C-SPAN program a couple of months ago with Tony, and I attacked him for the entire hour," said Mr. Kramer. "He called me up afterwards and said he thought the program went very well. I said, 'How can you say that? I did nothing but yell at you.' He said, 'You don't realize that you can say things I can't. It doesn't mean I don't agree with you.'"

Dr. Fauci claims he does not take the intermittent blasts personally. "That's the activist mode," he said. "When there's a disagreement their tendency is to trash somebody. But I know that when Larry Kramer says the reason we're all in so much trouble is because of Tony Fauci, he's too smart to believe that.

"I don't want them to change or compromise that mode," he added, "as long as they don't ask me to change my opinions."

What Fauci has accomplished over the course of his war on AIDS is nothing short of amazing: he has managed to build a bridge between deeply antagonistic constituencies, working all the while under the relentless glare of media scrutiny. And he has built that bridge using the tools he spent a lifetime cultivating—a tireless work ethic, a scrupulous honesty and an abiding sense of compassion.

### **Where Does He Get the Energy?**

It also helps that he has a spouse who shares his goals and values. Fauci is married to Christine Grady, who completed her bachelor's degree, with a double major in nursing and biology, in the mid-1970s—although she might have gone premed instead. She returned to Georgetown University more than a decade later, completing a Ph.D. in philosophy and bioethics in 1993. She currently heads the section on human subjects research in the department of clinical bioethics at NIH.

In a 1997 interview with the NIH Historical Office, she describes how she and Fauci met. Grady had spent two years in the early 1980s working as a nurse educator and manager of ambulatory care for Project Hope in Alagoas, Brazil; when doctors needed someone to translate for a Portuguese-speaking patient at the NIH hospital where she was working, they knew who to ask.

"I met him (Fauci) here over the bed of a patient who happened to be from Brazil. I was called in as a translator because this man wanted to go home, and they were afraid to let him go home because the guy had vasculitis. His vasculitis was not in great control. And so they said, 'Could you come translate for Dr. Fauci?' whom I had not met—the inimitable Dr. Fauci—everybody was afraid of. When he came in, I thought, 'What are they so afraid of him for? He is not so scary.'

"But it is actually a great story because Tony, in his very serious way, said, 'Make sure that you do your dressings every day and sit with your leg up,' and I forget all the details. But I translated that to the patient, and the patient said, 'You are kidding. I am so sick of being in this hospital. I am going to go home, I am going to dance all night, I am going to go to the beach, I am going to do this.' So I think to myself, 'How am I going to do this?' So I turned around to Tony and said, 'He said he would do exactly as you said.' I kept a straight face all the time."

When Grady was called to his office later that day, she figured that she had been found out. As it happened, the inimitable Dr. Fauci just wanted to ask her out on a date. Married for 17 years now, they have three daughters, ranging in age from 10 to 16. As a couple, they are in a better position than most to understand each other's work. During her career, Grady not only worked with AIDS patients in the early years of the epidemic, she also educated other nurses about caring for patients with AIDS. Her doctoral dissertation, published in book form in 1995, is titled *The Search for an AIDS Vaccine: Ethical Issues in the Development and Testing of a Preventive AIDS Vaccine*.

No fast take on the Faucis' family life seems to be complete without the notation that they tend to all eat dinner together around 9:30 every night—testimony both to their busy schedules and to the importance that they ascribe to spending time together.

One might ask: Where does Fauci—the researcher, clinician, administrator, politician, husband, father—find the energy? The truth is the good doctor, like a long-distance runner, seems to thrive on his efforts.

When asked about his multiple roles in the fight against AIDS, he responds by discussing the multifaceted character of the disease:

"It was complex. It was a health problem; it was an ethical problem; it was a legal problem—the legal rights of these people. And I just felt that if this problem needed to be tackled, I couldn't be completely unidimensional about it. And the more I got into the other issues, the more interesting it became, because they were all linked with each other."

It doesn't seem to occur to Fauci that he is doing the work of three people. For him, the key word is "interesting." Fauci is doing what he wants to do. On all fronts. And, for the most part, it appears he always has. For his part, this makes him, among other things, an extraordinarily fortunate man; and he knows it.

[Anthony S. Fauci, M.D., '62 Sidebar >](#)

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## Features

**Anthony S. Fauci, M.D., '62**

## Awards and Honors

- Dr. Fauci received the Frank Annunzio Award in the Humanitarian Field in 2001. Announced by the Christopher Columbus Fellowship Foundation, an independent federal government agency, the Award is presented annually to those individuals whose research has "led to creative work, process, product or other achievement that has had a significant and beneficial impact on society."
- Dr. Fauci has received 24 honorary doctorates for his scientific accomplishments from universities in the United States and abroad.
- In the years between 1981 and 1994, Dr. Fauci was the fifth most cited scientist—out of more than 1 million scientists worldwide that had published during the 13-year period.
- In 1985, the members of the Stanford University Arthritis Center Survey of the American Rheumatism Association agreed that Dr. Fauci's work on the treatment of polyarteritis nodosa and Wegener's granulomatosis was one of the most significant developments in patient management of rheumatology in the past 20 years.
- In March of 2002, Dr. Fauci was presented with the \$500,000 Albany Medical Center Prize in Medicine and Biomedical Research. The annual award, made possible by a \$50 million gift from a New York businessman, recognizes outstanding contributions to "improving health care and promoting biomedical research," as well as dedication to patient care.
- Dr. Fauci has written and edited more than 1,000 scientific publications.

**"People are talking"**

Here's what some prominent individuals have had to say about Dr. Tony Fauci '62:

- "Tony Fauci is one of the great scientists of this world, and I treated him accordingly."—Donna E. Shalala, secretary of Health and Human Services during the Clinton administration
- "I've never seen a time when Dr. Fauci came before a committee of Congress where he has not left the panel better informed and more impressed by his credentials and his commitment to finding an end to this terrible scourge."—U.S. Rep. Nancy Pelosi, D-Calif., a member of the House Appropriations Committee
- "He's got more history yet to make, and he will. At this point in time, I certainly think he's the greatest science administrator, combining both scientific leadership as well as science, that I have ever seen."—Dr. Robert Gallo, AIDS researcher and co-discoverer of HIV
- "Tony has a great skill for taking complex medical issues and boiling them down to simple kernels of information."—Clifford Lane, clinical director of NIAID
- When asked who his personal heroes were at the October 1988 presidential debate, George Bush replied, "I think of Dr. Fauci. You've probably never heard of him. He's a very fine researcher—a top doctor at the National Institutes of Health—working hard, doing something about research on this disease of AIDS."

["I saw people who were in pain" Feature >](#)

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## Press Releases

[ Press Release. (Dec. 10, 2001). First Andrew Carnegie Medals Awarded to Seven Visionaries of Modern Philanthropy. Carnegie Corporation. Reproduced for educational purposes only. Fair Use relied upon. PHOTOS INCLUDED. ]

# First Andrew Carnegie Medals Awarded to Seven Visionaries of Modern Philanthropy

12.10.2001



CARNEGIE CENTENNIAL

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Celebrating 100 Years of Andrew Carnegie's Philanthropy

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private wealth serving the public good



L/R: Moyers, Woodward, Fauri, Turner, Diamond (front), Gates, Brockway, Annenberg, Soros, Astor, Ramphel, Walters, Rockefeller (behind), Parsons, McCullough  
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Press Release. (Dec. 10, 2001). First Andrew Carnegie Medals Awarded to Seven Visionaries of Modern Philanthropy. Carnegie Corporation.  
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## MEDALS COMMEMORATE THE CENTENNIAL OF CARNEGIE'S RETIREMENT AND BEGINNING OF HIS FULL TIME PHILANTHROPIC CAREER

For further information contact:

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*Inaugural Laureates Are Philanthropists Whose Names and Careers Link Old and New Philanthropy*



L/R: Soros, David Rockefeller, Gates, Turner, Astor, Annenberg  
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Press Release. (Dec. 10, 2001). First Andrew Carnegie Medals Awarded to Seven Visionaries of Modern Philanthropy. Carnegie Corporation.  
Source: <https://www.carnegie.org/news/articles/first-andrew-carnegie-medals-awarded-to-seven-visionaries-of-modern-philanthropy/>

Celebrating the legacy of the man who 100 years ago shepherded in the era of modern philanthropy, the inaugural Andrew Carnegie Medals of Philanthropy were awarded today to seven world-renowned benefactors who have forged new visions for the philanthropic community as it embarks on a new century -- and millennium -- of giving.



The laureates of the first Andrew Carnegie Medals -- some of whom represent families -- are among the most illustrious in the history of philanthropy. They are Ambassadors Walter H. and Leonore Annenberg on behalf of the Annenberg Foundation, Brooke Astor, Irene Diamond, the Gates family, David and Laurance S. Rockefeller on behalf of the Rockefeller family, George Soros and Ted Turner.

The awards ceremony took place at the New York Public Library, symbolizing the great importance Mr. Carnegie placed on libraries. His early philanthropic contributions focused on libraries and some 2,500 public libraries were built in his name around the world.

"The Andrew Carnegie Medals of Philanthropy honor an extraordinary group of benefactors who understand the pivotal role that philanthropy plays in developing and sustaining our democratic institutions," said Vartan Gregorian, president of Carnegie Corporation of New York and chair of the executive committee of the 21 Carnegie institutions worldwide that spearheaded the centennial events.

"The laureates represent the diversity of the philanthropic community and its wide range of views on giving," Gregorian added. "December 10th offers an unprecedented opportunity to showcase these remarkable people, who are following in the path of Mr. Carnegie. By celebrating his legacy and theirs, we seek to reinvigorate and challenge the philanthropic community for tomorrow."

Also serving on the executive committee of the Carnegie Centennial were Maxine Frank Singer, president of Carnegie Institution of Washington, and Jessica T. Mathews, president of Carnegie Endowment for International Peace.

An audience of cultural, philanthropic and government leaders attended as history's first Carnegie Medals were presented by dignitaries with household names. The presenters included television journalists Tom Brokaw, Bill Moyers and Barbara Walters; Pulitzer-Prize winning historian David McCullough; AOL Time Warner Co-Chief Operating Officer Richard D. Parsons; the respected AIDS researcher and Director of the National Institute of Allergy and Infectious

Diseases at NIH Dr. Anthony S. Fauci and World Bank Managing Director Mamphela Ramphele. CNN's Senior Anchor Judy Woodruff, a trustee of Carnegie Corporation of New York, served as the master of ceremonies.

The awards ceremony celebrated one of the most important financial transactions of the 20th century, when J.P. Morgan purchased U.S. Steel for \$480 million (the equivalent of \$10.6 billion today) from Andrew Carnegie, who then devoted the rest of his life to philanthropy on a level not then seen in America or anywhere else. By his death, Mr. Carnegie had given away 90 percent of his fortune.

The awards ceremony formed the high point of the daylong centennial celebration, during which leaders of Carnegie institutions worldwide held a first-ever joint board meeting aimed at revitalizing their missions prior to jointly awarding the Carnegie medals and bronze bust of Andrew Carnegie to the seven laureates.

The Carnegie family of institutions voted on a resolution to select and award the Andrew Carnegie Medals of Philanthropy biennially.

According to citations for the awardees, Ambassadors Walter H. and Leonore Annenberg, who jointly head the Annenberg Foundation, were selected for the historic role their foundation has played in helping America's schoolchildren meet the challenges of the 21st century and for their personal commitment to strengthening education and the arts. Among their many gifts is the \$500 million Annenberg Challenge Grant, the largest single gift ever bestowed on public education in the United States. Ambassador Leonore Annenberg accepted the award on behalf of her husband and herself.

Brooke Astor, who as president of the Vincent Astor Foundation has been a major force behind the revitalization of the New York Public Library, was chosen for her unstinting efforts on behalf of New York City's great cultural and education institutions during 40 years of inspired philanthropy.

Irene Diamond -- who discovered the property that became the Hollywood classic Casablanca and who helped bring Burt Lancaster and Robert Redford to Hollywood -- was selected for her trailblazing gifts to combat AIDS and to educate the public about the disease. She served as president of the Aaron Diamond Foundation, which distributed all of its assets and became the nation's largest private supporter of AIDS research. She was also recognized for her continuing support of the arts in New York City.

The Gates family -- William H. Gates III, Melinda French Gates and William H. Gates Sr. -- who are setting new standards of giving for the 21st century as heads of the Bill and Melinda Gates Foundation, were selected for their leadership in reaffirming an ethic of responsibility to the world at large and for their landmark efforts to promote health equity around the globe, help all students achieve and to bridge the digital divide. William H. Gates, Sr., accepted the award on behalf of the Gates family.

The Rockefeller family was recognized for its exceptional record of philanthropy over the last century. Third and fourth generations of the family now continue to build on philanthropic roots established by John D. Rockefeller, who, along with Andrew Carnegie, set standards for all who followed. David Rockefeller accepted the award on behalf of himself, his brother, Laurance S. Rockefeller, and the entire Rockefeller family.

George Soros, whose global network of foundations and Open Society Institutes spend nearly a half-billion dollars each year to support projects in education, public health, civil society development and other areas, was chosen as a laureate for his leadership and vision in fostering open societies and a better life for billions of citizens of the world.

Ted Turner was selected for his leadership in the philanthropic arena, particularly with his historic \$1 billion gift to the United Nations, for his passionate stewardship of the environment and for the Nuclear Threat Initiative to reduce the global threat posed by nuclear and biological weapons.

Capping the Carnegie Centennial was an evening concert at Carnegie Hall, which Andrew Carnegie founded in 1889 after acquiring seven parcels of land on 57th Street, considered at the time an outpost on the city's cultural map.

Andrew Carnegie's philanthropic efforts actually began in 1870. In "The Gospel of Wealth," which he published in 1889, he outlined his philosophy of giving, which asserted that the rich are merely "trustees" of their wealth and are under a moral obligation to distribute it in ways that promote the welfare and happiness of the common man. He died in 1919, leaving his wife and their daughter. His great grandsons Roswell Miller and Kenneth Miller -- whose 15-month-old son is the first in the family to be named Andrew Carnegie -- attended Carnegie Centennial events.

## 21 CARNEGIE ORGANIZATIONS WORLDWIDE

Andrew Carnegie founded 21 organizations that today bear his name. Each of the organizations has its own funds and trustees and is independently managed. The organizations are Carnegie Hall, New York (founded 1889), the Carnegie Institute, Pittsburgh (1895), Carnegie Mellon University, Pittsburgh (1900), the Carnegie Trust for the Universities of Scotland, Dunfermline (1901), Carnegie Institution of Washington, Washington, D.C. (1902), the Carnegie Dunfermline Trust, Dunfermline (1903), the Carnegie Hero Fund Commission, Pittsburgh (1904), the Carnegie Hero Fund Trust, United Kingdom, Dunfermline (1908), Fondation Carnegie, France (1909), Carnegie Heltefund for Norge, Norway (1911), Fondation Carnegie pour les Sauveteurs, Switzerland (1911), Carnegie Heldenfonds, The Netherlands (1911), Carnegiestiftelsen, Sweden (1911), Carnegie Belønningsfud for Heltemod, Denmark (1911), Fondation Carnegie, Belgium (1911), Fondazione Carnegie, Italy (1911), the Carnegie Foundation for the Advancement of Teaching, Menlo Park, California (1905), Carnegie Endowment for International Peace, Washington, D.C. (1910), Carnegie Corporation of New York, New York City (1911), the Carnegie United Kingdom Trust, Dunfermline (1913) and the Carnegie Council on Ethics and International Affairs, New York City (1914).





L/R: Moyers, Woodward, Fauci, Turner, Diamond (front), Gates, Brokaw, Annenberg, Soros, Astor, Ramphela, Walters, Rockefeller (behind), Parsons, McCullough

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**Pictured:** L/R: Billy Don "Bill" Moyers; Judy Carline ("Judy") Woodruff; Anthony Stephen Fauci; Robert Edward ("Ted") Turner III; William Henry ("Bill") Gates II (Sr.); Thomas John Brokaw; Leonore Cohn ("Lee") Annenberg; George Soros; Roberta Brooke Astor (née Russell); Mamphela Aletta Ramphela; Barbara Jill Walters; David Rockefeller (behind); David Gaub McCullough; Richard Dean "Dick" Parsons.

**Backgrounders:** L/R (read: A British Pilgrims Society fellowship hour):

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**Anthony Stephen Fauci:** propagandist, eugenicist, abortionist, weaponized biology, physician, healthcare administrator, NIH, CDC, HIV, AIDS, SARS, Ebola, COVID-19 scare monger; advisor to the DoD Office of Net Assessment weaponization program

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**Mamphela Aletta Ramphela:** South African politician; managing director, World Bank; founder, Agang South Africa party; Harvard; director, Anglo-American Corporation; co-president, Club of Rome; British Pilgrims Society nuclear strategist with World Economic Forum Klaus Schwab and Sulzer-Escher-Wyss

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CAPTION:

L/R: Moyers, Woodward, Fauci, Turner, Diamond (front), Gates, Brokaw, Annenberg, Soros, Astor, Ramphela, Walters, Parsons, McCullough.

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L/R: Soros, David Rockefeller, Gates, Turner, Astor, Annenberg

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# List of College of the Holy Cross alumni

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This **list of College of the Holy Cross alumni** includes graduates and non-graduate, former students at the College of the Holy Cross. Since its founding in 1843, Holy Cross has graduated 157 classes of students and as of the 2005-06 academic year had approximately 35,000 alumni.<sup>[1]</sup>

## Contents

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### Artists, poets and authors

### Business

### Education

- Professors and researchers

### Entertainment

### Law, politics, and public service

- United States federal and state court justices

- Executive branch and United States Cabinet members

- Members of the United States Congress

  - Senators

  - Representatives

- United States governors

- Ambassadors and other diplomats from the United States

- Foreign Government officials

- Other United States political and legal figures

- Military

### Media and communication

### Religion

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### Sports

- Baseball

- Basketball

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- Ice hockey

- Other sports

### Notable Holy Cross faculty

### Presidents of the College

### References

## Artists, poets and authors

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- Vito Acconci 1962, artist and architect

# Hillary Clinton Email Archive

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## TONY FAUCI

From: Robert Russo  
To: Hillary Clinton  
Date: 2011-11-02 08:01  
Subject: TONY FAUCI

UNCLASSIFIED U.S. Department of State Case No. F-2014-20439 Doc No. C05783080  
Date: 10/30/2015

RELEASE IN FULL

From: Russo, Robert V <RussoRV@state.gov>  
Sent: Thursday, November 3, 2011 3:01 PM  
To:

Subject: RE: TonyFauci

Will do.

-Rob

From: H[mailto:HDR22@clintonemail.com]  
Sent: Thursday, November 03, 2011 3:00 PM  
To: Russo, Robert V  
Subject: Fw: Tony Fauci

Pls do letterof congrats.

From: Abedin, Huma [mailto:AbedinH@state.gov]  
Sent: Thursday, November 03, 2011 02:34 PM

To: H  
Subject: Fw: Tony Fauci

From: Quam, Lois E  
Sent: Thursday, November 03, 2011 02:14 PM  
To: Abedin, Huma; Mills, Cheryl D  
Subject: Tony Fauci

I thought you and the Secretary would enjoy knowing the Tony Fauci was just named by Government Executive magazine to be one of the top 20 federal government employees of all time.

See Also US Diplomatic Cable Search (<https://www.wikileaks.org/plusd/>)

Top



**COURAGE**



WL Research Community - user contributed research based on documents published by WikiLeaks.

(<https://our.wikileaks.org>)

Tor is an encrypted anonymising network that makes it harder to intercept internet communications, or see where communications are coming from or going to.

(<https://www.torproject.org>)

Tails is a live operating system, that you can start on almost any computer from a DVD, USB stick, or SD card. It aims at preserving your privacy and anonymity.

(<https://tails.boum.org/>)

The Courage Foundation is an international organisation that supports those who risk life or liberty to make significant contributions to the historical record.

(<https://www.couragefoundation.org/>)

Bitcoin uses peer-to-peer technology to operate with no central authority or banks; managing transactions and the issuing of bitcoins is carried out collectively by the network.

(<https://www.bitcoin.org/>)





The GiFiles,  
Files released: 5543061

**The GiFiles**  
(<https://www.wikileaks.org/the-gifiles.html>)  
Specified Search  
(<https://search.wikileaks.org/gifile>)



(<http://wikileaks.org/the-gifiles.html>)

# THE GLOBAL INTELLIGENCE FILES

On Monday February 27th, 2012, WikiLeaks began publishing *The Global Intelligence Files*, over five million e-mails from the Texas headquartered "global intelligence" company **Stratfor**. The e-mails date between July 2004 and late December 2011. They reveal the inner workings of a company that **fronts as an intelligence publisher, but provides confidential intelligence services to large corporations**, such as Bhopal's **Dow Chemical Co., Lockheed Martin, Northrop Grumman, Raytheon** and government agencies, including the **US Department of Homeland Security**, the **US Marines** and the **US Defence Intelligence Agency**. The emails show Stratfor's web of informers, pay-off structure, payment laundering techniques and psychological methods.

## US/FLU- Young children need 2 doses of H1N1 vaccine- US

Released on 2013-02-13 00:00 GMT

Email-ID	1680879
Date	2009-09-21 21:06:58
From	sean.noonan@stratfor.com
To	os@stratfor.com

US/FLU- Young children need 2 doses of H1N1 vaccine- US

<http://www.alertnet.org/thenews/newsdesk/N21313516.htm>

Young children need 2 doses of H1N1 vaccine- US

21 Sep 2009 17:45:44 GMT

Source: Reuters

\* Children 10 to 17 need one dose of swine flu vaccine

\* H1N1 vaccine affects people like seasonal flu vaccine

\* US to report on tests in pregnant women in October (Updates throughout with quotes, details and background)

By Maggie Fox

**WASHINGTON, Sept 21 (Reuters) - Younger children will need two doses of the vaccine against the new pandemic of H1N1 influenza, U.S. officials said on Monday.**

They said tests of Sanofi-Pasteur's <SASY.PA> swine flu vaccine showed children respond to it just as they do to seasonal flu vaccines, with children over 10 needing only a single dose.

Separately, Sanofi said it had won a U.S. government order for 27.3 million more doses of its vaccine based on the lower dose requirement.

Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, said young children will likely need to have their doses 21 days apart. But he said they could receive seasonal flu shots and H1N1 shots on the same day -- something that could ease the logistics of vaccinating children multiple times.

"As we had hoped, in children the 2009 H1N1 vaccine is acting just like the seasonal flu vaccine," Fauci told reporters in a telephone briefing.

Children aged 10 to 17 mounted an immune response that should protect them from H1N1 within 8 to 10 days, Fauci said.

The U.S. Centers for Disease Control and Prevention said 46 U.S. children have died from swine flu, which appears to have first emerged in Mexico in March and which spread around the world to cause a pandemic in only six weeks.

As soon as the new virus was identified, the U.S. government and companies started making a vaccine against it and testing began in August to ensure it was safe and to determine what dose would be needed.

About 25 companies globally are now making H1N1 vaccine.

The United States had ordered 195 million doses of H1N1 vaccine from five makers -- GlaxoSmithKline <GSK.L>, Sanofi, Australia's CSL <CSL.AX>, AstraZeneca's <AZN.L> MedImmune unit and Novartis <NOVN.AX>. With the new order from Sanofi, that would make more than 222 million doses.

This is not enough to cover the U.S. population of 300 million people but the CDC says almost every year influenza vaccines go unused and millions of doses are thrown away.

#### MORE TO GO AROUND

Most countries ordered H1N1 vaccine with the expectation that two doses would be needed, so the many now have more than anticipated.

The CDC has designated about 160 million people to be vaccinated first, including pregnant women, people with heart disease, asthma or diabetes and school-aged children.

With seasonal flu vaccine, children under 9 who are getting a flu vaccine for the first time need two doses, so Fauci said it is likely that young children who have never had a flu vaccine before will need four doses this year -- two seasonal flu doses and two swine flu doses.

But that may not mean four visits to a clinic or doctor's office, the CDC's Dr. Anne Schuchat said. "We do expect, based on what we know about vaccines, that it should be fine for the shot to be given on the same day," she said.

It gets a bit more complicated with MedImmune's nasal spray vaccine, she said. Children getting that needle-free vaccine will likely need to get FluMist, the seasonal version, separately from the swine flu formulated nose spray.

H1N1 is now the dominant strain of influenza circulating globally and Fauci said it is possible it may replace the seasonal form of H1N1 also circulating.

[Editor's Note: This is criminally bad science, vaccines take many years to develop after the target virus has been identified. This Stratfor piece is pure C.I.A.-inspired propaganda, in our opinion.]

[GlaxoSmithKline (the Wellcome Trust), Sanofi, AstraZeneca and Novartis are tightly aligned with the Bill and Melinda Gates Foundation, Merial Animal Health Institute (UK & China), The Pirbright Institute funded by DARPA (U.S.) & DERA (UK)]



# In Their Own Words...

NIH Researchers Recall the Early Years of AIDS


[Introduction](#)
[First Encounters](#)
[Tip of the Iceberg](#)
[Mobilizing](#)
[Discovery of HIV](#)
[Search for Treatments](#)
[Transcripts](#)
[Ms. Barbara Fabian Baird](#)
[Dr. William Blattner](#)
[Dr. Samuel Broder](#)
[Dr. Bruce Chabner](#)
[Dr. James Curran](#)
[Dr. Anthony S. Fauci](#)
[Dr. John I. Gallin](#)
[Dr. Robert Gallo](#)
[Dr. William Gay](#)
[Dr. Edward P. Gelmann](#)
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[Dr. Thomas Waldmann](#)
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[Dr. Robert Yarchoan](#)

**Harden:** I want to ask one more question about your background, because we covered this in terms of your motivation. Was your parents' interest in social issues and yours rooted perhaps in religion or rooted in civic activity? Can you pin it down? Was it both of the above?

**Grady:** I think it was probably not one over the other. Certainly my parents are very devoutly Catholic, and there is some service in the sense of the Catholic religion. But I think it is goes beyond that. There is a civic duty. Again, although my father was the orchestrator of much of the activity that I described earlier, I think perhaps the influence in this regard was really my mother. She was more behind the scenes, but always there, always pushing it. Still, to this day, she is very active and does a number of things in the community.

**Hannaway:** That is good to hear. We want to know about your coming to the NIH, which was in 1983, and you just mentioned that you knew already that you were coming when you were at the governor's school. Can you tell us how it happened that you came to the NIH, and then we will ask you questions about your experiences here.

**Grady:** We know how people put together their motivations in retrospect. I had a job in 1976, 1977, and 1978, maybe, at Tufts New England Medical Center. I worked there on an NIH-funded clinical study unit—it was a GCRC [General Clinical Research Center]—and I loved that job. Yet—I was just telling the story to someone the other day—we, at that time, had two major categories of studies. One was endocrine and the other was hematology-oncology, and both of them very powerful experiences. But the hem-onc studies were primarily bone marrow transplants for children and for some adults with leukemia or aplastic anemia. These were the early days of bone marrow transplants, where the patient was in what they called the life island, that is, they were completely surrounded by plastic. Everything that we did, we did through double layers of protection and through this plastic. It was a very elaborate contraption. Most of those people died; almost all of them died.

I can remember at the time being motivated to go back for a master's degree in public health because I could not quite justify in my mind this gross expenditure of resources, time, money, and people's efforts on something which ended up so much a failure. That is why I went to the school for public health and did the public health degree, taught public health, went to Brazil, which I would call public health work, although I was in a hospital, and then came back to the research, which was an interesting cycle.

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image in my mind of what I wanted. I said to people that I wanted the perfect job and the perfect place to live. Eventually, I asked, "Well, what is that?" I explored several possibilities in New England, which was where I had been previously. I almost accepted one job, which was a research job also, at the Brigham [Brigham and Womens Hospital].

But I was very much attracted to the research aspects of being at the NIH. I knew Washington a little from having gone to Georgetown [University School of Nursing]. So I specifically wanted a job at the NIH, and I called the Nursing Department and basically was told that there was nothing. Then I saw an advertisement for a job at the NIH in the *New York Times* the following Sunday, and I said, "How could this be?" I responded to the advertisement. I became pretty much open to any possibility in terms of a job.

In fact, the job in the advertisement that I responded to and applied for was a job as an educator. When I came and interviewed and met the people, the person who ultimately hired me said, "I want to hire you, but not for that job. I want you for a different job." I said, "Tell me more." I came as what is called a clinical nurse specialist; the position happened to be in the infectious disease area.

Much of what they wanted me to do initially—I do not know what the right words are—was to advance the level of knowledge of the nursing staff in immunology, because immunology was driving many of these infectious disease studies, and certainly much of the work in that area is and was immunology. So I came to the NIH and immediately, one of the first things I did was to develop a course in immunology, which I taught for several years to the Nursing Department. In fact, somebody asked me this morning, "Why can't you teach that course again?" I said, "My life has taken a little bit of a different direction."

**Harden:** Let me get you to explain where you learned your immunology, because that is the time when cellular immunology was just...

**Grady:** Exploding.

**Harden:** I tried to find materials about cellular immunology at that point, and it was very hard.

**Grady:** It was very hard. When I took the job, the person who hired me said, "We want you to teach a course in immunology." I said, "I don't know anything about immunology. How can I teach immunology?" She said, "You know as much as anybody else. You find out, and then you teach the rest of the staff."

I took two, maybe three, FAES [Foundation for Advanced Education in the Sciences] courses in immunology, I read many books, and I talked to all the investigators in NIAID [National Institute of Allergy and Infectious Diseases] that were doing intramural immunology. After everything that I read, I would go back and say, "This doesn't quite make sense. Explain it to me." After a time I felt like I knew a little of the basics. As I put the course together, I relied on the people in that institute to help me make sure that the things I was saying were correct. They reviewed materials for me and helped me update things. It was a very supportive group to work with in terms of some of those efforts.

**Harden:** Let me pin down one more matter here, too. You actually were hired as a nurse. You were paid by the Clinical

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Grady: That is right.

**Harden:** Did you ever move into working for NIAID?**Grady:** No.**Harden:** It has always been the Clinical Center?**Grady:** Yes.**Harden:** We have been trying to sort this out with everyone we interview.**Grady:** No, I never worked for NIAID. I worked during those years with NIAID because I was assigned to those areas clinically, but I always worked for the Clinical Center, until I went to NINR [National Institute of Nursing Research].

Then, clinically, AIDS was beginning on those units in those days, and it was really only beginning. I mean, there was a handful of patients, but it was clearly...

**Harden:** Is this 1983 that we are talking about?**Grady:** 1983.**Harden:** Yes.

**Grady:** But it was clearly something that was going to grow. That was obvious. And there was much interest on the part of the investigators and a lot of interest and concern on the part of the nurses. It was a natural thing for me to start to learn as much as I could about it as things were being discovered; and that is what I did. It became, over time, the area on which I focused the most attention. In the very beginning, that was not true. I learned as much as I could about it, but I was also learning about Wegener's granulomatosis and the other vasculitis diseases, and some of the allergic diseases that were being seen up there, and these infectious diseases, about which I felt like I had a little bit of an edge on information, since I had seen some of them in their real setting and other people had not.

**Hannaway:** Could you describe your first involvement with AIDS patients?

**Grady:** Yes, I think I can. Some of that is a little hazy. Some of the patients that I remember from late 1983 and 1984 were the patients to whom I became the most attached. I learned an incredible amount from them and became very close to some of them. Amazingly, there are two who are still alive and come here, and whom I still try to see whenever they come.

But in those early days, there were a couple of studies that I remember very specifically because of the nature of the studies and because of some of these individual people. One of them was a study of IL-2 [interleukin-2], which, ironically, is still going on, but in those days it was a very different product and there was a very different approach and many problems in terms of the way it was tolerated by people. Even though I was a clinical nurse specialist, I did take a couple of patients as primary patients, and the patients—I cannot remember if I volunteered for them or was assigned to them—were HIV patients on IL-2 protocols.



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Grady: The clinical nurse specialist's job is a very

job. It is in some respects undefined, and in other respects defined in a way that means it covers a lot of territory. They talk about it as advanced practice, which means you can and do take care of patients, but the primary responsibility that you have is not to have a caseload of patients, but to mentor and oversee the practice of the other members of the nursing staff and bring it to the highest level possible. That is done through modeling, education, working together, hands-on stuff, and research, to the extent it is possible.

I did take some patients in those days, but I spent a lot of time with the staff. With the investigators, I felt as though much of what I was supposed to do was to help make not only the goals of, but also, what was probably more important, the day-to-day operational aspects of the research understandable to the nursing staff. I also had to facilitate it so that the people would do what they had to do according to the protocol in the way that it got done and was of high quality, but did not take precedence over taking care of the patients. Do you see what I mean? It was somewhat of a balancing act in that regard.

I spent a lot of time reading and interpreting protocols, putting together the tools, testing out equipment, teaching nurses about the studies, developing educational materials for patients about the studies that the nurses could use, and things like that.

**Hannaway:** What problems would you say came to the fore most quickly? Was it concerns by nurses about safety, either their personal safety or the difficulties of working with patients with this syndrome, and all the range of infections that occurred? How would you describe it?

**Grady:** Certainly the concern about safety was one that was always there. But I have to say that, in my opinion, the Clinical Center did a much better job of dealing with that than did many other institutions. I had the opportunity at times to talk to nurses in a variety of other institutions—private, around the country, local, both. In some places, safety was a very big problem. In this building, it was not. It was a concern. Everybody was always concerned, legitimately. We did not know what we were dealing with in those early days. But the investigators that we were working with and the hospital epidemiology people were very good about telling us everything they knew and bringing everybody together in a room and saying, "This is what we know, this is what we think. Let's try to work on this together." That gave the nurses confidence that they were not being led down a path of deception, that if anything became known about danger or precautions that should be taken, we would know about it as soon as anybody else did.

I know that a couple of years later, in 1986, there were still concerns. I was thinking about that this morning because we had a conversation upstairs about working with tuberculosis patients, and the nurses' concern about safety is legitimate. In 1986, when I was pregnant and was working in the area, there was still confusion about whether or not it was safe, whether pregnancy was an issue in terms of immunosusceptibility or something like that. At the time, I also remember, again, talking to all the people around and getting the data that was available and being pretty assured, both in my own mind and by the people that I spoke to, that short of a needlestick or something, in being pregnant, I probably was not at any risk from the HIV.



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There is a story that I have told many people. We were fairly clear that CMV and pregnancy was—we still know that—and is a problem. There were people who advised me that there were some invasive kinds of procedures that I should avoid doing with the AIDS patients because they were heavy carriers of CMV, and I should use certain precautions, which I did.

Then I remember a patient, whom I took care of very intensively, who had eosinophilia, which is very different, had nothing to do with HIV, and he was dying. We were all over this man—and I was pregnant. Only later, by autopsy, was it discovered that he died of CMV pneumonitis. So we were doing chest tubes, and he was spewing sputum and coughing all over everybody. Those are the things that happen. You cannot predict. You cannot always protect yourself, but I guess I was lucky.

**Hannaway:** You mentioned the hospital epidemiologist, whom we have interviewed. Did you have much interaction with Dr. [David] Henderson? It sounds as though a clinical nurse specialist would be part of a team...

**Grady:** Yes, absolutely.

**Hannaway:**...working to develop guidelines and procedures.

**Grady:** We did, for several reasons. David was always very available to the nursing staff—and that was not just our group, and I think the world of the Clinical Center Nursing Department. He was very available, very up-front with information, responsive to any question and honest about what he knew and what he did not.

**Harden:** This was something he stressed in his interview.

**Grady:** He was, and he was very good at that. In addition to that general way he was with all the nursing staff and being very sensitive to this particular issue around the hospital, he happened to be located on the 11th floor [of the Clinical Center], which is where we were, and also he often went on rounds with the NIAID group. I and the 11th floor nursing staff had additional access to him and to some of the discussions. Plus we had the HIV investigators up there, the people that were doing... certainly they were not the only ones, but a large part of what was going on in the early 1980s was being done right there, certainly the clinical stuff, and in the NCI [National Cancer Institute]. There would be discussions, some more formal than others, about this.

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**Grady:** Yes. Again, this was an area in which nobody had anything to start with. As I may have already said, it became clear from my position that it was something that I needed to be very involved in, not only for helping in the local 11 West and 11 East areas, but in terms of being in a place where I had the opportunity to think through what the nursing issues were and to share that with people beyond our local group. Actually, Barbara [Baird] and I and others worked together in those early days. We would be giving lectures to people in 1985-ish, 1986. We were invited to many places to talk about what it was like to work with AIDS patients.

**Harden:** Outside the NIH?

**Grady:** Yes.

**Harden:** Around the country, or mostly locally?

**Grady:** Some of each. In about 1985, I think it was, there was a nurse in the NCI, Joan Jacob, who also worked with us a lot on some of these issues. She spoke to a group, and I do not remember their name any more. It was a Baltimore-based organization that basically put together educational programs for nurses and sold them to places around the country. She got us hooked into this group. It was primarily she and I in 1985—although I think Barbara probably did some of them, or maybe did some later—who gave these all-day seminars to groups of nurses all around the country. I remember going to Detroit, Dallas, somewhere else in the Midwest, like Dayton, Ohio, or someplace like that. I went to at least five or six different cities around the country to give this canned program that we had put together, a day-long seminar, which basically went through what we knew about the epidemiology of AIDS, what we knew about the clinical manifestations of these patients, and what we knew about treatment, which at that point was virtually nothing. There was a large section on nursing care, what kinds of nursing care were appropriate, what kinds of nursing diagnoses made sense. Then there was a large section on the issue of fear and contagiousness.

**Harden:** What did you hear from the people you were speaking to? Was it different in different places, or were there common themes?

**Grady:** It was a little different in different places. Certainly there were always people who were interested in how to do it better. "How do we deal with this? Anything you know that can help us take care of these patients, we want to know." It was always usually the minority, though, somebody in the group or a couple of people in the group, at least, who said, "It is just too dangerous. Why should I put myself at jeopardy, and my family?" "No matter what you tell me, I don't believe you. It's just not worth the risk," and sometimes even more damning statements than that, but basically that was the sentiment.

**Harden:** Did you feel obligated in your role as a teacher to argue the case with people who took such a position, or were they just allowed to express their opinion?

**Grady:** I always argued the case. But there was always a point at which I gave up. Some people you can talk to and some people you cannot. After a while I would begin to be able to figure who they were, or I thought I could.

**Hannaway:** You could differentiate between them.

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**Harden:** Are there any procedures or policies that stick out in your mind in the 1983 to 1986-1987 period? I thought were either very good or not so good in the way that the staff at the NIH dealt with AIDS patients?

**Grady:** That was a critical time in terms of being the time when the virus was actually discovered, and that confirmed what many people thought, that it was an infection of some sort. Even at that point, there was a fair amount of epidemiological evidence that the modes of transmission were limited. I think, in those days, there were changes in how we did precautions and things like that. But most of what I remember was confirmation of what we were already doing, to tell you the truth. There was a sense that we were on the right track even though we do not have all the information.

When you had asked before about contributing policy, contributions to nursing, or things that nursing did, I think the other thing that we were able to do here at the NIH that was helpful to people in those days, besides present lectures and so on, was to put together some publications. Some of them were informal "this is what we do here" kind of material that we would send out to anybody that asked—care plans and so on—and others were real publications. Barbara did some and so did Joan Jacob and I. There were others within the Nursing Department. Debbie Trivet in the ICU [Intensive Care Unit] was involved; Sue Simmons from Mental Health [National Institute of Mental Health]. There were people around who all had their areas. We all worked together, I believe, very nicely in terms of thinking through what made sense and trying to figure out how to make that available to as many people as possible.

**Harden:** Was there a strong sense that you were leading the nation, that what you were writing was going to get disseminated around the country?

**Grady:** I am not sure that there was a strong sense. There was some sense of, yes, we have to tell everybody what we know because we know more than they do. I can remember actually—I am sure others have echoed this—that sometimes people would call us and say, "Send me the written materials on such-and-such," and we did not have any. I mean, we would have what we did. We would know it. We did not have the time—we were pretty busy—to write it down into a formal procedure or policy, or even a "this is how it should be done" kind of article. We did not always have something in writing. But when we did, we let it be known.

**Hannaway:** Would you see nursing journals as the primary outlet for publications to inform the nursing profession?

**Grady:** Yes.

**Harden:** In 1989, you published an article in *Cancer Nursing* about the impact of AIDS on the nursing profession. I notice...I can quote this to you. I wrote it down primarily because I saw it in many of your articles, the same ideas that you had obviously dealt with this: "AIDS has confronted us with groups of patients whose lifestyles we may not know much about, may not understand, and of which we may disapprove. Each nurse must examine his or her own attitudes about and comfort with issues of sexuality, homosexuality, substance abuse, debilitating illness, and death, and each nurse must attempt to come to peace with these issues before being faced with a patient or a

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Now, was it the whole of your experience that inspired your statement, or were there particular things that inspired you to write this?

**Grady:** I think both. I think the reason I believe that is—although there was the issue that I have already described, that people were afraid of the contagiousness—that was not the whole story. I mean, some of them were, but there was also this, “I do not even want to hear about it because I do not like these people,” and some people were very blatant about it. They were happy to say, “I don’t like those people, I don’t want to take care of them, they deserve what they got, and I am not risking my life to take care of them.”

**Harden:** Did you hear that much at the NIH?

**Grady:** No. I do not think I ever heard it here. But I heard it a lot everywhere else, outside. I remember one person saying to me one time at a talk somewhere, “You could say anything you want. You don’t take care of patients. You don’t know what it feels like.” And I would say, “Sorry, but I do take care of patients and I do know what it feels like.” I think the reality is that those things have not entirely gone away. There are people who do not like homosexuals. There are people who do not like substance abusers as a category. They do not even think about the individual person. It is just, “I don’t like them. They shouldn’t do that. Why should I take care of them?” And it is not just health care workers. It is all kinds of people, patients in the next room.

I think that the real truth—and I am glad I said it in that article—is that in the health care professions, we have not—maybe there was not a reason to, but maybe there was—spent enough time understanding how much a person’s life habits are important in terms of not only taking care of them now, but just the whole understanding of how they got here and where they are going after this. We have an episode of taking care of them in the hospital. To understand a little about what life as a homosexual is like, who now is afflicted with this disease, and to put that in the context of, “I can’t tell anybody that I’m a homosexual. Even my mother doesn’t know I’m a homosexual. How can I tell her that I’m sick?” Those things create issues that, as a health care provider, we need to be able to help people with. If we cannot accept that that is part of what makes sense in that context, then we cannot help them.

**Harden:** Now, what you are saying is the rhetoric is different when you talk with a nurse than when you talk with a physician. This is apparently something that is more common with nurses, to care more about this more simply trying to solve a problem. Would you comment on other differences in how nurses and physicians work with and think about the patients.

**Grady:** I think they are vastly different. I think some of it is just logistics. When you are a nurse, you are with the person for a lot longer, especially when they are sick and in the hospital. You are with them, at least during your entire shift, in and out, maybe, because there are other patients and things to do, but you are basically there for the eight hours. And you are with them in some very intimate ways. You have to bathe them, you have to help them to the bathroom, you have to feed them, you have to clean them up. I mean, there are things that, relating to another individual, you do not do that unless you are in this kind of special relationship. Even though physicians sometimes

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that you are exposed to, that you know this person at a level that many people do not. It is different from person to person, but they sometimes look to you to understand something about them as a whole person and to be able to help with whatever you can do in your limited context, to put that into the sense of who they are. I have to say, I learned that eloquently from some people that had AIDS that I took care of, because they would say in the beginning, they would... I would talk to them about, "What do you want nurses to know? What do you want nurses to think about when they take care of you?" They would say, "The most important thing that you can do is not to judge me. I am me. I am not some statistic, a homosexual with *Pneumocystis* pneumonia. Sure, I happen to be homosexual, I happen to have *Pneumocystis*, but that is just things about me. I am me. I have got my thoughts, my feelings, my experiences, my life, and all those are important to how I am dealing with this, how I am accepting or not accepting treatment, how I am reacting to treatment, what I am going to do when I get out of here, those kinds of things."

There were several patients along the way who were able to express that in ways that I cannot even do justice to, but very eloquently and very convincingly, that you have to... I am a little bit of an idealist, and so I am of the opinion that health professionals in every profession should not forget that to the extent possible.

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**Hannaway:** The person who is sick there.

**Grady:** Yes. To the extent that you can put yourself in their shoes, you are going to be more helpful to them, more sympathetic to their plight, if you will. Now, you cannot put yourself in their shoes all the way. There is some point at which you do not want to all the way, because you have to keep some semblance of separateness in order to be able to function. But to the extent that you can do that in a healthy way, I think it helps. It helps the quality of your helping, if you will.

**Harden:** I want to follow up with two more tough questions now. As a nurse, you are bound to have had obnoxious patients, both AIDS patients and non-AIDS patients. And we have heard from other people, I mean, AIDS patients are human. Some are going to be obnoxious, some are going to be nice. How does that affect the quality of your care? Then I am going to come up with a second question when you finish here. What is your reaction, and what did you see? How was the behavior of people with AIDS who were sick?

**Grady:** Very variable. Some were models of courageousness and strength and worried about everybody around them, and others were a pain in the ass, and that is the way it is. I mean, some people are that way, and some of them have good reasons.

I think one of the things that I believe and that I have said to people is that, just because you are a nurse and you are responsible for taking care of ten people, you do not have to like all ten of them, and you cannot. There are some people you just will not like. The important thing, for my mind, is that you do not not like them before you have met them, which in this case sometimes happens. You learn, before you even come to work, you know there is somebody with AIDS there, or before you ever get the first patient with AIDS, you know you are not going to like them because they are gay or they are shooting drugs, and you do not like that. So you do not like them. I do not think that is legitimate. You cannot be prejudiced in this profession. Some people are. But you should not be prejudiced in this profession because you have to deal with individuals as individuals.

Then the second thing is, that even if you do not like somebody, if they are very difficult and you have tried, there are certain things that you still must do. Certainly the minimum of giving them their medications and making sure they are clean and taking care of them in that way, those are all minimal things. But in addition, I think you must try to, what is the way to say this, give them another chance, or something like that. You

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Somebody else does. And that should happen when it needs to happen.

But there are some people that are just difficult for everybody. Nobody wants to take care of them. They do not like anybody, and they are going to give everybody a hard time. Then, the important thing is to talk about it as a group and to figure out the most comprehensive strategy, if you will, that does not make that person be neglected. And whether that is little doses for everybody, or if some people who can take it more than others, there are different strategies. But you have got to figure it out, because the tendency with people like that is just to stay away from them.

**Harden:** Now, let us go to the other side of this coin. Many people outside the NIH, and some people inside the NIH, too, have differed in their opinions as to how the public health and research leadership should have responded. A number of people have said AIDS should have been treated more like syphilis and gonorrhea: the privacy right should not have been so rigidly respected, we should have done contact tracing, yet this was not the case. And the people who made that decision have been attacked. Have you seen or heard much of this, and do you have an opinion on it?

**Grady:** Certainly I have thought about it a lot, and I would guess, if I had to think through it a little bit, that my opinion may have changed over time. I think that it was issues like that that got me interested in ethics, to tell you the truth. Those are the kinds of discussions that we had early on, in addition to some that we have alluded to, that got me thinking about, how do you systematically approach some of these things and make sense out of them.

In response to that particular situation, in some respects it made sense that if there was a public health model that worked, we should apply it. But I think that there was enough, from my understanding even back then, of a question mark about whether it worked. First of all, do you just do something because it is been done, or do you stop and say, "Is this an analogous situation? Is the model that we have had in place before effective, and, therefore, should we apply it to this situation?" I think that there were enough questions, at least from the people that I heard discuss it, about the middle, primarily, that there was a door through which they were able to say, "Let us stop and think if we should not respect rights first, and maybe this is not the solution to protecting other people, because it will not work."

I have written about and spoken about confidentiality in this context quite a bit, and I still am not absolutely crystal clear on what I think is the right way to go. But I do believe that, as it became clear that there were people at risk by not having the information that I had, or that somebody had, and you could identify who those people were, and you had tried everything you could to have them informed in the most logical way, which is by the person who is putting them at risk, and failed, then there are times when it is legitimate to inform them. But that is really a case-by-case rather than a blanket policy that you inform everybody that this person comes into contact with. The consequences of informing in a more lax way were so devastating, in some cases, that it did not seem to be supportive. Sure you could say public health is more than

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**Hannaway:** It is. Just to come back to the nursing before we move on to some of your larger activities in the larger world, let us say, in the article that Vicky referred to earlier, you wrote that the multiple medical problems suffered by AIDS patients required an average of 28 percent more nursing time than for non-AIDS patients. Could you tell us a little about how the Clinical Center addressed this demand for nursing time? We are interested a little more in the description of organizational changes or these sorts of things.

**Grady:** That number I quoted is from another study, I believe. It was not a study that was done here. But it was apparent in the beginning that the clinical care of patients at the end stage of HIV disease was quite complicated, most of the time because they had multiple infections ongoing, any one of which would have been complicated in terms of symptoms. And the treatments have evolved over time, so in the early days it was not so much that the treatments were complicated, because there were not so many. Now that is a big issue. But the time and energy that it took to take care of somebody adequately at an end-stage disease... Unlike today, we have mostly ambulatory patients. We see a lot of patients in the clinic. There are some that are terminally ill, but in the early days we saw a lot more, and many patients died here—not so much anymore—with AIDS. Multi-system failure is really what it was. And yet you see that in other diseases, but many times you see that in an intensive care unit and not on a regular unit. We were seeing multi-system failure after multi-system failure, and it was very labor-intensive.

Now you asked about organizational changes at the NIH. The NIH, the Clinical Center is unique in this way anyway. We have more personnel per bed than probably anywhere in the world. That is because research is also labor-intensive. So, although there was clearly a recognition that in order to take care of some of the patients from some of these protocols, we might need more nursing staff, we were already pretty well staffed. And so I think there were, there have been, minor modifications in terms of FTEs [full-time equivalents] in areas that have more HIV versus less, for nursing staff anyway. I do not know about anything else. Starting in 1986-ish, a lot of the effort, NIAID effort anyway, moved to outpatient, and there was a clinic built up over time, an HIV outpatient clinic, which I think is a wonderful model of how nursing care can and should be delivered. But in terms of really ramping up the number of nurses in the inpatient area, maybe a few, but not overwhelming changes, no.

**Hannaway:** What about space and location? Barbara Baird described having a cart on which she kept everything at the beginning, and how she was in other people's offices on a temporary basis or that it was...

**Grady:** Because she did not have an office.

**Hannaway:** Yes. But I was wondering in terms of space allocation, these other sorts of debates that go on in hospitals, for one disease versus another and...

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I think some of that came with new kinds of categories of positions. Barbara added responsibilities and so was put in a category, if that is the right word, different from one that had existed before. So there was not an office for her. I mean, there was not a title for her at first. Those things evolved over time. So she was in a unique situation. But there were not too many people like her. She was unique in the early days in terms of what she did, and she was identified as such because she was very capable, but also very interested, and so she took on this role and developed it and built something out of her original position as a staff nurse.

**Harden:** But were you the only clinical nurse specialist dealing with the AIDS, so to speak?

**Grady:** Yes, in the NIAID areas. There were people in NCI, but most of the clinical specialists in those days were inpatient, and the NCI had very few AIDS inpatients in the early to mid-1980s. They had some, but not a huge number. So there were some clinical specialists up there who dealt with...

**Harden:** So you were learning what to do and teaching other people what to do, and it was all happening all at once.

**Grady:** Mm-hmm.

**Harden:** Again, as Caroline was saying, before we make the transition into more recent times and new things you have done, I would just like to ask a few questions with regard to your personal life. You have already spoken about the difficulty when you were pregnant the first time. You have been pregnant three times, have you not?

**Grady:** Yes.

**Harden:** You have three children. And you nursed AIDS patients who were in the hospital the whole time. Do you ever feel like AIDS has taken over your entire life? We have heard that some people have experienced difficulties from friends and family who are not sure they really want to shake your hand. Have you experienced any of this?

**Grady:** Sure, I have. I have the added complication of having met and married [Dr. Anthony] Tony [Fauci] while he was here, which had nothing to do with AIDS at the time. I met him here over the bed of a patient who happened to be from Brazil. I was called in as a translator because this man wanted to go home, and they were afraid to let him go home because the guy had vasculitis. His vasculitis was not in great control. And so they said, "Could you come translate for Dr. Fauci?" whom I had not met, the inimitable Dr. Fauci everybody was afraid of. When he came in, I thought, "What are they so afraid of him for? He is not so scary."

But it is actually a great story because Tony, in his very serious way that he can be, said, "Make sure that you do your dressings every day and sit with your leg up," and I forget all the details. But I translated that to the patient, and the patient said, "You are kidding. I am so sick of being in this hospital. I am going to go home, I am going to dance all night, I am going to go to the beach, I am going to do this." So I think to myself, "How am I going to do this?" So I turned around to Tony and

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But because of Tony and his work and his involvement

Obviously, probably my life has more AIDS in it than it might have otherwise. I mean, if I had just worked here and had gone home to a situation that had nothing to do with it, I might have separated them in different ways than I have done. Although people used to ask us, "Is that all you ever talk about at home?" and the answer is no. In fact, I think we have been quite good about separating our life from our work, although probably much more for Tony than for me, his life is his work in most respects.

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**Harden:** He said to us, when we interviewed him, that both of you had dedicated your life to this; it was here, you were both involved with it. So you are bound to share these feelings. But I think it is very hard for any NIH couple—I am a part of an NIH couple—to get away from it all. Yet you do live in a larger community, and you have children—not only have them, but they are going to school, and you are dealing with all this. Have they come home with any stories about...wondering about their parents working with AIDS, this kind of thing?

**Grady:** Not so many stories, but my eldest, who is only 10, has asked a lot of questions over the years, such as “How do you get AIDS? What is it? What are you trying to do, Daddy? What do you do, Mom?” those kind of questions. And only recently, actually, she has had more people at school ask her, because they see Tony on television and they put her together with him. But I do not think the younger kids have much of a sense of it at all yet. Yes, they will over time.

**Hannaway:** I agree. When your father is on the “Jim Lehrer Hour,” as he was on Tuesday night, was it... And “CBS News” on Monday.

**Grady:** Right.

**Hannaway:** What we would like to turn to now is some of your activities on commissions and so on beyond the NIH. First, would you discuss some of your activities as a staff member on the Presidential Commission on the HIV epidemic? And how would you assess the contributions of this Commission?

**Grady:** I was called at home one afternoon—I think it was a Sunday—by the head of the Nursing Department, who said she had received a call from somebody downtown, at DHHS [Department of Health and Human Services], asking about a detail, whether I could be detailed down to work at the Commission. I thought, “Gee, that is intriguing. I wonder what that is all about.” So I said, “Sure, I’ll try that,” thinking it would be very short term. And it was short term, but it ended up being longer than the original arrangement was.

It was an immersion in a whole different way of looking at this problem that I had not experienced before. I mean, some of the things that were really funny, in a way. When I first came, there was a physician there, and he and I worked together, and our area was to look at delivery of care, some of the more specific medical care issues. At one point they asked me, “Find out what you need to know about hospice care for AIDS patients.” So what I was used to, in writing papers and articles, is that you do a review of the literature and you put it all together, and you

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had to start with "what is a hospice" and end with "how much money are we spending in the United States on hospice care for AIDS patients?" and every other problem in between.

**Hannaway:** Go off the page.

**Grady:** That was a culture shock for me. But I quickly discovered that many of the people that worked at the Commission, staff members, had been congressional aides, and that is the way they worked. They deal with the problem, a comprehensive problem, boil it down into an understandable synopsis that hopefully covers the important things that somebody who has very little time can read and understand the important issues about. So I learned how to do that very quickly, and then we did lots of those over the time. After a while...

Actually, there were several other people. When I first went, there was another nurse from the Navy, and there was a social worker—from HCFA [Health Care Finance Administration], I believe, or maybe HRSA [Health Resources and Services Administration]—also detailed there, the two of them, the three of us. And then this physician was a Hopkins physician. And after maybe a month or two at the most, all of them left, and it was just me in terms of the health care aspects of this issue.

There were some very well-educated members of the staff in terms of some of the issues, but their backgrounds were primarily congressional rather than health care.

But, again, it opened up not only the world of how these things work, like commissions and Congress, but a whole other dimension in terms of how you look at some of these issues. I was used to thinking about how you take care of an individual and maybe how you put together a sense of, after having taken care of 100 individuals, what works and what does not, what is important and what is not. But now I am coming at it from the angle of do these people need hospice care, is hospice appropriate, who is going to pay for it, how do you justify it, and what do we have to do to strengthen what exists in terms of hospice organizations to be able to provide it, and what are the barriers? That was a really different angle on some of these situations, but immensely interesting.

I think you had asked, does the Commission make a difference? I do think they did. They were beleaguered by a lot of early political battles, and political battles right to the end, some members who did not agree with the final recommendations. But they took on the topic in a very comprehensive way and, I think, came out with some very reasonable recommendations about next steps. People have criticized it since. You know, maybe they did not go far enough or maybe nobody paid enough attention to their recommendations. There is probably truth to all of that. But they did do a lot, and a lot of people, in subsequent years, relied on both their summaries and their recommendations in terms of where to go.

**Hannaway:** So another activity you had at about the same time was the Task Force on AIDS of the D.C. Board of Education.

**Grady:** Yes. That was a very interesting process also. And through both of these experiences, I met a number of people,

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Hannaway: How did you get into the latter? You were  
detailed to that.

**Grady:** No, I was not detailed. I do not remember, actually, how I got there. But it was, again, they needed somebody, and somebody said, "Get her to do it."

**Hannaway:** "Why don't you ask her?"

**Grady:** I did it. I think it was through here. I live in D.C., but I do not think it was a D.C. connection. But perhaps they thought it was a good idea because I was also a resident of D.C. And it was definitely because...the nursing part was what they were interested in, in my opinion.

**Hannaway:** But it was not an NIH outreach effort.

**Grady:** No, I do not believe it was. I do not remember. But I was the only nurse in that group.

**Harden:** Were you involved in addressing the issue of distribution of condoms in the schools, or sex education, or all of that?

**Grady:** No. The major issues were, what do you do with children or faculty or staff who have HIV? Do you let them stay there? Who do you tell? How many people have to know? What kinds of precautions should you put into the local school? Do you give everybody gloves? Do you tell them only to use gloves with this kid or do you use gloves with everybody? Those kinds of issues are what we dealt with.

And it was very interesting because it was not just kids in school. The D.C. Board of Education also has some residential facilities for kids with chronic problems and mental retardation that have wide—not wide, but prevalent levels of hepatitis and other things, so that... And kids that needed day care and hands-on care and... So it was more complicated than just kids in school. But those were the issues. We did not deal with condoms or sex education at all on that task force.

**Harden:** Now, from January 1987 to September 1987, you served on the Intragovernmental Task Force on AIDS Health Care Delivery for the Public Health Service. Tell us what that group did.

**Grady:** What was his name? There was a guy, a very good guy. I cannot think of his name now. He was from Utah. He is a physician. He came to Washington as a member of Orrin Hatch's staff, and then was recruited as the director of HRSA around that time. He put together this task force, and it was members of all the federal government agencies.

We dealt with a lot of different issues, but I think some of them were system-wide, what the government, what the different agencies, should do or should have as priorities in terms of this issue.

And I had not thought about that report in a long time, and I could not probably even tell you what was in it, or I would have it on my shelf somewhere.

**Harden:** You were coming from the NIH, from a research point of view. But you are also a nurse, so you know a lot about health care delivery. I was really interested in whether this gave

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**Grady:** Absolutely, absolutely. I do not know for sure, but I always thought in those days that what they were after, from my perspective, was my nursing perspective rather than the research perspective. But I could be wrong about that. But that is always the way I approached it.

**Harden:** How was that group, if you can recall, different from the Public Health Service AIDS Work Group on Patient Care and Health Care Delivery, which you were also on at the same time?

**Grady:** The Intragovernmental Task Force was interested in a whole range of issues, and if I recall correctly, from the perspective of what should the respective agencies be doing. Whereas the other task force was more interested in specific issues related to patient care, which were more generic in some respects, but crossed agencies in other ways and had nothing to do with some agencies. That was a group that did not go as far in terms of a product. The Intragovernmental Task Force came out with a report. It was a time-limited entity which had a goal and a report, and then ended. The other one was supposed to be ongoing, but then fizzled out after a while. And we never had a product, so to speak. We just had ongoing discussions. I think perhaps it got incorporated into some other committees. I do not know what happened to it, but it fizzled at some point.

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**Hannaway:** From 1989 to 1993, you assisted in the design and conduct of intramural research on symptoms of HIV-infected adults, and this was during the early years of the National Center for Nursing Research [NCNR], which was initially set up in 1986 and then became the NINR in 1993, and comprised a portion of the intramural program of that center. Could you discuss your activities in this connection?

**Grady:** When the NCNR started, the first director wanted the NCNR to look like the other institutes in terms of having both an extramural program and an intramural program. She was exploring in 1989-1990 the possibility of creating an intramural program and decided to put a relatively small collaborative program out of her office in HIV and hired a person to do that. In the first few months that she was here, that person, Mary Roca, spent a lot of time with me, because I was in the clinic and I knew a lot not only about the clinic operations, but also about the HIV clinical area from a nursing perspective. We spent hours discussing possible research questions and priorities, how it would work in this environment, and so on.

One day she said to me, "How would you like to come work for me?" It was right at the time when my second child was born, and she made it even more attractive by saying I could work part time, so I did it. I went to work for her in helping her set up the program and in putting together the first couple of studies.

We did two major studies in those days. One was looking at nutritional aspects, because it was my and many other people's observation that nutritional problems were a big problem in AIDS. What was not known at the time was why. When did these things start to happen, what happened first, and was there a way to intervene to prevent them or to at least minimize them? So we put together a pretty complicated, longitudinal study of several cohorts of patients that were being seen here and followed them by documenting their nutritional status, their immune status, and clinical status over time to determine when and how these things changed.

Then the second study came out of, again, a clinical observation. We had been doing studies in the clinic with AZT from early on, and were among the first groups to notice that some people who had been taking AZT for a long period of time developed these rather profound muscle weaknesses. We wanted to understand that phenomenon better, so we put together a protocol to study people who had clinically determined myopathy and follow them prospectively to see how it impacted on both their muscle strength, but also other symptoms and functional abilities. Those are the two main

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Then in 1994, she left, and I was supposed to take over her work and also justify my existence by writing some more. So I put together another protocol, because one of the issues that I had been concerned about from the beginning of this disease, but also in many other diseases, is fatigue. It is a very prevalent symptom, one for which nobody knows what the heck to do about and, for some people, it is the most annoying symptom that they have. It ruins their life because they cannot do anything.

**Hannaway:** They have no energy to do anything.

**Grady:** No energy. So I put together, again, a small descriptive study of fatigue and had, because of the population available to me here, an interesting model, I thought, in terms of IL-2 patients, because IL-2, among other things, in most people causes a very debilitating fatigue. But that is transient. They start their IL-2, and by the next day they are flat. They cannot do much. But the day the IL-2 is stopped, within 24 hours they feel pretty good. That fatigue phenomenon was of interest.

But the other thing was that, as I was talking to patients, they would say, "The mouth sores go away pretty quickly, the fluid retention goes away," some of the other things that IL-2 causes, "but it takes me a long time to get my energy back." I wanted to see both how this worked during the IL-2, but also what happened in between cycles and whether or not it ever came back. So that was what that study was about.

**Harden:** Let us see if we can move into your current work in bioethics. We have touched on a number of issues already that pulled you in this direction, but how did you actually decide to go and get a degree in it? We also noted that you were a member of the Bioethics Liaison Group during this period also. Can you go back and bring us up to date on the bioethics the way we went through nursing?

**Grady:** Again, it would be hard to pinpoint when I first started to be interested in things that I would now call bioethics that I may not have always called, but certainly I was. When [Dr.] John Fletcher was here in—well, when I first came, he was here. He was doing some things that I found very interesting, and occasionally I would volunteer to work with him on such and such a project. When this Bioethics Liaison Group was created, the Nursing Department, I think, had two slots, and I lobbied hard to get one of them, which I did, though not immediately. Then when I was thinking about going back to school, John was a major influence in that regard in terms of studying ethics, because I was not sure that is what I wanted to study. What I ended up with was a degree in philosophy, and philosophy to me seemed sort of fluffy. I hate to say that, but it was true.....

**Harden:** In a sense.

**Grady:** Right.

**Harden:** Remote, yes. Fluffy, I would never.

**Grady:** Well, maybe remote is a better word. I mean, I was very concrete. My education had been very concrete. I was doing these things, and I thought perhaps it might have been better for me to do public policy or something like that, because I was definitely interested in the public policy aspects of some of this, and those were the bigger-picture questions about health care issues. But the more I thought about it and the

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**Hardenway:** That was your initial reaction.

**Grady:** Intense is probably a better word. So I decided to get a degree. Certainly, Georgetown has a very good philosophy department, but also a reputation for the health care-related ethical questions that I was definitely interested in, and I had the added advantage of being close, so it seemed like a good place to try to go. I was happy and lucky to get in.

It was an interesting time, because I was studying philosophy, I was still working here at the Commission during those years, too, and I was having children all at the same time. There was a lot going on.

**Harden:** Yes.

**Grady:** All of which, in many ways fed into each other. There were certainly issues that I was dealing with clinically and in the Commission that were ethical issues. They were blatantly so in some cases and not so blatantly so in others. And having children—I do not know if either or both of you have children—gave life a different dimension and a different perspective than I had had previously. I think that added to my appreciation of philosophy, to tell you the truth. There were moments when I was thinking, “What am I doing trying to do all this?” and I have some great stories about going into labor in the middle of metaphysics class. But in other ways, it all sort of came together.

As I was studying philosophy, of course, I continued to be interested in the things I was doing clinically. When I first started to get ready to do a dissertation, my topic was not going to be anything to do with HIV. I was interested in studying something related to something I had seen here, the participation of women in research and whether that was an injustice issue or some other issue; I had talked to several people in terms of trying to recruit a committee and was not getting too far. There were some people who were not that interested and other people thought it was not philosophical enough. There were lots of things going on.

Then I went to [Dr.] Leroy Walters, who ultimately was my mentor, and had a long conversation with him one day about, “What should I do?” And he said, “Maybe you should start thinking about a different topic and think about something that is related to your work.” I said, “Well, there are about 200 that I could think of,” issues that I thought of in my work that might be... And he said, “Tell me about them.” I said, “All of them?” He said, “Yes. Tell me about them.” So I started to talk about all these things that I had thought about or seen in clinical medicine, and when I started to talk about vaccines, he said the pitch or something, the enthusiasm changed. He said, “That is the one. That is the one you have got to do.”

And that was a clinical thing. It started in the clinic, we did the first Phase I HIV vaccine study, which was, at the time, leading-edge science. It was very exciting in that regard. But I know that I remember many a day sitting in the clinic with the other nurses and some of the investigators and saying, “Who in their right mind would ever volunteer for this thing?” “How are we ever going to do this study?” We put together in the clinic a small study to study the motivations of people who were participating in this vaccine study, because it seemed like

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Then, at the Commission, thinking and talking about

importance of developing a vaccine and thinking about, if we have trouble getting people into this early Phase I study, or I think we should, what happens when you get to the stage of trying to figure out if it works? How do you do that? So I started getting interested in that whole subject, and the rest turned out to be my dissertation, which other people liked enough, too, to publish.

**Harden:** It certainly addresses the most up-to-date question with regard to AIDS. The therapies are nice, but they are expensive and they are not going to solve the problem in the Third World.

**Grady:** Right.

**Harden:** And the vaccine has to be pursued. So I would expect that your book has probably generated a lot of interest for people working in that area.

**Grady:** It has, although it is interesting. I think there is more interest today in late 1996, early 1997, than there was in 1993, when I actually finished that, 1994.

**Harden:** That is the way you sell books.

**Grady:** Yes.

**Harden:** All right. So we have brought you virtually up to where you are now. You are now responsible for planning and management of the bioethics program, which has grown considerably since John Fletcher was the only bioethicist at the NIH, is my recollection.

**Grady:** That is right.

**Harden:** But a part of your responsibility involves participation in the Institutional Review Board of clinical protocols. Could you comment on how your training as a nurse and as a bioethicist informs the way you approach that duty?

**Grady:** That duty. Yes, I can. From early on in studying ethics, but probably predating my study of ethics, I have been interested in the ethics of research, I think from being here, from watching it, from thinking about what it is. So I spent a fair amount of time studying that in terms of what has been done and written in the past, which gives me, perhaps, an advantage in the IRB [Institutional Review Board] work in the sense that I have thought about some of the issues of research more than a lot of people on the IRBs have. I have had the opportunity to read about them, talk about them, write about them, and so on.

I think in all that I have done and hope to do in ethics, the fact that I am a nurse gives me a distinct advantage in that I can understand the other side, if you will. From the perspective of designing research and putting together a study that answers an important question, and being clear about methods and, putting protection in for human subjects, in some respects that is also abstract even though some of the people who do it are in contact with the patients as well. But some people on the IRBs are not. Yet there are certainly things that you need to look at in the abstract. But then to be able to envision in a more real way what the person at the other end who is participating in this research is experiencing I think gives me an advantage. I



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Harden: Are you the first person with training as a  
has sat on the Clinical Center IRB?

**Grady:** Well, the Clinical Center does not have an IRB, so it is the other NIH IRBs, for each institute. Interestingly, I have actually done this through the Bioethics Department before. And there have been at least one or two other nurses, in the time that I am aware of, anyway.

**Hannaway:** I actually had a follow-up question to something that you remarked on earlier. You mentioned the clinical trials for AZT. Were you involved with the patients who were part of those trials as well as the ones for the vaccine?

**Grady:** Yes.

**Hannaway:** Can you just tell us a little about that, because there has been a lot of discussion about AZT and how when it was in the Phase II trial, the decision was made to alter the nature of the trial, so to speak. But I was interested in the Phase I.

**Grady:** Yes, because that is really what we did here, the Phase I. And at the time, it was no different than any of the other things that we were testing in Phase I, some of which did not work and some of which did, so there was nothing special about it as a category of research, in a way.

But the difference, perhaps, is that there were people who were enrolled in that early Phase I study who stayed with us for a long time and, as AZT became more accepted, either stayed on it because they tolerated it well and it was accepted, or had to get off it because they could not tolerate it well and tried something else. There were some of them who rolled over into other studies where they added things without taking the AZT away. Then there were people like the ones that we ended up on this myopathy study, who at the time may or may not have still been on AZT, but many of whom, though not all, were from that original cohort and had been on it for a long time.

What we have certainly learned about since is a lot of the community reaction to AZT and how people hate it. We did not see that so much because we were...it was early, nobody knew enough about it to hate it, and the people who came here were the ones who were willing to try it anyway, so we did not get that kind of attitude from the patients that were here.

**Hannaway:** It is only longer term that this has become more apparent and longer-term effects have become more apparent, obviously, too.

**Harden:** Do you want to make any final comments? We did not really get you to talk too much about your book, in your view, after having written this, on the future of AIDS vaccines. Are we going to get one soon?

**Grady:** I hope we are going to get one. I do not know that I will comment on the "soon" part. It is hard to say. I mean, right now everybody's looking carefully at canarypox and hoping for something there. From what I have read about it, it certainly looks as though it has some potential in terms of being able to stimulate both cellular and humoral immunity, and that is, at least to the degree that we understand immunopathogenesis at all, those seem both to be necessary in this particular case. But whether or not they are adequate and whether or not the

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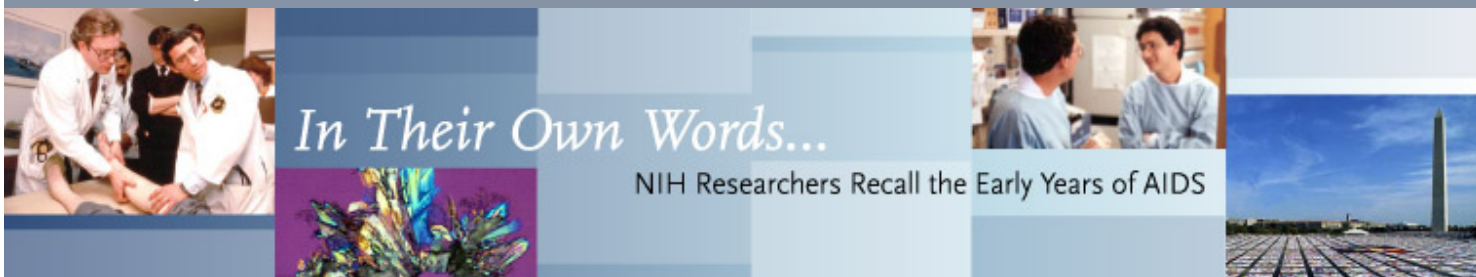
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People were very excited recently about this DNA, naked DNA vaccine, but I have heard other people say there are dangers lurking that we have not yet uncovered because we do not have enough experience with it. They are using a similar approach in other diseases.

But I think the only way we are ever going to get a handle on this epidemic is through a vaccine. I am fairly convinced of that. So I am very hopeful that there will be one, and I think that there is certainly enough scientific interest and some very good scientists who are working on it. You could argue about whether there is enough money and enough people and all that. There is always room for more, more money, more people, dedicated to that.

I think this current discussion about whether we need a March of Dimes. What was I reading in the paper this morning about [Dr. Myron] Max Essex saying we need a March of Dimes effort or a Manhattan-Project-type approach. It is an ongoing battle. Some people say that will work and some people say it will not work unless you have the science. It will not work unless you have the science, so I do not really know whether that is the right approach. I certainly think more money could go into vaccine research without being wasted.

**Hannaway:** Some have the perspective that if a treatment that at least keeps HIV under control becomes the predominant way of trying to help those with the disease in America, that the interest in vaccines for the developing world will decline. Would you have an opinion on that?

**Grady:** I am afraid that is probably true. The sad reality of the economics of it is that developing anything, including a vaccine, is very expensive and market-driven to a large extent. Even though the need in the developing world is enormous and will continue to grow, the ability to support economically either the product or the process does not exist, and that is a problem.

**Harden:** We have just about exhausted our questions. I always like to ask if is there anything else that occurs to you that, points that you would like to make, before we stop?

**Grady:** Only one, and I may have said it already. But I think the experiences that I have had as a nurse in HIV have confirmed, probably, an opinion that I have held for a long time, and that is that nursing is a wonderful profession. The nurses that I have had the opportunity to work with in this context are sensational, almost without exception, courageous, committed, hard-working, very good people.

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Grady: Right. But also all over. I have had the opportunity involved in a continually growing network of nurses nationally that created an organization some years ago, the Association of Nurses in AIDS Care. In the early days, there was a handful of people from all over and we all knew each other. And we still see each other sometimes. Some are no longer involved in that group, but most still are. Although the number of people involved have grown—I do not know them all, obviously—but that initial group was a very special group of people.

**Harden:** Thank you very much. We appreciate your talking with us.

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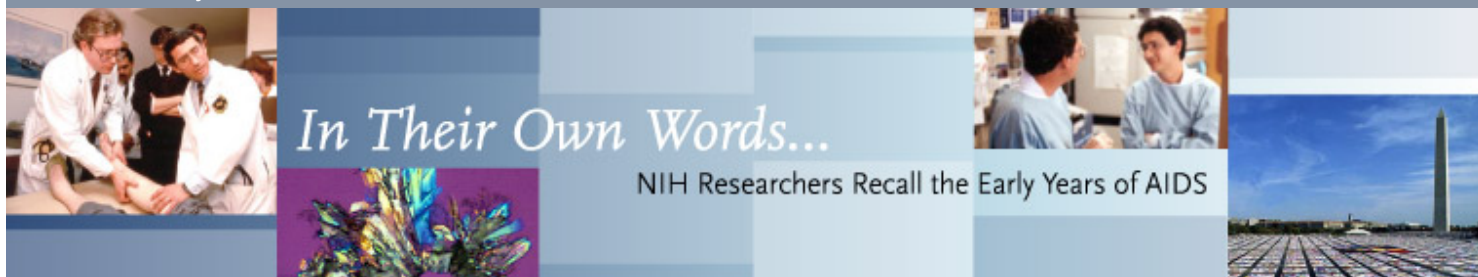
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## Interview with Dr. Christine Grady

**This is an oral history interview with Dr. Christine Grady about the National Institutes of Health's response to AIDS. The interview was conducted on 30 January 1997 in her office in the Clinical Center at the NIH. The interviewers are Dr. Victoria Harden, Director, NIH Historical Office, and Dr. Caroline Hannaway, NIH Historical Consultant.**

**Harden:** Dr. Grady, we would like to start with your growing up. Where did you grow up, and who influenced your decision to go into nursing?

**Grady:** I grew up in New Jersey, one of five kids in a very close family that is still very close. It is hard to say who influenced my decision to go into nursing, because nobody else in my family—parents, grandparents, aunts, uncles, nobody like that—is medical or in any way related to health fields. When I was little, I had the usual range of “what I want to be when I grow up” kinds of things. But when I was fairly young, I thought I wanted to be a nurse, and my mother encouraged it the most, even though she was not one herself. She thought nursing was a noble profession and a good thing for me to do. So she encouraged that.

**Harden:** Tell us about your college experiences. Did you go straight to nursing school?

**Grady:** Interestingly, I applied to several colleges—I cannot remember the number any more—but only one was a nursing school, and I got early admission. It was Georgetown, and I decided to go there. There was at least one juncture during the course of my four years there that I tried to switch out of nursing and was convinced by the then secretary to the dean not to.

I guess I was finishing my sophomore year when I decided I wanted to go to medical school, and therefore I needed to take some courses that otherwise would not be available to me. This particular woman, who in many respects was the heart of the nursing school, convinced me that I should do both. She said, “Why not do both? You can do it. Just take a few extra credits. Do the hard sciences, keep the nursing. You might be glad you did.” So I did.

I finished with a double major, nursing and biology, and I did apply to medical school when I graduated from college. But that first time around, I did not get into medical school anywhere, and I quickly realized, after I started working as a nurse, that I was very happy doing what I was doing. I never did go back

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**Harden:** Did it? Why was that, in your opinion? The point of view?

**Grady:** No, it was just the status, for lack of a better word, of nurses. A college degree was one thing, and I had the double major, but it did not matter. The fact that I had been prepared and trained as a nurse throughout my college years, I think, I was sure of it, counted against me.

**Harden:** Looking at your curriculum vitae, we could see that you were active in various theoretical issues, such as the rights of the mentally ill, in addition to your bedside nursing responsibilities. How did you develop these kinds of interests?

**Grady:** Many of those were in my college days. I think some of it came from the orientation that my parents gave me. When we were children, I can remember at young ages going on civil rights marches and things like that, because my parents took us there. We did not know what they were really about, because at the time, although I was older than some of my brothers and sisters, I was not that old. Some of those things did not register directly then, but I think they had an impact later on. So I have always been interested—again, there was my parents' influence—in social issues.

When I got to college—of course, I was a product of the 1960s and 1970s, so some of that was a cultural time situation as well—there were several issues that interested me. I was very interested in women's issues and did many things in college that were related to women's interest groups. Then I became involved in a public interest research group which was just beginning in the early 1970s. It has since evolved into a much more widespread and formalized institution than it was in those days. In those days, it was a very grassroots organization. It was open to any issue. The particular group that I was hooked up with happened to be doing a project on the rights of the mentally ill. So I did not select the topic, I selected the group. Nonetheless, I found it very interesting in terms of what the project was about.

I spent some time during those years at St. Elizabeth's [Hospital] interviewing people, both patients and staff, and I worked with a couple of lawyers who were most interested in issues relating to voluntary and involuntary commitment.

**Harden:** We are always interested in learning how these early experiences led a person to the position that they have now.

**Grady:** I did not know much about that one, but I bet it had some influence. I am sure it did.

**Harden:** But at least it gave you experience in certain areas.

**Grady:** Yes, absolutely.

**Harden:** What about your two years in Brazil, working with Project Hope. What led you to that, and what did you learn?

**Grady:** Again, it was probably the sense of social responsibility that I have already alluded to. I remember as an undergraduate hearing about some of these international health organizations and being very interested in that. I had a sense of our

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when I lived in Boston, to both the Peace Corps and Project Hope.

Again, the opportunity arose at a juncture in my life when it made sense to do it. I did not select Brazil. They selected Brazil for me. But it was an incredible experience, both in terms of the health perspective and life experience, living and working there.

**Harden:** Did you speak Portuguese before you went?

**Grady:** No, I did not.

**Harden:** You learned the language while you were there?

**Grady:** I learned it there. And learned it under fire. I had some classes the first month or so that I was there. But then I was thrown into a hospital situation where I was the only English-speaking person, and I was initially put in charge of a group of clinics. There were, I think, 25 clinics altogether. There were a couple of nurses, but primarily there were nurse's-aides-type people. But I had a staff of maybe 30 people that I was supposed to supervise, so I had to be able to speak to them. I learned very quickly.

I also ended up sharing an apartment with a Brazilian woman and learned a lot from her. She did not speak a word of English. In fact, my parents still talk about calling me up on the phone and hearing this panic at this other end when she would answer and say, "I don't know, I don't know," and get rid of the phone as quickly as she could.

But Brazil was a fabulous experience for a number of reasons. At that point I had had several years of working as a nurse in different situations in the United States and also of teaching nursing, and I had dealt with a lot of what you sometimes think of as crises in the respective jobs that I had. I remember, in fact, very specifically the night that I went to Project Hope for an interview. I had just come off of a day where I ended up doing a double shift because people did not come in. This was in a hospital that was fairly well staffed and had its range of issues, but it was a reasonably well-organized situation.

Then I went for the interview and was given enough information to imagine what Brazil would be like and the lack of resources that I would encounter when I got there. But even then, hearing about it is nothing like experiencing it.

The range of health problems that we were presented with was great. In fact, the large majority of problems were infectious diseases, which was not surprising, but again it was something that you have not thought about very much when you are coming from a hospital in the United States, and some of the areas that I had worked in were quite specialized as well. Often the situation would be complicated by the fact...

The particular hospital where I worked was located on the edge of a city in a very poor state in Brazil, and the majority of the patients came from the interior of the state. Their arrival would be at the end of a five- or six-hour, or sometimes two-day, journey on a bus to this hospital. And that was the first place that they came to, a federally supported hospital that was supposed to service everybody in the state—in the country, really, but in the state.

We were often faced with the problem of physicians who would come in and say, "I am going to see only 10 patients," and there would be 75 to see. Or a physician would see a patient

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have it, the patient had no money, and that was the end of treatment. Or situations where, for instance... I can recall a patient that I knew quite well who had leukemia, and to the medications that she could not get, there were often crises where she bled, and there was no blood available for transfusion. Or equipment. A large part of the equipment that we used was equipment that had been donated over the years, some through Project Hope and some through other organizations.

But one story that I have told many times since is about the syringes, which were disposable syringes. We use them once here in the United States and then throw them away. In Brazil they were re-sterilized over and over again. Presumably the sterilization was adequate, but over time the bluntness of the needle made it a whole different ball game. You needed a different degree of strength when you went to give somebody an injection. I remember after coming back to the United States, that in the first injection I gave here after having spent two years there, I almost went right through the person's bone. I just forgot the degree of difficulty of inserting a blunt needle versus that of a sharp needle.

But there were a number of wonderful, eye-opening experiences about being in Brazil. Brazil is unique in the sense that it is a wonderful place—the people are very special and the area was physically one of the most beautiful places I have ever been. But the poverty was also about as severe as any I have seen.

**Harden:** At the hospital in Brazil, did you get many tropical diseases that were similar to some of the kinds of problems that AIDS patients get today?

**Grady:** Yes. There was a huge amount of schistosomiasis, which AIDS patients do not get. But once I came to the NIH and started working in the allergy and infectious disease units, we did have some schistosomiasis patients. The other disease was leishmaniasis, which, again, I had never seen prior to being in Brazil, but have seen here at the NIH since. Those two were quite common.

There was also a lot of Chagas disease, which is pretty much unique to that part of Brazil. There are some other areas in the world that have it. And a large percentage of the infectious diseases were simple things like Ascaris and ringworm and things like that.

**Harden:** Now, it was during this time, if my memory is correct, that AIDS came on the scene. Before we discuss your coming to the NIH, can you comment on when you first heard about AIDS, what you heard, and what you thought about it?

**Grady:** Yes. I actually did not hear about it in Brazil. I may have read something in the newspaper, but it did not register at the time. I came back—I do not remember the exact date, I guess it was around the end of 1981—and worked for a while on a per diem basis at a number of hospitals, mostly in Boston but also in one in New Jersey near my parents' home; and that is when I first heard about AIDS. There was at least one patient, actually, in the hospital in New Jersey that people thought probably had this disease. And although there was very little understanding of anything, there was fear, certainly, in that particular environment.



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**Grady:** I think it was everybody, although I was more tuned into what the nurses were talking about. I was a temporary staff person, so I was not as hooked in as some were. But I do remember two patients in particular, one a young woman and one a young man, who had these unknown ailments, they had lymphadenopathy and fevers. He actually had something else, although I do not remember any more what it was. But there was just this buzz around the nursing station: maybe they have this new disease, do we really want them here, and what are we going to do about taking care of them. Yet, there was no diagnosis or anything. It was very possible that either one of them could have had something entirely different. Just because they had some of the symptoms and their age and a question mark about diagnosis, they were lumped in this category.

Then I remember more vividly a conversation that I had. I had spent some time that summer, right before I came to the NIH, teaching at a governor's school in New Jersey. It was high school students, but gifted high school students who were selected for this program, and there was a faculty of people from a variety of different disciplines. It was a very interesting program, an interesting experience, and many very intellectual conversations occurred over the course of the month or whatever it was that we were there. This issue of AIDS came up at one meeting. We were sitting around and people were talking about this disease. They were asking, "Wouldn't you be afraid to take care of these people?" Nobody else was a health care professional in this group. I was the only one. At that point I knew that I was coming to the NIH and that I was going to be working in infectious diseases. I guess that at some level I knew there was HIV here, although we did not call it that then. I knew that they were studying this issue here, or they should be. I remember at the time defending this issue by saying that you take care of people because that is your job. You do not worry about what they have. You cannot, or you would not be able to do what you have to do. I was dismissing it pretty offhandedly, probably out of ignorance. I did not have fear, but I probably did not have enough knowledge even to be afraid.

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"If you look at the history of where new viruses come in, frequently what they do is come back the next year and displace one or even more than one of the circulating strains," he said. "It is a distinct possibility that this might ultimately be incorporated into a seasonal flu vaccine."

(Additional reporting by David Morgan, editing by Vicki Allen)

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- [Philip Berrigan](#) 1950, author and activist
- [Billy Collins](#) 1963, former [Poet Laureate](#) of the United States
- [Leo Cullum](#) 1963, cartoonist best known for his work in [The New Yorker](#)<sup>[2]</sup>
- [Michael Earls](#) 1895, Jesuit priest, writer, poet, teacher, and Holy Cross administrator
- [Michael Harrington](#) 1947, socialist historian and author of [The Other America](#), which is believed to have inspired [Lyndon Johnson's Great Society](#) social programs
- [Michael Harvey](#) 1980, author of [The Chicago Way](#) and [The Fifth Floor](#); co-creator of the TV program [Cold Case Files](#)
- [Jack Higgins](#) 1976, Pulitzer Prize–winning editorial cartoonist for the [Chicago Sun Times](#)
- [Kristan Higgins](#), New York Times bestselling romance author
- [Edward P. Jones](#) 1972, MacArthur Award winner and 2004 [Pulitzer Prize Award](#) in Fiction for his novel [The Known World](#)
- [Paul LeClerc](#) 1963, President Emeritus of the [New York Public Library](#)
- [Joe McGinniss](#) 1964, bestselling author of [The Selling of the President](#), [Fatal Vision](#), and other books
- [Jay O'Callahan](#) 1960, storyteller
- [Josh Pahigian](#) 1996, author of [The Ultimate Baseball Road Trip](#) and more than a dozen other books
- [Barry Reed](#) 1949, Boston trial lawyer and author of [The Verdict](#), which was made into the Oscar-nominated 1982 film starring [Paul Newman](#)

## Business

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- [Bill Abbott](#) 1984, CEO of [Crown Media Network](#)

[William E. McKenna](#) 1947, Senior Vice President of [Litton Industries](#), President [Hunts Food](#), Chairman of the Board of [Norton Simon Industries](#). President and Chairman of the Board [Technicolor](#), Chairman of the Board [Sambo's Restaurant](#).

- [Douglas M. Baker Jr.](#) 1981, CEO of [Ecolab Inc.](#)
- [James E. Burke](#) 1947, former CEO of [Johnson & Johnson](#); named one of the ten greatest CEOs of all time by [Fortune Magazine](#)
- [Randall Caudill](#) 1969, president and founder of [Dunsford Hill Capital Partners](#)
- [Arthur Ciocca](#) 1959, Chairman and owner, [The Wine Group](#)<sup>[3]</sup>
- [Nicholas D'Agostino Jr.](#) 1960, Chairman, President and CEO, [D'Agostino Supermarkets](#)<sup>[4]</sup>
- [Richard A. Davey](#) 1995, Secretary and CEO of the Massachusetts Department of Transportation
- [Richard B. Fisher](#) 1947, Chairman of [Federated Securities Corp.](#) and Vice Chairman of [Federated Investors, Inc.](#)<sup>[5]</sup>
- [Joe Hazelton](#) 1997, COO of [Charleston Laboratories, Inc](#)
- [Pedro Heilbron](#) 1979, CEO of [Copa Airlines](#)
- [John J. Issa](#) 1960, founder and Chairman of [SuperClubs Resorts](#)<sup>[6]</sup>
- [Jason Hoitt](#) 1999, Chief Commercial Officer [Dova Pharmaceuticals](#)
- [James W. Keyes](#) 1977, former Chairman and CEO of [Blockbuster, Inc.](#)
- [John Koelmel](#) 1974, President of [HARBORcenter](#), former CEO of [First Niagara Financial Group](#)
- [Edward J. Ludwig](#) 1973, former Chairman, President, and CEO of [Becton Dickinson](#)<sup>[7]</sup>
- [Victor Luis](#) 1988, President of [Coach Inc.](#) (COH)<sup>[8]</sup>

- [William J. McDonough](#) 1956, former President of the [Federal Reserve Bank of New York](#) and current Vice Chairman of [Merrill Lynch](#)
- [Charles E.F. Millard](#) 1954, former Chairman of the Board, CEO Coca-Cola Bottling Company of New York
- [William F. O'Neil](#) 1907, founder of the [General Tire and Rubber Company](#)
- [John Peterman](#) 1963 (aka J. Peterman), catalog and retail entrepreneur
- [James David Power III](#) 1953, founder of [J.D. Power and Associates](#)
- [Roberto Quarta](#) 1971, partner of [Clayton, Dubilier & Rice](#), Chairman of Italtel, and former Chairman of [BBA Group](#)
- [Loren Ferré Rangel](#) 1992, vice president for new products at El Día, Inc. and a trustee of the Conservation Trust of Puerto Rico
- [Carolyn Risoli](#) 1986, former President of Marc by Marc Jacobs, [Marc Jacobs, Inc.](#)<sup>[9]</sup>
- [Frank Shakespeare](#) 1946, former president of CBS Television; former director of the [U.S. Information Agency](#); Ambassador to [Portugal](#) and Ambassador to the [Vatican](#)
- [Sarah Romano](#) 2002, CFO [EyeGate Pharmaceuticals, Inc.](#)
- [Joe Shoen](#) 1971, President, Chairman of the Board, and Chief Executive Officer of AMERCO, the holding company of [U-Haul, International](#)
- [Mark Shoen](#) 1967, largest shareholder and former Chairman of AMERCO, the holding company of [U-Haul, International](#)
- [John T. Sinnott](#) 1961, retired Vice Chairman of [Marsh & McLennan Companies](#)<sup>[10]</sup>
- [Kieran Suckling](#) 1986, co-founder of the [Center for Biological Diversity](#)
- [William J. Teuber Jr.](#) 1973, Senior Operating Principal of Bridge Growth Partners and Former Vice Chairman of [EMC Corporation](#)<sup>[11]</sup>
- [John F. Thero](#) 1983, President and CEO, [Amarin Corporation](#) and on Board of Directors at [Chiasma, Inc.](#)
- [Maggie Wilderotter](#) 1977, President and CEO, [Frontier Communications](#); as of 2012 had been named one of the "Fifty Most Powerful Women in Business" by *Fortune* for four years in a row

## Education

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### Professors and researchers



Name	Year/Degree	Notability	Reference
<u>John E. Brooks</u>	1949	President Emeritus of <u>College of the Holy Cross</u> and former President from 1970 to 1994, noted for introducing co-education at the college in 1972;member of Religious Studies faculty	
<u>Robert L. Devaney</u>	1969	professor, mathematics, Boston University; research interests include complex dynamical systems, chaos, fractals	
<u>David Granfield</u>	1943	Professor Emeritus at <u>Catholic University Law School</u> in Washington DC; noted as a canon lawyer for his exposition of the Catholic Church's view on <u>abortion</u>	
<u>Jane M. Hawkins</u>	1976	professor, mathematics, University of North Carolina, Chapel Hill, NC; research interests include ergodic theory, smooth dynamical systems, complex dynamics, and computer generated graphics images related to nonpolynomial dynamics	
<u>Patrick Francis Healy</u>	1850	first African American to earn a Ph.D. and former President of <u>Georgetown University</u>	
<u>Traugott Lawler</u>	1958	medievalist scholar; expert on <u>William Langland</u> ; emeritus professor of English at <u>Yale University</u>	
<u>Timothy Leary</u>	1942	<u>LSD</u> -pioneering Harvard professor; attended Holy Cross before transferring to <u>West Point</u>	
<u>Joseph McCartin</u>	1981	professor of history at <u>Georgetown University</u> ; 2003 Charles Warren Fellow at <u>Harvard University</u>	
<u>James McCarthy</u>	1971	President of <u>Suffolk University</u> in Boston	
<u>Paul Reiss</u>	1952	14th president of Saint Michael's College, professor and author	
<u>Robert K. Wright Jr.</u>	1968	military historian and author	

## Entertainment

- Dick Cusack 1950, actor, director and producer
- Neil Donohoe 1978, Chair and Director of the Theater Division at Boston Conservatory<sup>[12]</sup>
- Ann Dowd 1978, Broadway, movie, and television actress; received the National Board of Review award and an Emmy award.
- Brian Gallivan 1991, improvisational actor and executive producer of CBS TV show The McCarthys
- Thomas Ian Griffith 1982, actor and writer
- Brian Gunn 1992, screenwriter
- Mark Gunn (screenwriter) 1993
- Dave Holmes 1994, MTV host<sup>[13]</sup>
- Neil Hopkins 1999, television and film actor and writer
- Peter Jankowski 1986, executive producer, Law & Order
- Douglas Netter 1942, founder, Netter Digital Entertainment and executive producer of Babylon 5
- Kevin O'Connor 1990, host of PBS's This Old House
- Thomas F. O'Neil 1937, former Chairman of RKO General Studios, who brought movies to television and experimented with an early coin-operated pay TV system

- Bartlett Sher 1981, director of Tony Award-winning Broadway musicals *South Pacific* and *The Light in the Piazza*
- Stephen Tkowski 2011, professional wrestling champion
- Bob Wright 1965, Chairman of the Board and former CEO of NBC Universal; Vice Chairman of General Electric; co-founder of Autism Speaks<sup>[14]</sup>

## Law, politics, and public service

### United States federal and state court justices

Name	Year/Degree	Notability	Reference
<u>Andrew Augustine Caffrey</u>	1941	United States District Judge for the District of Massachusetts; nominated by President <u>Dwight D. Eisenhower</u> in 1961	
<u>Francis Patrick O'Connor</u>	1950	appointed by Governor <u>Edward King</u> in 1981, served 16 years on the Massachusetts Supreme Judicial Court	
<u>Christopher Droney</u>	1976	United States Court of Appeals Judge for the Second Circuit; nominated by President <u>Barack Obama</u> in 2012	
<u>John J. Farley, III</u>	1964	Founding Judge of the United States Court of Appeals for Veterans Claims; nominated by President <u>George H. W. Bush</u> in 1989	
<u>Wendell Arthur Garrity Jr.</u>	1941	United States District Judge for the District of Massachusetts; nominated by President <u>Lyndon B. Johnson</u> in 1966	
<u>John J. Gibbons</u>	1947	former Chief Judge of the United States Court of Appeals, Third Circuit	[15]
<u>John Greaney</u>	1961	Associate Justice for the Supreme Judicial Court of Massachusetts and Director of the Macaronis Institute for Trial and Appellate Advocacy at <u>Suffolk University Law School</u>	
<u>Edward Francis Harrington</u>	1955	United States District Judge for the District of Massachusetts; nominated by President <u>Ronald Reagan</u> in 1987	
<u>James Patrick Leamy</u>	1912	United States District Judge for the District of Vermont; nominated by President <u>Franklin D. Roosevelt</u> in 1940	
<u>Richard J. Leon</u>	1971	United States District Judge for the <u>District of Columbia</u> ; nominated by President <u>George W. Bush</u> in 2002	
<u>William T. McCarthy</u>	1905	United States District Judge for the District of Massachusetts; nominated by President <u>Harry S. Truman</u>	
<u>Edward McEntee</u>	1928	Judge of the <u>United States Court of Appeals for the First Circuit</u> .	
<u>Matthew Francis McGuire</u>	1921	United States District Judge for the District of Massachusetts; nominated by President <u>Harry S. Truman</u> in 1949	
<u>Clarence Thomas</u>	1971	Associate Justice, <u>United States Supreme Court</u> ; nominated by President <u>George H.W. Bush</u> in 1990	

## Executive branch and United States Cabinet members

- Joseph A. Califano Jr. 1952, former U.S. Secretary of Health, Education, and Welfare and Chairman of the National Center on Addiction and Substance Abuse
- Broderick D. Johnson 1978, White House Cabinet Secretary for President Obama
- John William Middendorf II 1945, former U.S. Ambassador to the Netherlands and Secretary of the Navy

## Members of the United States Congress

### Senators

Name	Year/Degree	Notability	Reference
<u>Robert P. Casey Jr.</u>	1982	United States Senator for Pennsylvania, served as Pennsylvania Treasurer	[16]
<u>John A. Durkin</u>	1959	United States Senator for New Hampshire from 1975 to 1980	
<u>Thomas A. Burke</u>	1920	United States Senator for Ohio, served as the 48th mayor of Cleveland; namesake of <u>Cleveland Burke Lakefront Airport</u>	
<u>Maurice J. Murphy</u>	1950	United States Senator for New Hampshire	
<u>David I. Walsh</u>	1893	United States Senator for Massachusetts; Massachusetts' first Irish Catholic governor	

### Representatives

Name	Year/Degree	Notability	Reference
<u>Tim Bishop</u>	1972	United States Representative from New York's 1st congressional district	[17]
<u>William P. Connery Jr.</u>	1920	United States Representative from Massachusetts	
<u>Joseph Daniel Early</u>	1955	United States Representative from Massachusetts' 3rd congressional district from 1975 to 1993	
<u>Mark DeSaulnier</u>	1974	United States Representative from California	
<u>Ambrose Kennedy</u>	1897	United States Representative from Rhode Island	
<u>James B. Longley Jr.</u>	1973	United States Representative from Maine's 1st congressional district	
<u>Martin B. McKneally</u>	1937	United States Representative from New York	
<u>Michael R. McNulty</u>	1969	United States Representative	[18]
<u>James P. Moran</u>	1967	United States Representative	[19]
<u>Frank William Towey Jr.</u>	1916	United States Representative from New Jersey's 12th congressional district from 1937 to 1939	
<u>Peter F. Welch</u>	1971	United States Representative for the U.S. state of Vermont's at-large congressional seat	

## United States governors

- Bob Casey Sr. 1953, Governor of Pennsylvania 1987–1995
- Edward D. DiPrete 1955, Governor of Rhode Island 1985–1991
- David I. Walsh 1893, first Irish Catholic Governor and U.S. Senator for Massachusetts

## Ambassadors and other diplomats from the United States

- Kevin J. McGuire, 1964 U.S. Ambassador to Namibia<sup>[20]</sup>
- John William Middendorf II 1945, former U.S. Ambassador to the Netherlands and Secretary of the Navy
- Harry K. Thomas Jr. 1978, U.S. Ambassador to Bangladesh, the Philippines, and Zimbabwe<sup>[21]</sup>

## Foreign Government officials

- Henri Bourassa 1890, French Canadian political leader and publisher; ideological father of Canadian nationalism
- Louis-Rodrigue Masson 1853, Canadian member of Parliament, Senator, and Lieutenant-Governor of Quebec

- [Jarosław Wałęsa](#) 2001, member of the [Sejm](#), the lower chamber of Poland's Parliament; son of [Lech Wałęsa](#)
- [Guillermo F. Pérez-Argüello](#), 1973, UN Official (1980-2000), Nicaraguan Ambassador to Brazil (2002-04)

## Other United States political and legal figures

- [John B. Anderson](#) 1957, former mayor of [Worcester](#)
- [Jose Cojuangco Jr.](#) 1955, former Philippine Congressman
- [Michael Delaney](#) 1991, New Hampshire Attorney General 2009–present
- [Mark DeSaulnier](#) 1973, representing California's 7th State Senate district
- [Christopher Doherty](#), 1980, Mayor of [Scranton, Pennsylvania](#) since 2002
- [Daniel M. Donahue](#) 2009, Massachusetts state representative in the 16th Worcester district
- [John Droney](#) 1968, participated in Connecticut state politics; senior partner of [Levy & Droney](#)
- [Jon Favreau](#) 2003, chief speechwriter for [Barack Obama](#)
- [Joseph H. Gainer](#) 1899, 26th mayor of Providence, Rhode Island<sup>[22][23]</sup>
- [William Glendon](#) 1941, attorney who specialized in issues relating to the First Amendment to the [United States Constitution](#) and represented *The Washington Post* in the [Pentagon Papers](#) case
- [Kirby Hendee](#), Wisconsin State Senator
- [Chris Korzen](#) 1998, founder of [Catholics United](#), founder and director of [Maine's Majority](#)
- [Robert Maheu](#) 1939, lawyer, who worked for the FBI and CIA, and as the chief executive of Nevada operations for the industrialist [Howard Hughes](#).
- [Ed Martin](#) 1992, chairman of the Missouri Republican Party
- [Joseph A. McNamara](#), U.S. Attorney for Vermont<sup>[24]</sup>
- [Howard C. Nolan Jr.](#) 1954, former member of the [New York State Senate](#)
- [John P. O'Brien](#) 1894, former mayor of New York City
- [Mark Kennedy Shriver](#) 1986, former member of Maryland legislature, Vice President and Managing Director of US Programs for [Save the Children](#)
- [Thomas J. Spellacy](#) 1889, political leader and lawyer
- [Kathy Sullivan](#) 1976, attorney and former chairwoman of the New Hampshire Democratic Party
- [Jane Sullivan Roberts](#) 1976, leads the in-house practice group at Major, Lindsey & Africa; wife of Chief Justice [John Roberts](#)
- [Austin J. Tobin](#) 1925, former director of the [Port Authority of New York and New Jersey](#) 1942–1972; oversaw the construction of the World Trade Center
- [Ted Wells](#) 1972, lawyer, rated by *The National Law Journal* as one of America's best white-collar defense attorneys
- [Edward Bennett Williams](#) 1941, trial attorney; former owner of [Baltimore Orioles](#) and the [Washington Redskins](#)
- [James Assion Wright](#) 1923, lawyer from Pennsylvania who served in the U.S. Congress from 1941 to 1945

## Military



Name	Year/Degree	Notability	Reference
<u>Barry M. Costello</u>	1973	<u>United States Navy</u> Commander, <u>United States Third Fleet</u>	[25]
<u>Peter H. Daly</u>	1977	<u>United States Navy</u> Vice Admiral (Ret.) and CEO of the <u>United States Naval Institute</u>	
<u>Michael A. Healy</u>	Prep 1849–1854	Captain, <u>United States Revenue Cutter Service</u> (predecessor of <u>United States Coast Guard</u> ), first <u>United States Government</u> ship commander with African-American ancestry	
<u>William J. McCarthy</u>	1976	Commander, Operational Test and Evaluation Force, <u>United States Navy</u>	
<u>Bruce E. MacDonald</u>	1978	Rear Admiral, Judge Advocate General, <u>United States Navy</u>	[26][27]
<u>Bernard E. Trainor</u>	1951	retired <u>Marine Corps</u> Lieutenant General, bestselling author, and military analyst for NBC	
<u>Kevin Sandkuhler</u>	1975	lawyer, retired Brigadier General in the <u>United States Marine Corps</u>	
<u>Anthony T. Shtogren</u>	1940	retired <u>United States Air Force</u> Major General	

## Media and communication

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- Dave Anderson 1951, New York Times sports columnist, 1981 winner of the Pulitzer Prize for commentary
- George-Édouard Desbarats 1850, Canadian printer and inventor
- Chris Matthews 1967, host of MSNBC's *Hardball with Chris Matthews* and NBC's *The Chris Matthews Show*
- Gordon Peterson 1960, broadcast journalist and television news anchor; co-anchor for ABC affiliate WJLA-TV and moderator and producer of *Inside Washington*
- Dan Shaughnessy 1975, sports columnist for the *Boston Globe*
- Bill Simmons 1992, HBO Sports personality, founder of The Ringer, founder of Grantland and formerly ESPN sports columnist and podcaster (Page 2 and The BS report), founder and co-creator of ESPN hit documentary series “30 for 30”
- Ed Walsh 1969, WBZ NewsRadio 1030-AM, morning news anchor

## Religion

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Name	Year/Degree	Notability	Reference
<u>Most Rev. James Augustine Healy, D.D.</u>	1849	first African American bishop in the United States	
<u>Most Rev. Frederick Anthony Donaghy, M.M., D.D.</u>	1925	Maryknoll missionary to China who became the first bishop of Wuzhou; his brother, William A. Donaghy, S.J., served as the president of Holy Cross	[28]
<u>Rev. William O'Malley, S.J.</u>	1953	prolific author and teacher of theology at <u>Fordham University</u> ; famous for his role in <i>The Exorcist</i>	
<u>Msgr. Peter Vaghi</u>	1970	pastor of the Church of the Little Flower in Bethesda, Maryland and chaplain of The John Carroll Society in Washington, D.C.	

## Science, technology, and medicine

- Arthur L. Beaudet, M.D. 1963, Henry and Emma Meyer Professor; Chair of Department of Molecular and Human Genetics, Baylor College of Medicine; known for his pioneering work in gene therapy, particularly the muscular dystrophy gene
- Helen W. Boucher, M.D. 1986, Director of Infectious Disease at Tufts Medical Center, Scientific Advisory Board Entasis Therapeutics
- Edward Bove, M.D. 1968, Professor of Surgery at the University of Michigan School of Medicine, recognized for his contributions to the repair of congenital heart defects
- James William Colbert Jr., M.D. 1942, first Provost of Medical University of South Carolina and dean emeritus of St. Louis University School of Medicine
- James J. Collins, Ph.D. 1987, Rhodes Scholar, 2003 MacArthur Fellow and Termeer Professor of Medical Engineering & Science at MIT
- Benjamin Covino, M.D., Ph.D. 1951, Regional anesthesia pioneer and first Chairman of the Anesthesiology Department at Brigham and Women's Hospital
- John P. Donohue, M.D. 1954, pioneered the development of chemotherapy and nerve sparing surgical techniques for testicular cancer
- Anthony Fauci, M.D. 1962, head of the National Institute of Allergy and Infectious Diseases, National Institutes of Health
- John A. Fallon, M.D., M.B.A. 1970, on the Board of Directors for numerous companies including Exact Sciences Corporation
- Robert Harrington, M.D. 1982 American Heart Association president.
- Thomas W. Hungerford, 1959, mathematician and author of many textbooks including *Abstract algebra*:
- Joseph P. Kerwin, M.D. 1953, astronaut who spent 28 days in space for the Skylab 2 mission
- David McDowell, B.A., M.A., M.D. 1985, psychiatrist, author, expert on substance abuse treatment
- Joseph E. Murray, M.D. 1940, Nobel Prize in Medicine for the first successful kidney transplant
- William Nolen, M.D. 1950, surgeon and author
- Jennifer Schneider, M.D. 1997, President and Chief Medical Officer at Livongo.
- James Augustine Shannon, M.D. 1925, former Director of the National Institutes of Health

- Tony Stankus, MLS, FSLA 1973. Most published science librarian in the world, 2011-2015. <https://doi.org/10.1080/0194262X.2017.1323070><sup>[29]</sup>
- Steven Stack 1994, youngest American Medical Association president.
- Gordon Zubrod, M.D. 1936, received the Lasker Award in 1972 for his work in cancer research

## Sports

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### Baseball

- Brian Abraham 2007, World Series Champion with the Boston Red Sox
- John Joseph "Jack" Barry 1905, shortstop, second baseman, and manager in Major League Baseball, and later a renowned college baseball coach<sup>[30]</sup>
- Dick Berardino 1957, player development consultant for the Boston Red Sox
- Matt Blake 2007, New York Yankees pitching coach
- Pat Bourque 1969, first baseman in Major League Baseball; played on the 1973 Oakland Athletic World Series Championship team
- Ownie Carroll 1925, Major League Baseball pitcher for eleven seasons; baseball coach at Seton Hall 1948–1972
- Declan Cronin 2019, drafted by the Chicago White Sox
- Gene Desautels 1930, catcher in Major League Baseball who played with four different teams between 1930 and 1946
- Liam Dvorak 2021, RHP for the Irish National Team
- Joseph "Jumping Joe" Dugan 1920, late Major League Baseball player<sup>[31]</sup>
- John Freeman 1927, played for the Boston Red Sox
- Jack Hoey 1903, MLB outfielder for the Boston Red Sox
- Dick Joyce 1965, major league pitcher; member of the Cheverus and Holy Cross Hall of Fame; member of Maine Baseball Hall of Fame<sup>[30]</sup>
- Art Kenney 1938, LHP in MLB Boston Bees 1938 (Braves) Holy Cross Hall of Fame (2011)
- Brendan King 2017, RHP drafted by the Chicago Cubs
- Bill Lefebvre 1938, homered in first at bat as a professional baseball player
- Jack McKeon 1952, manager for the World Series Champion Florida Marlins
- Doc McMahon 1908, pitcher who played for the Boston Red Sox in their inaugural season
- Bill Mills 1944, catcher for the 1944 Philadelphia Athletics
- Joe Mulligan 1934, MLB pitcher for the Boston Red Sox
- Pete Naton, 1953, catcher for the 1953 Pittsburgh Pirates
- Al Niemiec 1933, second baseman for the Boston Red Sox and Philadelphia Athletics
- James O'Neill 1952, pitcher; won 1952 College World Series Most Outstanding Player award
- Mike Pazik 1972, drafted by the New York Yankees
- Louis Sockalexis Prep-1897, first Native American player in major league baseball

### Basketball

- Rod Baker 1974, head coach for the ABA Champion Rochester Razorsharks
- George Blaney 1961, college basketball coach and former player for the New York Knicks

- Bob Cousy 1950, Basketball Hall of Fame member; former Boston Celtics player and coach
- Jack Foley 1962, consensus All-American who played for the Boston Celtics and the New York Knicks.
- Kevin Hamilton 2006, professional basketball player and member of the Puerto Rican National Team.
- Tom Heinsohn 1956, Basketball Hall of Fame member and former Boston Celtics player and coach
- George Kaftan 1948, retired NBA player and a member of the New England Basketball Hall of Fame and the Holy Cross Varsity Club Hall of Fame
- Malcolm Miller 2015, first player to sign a two-way contract with the Toronto Raptors
- Joe Mullaney 1949, drafted by the Boston Celtics and former head coach of the Los Angeles Lakers
- Dermie O'Connell 1948, former NBA guard
- Togo Palazzi 1954, played six seasons in the NBA; captain of the Crusaders team that won the 1954 NIT Championship
- Keith Simmons 2007, professional basketball player
- Torey Thomas 2006, member of the New York Knicks
- Michael Vicens 1978, drafted by the New Jersey Nets and played for Puerto Rico in the Olympics
- Garry Witts 1981, former NBA player

## Football

- Bill Adams 1972, former offensive guard in the NFL for the Buffalo Bills
- Daniel Adams 2006, linebacker for 2007 champion United States national American football team
- Patrick Barry (Defensive Back) intercepted Doug Flutie] on the day he won the Heisman Trophy (Dec 1, 1984)<sup>[32]</sup>
- Clyde Christensen, football coach at Holy Cross, later coached in the NFL
- Kevin Coyle, football coach at Holy Cross, later coached in the NFL
- Bob Dee 1955, three-sport letterman at the College of the Holy Cross; one of the first players signed by the Boston Patriots
- Mark Duffner, football head coach at Holy Cross, later coached in the NFL
- Fred Farrier 1994, wide receiver at Holy Cross
- Gill Fenerty 1986, award-winning all-star running back with the CFL Toronto Argonauts and later with the NFL New Orleans Saints
- Chandler Fenner 2012, Super Bowl champion as well as CFL Grey Cup Winner
- Dave Fipp, football coach at Holy Cross, later coached in the NFL
- Lee Hull 1988, NFL wide receiver coach for the Indianapolis Colts
- Ed Jenkins 1972, wide receiver for the Miami Dolphins, Buffalo Bills, and New York Giants
- Bruce Kozerski 1984, played center for the Cincinnati Bengals for twelve seasons
- Gordon Lockbaum 1988, College Football Hall of Fame member
- Anthony Manfreda 1929, played in the NFL; holds the Holy Cross record for most yards gained in a kickoff return
- Nick McBeath 2018, linebacker signed by the Ottawa Redblacks in the CFL
- Mike McCabe 2012, offensive lineman signed by the Green Bay Packers; his father played for the Washington Redskins

- Jim Moran 1934, guard in the National Football League for the Boston Redskins; father of James P. Moran Jr.
- Jon Morris 1964, All-American center; named to the second team, All-Time All-AFL for his years playing for the Boston Patriots
- Jimmy Murray 2018, offensive lineman signed by the Kansas City Chiefs
- Andy Natowich 1940, former running back in the National Football League for the Washington Redskins
- Bill Osmanski 1939, Chicago Bears fullback, member of the NFL 1940s All-Decade Team, the College Football Hall of Fame, and a licensed dentist
- Peter Pujals 2018, QB in the NFL and AAF
- Vince Promuto 1960, Washington Redskins guard from 1960 to 1970
- George Pyne II, American football player
- Dominic Randolph 2010, Walter Payton Award candidate and QB for the New York Giants
- Kalif Raymond 2016, wide receiver and punt returner for the Denver Broncos, New York Giants, New York Jets, and Tennessee Titans
- Mike Sherman, football coach at Holy Cross, later coached in the NFL
- Jim Zyntell 1933, offensive lineman in the National Football League<sup>[33]</sup>

## Ice hockey

- Nicole Giannino 2015, professional hockey player
- Erin Hall 2017, professional hockey player
- Scott Pooley 2018, ECHL champion
- Patrick Rissmiller 2002, has played in the NHL for the San Jose Sharks, New York Rangers, and Atlanta Thrashers
- James Sixsmith 2007, professional hockey player
- Jim Stewart 1979, goaltender Boston Bruins

## Other sports

- Frank Carroll 1960, Olympic figure skating coach, former competitive skater
- Bob Daughters 1936, MLB player and former president of the Holy Cross Varsity Club
- Neil Fingleton 2004, the United Kingdom's tallest British-born man, professional basketball player, actor, and clothing retailer
- Keitani Graham 2003, competed in London 2012 Olympic Games as a wrestler for Micronesia
- Paul Harney 1952, professional golfer and golf course owner; in 1995, enshrined into the PGA Golf Professional Hall of Fame
- Patrick McCann, 2013, professional soccer player for Finn Harps FC
- Alejandro Melean 2010, professional soccer player for the Bolivian club Oriente Petrolero
- Paul Pearl 1989, men's ice hockey head coach at Holy Cross
- James F. "Jimmy" Quinn 1928, winner of gold medal in 4 × 100 m relay at the 1928 Summer Olympics
- Richard Regan 1976, Athletic Director at Holy Cross; former operations director of NFL International
- Kevin Swords 1982, most “capped” player on the Eagles, the U.S. national rugby team; played in the 1987 World Cup Rugby and captained the US team in the 1991 World Cup



- Willie Turnesa 1938, known as "Willie the Wedge", one of 13 men who have won both the British Amateur (1947) and U.S. Amateur Championships (1938, 1948)
- Ralph Willard 1967, former NBA coach; head coach of the Holy Cross basketball team

## Notable Holy Cross faculty

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- Patricia Bizzell, Ph.D., prolific author and former Chairperson of the English Department
- John Esposito, Ph.D., widely published professor of Islamic Studies; former Holy Cross Middle East Studies and Religious Studies Chair
- Osvaldo Golijov, Ph.D., Grammy Award-winning composer; assistant professor of music
- Claudia Koonz, Ph.D., feminist historian of Nazi Germany
- Shirish Korde, Ph.D., composer; Chair of the Music Department; founder of Neuma Records
- Joseph T. O'Callahan, first chaplain Medal of Honor recipient; former director of Holy Cross Mathematics Department

## Presidents of the College

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Order	Name	Position(s)	Joined College	Ascended presidency	Left/retired	Alumnus/na?	Reference
1	<u>Rev. Thomas F. Mulledy, S.J.</u>	President	1843	1843	1845	no	[34]
2	<u>Rev. James A. Ryder, S.J.</u>	President		1845	1848		[34]
3	<u>Rev. John Early, S.J.</u>	President		1848	1851		[34]
4	<u>Rev. Anthony F. Ciampi, S.J.</u>	President		1851	1854		[34]
5	<u>Rev. Peter J. Blenkinsop, S.J.</u>	President		1854	1857		[34]
6	<u>Rev. Anthony F. Ciampi, S.J.</u>	President		1857	1861		[34]
7	<u>Rev. James Clark, S.J.</u>	President		1861	1867		
8	<u>Rev. Robert W. Brady, S.J.</u>	President		1867	1869		
9	<u>Rev. Anthony F. Ciampi, S.J.</u>	President		1869	1873		
10	<u>Rev. Joseph B. O'Hagan, S.J.</u>	President		1873	1878		
11	<u>Rev. Edward D. Boone, S.J.</u>	President		1878	1883		
12	<u>Rev. Robert W. Brady, S.J.</u>	President		1883	1887		
13	<u>Rev. Samuel Cahill, S.J.</u>	President		1887	1889		
14	<u>Rev. Michael O'Kane, S.J.</u>	President		1889	1893		
15	<u>Rev. Edward A. McGurk, S.J.</u>	President		1893	1895		
16	<u>Rev. John F. Lehy, S.J.</u>	President		1895	1901		

Order	Name	Position(s)	Joined College	Ascended presidency	Left/retired	Alumnus/na?	Reference
17	<u>Rev. Joseph F. Hanselman, S.J.</u>	President		1901	1906		
18	<u>Rev. Thomas E. Murphy, S.J.</u>	President		1906	1911		
19	<u>Bishop Joseph N. Dinand, S.J.</u>	President		1911	1918		
20	<u>Rev. James J. Carlin, S.J.</u>	President		1918	1924		
21	<u>Bishop Joseph N. Dinand, S.J.</u>	President		1924	1927		
22	<u>Rev. John M. Fox, S.J.</u>	President		1927	1933		
23	<u>Rev. Francis J. Dolan, S.J.</u>	President		1933	1939		
24	<u>Rev. Joseph R.N. Maxwell, S.J.</u>	President		1939	1945		
25	<u>Rev. William J. Healy, S.J.</u>	President		1945	1948		
26	<u>Rev. John A. O'Brien, S.J.</u>	President		1948	1954		
27	<u>Rev. William A. Donaghy, S.J.</u>	President		1954	1960		
28	<u>Rev. Raymond J. Swords, S.J.</u>	President		1960	1970		
29	<u>Rev. John E. Brooks, S.J.</u>	President		1970	1994		
30	<u>Rev. Gerard Reedy, S.J.</u>	President		1994	1998		
	<u>Frank Vellaccio, Ph.D.</u>	Acting President		1998	2000		

Order	Name	Position(s)	Joined College	Ascended presidency	Left/retired	Alumnus/na?	Reference
31	<u>Rev. Michael C. McFarland, S.J.</u>	President		2000	2012		[35]
32	<u>Rev. Philip L. Boroughs, S.J.</u>	President		2012			

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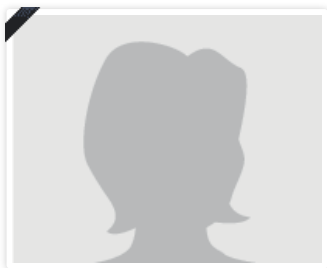
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# Eugenia Lillian Fauci

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## Eugenia Lillian Fauci (Abys)

Birthdate: circa 1911  
 Birthplace: New York, NY, United States  
 Death: October 29, 1965 (49-58)  
 New York, United States  
 Place of Burial: Brooklyn, Kings County, NY, United States  
 Immediate Family: Daughter of [Giovanni Abys](#) and [Raffaella Abys](#)  
 Wife of [Stephen Antonio Fauci](#)  
 Mother of Private and [Dr. Tony S. Fauci](#)  
 Sister of [Emily Lenora Melici](#)

 Managed by: [Tamás Flinn Caldwell-Gilbert](#)

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Eugenia Fauci in New York  
State Deaths, 1957 - 1969



Eugenia Lillian Marta  
Lucrezia Fauci (born Abys)  
in FamilySearch Family Tree



Eugenie Fauci in 1930  
United States Federal  
Census

## Immediate Family

[view all](#)


**Stephen Antonio Fauci**  
husband



**Private**  
child



**Dr. Tony S. Fauci**  
son



**Giovanni Abys**  
father



**Raffaella Abys**  
mother



**Emily Lenora Melici**  
sister

## About Eugenia Lillian Fauci

"Both sets of grandparents immigrated to New York City via Ellis Island at the turn of the twentieth century and initially settled in lower Manhattan's Little Italy, where Tony's mom, Eugenia Abys, and dad, Stephen Fauci, were born. Later, both families moved independently of each other to the Bensonhurst section of Brooklyn. Eugenia and Stephen met in eighth grade, attended high school together, and were married one year after graduation. Tony's dad attended Columbia University and became a pharmacist while his mom attended Hunter College. They had two children, first a daughter, Denise, and then a son, Anthony Stephen, who was born in Brooklyn Hospital.

The Faucis ran a neighborhood pharmacy at 13th Avenue and 83rd Street and lived in an apartment above (Figure 1). The whole family helped out in the business — his dad working in the back of the pharmacy while his mother and sister operated the register. Tony delivered prescriptions from the time he was old enough to ride a bike. He was raised in a Catholic tradition, receiving his first communion at age 7 and confirmation at age 12. Strong family relationships were an important part of Tony's upbringing."

- Source - <https://www.nytimes.com/1965/11/01/archives/tony-fauci-son-of-eugenia-abys-died-at-49.html>

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Eugenia Lillian Fauci's Timeline

view all

1911

1911

Birth of Eugenia Lillian Fauci

New York, NY, United States

1940

December 24, 1940

Birth of Dr. Tony S. Fauci

Brooklyn, Kings County, New York, United States

1965

October 29, 1965

Death of Eugenia Lillian Fauci

Age 54  
New York, United States

????

Burial of Eugenia Lillian Fauci

Brooklyn, Kings County, NY, United States

Genealogy Directory:

- A
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- E
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- G
- H
- I
- J
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- P
- Q
- R
- S
- T
- U
- V
- W
- X
- Y
- Z

## Dr. Tony S. Fauci

[Back to Fauci surname](#)

## Dr. Anthony Stephen Fauci

Also Known As: "Tony"

Birthdate: December 24, 1940

Birthplace: Brooklyn, Kings County, New York, United States

Immediate Family: Son of [Stephen Antonio Fauci](#) and [Eugenia Lillian Fauci](#)  
 Husband of Private  
 Father of Private; Private and Private  
 Brother of Private

Managed by: [Tamás Flinn Caldwell-Gilbert](#)

Last Updated: May 2, 2020

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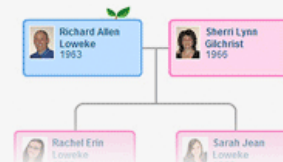


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Private child



Private child



Private child

[Stephen Antonio Fauci](#) father[Eugenia Lillian Fauci](#) mother

Private sibling

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## About Dr. Tony S. Fauci

**Anthony Stephen Fauci** (born December 24, 1940) is an American immunologist who, as a physician employed by the National Institutes of Health of the United States, has served public health in a variety of capacities for more than half a century. He has made substantial contributions to HIV/AIDS research and other immunodeficiencies, both as a scientist and as the head of the National Institute of Allergy and Infectious Diseases (NIAID) at the National Institutes of Health (NIH). He has been called "the nation's leading expert on infectious diseases". He is a member of the White House Coronavirus Task Force addressing the 2019–20 coronavirus pandemic.

- Genealogical Information: [NCBI](#)
- Reference: [Wikipedia](#)

Dr. Tony S. Fauci's Timeline

December 24, 1940

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1940

Brooklyn, Kings County, New York, United States

Genealogy Directory:

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