Oral History #60

An Interview With

Richard Grimes

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Interviewer: Michelle Ramstake
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AN INTERVIEW WITH RICHARD GRIMES

MICHELLE RAMSTACK: This is Michelle Ramstack interviewing Richard Grimes for The oH Project Oral History Program. This interview is taking place on June 20, 2019, at his home, located in Bellaire-Houston in Texas. I am interviewing Dr. Grimes in order to obtain his recollections concerning the medical and public health side of the Houston response to HIV/AIDS.

When and where were you born?

RICHARD GRIMES: I was born in Detroit, Michigan, in 1940.

MICHELLE RAMSTACK: Can you tell me a bit about your family and early life?

RICHARD GRIMES: I was born into an Irish Catholic family which doted on me. All the time growing up, I had several unmarried aunts and uncles who always looked after me. I was the fourth child in the four-child family, so the older kids doted on me. Went to Catholic grade school and then went to a Jesuit high school, which gave me an extraordinary education, as the Jesuits do, and I am so grateful for the education. Even though I graduated 61 years ago, I still send a check every year to that school in gratitude for the education they gave me.

I started college at the University of Detroit and transferred to the University of Michigan, which had opened a new branch in one of the suburbs of Detroit, Dearborn.

MICHELLE RAMSTACK: What were you studying?

RICHARD GRIMES: I studied business. My undergraduate degree is in accounting and economics. I then went to Ann Arbor to do my MBA [master of business
administration], which I did in finance. While I was working on my master’s, I married Deanna Evans, 56 years ago. Deanna was working as a nurse at University of Michigan Hospital. When she got pregnant, she was told she couldn’t work after the fourth month, because in those days women were so fragile that if they got pregnant, why, they couldn’t continue to do the heavy labor of — nowadays, we give them 20 minutes off for delivery. Anyway, I didn’t have a job. I actually had a half-time job, and I heard somebody was doing research.

RAMSTACK: Where was your part-time job?

GRIMES: I was doing clerical kinds of work, and I heard that there was a project on trying to develop staffing standards for hospitals. I went over and talked to the guy that ran the program. One of the areas they were studying was hospital laundries, and I had grown up in my father’s dry cleaners and laundry, so I told them I was an expert on laundries. They hadn’t, so he hired me, the result of which is you may be meeting the only person you ever knew who wrote a book on hospital laundries. That was my first publication. Anyway, I did that for a couple of years.

The group that I was working with had started up a nonprofit organization that did consulting in hospitals, so I went to work for that group and had a good experience, learned a lot about what goes on in hospitals. I got asked to be on a committee of the American Hospital Association on computers’ use in hospitals. Now, this was 1966, 1967, so other than maybe doing some billing, that was the only kind, and we were, of course, using punch cards, which you may have never seen, for data input.

While I was there, a fellow and I did a little painting of Chicago red, and
the more we drank, the more we liked each other. He invited me to come down and interview with him at the University of Missouri. I came down to the University of Missouri, and he couldn’t see me when I first arrived, so he asked some other fellow to interview me and talk with me. We finally got together and discovered that we really didn’t like each other sober. Some of it was like going to be no contact there, and I went back to Ann Arbor, but the guy I interviewed with in the morning called me up and said would I like to come work for him? I said I would if I could then work on a doctorate while I was down there.

RAMSTACK: Where were you working?

GRIMES: At the University of Missouri.

RAMSTACK: What were you doing?

GRIMES: I was still doing the consulting world at that time.

So we moved to Columbia, Missouri, and I started working on what was called the Regional Medical Program, the purpose of which was to transfer technology and knowledge from the medical center to the rural areas. We were thereby going to stamp out heart disease, cancer, and stroke. We failed. Anyway, I was put in charge of a program to utilize a huge database of hospital discharges. In fact, it was like a half million hospital discharges in the database. I did lot of analysis of those data while I was doing my coursework for my doctorate.

RAMSTACK: What was your coursework?

GRIMES: I did a major in management from the business school and a minor in finance and a minor in community medicine. The community medicine was out of the medical school, because one of the things that I had learned in my consulting days was, I needed to learn how physicians think if I was going to be a successful
health administrator of some sort, so that’s why I went with them. It was my academic involvement with public health. I did biostatistics and epidemiology and environmental health and so forth kinds of courses and actually ended up teaching their public health administration in that department.

RAMSTACK: Did you enjoy working more in the public health fields than like in business?

GRIMES: What I really got my public health education from was there were two older faculty in the department, and like me at my age, liked to tell stories. They had both been director of the state health department at various times, so they used to tell me public health stories.

Then I got involved in a couple of disease outbreaks, one of which was a typhoid epidemic that had occurred at a church camp. People had come in and camped and done religious activities and then scattered back to four other states, where they then had typhoid cases in those states.

The other was an outbreak of trichinosis which came from pork that was used in making some sausage. There had been a man who all his life had made sausage and retired, and the son took over the business but didn’t quite get the recipe right, apparently, to make sure that all the smoking had killed all of the organisms. That was the kind of incident, and then it was trying to trace back to find out where the pork came from, but it was impossible. There were too many pieces of pork going on.

Anyway, while there, I also met a dear friend who was a public health physician interning there to get his boards in preventive medicine, and his wife was a pediatrician, and they became our best friends, probably for life. He got a
job working at the School of Public Health.

RAMSTACK: What was his name?

GRIMES: Clarence Skrovan. He lives up Central Texas. His wife is now dead.

Clarence came down and took a job at the School of Public Health here and told the dean he had to recruit me because I would be a great public health administration teacher. So I came down here to be at the School of Public Health, and the School of Public Health had just opened.

RAMSTACK: What year was this?

GRIMES: 1972. Starting the school, the dean was kind of having a problem with very difficult to recruit faculty to a swamp on the Gulf Coast in a brand new school, et cetera. What he did very cleverly was — in those days it was legal to force retirement at 65, so many schools of public health cut loose their very elderly faculty, 65 being very elderly. I don’t know, but it seems quite young to me now. He recruited them, and then the other people he could recruit were very young, fresh-out-of-school people like me. I used to think that the school was staffed by the Niles family, the juveniles and the seniles, but the wonderful thing is, they all told me stories.

Fay Hemphill was on the faculty. He was the statistician for the Salk vaccine trials and would tell me Jonas Salk stories and would tell me Sabin stories, and the only thing he ever knew about Sabin and Salk was they hated each other. He had also been in public health forever, had done diphtheria epidemics in the 1930s. Actually, he was on the faculty at the University of Texas for its 50th anniversary and for its 100th anniversary.

RAMSTACK: Wow. So listening to all these stories really got you more interested in
GRIMES: That’s how I learned public health.

RAMSTACK: That’s how you learned? Okay.

GRIMES: Yeah, I mean, the best way to learn is examples, and they had a million examples. Fay did the study that demonstrated how retrolental fibroplasia was occurring in infants who were born prematurely. All infants in those days were put in incubators, but some kids got it and some kids didn’t. What Fay figured out was, there was a narrow range of oxygen concentration that if the child was put in that narrow range, they went blind. Due to his wonderful epidemiologic work, he saved thousands of children from going blind, which is an amazing thing. They would tell me the stories about it. He was one of the people that worked on the Framingham Study of heart disease for many years.

Jim Steele was on there, who was a veterinarian, and really put together the notion of the interactions between veterinary diseases and human diseases; for example, swine flu. He had worked in the CDC [Centers for Disease Control] for 40 years or more, retired as a — the Public Health Service has a Commissioned Corps which is equivalent to the military ranks. He retired as the equivalent of a one-star admiral, in the Public Health Service. Had been all over the world, had the most incredible memory.

RAMSTACK: Could you tell me more about your early involvement with AIDS?

GRIMES: Okay. You’re doing the right thing, which is once I get to telling stories, I don’t stop, and so interrupt me.

I had happily taught public health administration, been promoted and tenured at the School of Public Health, wrote some papers on management of
healthcare organizations, and got them published. One afternoon, I was sitting in my office, and one of my former students, who was gay, came in and said they had started a voluntary clinic in Houston called the Montrose Clinic, which was having lots of difficulties of management, board members being irresponsible, staff members being irresponsible.

RAMSTACK: Do you remember their name?

GRIMES: Whose name?

RAMSTACK: Your student.

GRIMES: Craig Litton. I don’t know what happened to Craig. For a while he worked at NASA [National Aeronautics and Space Administration], and then for a while he was the occupational health person for the arts community here in Houston, the opera and the Alley Theatre.

RAMSTACK: But he came to you and —

GRIMES: And said they were starting this clinic. Would I go on the board?

   I said, well, my thought was at the time that public health in those days was mainly chronic disease prevention, which always consisted of if you ate your oat bran, you’ll live to be 78 instead of 77, and the feedback loop on that is kind of long as to whether you’re doing any good or not. Of course, if you’re doing any of that stuff, a new paper will come out next year saying that was all wrong last year. So I thought, “Man, I could go someplace where somebody has a disease, they get a shot, and they go out, and they are cured. Hey, that’s a deal. I’ll go on that board and see what happens.”

   Of course, three months later, we’re up to our ass in AIDS, and that era was so frightening for everyone because there was clearly this mysterious disease
that was very widespread, and actually a wonderful piece in Randy Shilts’ book *And the Band Played On* where the disease was being seen in various places, and it was kind of like the blind man and the elephant story. Do you know the blind man and the elephant story?

RAMSTACK: Yeah.

GRIMES: Oh, where blind men touch a various part of the elephant, and somebody says it’s like a wall, and somebody says it’s like a spear, and somebody else says it’s like a snake, and of course, the final line, of course, that someone said, “No, it’s a rope that comes down from heaven, and when you pull on it, you’re covered with waste.”

Anyway, there was a guy in Harlem, a pediatrician, who was seeing all these babies born to drug-using women who had the syndrome, so he knew it was a pediatric disease. There was a guy in Georgia that treated hemophiliacs, so he knew it was a hemophiliac disease, and he couldn’t say whether everybody else was crazy. Of course, there was the gay population in New York and California. Then there was a guy in Florida that said, “No, no, it’s a bunch of Haitians who have the disease.”

RAMSTACK: How was it here in Houston?

GRIMES: Well, here in Houston, it was gay for quite a while.

Eventually the CDC got all of that data together and worked out all of the routes of transmission for HIV before the virus was identified, which was a really impressive piece of work.

Not long after I started on the board there and we were trying to figure out what to do with HIV, the virus was discovered, and then a few months later, they
developed the test to identify antibodies to the virus, and so that was the first ability to test people.

The director of the health department at that time, whose name escapes me now — Jim is his first name, but I can’t remember — came to us and said, “We need to do testing in the gay community, and we know we have a very bad reputation in the gay community from our STD [sexually transmitted disease] clinics. People will not come to us. Can we subcontract to you guys, because we’ve got money from CDC to subcontract to you guys to do the testing?”

Well, then we had to set up a training program for how to pretest counsel people and posttest counsel people. We only had volunteers who agreed to do this. Again, at that point, there was a lot of problem with volunteers because they kept dying; that when they got sick, they got fired from their jobs, they had time to do volunteer work. Anyway, we churned a lot.

RAMSTACK: So the majority of the volunteers were HIV —

GRIMES: HIV infected, many of them were. Then we got lots of other people from the community. We were going along just fine with the testing, and we’d worked out a deal with the health director that he would pay us per person we tested.

At that point, there was enormous denial in the gay community about, “Well, I don’t hang around those kinds of people.” I remember somebody saying that his definition of “safe sex” was they were very careful of who they invited to the orgy. This is literally true.

Anyway, Rock Hudson, the actor, came out that he had AIDS, which blew the whole denial thing away. I think the week that that was announced, I think we tested 700 people that week. We were in an old house, and our privacy routine
was to hang sheets between places where people were being tested and counseled. We were testing and counseling people on the front porch, in the backyard, whatever. Thank God for the volunteers who came.

RAMSTACK: About how much space was in between to create up these curtains to make rooms?

GRIMES: Between when?

RAMSTACK: Between the curtains for the rooms. I’m trying to build a mental picture.

GRIMES: The cubicles were probably 6-foot. It depended on the room size, how many you could get in there. Of course, at that point, there was so much stigma with the disease that God help us that we couldn’t do anything better for privacy for people than to just hang curtains between them. They at least couldn’t see each other. I think in the time of the 10 years that I was on the board there, most of which I was the president, I think we did 70,000 people, tested 70,000 people, and I think had 7,000 positives that we identified.

One of the stories I like to tell about down at the health department was, when we had that week of 700, sent in the bill, the department director called me and said, “You’re running all my money out,” because he got a lump sum from CDC.

So he and I got together, and I said, “How much money have you got left?” and he told me whatever it was, and I said, “Okay, what we’ll do is bill you per session.”

He said, “How much money?”

Then I counted how many sessions we would run between then and until they get the next batch of money. I did the division and said, “Okay, we’ll charge
you X dollars per session, and that way it won’t be dependent on our volume.”

The health department was providing all of the syringes for us as well as they were also still providing the antibiotics for the STD clinic, and the STD clinic was a good place, again, to recruit people. Somebody comes in with syphilis, you say, “You better get tested. You’re obviously at risk.” There was also evidence at that time that the STD’s created lesions which made easy entry for the virus.

We were going along just fine, but at some point, we weren’t getting enough money to do this, so we started with asking people to make a voluntary donation. We were saying $10 would be a good voluntary, to be tested. If you haven’t got $10, we’ll still test you, but we need the money to stay alive.

We were going along with this for about a year. I got a call from the CDC accounting people, who said that that was program-related income, and I would have to give that back to CDC. It was a significant amount of money at that point, $10,000, $20,000.

So I said to the guy, “Okay, I can tell you what you can do. We’re not going to pay you back, because we don’t have it. You can come and seize all our assets. I think we’ve got $60 in the bank, and we’ve got some used furniture here. You can have all that, but you will be on the front page of the Houston Chronicle that CDC has closed the only HIV testing clinic in Houston. Do you want that publicity?”

I never heard back from him, and we continued to collect that money.

The other thing that was interesting about that financing time — all my accounting skills came back to me — was that the health department got an
annual batch from CDC that was to start on January 1, but it took paperwork time before the money got transferred in, and then it took paperwork time at the health department to process the subcontract and then cut a check to us. Usually we would end up in January, February, and March with no income from the city. Then we would get a big check back-paying us for January, February, March.

The only thing that was saving us in those days — because, again, we were, I believe, charging for STD treatment — was that Christmas party time, lots of people got STD’s, so January, our revenue was up really good, and February was Valentine’s partying, so we got a pretty good dose in February. March was very thin.

We actually had a hierarchy of who got paid. The lowest-paid person got paid first and moved up the chain to the director at that time, Ralph Lasher, I think. No, Tom Audette was still probably the director then. Usually by the end of March, we could pay for the first two weeks for everybody and then got the other folks. Then when the big check came, you could back-pay people who had not been paid. I always admired that those people stuck at it, even though we sometimes didn’t pay them for weeks at a time.

RAMSTACK: Where were you on that hierarchy?

GRIMES: I wasn’t paid. I was a volunteer all the time. I had a job. At some point, the first year after Tom Audette, who had HIV — well, I know he was — would have been in the early 1990s, he said, “I can’t work anymore. I have to quit.”

He was actually a funny man, really. I remember as he was dying, someone asked him how did he want to be remembered?

He said, “As a slut.”
But he was funny all the time. Another thing I remember about Tom is that there was a meeting of some sort that I came to, but he was sitting in a chair. He was the only person in the room when I got there. I put my hands on his shoulder, and he said, “That feels so good. No one touches me anymore,” which again was the level of fear.

I remember sitting in rooms with people who I knew were infected, thinking, “God, I hope this isn’t airborne, because I’m at risk if it is, in a closed room with people.” Actually, what I hadn’t thought about was that my real risk was TB [tuberculosis]. Actually, the first person I knew who died with HIV died with TB. He was a medical school faculty member.

Am I rambling on?

RAMSTACK: No, no, I’d like to hear more about him.

GRIMES: Those early days?

RAMSTACK: Yeah, and about the faculty member. You mentioned him before.

GRIMES: It was very early in the disease, early 1980s, and it was clear that Pneumocystis carinii pneumonia was a major cause of death in HIV people. He had lung disease and so was being heavily treated for Pneumocystis. The treatment at that time was aerosolized pentamidine, and people inhaled it into their lungs to try to kill the bacteria. He was being treated for Pneumocystis, and the resident looked at the X-ray one day and said, “This really looks like TB.”

As he said, “Great, they might have figured this out.” He died two weeks later.

Tom died. I don’t know when Tom died. At that time, all you knew was everybody was going to die. How they were going to die was never quite clear
because there were so many different ways you can die when your immune system is ruined. You can die from cancer. You can die from TB. A lot of people died from diarrhea, essentially. They could not stop diarrhea.

The other thing I remember about that was, because I worked so close with these people, they became friends. I used to say that I mourned three times with them. I would mourn when they told me, because I knew what the end was. Then I would mourn when they became symptomatic, because that started putting a timeframe on it. It’s going to be a year or two. Sometimes I’d mourn after they died, but most of the time I felt relieved for them because it was an awful way to die.

There were just so many things went to hell in a hurry. There were treatments for most of the conditions, but they piled on top of each other. You could treat Pneumocystis, but that’s all right, they had a MAC [mycobacterium avium complex] infection, bad diarrhea, and they would get dehydrated, and then everybody who stayed alive very long wasted because there were horrible oral lesions that people got from HIV which made it hard to eat and drink. They also had lots of infections, so they ran fevers and burned a lot of calories in the fevers, and then they had diarrhea. The combination of those three things made it very difficult to maintain weight, and a lot of people just wasted away.

I mentioned the pentamidine to you, which was an interesting set of stories with that, which was we wanted to offer the pentamidine at the clinic, but there’s a terrible trap in starting a lifesaving treatment. What happens when you run out of money? So you can’t take everybody. We finally developed a rule that said unless we had enough money to guarantee somebody a year, we wouldn’t admit
anybody new to the program.

One of the things I remember is, one of the people who was at the office one morning, a man walked in with a case of pentamidine, put it on the table, and said, “Don’t ask where you got it,” and walked out. It was in these vials, and it was like, “Shit, is this stuff poisoned? Is it stolen? Are we receiving stolen? God, it could save some people, or prolong some deaths anyhow.”

So I call him, and he said, “What should I do with it?”

I said, “Well, call the manufacturer and give them the case number and say do they have any report that it’s stolen?”

They said no, they didn’t.

Then I said, “Sample three or four vials, and send it to them and ask them to analyze it and see if it’s been contaminated.” It turned out to be perfectly fine.

Again, people hated you because you had the disease. I even had people who wouldn’t shake hands with me because I was working with it. I mean, that was the level of fear and the homophobia, which if I compare 1983 to 2019, in terms of it’s almost stylish to be gay now, where everyone was in the closet, or almost everyone. One of the things HIV did was to give people the right to come out of the closet, and there was great activism in the community with people who had HIV because they had nothing to lose. They knew they were going to die. They couldn’t get a job. They didn’t have health insurance.

RAMSTACK: What were your feelings at the time?

GRIMES: I’ll have to say, growing up an Irish Catholic, I had all of the homophobia that would be associated with coming to age in the 1950s and 1960s, and I had to learn to shed that. Fortunately, the people I worked with were such nice people and
suffered so much for being gay. It was like my original thought was people must choose that lifestyle, and it was like no, you can’t ever choose that much misery, because that was what it really was. Internalized homophobia was really — people hated themselves because they were gay.

The other thing I laughed about was, because I got involved, people assumed I must be bi. I’ve laughed about that I had to learn at 45 what my daughters knew at 15, which was how to spot the hit coming and turn it off. How do you turn off the hit without turning off the person? Because I got hit on regularly for a while.

RAMSTACK: By people you worked with?

GRIMES: By gay men who thought I must be bi. Word eventually got around that, “No, he’s straight. Don’t bother him.”

RAMSTACK: You were married, right, at the time?

GRIMES: Oh, yeah, but that’s bi with many. Again, when you do HIV testing, you learn nobody is who they are. It’s almost 40 years, 35 years, 36 years I’ve been working in HIV, and the only thing I know for certain is everyone lies about their sex life.

I had a student who was a former STD investigator for the state health department, and she said, “I used to know that everybody lied, but I knew which way they were lying, because women always got syphilis from their single sexual encounter of their entire life, and men said, ‘Who can count?’”

All of a sudden, the world changed, and women were afraid to admit they didn’t have a sex life, and men were learning they had to be sensitive.

RAMSTACK: Did you have any reservations when you first started working at the
GRIMES: My thought was, this is the epidemic of my lifetime, and as a public health person, I have to be involved. I don’t ever remember not wanting to do it after I got there. I remember the first time I went to the clinic, which was I kind of thought I had fallen back into the 1960s. They were running a not-for-profit, donation-based clinic serving their community. It was the kinds of things that the hippies did 20 years before. In that sense, I’d like that atmosphere. I don’t ever remember, like I say, not wanting to be involved.

Now, did I learn a whole bunch of things that I didn’t know, and did I learn a bunch of things about lifestyles I didn’t know about, and so forth? Yes, and sometimes I’d get appalled, but after a while nothing bothered me.

RAMSTACK: You worked with HRSA [Health Resource and Services Administration], as well?

GRIMES: In 1989, HRSA had started a program called AIDS Education Training Centers, which had a really interesting approach and purpose, which was that no health professionals had been trained in HIV, so the fear of health professionals, the “We don’t know what the hell to do when we see people. I do lungs, and this person has got lungs and cancer. What do I do?” et cetera. “I don’t know anything about infectious diseases, but I know about cancer and so forth,” that kind of thing.

So they said, “Okay, we’ll set up programs throughout the United States, the purpose of which is to train health professionals on how to deal with HIV folks.”

I wrote a grant and got funded, and eventually I think I got about
$9 million over the years to train health professionals in Texas and Oklahoma, which turned out to be an overwhelming task. I think at one point, I think we did training sessions for 65,000 people during that period. Texas and Oklahoma is a huge area.

RAMSTACK: Yes, did you do any training programs? Were you working —

GRIMES: Did I teach?

RAMSTACK: Yes.

GRIMES: I taught all the time. I don’t know. I gave hundreds of lectures and seminars all over. Had interesting experiences doing them. Did a lot of work with the Indian Health Service in Oklahoma. Do you know the Indian Health Service?

RAMSTACK: A bit.

GRIMES: Maybe other folks won't when they will listen to this, which is when the United States made treaties with the various Indian tribes, one of the things they promised was to provide medical care. For a long time, they did that by doing a contract with a local physician or hospital, and it didn’t work very well.

Eventually in the 1940s, they created an Indian Health Service, which then built hospitals and clinics throughout the United States, wherever there were concentrations of Native Americans. By the way, the Indians always call themselves Indians. They never call themselves Native Americans.

Side story here for a minute, which was, there was always a problem deciding how many HIV cases are there in Native Americans? A guy did this study in Oakland, California, where there is a big concentration of many tribes of Indians. When they go to the city, the western Indians often go to Oakland when they leave the reservation.
He went and did do things, one of which is he went to a community-based organization then that was serving Native Americans with HIV, got their names, permissions, and went and checked them against the database on who had been reported. What they discovered was, many people who were Native Americans had either been called Hispanic or White, because we identify people: either get them to check a box, or we look at them, or we look at their last name, and that’s how we classify people racially and ethnically. He then went to the database that had all the people that were listed as Native Americans and then went and interviewed them and said, “What tribe are you from?”

“Tribe?”

“It says here you’re a Native American.”

He says, “My daddy was born a Texan. My granddaddy was born a Texan. I’m a native American.”

Sometimes bad data comes from political correctness. That’s a side story. Did a lot of work, and it took a long time to be trusted. If I were a Native American, I wouldn’t trust white people either. There’s nothing in the history that would tell you to do that.

The other thing of it that was different was to get into a culture that didn’t do things directly. We say, “These are the three things we need to solve.”

Somehow they communicated in ways I never understood in these meetings, and then say, “Okay, I guess we’ve agreed on that.”

And I’ll go [demonstrating looking around in confusion]. I had no idea what they were agreeing on. Eventually I got very well trusted, actually got invited to go on a sweat with some Cheyenne. Long story. I won’t bother you
with it. Anyway, we did that training all over the place.

RAMSTACK: Did you work primarily with tribal groups in Oklahoma versus Texas?

GRIMES: In Oklahoma. There aren’t any in Texas. There’s just a handful in Texas.

We ran them all off to Oklahoma 100 years ago, 200 years ago. I don’t know.

Whatever, 150. There is a small group, Alabama-Coushatta, and some Kickapoo
down on the border, but other than that, there aren’t any in Texas.

Mainly it had dealt with trying to get health providers. That thing we set
up was hands-on training. We tried to do cross-training. We did have a program
where people would come to Houston or they were already here. If they were a
physician, we had them work several days in the Thomas Street Clinic,
supervised, so they saw patients, saw what the disease looked like, saw how
people dealt with it. Then we had them spend a day with Mark Nichols, who runs
the Bering Dental Center, treating dental problems of HIV-infected people. All of
them, or many of them, said to me, “When I was educated, I was really well
educated up through my chin and then from the nose up, but they always said,
‘The dentist takes care of that’ [indicating]. I never saw a dentist work. I never
saw what oral lesions looked like.”

[END OF AUDIO PART 1]

RAMSTACK: Why did you send them to the dentist?

GRIMES: They’re going to see oral lesions, and they needed to look for them, as well as
it was one of the really good ways, in those days, to identify people who needed
testing. If somebody came in with a big sore in the side of their mouth and
complained about it, you probably wanted to talk to them about their need to get
tested kind of thing.
We also sent them to Montrose Clinic as an observer to a couple of HIV testing and counseling sessions so they understood how to do that sort of thing. It was very labor intensive to do it.

Also ran a dental clinic in Dallas in which we brought in dentists to learn about HIV, and they would then examine patients. It was done at the dental school up there, and they would examine patients and then come and report what they had seen. They were a little squeamish about it, but they would go ahead and do it. They wouldn’t otherwise have come if they weren’t wanting to learn.

When we got done, we would always say, “Now, which of those patients wasn’t gay, and which one wasn’t infected?” because we always put a ringer in, and we always put a woman in, and the woman was infected, but of course she was immediately excluded, and so it was a way to teach you can’t look at people and say whether they’re infected or not. Then we would always have somebody who would camp it a bit, who was not gay, in the group, so it was, again, a way to teach people just because you look at them or hear them or whatever, you can’t make a judgment.

Then we did all kinds of presentations. We also did, in that period, and this may be a part of your later interview, did a bunch of things in Mexico, and I’ll get to that later. We did a bunch of teaching and training sessions down there. There’s a good story that comes with that.

RAMSTACK: About how long would this training period take?

GRIMES: Depending on how much time people had. We did a lot of training of people from Indian Health because they could get a week or 10 days off, where people in private practice, well, taking a week off meant that lost a week’s income. But we
did get some faculty to come, got some residents to come, and found some people who were wanting to shift their practice from whatever they were doing now to something different.

Again, I have to greatly honor all of the volunteer people who helped. Mark Nichols helped with every person we sent to the dental clinic. I think at some point we subcontracted, bought some dental supplies for him, but that was it. He never took any money for it. The people at Thomas Street never took any money, and they were glad to do it, glad to help people.

One of the young men who went through the program, he and I wrote a couple of articles on his learning process. If I can find the articles, I’ll give you a copy of them or send it to you. I’ve got your email now, because you emailed me this morning. It’s on becoming an AIDS caregiver, and he talked about being in the program.

We actually made CNN [Cable News Network] one time. They gave us quite a bit of time. Sent a crew.

The other thing we had our physicians and the nurses do was home visits, go see what it was like to be dying in your home or very ill in your home, et cetera.

Then at some point, people at the medical schools started sending people to take my AIDS class, because I was teaching a class on HIV at the School of Public Health, and so they came. A dozen or so young physicians came, and maybe that gets to your next — involvement of young professionals. I did a whole thing on what is the disease, and what’s the public health response to the disease, and what’s it like to be a patient?
One of the things I did with that, and I get feedback on this all the time, is in those days the drug regimens were very complicated. Took three different drugs, which were often on different schedules. So ones were two a day, and one was three a day, and some could be taken with meals, and some couldn’t be, and some had to be taken with meals, so it was very complicated regimens.

I used to make up prescriptions with M&M’s, and the students then had to take the pills as instructed, and then we would get together and talk about — and Judy Levison, who is one of God’s good creatures, who delivers most of the HIV-infected women in Houston, she’s Baylor faculty, she said she never again criticized patients who couldn’t adhere to their regimens. “I couldn’t do it for a week, and they tasted good.” That was one of the things.

The other things I did were some ethics cases. I would give up one class, break the class into groups, and assign them an ethics case. My favorite one I did was, assume somebody has invented a cure for HIV infection, but there’s only the production capacity to treat half the people with the infection. How would you prioritize?

Everybody wanted to treat babies as a first priority, and then they got into do you treat people early in the disease so they don’t go bad, or do you treat people who are already damaged so you then make people who are damaged live longer, or they’ve already got diseases that can’t be cured? We would get into all these do we want to extend life? Do we want to restore, et cetera?

After this all got done, eventually somebody would say, “What’s your solution?”

I said, “I’d treat the most promiscuous.” That’s the public health
approach. The people who are most likely to transmit the disease. And babies are the last priority, because a baby infection is a dead end. Of course, I would be immediately chastised by the entire world for implementing such a thing, but I was just trying to get people to think in a public health way.

It’s interesting, because in the early days of kidney dialysis, that was the condition. There were a small number of machines and a large number of people. Committees used to have to meet to decide who got on dialysis.

The other thing people would do would be by economics. Good producers should be the first people to get it.

I said, “That really makes white men at the top of the scale here. Now, is that what you want to do? You want to take them?”

Of course, the class was mixed of various people, and so it was an interesting way to think about what are your priorities? That was one of my fun things. I am still pleased that many of those people are still taking care of HIV-infected folks. Some of them moved on to other things. You can’t blame them. It’s a hard practice, even now when you’ve got good drugs and people don’t take them and whatever.

Center for AIDS Research. I, on occasion, get asked to do reviews for NIH [National Institutes for Health]. Do you understand the review process at NIH?

RAMSTACK: No.

GRIMES: NIH has the whole ramification of disease in the United States to fund research for. People have to apply to get the money from them. Now, the question is, who’s to decide that it’s a good application or not a good application
that somebody has? NIH right away recognizes they don’t have the capacity to do that, so they organize panels of experts who then get a batch of applications to review, and then you go to Washington and get in a room together and argue over which are the best ones. Somebody presents what’s being done, and there are usually three assigned reviewers who then try to educate the rest, if you’ve got the time, but the last one I was at had 45 applications to review, so I didn’t interview. I had like eight of mine I had to do, and these are extensive.

Anyway, it’s the idea of getting expertise from outside to review things, so I periodically get invited to do, so in one of the meetings, you go around the table and introduce yourself and say where you’re from.

There was a woman there who said she was from Baylor, and a group of us, including her, went out for dinner that evening. We got chatting, and she was head of the Center for AIDS Research at that time at Baylor, and the Centers for AIDS Research notion was, it was a way in which to coordinate research within the same institutions. Because people sometimes were being funded by the National Cancer Institute in one department and by the National Institute of Allergy and Infectious Diseases in another department, they didn’t even know the other person had the money or what they were working on or anything. So the idea was to bring together, and you could get money, I think it was up to 10 percent of your NIH-funded research up to, I think, $1.5 million to put together a coordination.

Baylor at that time had about $7 million, but they had a really good basic science group. They also had a really good pediatric group from Texas Children’s, but they didn’t have an adult group.
So on the way back — we flew back together on the plane — Janet Butel was the person, was a virologist, and I talked, and she said, “Would you come on our advisory committee?”

I said, “Sure, I’ll come on.”

They were getting up for renewal, and they knew the reapplication would appear weak with no adult HIV in it, so I got one of the UT [University of Texas] faculty to come in. And they also did not have a behavioral science group, so I came in as behavioral science person and brought people from the School of Public Health with me to that.

Roberto Arduino from UT, who was very active at Thomas Street and had a bunch of research money, brought in an adult clinic, and so the application was then much stronger, and the UT people had some grant money too, so that bumped up the amount of money that was available, so it became the Baylor-UT Center for AIDS Research, and I always pride myself on perhaps being the only person who ever got Baylor and UT to work on the same thing.

I was then made associate director of that, in charge of the UT piece and the liaison to the UT piece. I did that from 2004 to 2016. In 2016 the grant was not funded, so the operation folded up. In that process, I did a lot of mentoring and publishing with young faculty in Baylor and UT and even a young fellow from MD Anderson.

I retired from the School of Public Health in 2007, moved over to the UT Med School, and took my grant money with me. My job became one of helping young people get started doing research, which I continue to do now, even though I’m not being paid, and enjoy it immensely to be able to work with young people
in that time.

Another thing that was neat for me about the Center for AIDS Research was, I was able to learn a lot of the hard science. I learned a lot about virology, I learned a lot about immunology because I hung around those people and they were quite willing to teach me.

One of the things I remember out of that was a rethinking of when I was at the University of Michigan, fresh out of my master’s degree, going to some research seminars on research in hospitals. They were all being conducted by social behavioral scientists. Of course, they always had poor measurements and bad data and difficult things.

After one of the meetings, I was walking down the hall and mumbling, and one of the old professors said, “What’s the problem?” and I told him that I couldn’t stand any more of these.

He said, “Well, you have to understand that people who are trained in the hard sciences have rigorous methodology and spend their whole life hoping they can find a significant question to apply it to. People in the social and behavior sciences spend their whole life with significant questions, hoping they can find a methodology to study it.”

I decided I wanted to work with significant problems, even if I failed at it. That was kind of my Center for AIDS Research stuff.

RAMSTACK: Did I miss any boards that you were on in here?

GRIMES: You started to ask me about involvement with charities. I did get the Catholic bishop for the Houston Galveston area diocese to fund a diocese, an AIDS ministry. I went to him and said, “We’ve got this problem, and the Church needs
to be involved.”

He said, “I want it to be involved, but I don’t know what to do.”

There was a nun assigned to work as head of that. We created a board. I was chair of the board, and I set it off separate because the lawyers were all terrified that suits would come. Again, we started into trying to educate in the parishes.

The other thing that was a problem was, people wanted to help with the care of ill and dying patients but didn’t know how. My wife is a retired professor of nursing, so she organized and conducted many programs teaching people how to lift people in bed, how to move people around, how to keep them from having bedsores, how to keep your back from getting torn up while you’re trying to move people, all those nursing skills. She did a whole bunch of those seminars.

I did all kinds of activities of going to some parish someplace to teach about what is HIV and why you shouldn’t be afraid of it. The thing that was interesting with that was the change over time, which was when I first started, there would be a very small group of older people.

RAMSTACK: What year did you first start, roughly?

GRIMES: It was in the 1980s, or late 1980s probably. Maybe middle 1980s, I don’t know.

Anyway, there would be a few older people who after a while it was very clear they had an infected child. Oftentimes, the child had come home to be cared for. I used to see these older women who had disabled husbands and dying sons and were running two-bed nursing homes. The amount of suffering they had was significant.
No one interacted with anyone else in the small groups that would be there. They hardly ever looked at each other, even. They didn’t want anybody to know why they were there, and their questions were all indirect, “If a person had” kinds of questions.

Within a few years, there would be big groups, some of those being older, but many being people who had volunteered to work somewhere and wanted to learn more or wanted to know what to do to protect their children. It was an interesting shift which really mirrored what was happening in the big community, which was, being homosexual was being acceptable in a major way.

Another just side story with that. In those days, did talks everywhere and whatever you wanted. Ended up on a radio show, with a call-in radio show about HIV, and with some city councilperson who was adamantly anti-HIV, so it was going to be this big debate thing. The guy had a call-in from somebody and said, “Isn’t AIDS a punishment from God for being homosexual?”

The councilman said, “I think that’s being the case.”

I said, “Well, God as I recognize Him doesn’t make a lot of mistakes, so if He was going to punish homosexuality, why would male homosexuality be dangerous and lesbian sex being the safest sex there is? And by the way, why would babies be getting it?”

The councilman shut up after that one, deferring to, “Well, see what Dr. Grimes thinks about that.”

Every so often, your brain works just right to get a zinger in. Anyway, that’s another one.

The other thing that we did through Montrose Clinic is, we set up a profit
cooperation. Baylor and UT Medical School were late in coming to the party, with HIV clinical research. Now, the basic-science people really jumped on it at Baylor.

Another side story, but I’ll stay where I’m going. There was no clinical research going on in Houston. Again, this is in the 1980s. So we set up a nonprofit corporation called the Houston Clinical Research Network in which we recruited private physicians who were seeing HIV patients. We then contacted, worked with, got drug companies to agree to do clinical trials in Houston for new drugs, particularly new drugs, new-drug applications. What we did with the private physicians is say, “We’ll do all your paperwork if you’ll see the patients.”

Of course, they were getting free drug for their patients, often new and better drugs than they were able to get regularly. So we created really an interesting partnership, and that went on for, I’d say, 10 years. I was the chair of that board also.

So Montrose Clinic was doing — the other thing was, there would have to be simple follow-up visits, so we then hired some part-time nurses who would do those simple visits at the clinic. We basically developed a support structure for the private physicians who, if you were doing HIV drug trials, there was enormous paperwork associated with it. So we would contract for all the paperwork stuff, and we set up then an IRB. Do you know IRB’s? Internal review boards?

RAMSTACK: Okay.

GRIMES: We set up one to vet the trials. I served on that board for 20 years reviewing clinical trials.
As Montrose Clinic morphed into Legacy, they stopped doing clinical trials because there was no need to anymore. The medical schools had stepped in and were doing that. I’m wanting to say that we got free drug for maybe 600 people through the trials, and often those were two-year trials and so forth.

We also wouldn’t take a trial unless they agreed to provide the drug after the trial was over, because we didn’t want somebody to spend 18 months on drug, and then, “Oh, you don’t have any insurance? Tough shit,” which had been a model.

They were always trying to get us to put into our consent forms that if there was any damage or injury to them from taking this drug, they should seek local care for taking care of it.

I said, “No, you’re going to pay for it, if it happens,” so that we got that in there.

Sometimes we got stupid stuff and turned it down. Sometimes we got — I can’t decide whether it’s immoral or amoral — trials they wanted to do, and we’d turn those down. Again, because this was so complicated, there would be these consent forms that at some point got up to like a dozen pages long with “These are all the other options you could have,” “These are all the possible side effects you could have,” “This is how you” — and they always were written by the drug-company people.

You had to go through them and say, “No, this is not acceptable to us. If you want to work with us, you’ve got to take this out.”

Then they were always written in technical language. We had a wonderful guy, Brian Bell was his name, who would go through these and simplify them, put
them in English so that people could actually understand them. We used to call it “Brianizing” the consent form. He did wonderful work for us for years doing that kind of effort. That was one of the other things I feel real proud about having gotten involved.

Another thing I hadn’t mentioned earlier about the early days, that comes to mind now, was, we went through this we’ll test somebody. “Yes, you’re positive. Have a nice life.” There was no follow-on to it. So we put together a program called Next Step, which was, “Now that you’re positive, what are you going to do with the rest of your life? How do you get a doctor? Who are the good doctors to see? Who are people who are still taking HIV patients? This is not an immediate death sentence for most of you. You’re healthy. People live 10 years with the infection, so change your” — because again, my wife did a bunch of interviews with people who were HIV infected, about what they had done.

People would say they got positive, so they ran around giving away things because they were going to die next week, and “Here’s my stereo,” and calling their mother to come take care of them, and after a month or two, nothing has changed. “I still feel healthy. I got the infection. Sorry, can I have my stereo back?” so forth.

So the idea was to give people a notion. Then we went through, “You need to have a will, and here are the people who will help you write a will,” because there were a bunch of gay lawyers that were doing that. “You need to have a power of attorney. You need to have a medical power of attorney. Here’s why you need them,” et cetera. “You’re going to have the following kinds of labs done on you. Here’s how to interpret your labs. What is a CD4 count, and what’s
good CD4 and what’s bad CD4? What’s a viral load, and what’s good and bad viral loads?” and so forth.

We ran that for a long time. They were still running it for years after I left. I went on sabbatical to Washington in 1995, I think. I was going to be gone for an extended period of time, so I dropped all my community activities at that time and left the diocese AIDS ministry and the Houston Clinical Research Network, Montrose Clinic. I took a leave from the IRB because I wanted to continue doing that when I returned. The other was, “These organizations are going fine. They don’t need me anymore. I’ll be around for advice, or I’ll have a beer with you, or whatever, but you’re doing fine,” and all of them did fine.

It’s interesting. When I started at Montrose Clinic, its budget was $30,000. When I left, 10 years or so later, it was $2 million. Of course, now they’ve become not just an HIV place, but a community health center. The last I heard, their budget was over $20 million, so they probably didn’t need me.

RAMSTACK: Why did you go on sabbatical?

GRIMES: I needed to be refreshed. I needed to spend some time processing what I had been doing. And did a lot of writing during that period, and it really shifted me more to my writing research area, and then that coincided with getting involved with the Center for AIDS Research. My real heavy community involvement got over in the middle 1990s, which also coincided with good drugs became available, so the — all the dealing with death and so forth. Also, the stigma had really gone. “It’s a disease,” as opposed to, “You do those rotten things that make you get sick, and God’s going to punish you for it.” I mean, that attitude isn’t gone, but it’s damn near gone, as opposed to being mostly universal. I don’t think
anybody worries about getting HIV. The behaviors are well known. The preventions are well known.

Want another side story?

RAMSTACK: Sure.

GRIMES: It’s a story I used to tell when people used to say, “Well, abstinence is the cure for this.” During World War I, the approach to STI’s [sexually transmitted infections] from the Army was to get the troops together and lecture them, saying, “You’re representatives of the moral New World, and you need to go to the Old World and set an example.” After influenza, STD’s were the second leading cause of disability in the troops.

When World War II came around, the approach was to show films of all the nasty lesions you can get in places on your body where you don’t want to have nasty lesions, and handing out condoms. At one point, they were handing out 7 million condoms a week, the military was.

A group of moralists went to the colonel in charge of the program, to say that he was encouraging these young men to have sex and all he had to do was tell them that it was morally wrong.

His response was, “Try as we might, we’ve been unable to make the sex act unpopular.” I used to use that regularly with people.

Anyway, I haven’t covered all the things I did in those years, but you don’t have that much time or tape.

RAMSTACK: I mean, I’m fine, if you want to keep going. Or if you want to take a break, we can take a break as well.

GRIMES: Do you want to take a break?
RAMSTACK: We’re recording again.

GRIMES: On the charity business, I think is where we left off.

RAMSTACK: Yes, I’d like to hear more about the other charities that you worked with.

GRIMES: My favorite story was working with United Way. Montrose Clinic went through the process to get approved to be a United Way agency. Then when you do the United Way, there’s a long list of agencies that you can say you want your money to go to, but it turns out that the United Way has already budgeted for all of those agencies. The notion is, if there are more people saying they want to donate to this agency, and the money is more than the budget, they get the excess over the budget, but most people just say, “Here’s my United Way money,” so they then use that to distribute. Well, they’ve never had anybody get over their budget amount, so they never had a problem with doing that, but it sounds really good, doesn’t it, that you’re going to be able to donate to this agency that you’re really fond of?

Well, it turned out that when we got put on the list, every gay and lesbian person, I think, in Houston then designated us, and so the amount that was designated for us was more than twice what they had budgeted for us, which they then wanted to weasel out of that, and I didn’t let them, saying, “That would be very bad publicity for you.” Anyway, we got a lot of extra money.

The other thing I remember is, the year we got approved, we hadn’t been on the list, and so they said they had $30,000 in surplus funds, but what would we do with it?

We had run a number of special things, but I said, “What we really need is
a nurse practitioner for our STD clinic at night.”

They said, “Well, why did you pick that?”

I said, “It’s easy to raise money for HIV. It’s very hard to raise money for STD’s. It’s very hard to see the socialite having the party at her house to raise money for clap,” which got a big laugh out of them. Actually, again, many of the socialite kind of people did step in and raise money for HIV.

Another population that we worked with was deaf people. Deaf people are on the fringes of society and are desperate to be involved, to be liked. As a result, they really get sexually exploited. The other thing nice about sexually exploiting them is, they can’t tell people.

We then got a guy who did signing, and we set up testing and counseling for deaf people. That was a great scheme, because I think I sold deaf people three times to various charitable organizations, though, to give us money.

The other thing that I didn’t talk about with the Montrose Clinic was, when I started, we were in a little, old house in the 100 block of Montrose [104 Westheimer]. We then moved to a house on Hawthorne, which was bigger, which was where we were doing the testing and counseling between sheets. Then we moved to a place on Richmond, which had been a veterinary clinic, but at least had some rooms in it. That’s where we started doing pentamidine.

Side story. At some point, we needed to get people to lie back while they were getting their pentamidine, and so we scraped together enough money to go buy a La-Z-Boy, and went to Mattress Mac, and he asked what we were doing. He asked the guy that worked there what we were doing, and he told him. He sent us six chairs and didn’t charge us for any of them. When you see Mattress
Mac on TV, that’s the kind of person he is.

It was clear to us we needed a much bigger space, because things were just ballooning in those days. We went around trying to rent things, and nobody would rent to us, and not because they were necessarily prejudiced, but they were recognizing when the lease runs out, what’s the marketability of a used AIDS clinic? I could see their point; didn’t like it.

We found a wonderful place across from the Greek Orthodox Church there in Montrose and were down to getting ready to close on it because we scraped together some money and were going to borrow and got somebody that would loan us money and so forth, and all of a sudden, the realtor came and said the orthodox church has made a much bigger offer. Of course, naïve as I was, I’m sure that real estate agent went and said, “Do you want those kind of people across the street from your church?”

So we decided we had to get our building. There was an abandoned motel on lower Westheimer. It was finally known as the No Tell Motel and was where many people got a quickie and got infected with HIV, so it was the certain irony, and then when it went out of business, the street kids broke in there and shot up drugs, so people got infected that way too in those days.

Anyway, we bought it, and then set off. We had to raise a half million dollars to do so, and got some foundations that got good at the stuff. The folks would always set up the meetings, and then I would go and wave my wedding ring and talk about my academic and public health and et cetera so they’d know they weren’t just funding a bunch of queers, and a bunch of people gave us money.
We applied for money for — it was a program to do housing and other urban renewal kinds of federal dollars that had come to the city, and they ended up with leftover money, which if they didn’t spend in a certain period of time, they would have to give back to the feds, so we applied for the money, and there was a lot of resistance from the staff that that money shouldn’t go to places like us. HUD money. It was the Housing and Urban Development money.

We eventually got that money and then hired architects, because it really needed remodeling, but in one way it was very nice because they were all very small rooms because they weren’t going to be stayed in overnight, so they made nice exam rooms. They all had plumbing to them and so forth. There was a swimming pool in the middle of it, which we filled in, and then that became the waiting room for patients coming in to be tested and counseled and treated.

We then went to the city. The city ran an experiment at that time with zoning, but they had never done it before, so they didn’t know what the process was. It took us like six months of, “Well, you’ve got to get this permit,” and, “You’ve got to get the fire department permit,” and, “You’ve got to get an,” et cetera, “permit for everything you’re doing,” at which point they finally said, “Oh, we’re not going to do zoning anymore.”

We eventually built the place, and then that was outgrown, and they moved to the new Legacy.

Have you been to the new Legacy place?

RAMSTACK: Not yet.

GRIMES: There’s a person there. I don’t know if they’ve been talked to, but it would be a wonderful interview. Every five years, that person has an anniversary, and
we’ve done 25 years, and I think we’re almost to 30 years since they found out 
they were HIV infected, which says a great deal, first, about them, that they 
celebrate it. That person would have an enormous perspective on being a patient, 
and there’s hardly anybody left, I think, that can tell you what it was like to be a 
patient 30 years ago before there were any drugs or whatever.

Anyway, back to wherever I was before I lost track.

[END OF AUDIO PART 2]

RAMSTACK: We were talking about the Montrose Clinic, and then you were talking 
about charities, a well.

GRIMES: The United Way business, I’ve talked to you about, and then I was raising 
money for the clinic. We eventually got the HUD money from the city. We went 
to the county, and there it was like a month and we had a check from them. The 
city was a year, I think, people fighting us until they finally decided they were 
going to give it back to the feds if they didn’t give it to us. I can’t remember all 
the foundations we got money from. Houston Endowment, I know. Fish 
Foundation.

Anyway, built that building. It was nice. They’ve outgrown it, moved to 
the new Legacy, and I think the place is just empty down there now. I don’t 
know. It’s in the 200 block of Westheimer. I haven’t been by there in a long 
time. Maybe they’ve sold it. It’s interesting, because if you took HUD money, 
you couldn’t use it for another purpose for 10 years. Well, 10 years have more 
than passed now.

RAMSTACK: Now they’re doing all sorts of stuff over at Legacy.

GRIMES: Are they? Yeah, then maybe they’re using the old building then, too. I don’t
know. I haven’t talked to those folks in a while.

What are other things I did? I just did a three-year stint with the City of Houston Health Department trying to find people who have dropped out of HIV care and reengage them with care. It turns out to be an extraordinarily difficult thing to do. One of the things we did was looked at the database. All of HIV testing, including CD4 counts and viral loads, have to be reported to the health department. Then you can search those and say, “Who hasn’t had a viral load and a CD4 count in six months?” and suggest maybe they’re out of care.

Somebody pulled those data, and there were 6,000 names in that database. Well, then, pretty soon, you started looking a name. They were there in the seventh month and there in the eighth month. It turned out the lab didn’t report for a couple of months, and so you start whittling down that way. Then you start looking at who’s in jail, who’s died, et cetera, to find out what your base is, and then you get down to a fairly small number through that whittling process. Who’s moved out of this area? There’s a police database for that, by the way. You’ve got to get the county jail database, and you’ve got to get the Texas Department of Corrections database.

The poor lady who did this I think ended up working with nine different databases and had to get certified for each one and so forth, to whittle down. I think we eventually got down to like 900 out of the original 6,000. We also asked the clinics to give us who they thought were out of care.

Then you set out to try to find the people. It gets crazy because sometimes people are “Jose Hernandez,” and sometimes they’re “Joe Hernandez,” and sometimes they’re “J.L. Hernandez,” and it’s the same person, and they’re in
different clinics, so you think they’re out of care, but they’re not really out of care because they used a different name when they went somewhere else. You can track through and then try to find people.

The problem is, you’re a year after their last visit, and it’s a very mobile population, much of that, particularly the dropout people or people who are street people or unemployed or they lived with their sister for a while until she kicks them out.

You have phone numbers, but the phone numbers are a year old, and they’ve switched providers, cell phone providers, or they’ve lost their cell phone because they can’t pay for it. You keep trying to not contact them.

Eventually you end up with what you think is an address for somebody, and you go knock on the door and say, “I’m from the government, and I’m here to help you.” It turns out that many of these people’s immigration status is irregular. When somebody comes and knocks on the door and asks for Jose Hernandez, “Nobody by that name lives here. Never has,” et cetera.

But sometimes you contact the people, and then you say, “Let me meet with you and talk with you.” So you set up to meet at McDonald’s because they don’t want the health department people in their neighborhood, coming or whatever, or they don’t want you to know where they’re really living now or whatever.

Then you spend some time with them, and then you try to build some trust with those folks, and then you say, “We’ll drive you to reengage you with care.”

Out of the 900 that we thought were real by the time you sorted out all those that had moved or died or whatever, I think we got 65 people reengaged.
We spent a million dollars doing that. Got a grant from Merck Foundation, Merck drug company. It really taught us the lesson of you’ve got to prevent dropouts because after that, God knows where they are.

Again, some of them we found through the state health department, they were in care in Dallas. On occasion, we got calls from Dallas saying so-and-so has moved to Houston, so you need to do a follow-up on them.

I was sure it was going be an easy, and why they thought the health department would be able to do it really well because they do that with syphilis. Every case with syphilis comes into their clinics, they get the contact information from the person, and then they go find those contact people and say, “Someone who has syphilis reports that they have had sex with you. We need to have you come in and get tested for syphilis, and we can treat it so we control the syphilis.”

The health department is really expert at tracking down people, but of course somebody goes in with syphilis two weeks after they get symptomatic, so it’s a month you’re chasing people rather than a year that you’re chasing people. That really is a problem. It was another one of my adventures of HIV.

Let’s see. What else are you looking at? International involvement.

RAMSTACK: Yeah, touch a little bit on some of your international.

GRIMES: Probably the most amazing experience was an organization called Save the Children, which actually appeared in the newspaper yesterday because they’re working with the children on the border who have been separated or who have come as children. Asked a group of us from Houston, including my wife, to go to Romania because Romania had a huge outbreak of pediatric HIV, which was all done by government policy, inadvertently, but the result of the dictator,
Ceaușescu, who ran the country from the end of World War II into the 1980s, at some point decided that the way that Romania was going to become a great country was to increase its population, so women were not allowed access to abortion or birth control until they have had six children.

Romania at that time was the second poorest country in Europe, so women had these children they couldn’t feed. So the government set up these enormous numbers of orphanages where people would drop their children off.

One of the things we learned while we were there was, the food budget was based on what are the calories necessary to sustain life in those children? There was lots of failure to thrive, and they were separated from their parents. There were children who were never out of a crib, and they were five years old, because, again, the staffing was like one woman for 50 children. If the kid got his diaper changed in a shift, that was about the max you could do with that population. Nobody held the children.

They talked about taking these children, three- and four-year-old children, out of their crib, putting them on the floor, and they panicked, because they had never felt anything solid on their feet. The rehab with these kids was —

The other thing they did was that the wife of the dictator was the head of science for the country, even though she had no training in it, but she believed that failure to thrive could be cured with microtransfusions, like 10 cc’s or 20 cc’s, and that would help the children survive.

Blood was used, donated blood, which didn’t need to be screened because AIDS was only a disease of the decadent capitalist countries. Good socialists would never have such a disease. I don’t know how they expected to get six kids
per woman without sex.

The other treatment for failure to thrive was massive vitamin injections. I remember seeing one study they had done of children under three that had had a hundred vitamin injections.

The other thing the dictator had done is closed all of the nursing schools 10 years before, and young women were encouraged to get practical experience to become nurses, but they didn’t learn things like antiseptic technique or any of those kinds of things, so one of the things they did when they ended up giving the injections to all these kids is, they would load up a syringe with, say, 100 cc’s of the vitamins, go along and hit 10 kids with them. [Gesturing injection motion]

So they introduced HIV into the orphanages — the official count for children who were infected was 3,000. The actual number was probably 30,000, at least when you talk to people that are saying, “We were given a quota of how many we could report.” It was an extraordinary lesson. By the way, going into wards filled with dying children is just the most depressing thing.

Mark Kline, who is another person somebody ought to be interviewing, is head of pediatrics now at Baylor, so he might be hard to get to. He was the physician on the trip, the pediatrician, and he came back and said, “This cannot stand.” He went around and banged on the doors of all the drug companies, got them to donate drugs, which was, again, a problem, because they weren’t making pediatric doses, but he eventually got that worked out, went back, and set up clinics several places in Romania to treat the children.

The model was so good, he took it and went to Africa with it, at least a dozen or 15 countries, and there’s 250,000 children getting antiretrovirals now
because of his program. Truly an extraordinary man in terms of his ability to put this together.

Then he decided he had to get better training for the local people that were using the drugs, so he set up what was called the Pediatric AIDS Corps, a program kind of like the Peace Corps, and volunteer physicians would agree to do a year or two in Africa teaching and showing how to care for the children.

Then, of course, he immediately found out that you can’t just treat the children. You have to treat the parents, as well, because otherwise, you’re just creating orphans, healthy orphans, but — and he’s gone all over the world with it. It’s in Mexico and Asia.

RAMSTACK: You mentioned that you went into Mexico, earlier?

GRIMES: Oh, yeah, I made a trip down there for some reason that I no longer remember and met some infectious disease physicians who were taking care of HIV patients. They were putting together an international conference on HIV. I went several years, six, eight years, I don’t know, five or six years, to Monterrey, Mexico, to teach at that symposium.

My favorite story out of that was, one year they said, “Doesn’t your wife do some HIV stuff?”

I said, “Yes.”

She said, “Well, why don’t you come down with her, and she can do a session for what nurses need to know about HIV?”

Well, we got there, and she was in her “I’m the tagalong spouse, but that’s fine.” I’ve been tagalong spouse to her. Got there, and she was immediately grabbed by the dean of the nursing school and taken off while I was doing my
first day of the conference, my part of it. Well, she had written a book on infectious diseases for nurses, which had been translated into Spanish and was used as a textbook in the nursing school there, so it was her on the stage at graduation handing out the diplomas to the graduating nurses, and I became the tagalong spouse.

She then ended up being followed around by groupies because, again, it’s not a highly respected profession in most places. The notion that there was a nurse who had two master’s degrees and a doctorate and traveled all over the world teaching was like a fantasy that could hardly ever been accomplished, but it was like, “Oh, that’s what you could be as a nurse” kind of thing.

Her first lecture was after lunch, and the entire room filled with nurses. There were no seats for the physicians. When they came in the conference, they had to stand in the back of the room. That was just kind of a wonderful piece, again, because that era, Mexico was well behind us.

One of the years we went down to give a seminar that one of my colleagues here was an ob-gyn who came and did, and he had actually done his medical school in Mexico, so he was competent in Spanish, which I never got competent enough, but if I was in Mexico a few days, I could hear my Spanish again, but the grammar always screwed me up on Spanish.

Anyway, Deanna and I had written a paper on, again, the psychological manifestations of AIDS in that era when everybody died, which is how do you deal with it? How do you help people through? How do you deal with the anger you’re going to get? How do you help people make end-of-life plans? I’ve been going down there for years saying the same shit, so maybe I’ll just do the
psychological manifestation thing, and presented what was in the paper.

Afterwards, got finished, got the question answered, and one of the physicians in the group stood up and made kind of a long talk. Andy Helfgot said, “Where we are in treating of HIV, this is the most important lecture I ever heard,” because everybody was dying. They couldn’t get the drugs. They couldn’t get the labs. They couldn’t get any of those kinds of things. So how do you help people die? Which was really an interesting lesson in lack of resources. Mexico is not really a Third World country. It’s a middle-income country, but they were a few years behind us at that time.

Another thing was, the time we were down there, one of the nurses came to us and said that her brother was supposed to get viral loads, but it wasn’t available in Mexico, and so he was having to take a bus to Laredo, come here across the border, and they were charging $300 to do the labs, and was there some way she could ship his blood to Houston and we could get it done cheaper than that?

I said, “I’ll look into it.”

Of course, the problem was getting it through Customs. They weren’t about to say, “Yes, you can take infected blood into the United States,” so we couldn’t do it. But again, it was the notion of the desperation or the difficulties in another world. So that was Mexico.

Deanna did multiple trips to China. The World Health Organization hired her. China had stopped having public health nursing as part of the curriculum in the nursing schools because it wasn’t necessary. Suddenly, with the one-child policy, they had enormous numbers of elderly with no one to care for them, so
they were now trying to say, “We need to have nurses making home visits. We need to have them operating screening clinics,” et cetera, but there was no training, so they went to the World Health Organization and said, “We’ve got to change this,” so the World Health Organization hired Deanna to go to China and start teaching in various schools all over China.

She made a lot of good contacts, and then at some point they invited her and me to come and teach about HIV, which was now appearing in China, and they had a big blood-borne nonscreening-of-blood activity. We’ve done that twice, gone and done that work with Chinese nurses.

Deanna also attracted a number of Thai nurses to come study with her at UT School of Nursing, and then they started inviting us to go to Thailand, and we then regularly met with the faculty, who were trying to get traction on doing research. They often had good ideas on research but weren’t quite sure how to carry them out, and then wanted to get them in English-language journals. They all speak some English. We refer to it as Taglish, but basically a difficulty. Don’t write it well, and so they would ask us to help analyze data and write it up.

We did that maybe eight, 10 years. We probably between us got 20 papers we co-authored with the Thais. Actually, had one just got published a few months ago, the last of those. What pleases me about it is, they stopped asking for help, suggesting they were on their way, didn’t need us anymore. It’s kind of like my community involvement stuff. The organizations were doing fine. They didn’t need me anymore, so that was a kind of nice piece to working in Thailand.

That was kind of various things I’ve done in foreign countries. We’ve also presented research all over the world at various conferences. I would say 20
countries, probably, where we’ve — North America, South America, Asia, Africa, all over Europe. I think we’ve missed Antarctica.

RAMSTACK: I think we’re wrapping up, here. Is there anything that you would like to add that I haven’t asked about?

GRIMES: I guess I would want to say that people keep thinking there’s going to be a cure for HIV, and I think it isn’t ever going to happen. People keep saying there’s going to be a vaccine for HIV, and I don’t think it’s ever going to happen, and it’s because of the complexity of the virus.

First off, you have to understand that a person who’s not being treated, who’s HIV infected, is thought to produce about 10 billion new viruses every day, but 1 in 100,000 of those are mutants, meaning you could end up, then, with about 100,000 mutants a day, almost all of which are not viable. They just won’t reproduce themselves, but some do, and you do that 365 days a year. You’ve got an extraordinary number of variants there as well as HIV is not as simple as “a virus.” There are two viruses: HIV-1, HIV-2.

HIV-2 has, and I haven’t looked at this in a while, but had six subtypes which are distinct from one another, mainly the same but distinct. HIV-1 has now been divided into three groups, M, N, and O, “M” being main, “N” was new, and “O” was outlier, and there’s probably more since I last looked at this.

Now, if we take the M group, the main one, the last I knew, it had 11 subtypes, and they are lettered A through J, I think, and then some them are others, like F1 and F2 and so forth. Some of them were found not to be really distinct, but somewhere around a dozen subtypes, and they’re called clades.

Somebody who is clade A has sex with somebody who has clade G, and
the virus recombines and creates a new, called an AG. Then somebody with AG has somebody with DE, and so forth. At some point, they didn’t get that sample, and they now are just called cpx, meaning complex. Last I knew, there were 70-some of those recombinant forms, so it’s very difficult to think that we’re going to find something that will cure all of those different kinds, let alone being able to distribute it all over the world to get people to take it, all those kinds of problems.

The immunology people that I know that are fooling around with a vaccine keep trying to identify a place on the virus that doesn’t mutate so then the vaccine could attack that part of the virus. I don’t know. I’ve been at this over 35 years now, and every five years or so, somebody tells me we’ll have a cure in five years or we’ll have a vaccine in five years, and I haven’t seen it yet, and it’s because I don’t think people really understand how really complicated that virus is and that it’s not a virus. It’s a family of viruses. It’s distant relations in that family do that too, and you know how that distant-relation uncle of yours is never-. Everybody has got an uncle like that, don’t they?

Anyway, I think the best we can do is try to prevent transmission, but try as we might, we’ve been unable to make the sex act unpopular.

RAMSTACK: Well, now, with the PrEP [pre-exposure prophylaxis] and all those preventive drugs where you can take it to make your virus not viable, that’s where we are now.

GRIMES: We can’t get people with the disease to adhere to their drug regimens. Why somebody thinks we’re going to get people who don’t have disease to adhere to the regimens, when we know they weren’t adhering to condoms, it’s nice, but I
also think it’s a bit of a fantasy, particularly at its price. The average wholesale price is like $20,000 a year. I think the real prices that they charge are about $10,000 a year. I find it unlikely that that’s going to sustain itself, but maybe somebody will come up with something. Wouldn’t it be nice if we had a shot that prevented it for a year?

RAMSTACK: Yeah.

GRIMES: We don’t have any good models of adherence to medication except for two. One is just birth control pills, and the other is hormone replacement therapy. I don’t know whether women are just good at that, but that’s the only ones that I know of that people are good at taking their meds. I think PrEP is one more of those wonderful ideas. It’s a little short of reality.

It’s interesting. Deanna and I are just finishing a paper.

Do you know the 90-90-90 suggestion of policy? The idea is that you’re going to identify, test, and find 90 percent of the people who are HIV infected, you’re going to get 90 percent of them on drug, and 90 percent of them are going to get their viral load to undetectable, which means they’re really not able to transmit. Beautiful. Simple concept.

Of course, you have to know how many HIV-infected people there are. A lot of people make guesses at it. Not only that, they have to find them and get them into care. In many subpopulations, stigma still exists. Then you’re going to have to figure out how to pay for drug for all of those people. And then you have to figure out how to get them to take it. We’re saying until you know what prevalence is, it’s a fantasy. We’ve been unsuccessful so far getting it published, or it keeps getting rejected, because it’s not politically correct to say this
wonderful, logical idea — you were buying right into it, weren’t you, when I was
telling it to you?

RAMSTACK: Yeah.

GRIMES: It’s so logical.

Anything else you wanted to —

RAMSTACK: I think we’ve pretty much covered everything. Thank you so much for
taking the time to sit down and talk with me and for us to record this.

[END OF AUDIO PART 3]

[INTERVIEW CONCLUDED]

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