Oral History # 019

An Interview With
Stella Fitzgibbons

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AN INTERVIEW WITH STELLA FITZGIBBONS

LYNN SCHWARTZENBURG: This is Lynn Schwartzenburg interviewing Stella Fitzgibbons for The oH Project. The interview is taking place September 26, 2016 in Houston, Texas. I’m interviewing Dr. Fitzgibbons to document her recollections concerning the response to HIV/AIDS in Houston, Texas.

Hi and welcome.

STELLA FITZGIBBONS: I’m happy to be here.

LYNN SCHWARTZENBURG: Let’s start at the beginning. Tell me, when and where were you born?


LYNN SCHWARTZENBURG: What was your childhood like?

STELLA FITZGIBBONS: Pretty boring. I was an only child in a reasonably prosperous family. Things went fairly much as expected.

LYNN SCHWARTZENBURG: When you were younger, did you know what you wanted to be when you grew up?

STELLA FITZGIBBONS: Well, I thought about being a doctor, and then I got into college and I thought it would take too long, so I went to engineering school instead. After a few years of that, I decided doctoring was more interesting and it made me feel a little more useful.

LYNN SCHWARTZENBURG: Where did you go to high school?

STELLA FITZGIBBONS: Central High School in Memphis.

LYNN SCHWARTZENBURG: In what year did you graduate?

SCHWARTZENBURG: For college, is that something you just knew that you would do?

FITZGIBBONS: Well, I started out as a premed in college, but I was already majoring in chemistry. I thought that would be a good thing to go into until I found out that you need a Ph.D. to do anything except wash glassware. I was taking courses along with chemical engineers and found out that they were doing interesting things, and it looked a lot more practical. On top of that, I found out how much I hate doing research, so engineering looked like a good deal. I applied to graduate schools and got a master’s degree and enjoyed working there for about four years.

SCHWARTZENBURG: Where did you do your undergrad?

FITZGIBBONS: Tulane.

SCHWARTZENBURG: What was your experience like there?

FITZGIBBONS: Oh, it was fun. Tulane is a party school. I played in a musical group. There is New Orleans right there. It was a fun experience.

SCHWARTZENBURG: So you graduated from there, and then you went to MIT [Massachusetts Institute of Technology].

FITZGIBBONS: Then I went to MIT for the master’s, and that was fun too. When I started medical school, it was a change, but it was so much fun, I didn’t care.

SCHWARTZENBURG: You came to Houston?

FITZGIBBONS: Oh, I came to Houston when I got out of graduate school. Houston and Groton, Connecticut were the only places where my husband and I both had job offers. I figured it would be a lot easier to change jobs in Houston than it would be in Groton, Connecticut.
SCHWARTZENBURG: Where did you meet your husband?

FITZGIBBONS: At MIT.

SCHWARTZENBURG: So you went to Baylor College of Medicine?

FITZGIBBONS: Right.

SCHWARTZENBURG: Specialties? Fellowship?

FITZGIBBONS: Well, medical school is medical school. I decided early on that I wanted to be an internist and took my senior electives in that direction. Then I did residency at Baylor also.

SCHWARTZENBURG: And then when you were out of residency what did you do?

FITZGIBBONS: Well, when I got out of residency, first, I had a baby, then I worked about a year for the Harris County Community Clinic System and worked mornings there and afternoons at Seven Acres, which at that time was the Jewish home for the aged. At the end of that year, I went to work for MacGregor Clinic seeing patients on an outpatient basis. Pretty quickly, after two or three years, I started seeing hospital patients, and we rotated. I’d usually do about three months a year in the hospital plus night call the rest of the year.

SCHWARTZENBURG: Describe the care model at MacGregor.

FITZGIBBONS: Well, what MacGregor had was a joined-at-the-hip relationship with Prucare Health Insurance. If you were on the Prucare HMO [Health Maintenance Organization], you went to MacGregor for your doctor, went to MacGregor hospitals even if you presented somewhere else at their ER, and vice versa. I think 95 percent of our MacGregor patients were with the Prucare HMO, so most of them came to us by way of their employment.

SCHWARTZENBURG: Did you see the same patients over and over?
FITZGIBBONS: Oh, yeah.

SCHWARTZENBURG: Were they assigned to you?

FITZGIBBONS: They weren’t assigned. They were allowed to make an appointment with whomever they wanted, and people would refer each other. It was a case of location and convenience, but MacGregor had locations all over town, so that helped.

SCHWARTZENBURG: When did you first start seeing AIDS patients at MacGregor Clinic?

FITZGIBBONS: The AIDS epidemic first started to appear in the early 1980s. We were starting to get a few reports even here in Houston of patients, and it seemed to be related to gay men. We had a patient who wouldn’t say much about himself, but his immune system was falling apart, and one of our gay professors managed to get him to confide that he was gay, and that was about as far as it had gone.

With MacGregor, the HMO option was probably the least expensive health insurance, and it tended to attract a fairly young group of people, so young gay men who would be expected to be the most sexually active started turning up with a lot of problems, and we started having ways to identify them even before we had a blood test.

Everybody laughed in Houston when they started telling us that recurrent sinus trouble was one of the markers of this strange new disease, because that would have meant that two-thirds of the population of Houston had it. But there were skin diseases; pneumocystis pneumonia, of course; and just various abnormal blood tests; started having eye problems.

By 1988 or so, we were starting to see significant numbers of them. I
think by that time, we had a blood test and they started coming. Our main
hospital for internal medicine admissions was St. Joseph, and they started
doing — with that, plus their inner-city business, we started seeing a lot of AIDS
patients.

SCHWARTZENBURG: And those were fairly late signs, that type of symptom.

FITZGIBBONS: Oh, yeah. Before then, we didn’t have a way to identify them early,
and even if we had, we wouldn’t have had anything to give them. But we started
having AZT, I think 1984 or 1985, and all we could do was give them AZT,
which we now know is just barely even a stopgap, and they had to take it every
four hours on the dot, set an alarm.

Gradually things got better. You may remember the second HIV drug,
which was ddl [didanosine], and it was developed by Bristol-Myers. Normally
when a new drug comes out, there is a phenomenal amount of paperwork
involved. You have to fill out a phone book, practically, every time one of the
patients comes to visit. Bristol-Myers managed to condense the paperwork to a
point that regular doctors who did not have research assistants could actually
manage the paperwork. I had a whole string of those, and we had to hand them
out their medication. It wasn’t even in pill form. It was in little bags of powder
that they had to mix with some kind of liquid and drink, plus sometimes they
weren’t able to get in to pick it up. One time I had to take it to one of the guys at
his Galleria office, and I just told people that he was helping with a research
project.

That went on, and at the end of it, when the medicine finally got approved
by the FDA [Food and Drug Administration], Bristol-Myers got my vote when
they sent out a personal thank-you letter to every doctor who had patients enrolled in the study. I thought that was pretty classy.

SCHWARTZENBURG: That’s very classy.

FITZGIBBONS: So we did that, and we developed it. As time passed, the pharmaceutical companies started coming up with answers to problems. We had people coming in with CMV [cytomegalovirus] retinitis, and I remember one of these guys came in and we treated him with the first medication that we used, and the second medication wasn’t yet approved and we couldn’t get ahold of it, so we had to re-treat the guy with a higher dose of the first medicine. And then by the time he finished that, he still had plenty of eyesight left, so we could use the second one, and then he got pneumonia and died. But we at least — we bought him some very good months.

Pneumocystis pneumonia, we now have lots of medicines for. We also tested one of the medicines we used for that, and we had to deal with the side effects too. It was a problem if a patient was allergic to sulfas, because even now the best medicine for pneumocystis is still Bactrim, which is trimethoprim/sulfamethoxazole. I had a patient who was allergic to sulfas, so we had to give him pentamidine.

If you read the patient warnings on pentamidine, it can cause their blood sugar to go crazy. Sometimes we would have diabetics whose blood sugar would double or triple. Other times we would have people whose blood sugar would bottom out. The textbook says that low blood sugar can cause neurologic symptoms. Okay. What kind of neurologic symptoms? Well, usually it imitates a stroke.
One of my patients, who was a nice, mild-mannered librarian or teacher or something, well, he got very angry and started throwing furniture. St. Joseph hadn’t dealt with that quite before. Security came and tied him down, and we got him off the pentamidine, and I think the infection doctor came up with something better, or else we just stopped the antibiotic a little earlier than we were supposed to. So we had to deal with all of that.

Meanwhile, we learned some things. The research people in immunology were finding out what T cells were. Nowadays it’s just routine for HIV patients to know what their T-cell count is. The T cells we are interested in are CD4’s. Well, now we have CD’s all the way up into the 50’s, and we’ve learned a tremendous amount about which ones control blood cell development and production. We’ve found out about one of them that causes your bone marrow to make more blood cells, and that’s used in treating radiation poisoning. We use the antifungal medicines that we had to have because of all the Candida and other funguses. That meant we could use those on diabetics with esophagitis and other things going on with funguses. A whole family of antibiotics came out of that. It was good, getting to watch all of this.

IV [intravenous] infusion companies now have sprung up all over the place. When I was a resident and we had a patient with a bad bone infection or a heart valve infection or certain types of pneumonia, they would need six weeks of intravenous antibiotics, and they still do. But now they either have somebody come out to the house or they stop in at an infusion center on their way home from work, and they never think that the HIV patients were a large part of the reason those things developed.
SCHWARTZENBURG: Before that, everybody was in the hospital for all that time.

FITZGIBBONS: Yeah, they would be in the hospital for donkey’s years.

Oh, the insurance companies were ecstatic.

SCHWARTZENBURG: You talk about “we.” Who is “we”?

FITZGIBBONS: I was just a general practitioner, but I saw these patients in the hospital, and actually so did the other internists on the hospital team. We had infectious disease doctors: Seema Shah and Ayse Gokaslan. We had Paul Gustafson, who was a hem/onc doctor. We had Kirk Heyne, H-e-y-n-e, who is still in Houston somewhere, in the same specialty. We had a neurosurgeon, Hatem Megahed, M-e-g-a-h-e-d, whom we got because he was married to Seema Shah. He helped take care of a lot of the neurologic things. I think we had three or four neurologists who came through.

I had one interesting night when I was on call, and I called Seema at 2:00 o’clock in the morning to say, “I’ve got an HIV patient here who had a CT scan of the brain. He’s having seizures and fevers, and he’s got this big lesion in his brain that lights up with IV contrast.”

Seema said, “Well, it might be a lymphoma, and it might be toxoplasmosis.”

Well, treating him for toxo won’t help a lymphoma, and treating him for a lymphoma could make the toxo worse, so she says, “I think we’re going to need to get a brain biopsy.” And then she said, “Hold the phone a minute.”

And I heard in the background, “Honey, honey, wake up. Stella has got a patient who needs a brain biopsy.”

So he got his brain biopsy and he got treated.
SCHWARTZENBURG: What great collaboration.

FITZGIBBONS: Oh, yeah, it was very close. Things were not quite as tightly regimented, and the thing was, it was a very close group of doctors. We had the GI [gastrointestinal] doctors also taking care of things. They had to scope people to see when their esophagus was infected. CMV also does colitis. The neurologist, we had Stella Tsai, T-s-a-i, and Anne McCammon. And boy, they were in on the ground floor. I think both of them moved somewhere else, but they were definitely taking care of a lot of that.

SCHWARTZENBURG: Tell me about St. Joseph’s Hospital.

FITZGIBBONS: St. Joseph was nice. The nice thing about St. Joseph was, it was run by nuns, and no matter what you were doing or what kind of patients, you could always find an administrator because she’d be wearing a penguin suit. It was just a case of flagging down a sister if you thought something needed to be taken care of.

Well, the AIDS patients came in, and St. Joseph had a problem because everybody thought they were worse than Typhoid Mary. They thought you could get HIV by breathing the air. The food service people would just put their trays outside the door and run away.

The head nun of that particular chapter had a twin sister named Sister Benedict who had worked in Africa with AIDS patients before it came here, and Sister Benedict came in and straightened things out. When AIDS patients would come in, Sister Benedict, now specifically labeled as the AIDS nun, would go in there and introduce herself and mother the patients. She was a huge help in dealing with the family situations. She would straighten out all the family. Some
of the families who had just shown up for the first time in 20 years and made it clear that all this was the patient’s fault, she would kind of straighten them out on that.

Father Pat O’Malley, I think, would come in and help out with that too. He was also a great hospice priest and was wonderful at talking to families about when it was time to call a stop to aggressive medical care. They were all a big help. Families were a problem, and we all had to deal with that. I know my friend at OutSmart has probably told you about what they went through with that family.

We also had families like one that came to see one of my favorite patients when he was in our hospice facility and said that they were really too busy to stay in Houston and take care of him or to bring him back to where they lived, so they asked me to just take good care of him and use common sense, so I did, but that was better than the really hostile ones.

It was touching, the number of families who really rallied around the patients. We had patients who were members of socioeconomic groups that you would think would be ready to throw away anybody they thought was homosexual.

We had one gentleman in his fifties who had nieces. “We always knew that Uncle was different. We don’t care. He’s our uncle, and we love him.”

Same thing with one guy who was fresh off the boat from Mexico, and his sisters came around and said he was their brother and that was that.

We spent a lot of time just talking and making plans and things. It wasn’t all hospital. I enjoyed the evolution of what we did as we got more and more
capable of helping out and watching people’s T-cell counts come up. Then we had viral loads. Once we had some effective medicines and a way to follow the disease so that it at least became something they could put off, then it got to be kind of fun hearing them talk about what they were doing on their bucket list.

You could sell your life insurance policy with viatical plans and you could get paid your life insurance money. I never have figured out how the companies benefited. I think the companies made more money if you lived longer, so the longer they lived, the happier the companies were, because they were still paying premiums. A lot of the guys who didn’t think they had much time would go to Australia or something, and that was great.

SCHWARTZENBURG: Tell me about your brother-in-law Peter.

FITZGIBBONS: Well, Peter was a great example of the bucket list. He got infected when he was in his twenties. I think he was hanging out with a very swinging crowd. We had by that time become great friends. He had never had a sister, and I had never had a brother, and he had come out to me long before he did to the rest of the family.

When he got the word that he was HIV positive, he got very, very good care. He was always on the cutting edge. If a new medicine came out, he would be taking it. He finally moved to New York, which he’d like to do anyway, and he and Mom went on some really great trips together. At the time he died, he was studying to become a massage therapist and helping at a florist’s and working with GMHC [Gay Men’s Health Crisis] as a volunteer, studying Spanish to try and help some of the Spanish people that were coming in then.

He finally, we think, had a big blood clot to the lungs, and I’m so happy
he died suddenly. We didn’t have to worry about hospice care or when to stop or anything like that. I got to watch him all through and enjoy his company.

SCHWARTZENBURG: Because you were part of this at the very, very beginning, where there was no survival, how did you deal with all of the death? What did that feel like, then, when finally you were having successes and people were living longer?

FITZGIBBONS: Well, it was great. I was happy we could help the ones we did. Back in the first days, of course, it’s questionable whether the medicines we have now would have prolonged their lives very much. Their immune system was pretty much shot, and it’s going to take a long time before we have something that will really resuscitate somebody who is in end stage.

SCHWARTZENBURG: Right, we just found out too late for anything to be helpful.

FITZGIBBONS: Well, that makes me feel better. I know some of them, we could have. One young man came in, nice-looking guy in his twenties, and he had had a blood count done for some unrelated reason and was told that his white blood cell count was low.

I had made myself sort of the go-to primary care doctor for HIV patients, and a lot of my colleagues started sending me patients like him and also patients who had had a positive test or maybe positive preliminary test and they were waiting on the confirmatory test. They would send me those guys and let me tell them.

I distinctly remember one great big, muscular guy who, when I told him, got ready to storm out the door and probably would have done himself in or jumped off a bridge. I don’t know what. But here is 130-pound Fitzgibbons
grabbing somebody twice your size and walking him back in and sitting him down and saying, “You’re not leaving until I tell you that there is some good news.” Somebody else took him through the therapy, I think maybe one of the infectious disease doctors.

It was not unusual to have somebody get the news and then disappear. Sometimes we heard that they had committed suicide, and sometimes we didn’t know what had happened.

We had a great group of people to work on because we weren’t getting people fresh out of prison. We weren’t dealing with drug abusers, or at least not many. I had one of the first Houston crystal meth addicts, but he was a nice person. We had a pretty nice crowd, and they were cooperative. They’d show up for their appointments. They’d call when they had problems.

We had a deal with my phone techs. I told the patients to tell the phone tech that you’re a VIP, and if the phone tech was in on it, she would smile and say, “Sure.” If she wasn’t in on it, she’d still figure it was somebody important. That way, they got through to me quicker on the phone, so we could at least be prepared for disasters.

Of course, we also had to deal with things like partner notification, and fortunately I didn’t have to do much of that. We had an awful lot of really devoted couples, and that was also part of our job, was getting the partner through it. Back then, nobody had even considered the concept of gay marriage. We certainly knew it was the real thing. We even had one of our MacGregor doctors die of AIDS. Super guy, known to everybody in the group, and we just put him in hospice and did the best we could. Fortunately, he went really quickly.
SCHWARTZENBURG: Did it affect you when the disease started moving from gay white men to more of the minority community?

FITZGIBBONS: Oh, yeah. I was still known as the person to send them to when they were first diagnosed. We had a middle-aged black lady come in and say that she had not known she had anything to worry about until she read it on her husband’s death certificate. She had known he was sick, and he had concealed it from her, and sure enough, she turned up positive. It was awful. She didn’t know jack about HIV. She hadn’t read about it. She didn’t know anything. Every time I saw her, what should have been a 15-minute appointment spread out into 30 minutes of education that somebody else could have been doing just as well, like at AIDS Foundation Houston. They had a great thing. They had groups to meet with and everything.

When I asked her why she didn’t try going to something like that, she said, “Oh, I couldn’t go there.”

I said, “Why not?”

She said, “Well, what if somebody from my church saw me going into there?”

I was too speechless to say, “You need a new church,” and that probably wouldn’t have helped anyway, so we just kept on keeping on. I think she eventually wound up being one of the ones I sent to the infectious disease doctors.

I left MacGregor in 2000. By that time, I was down to about a dozen HIV patients. It had reached the point that we had so many drugs and we knew so much about it that it was really very appropriate for them to take over, so I didn’t feel too bad.
SCHWARTZENBURG: You were there during the crisis time and got to see it come out
the other.

FITZGIBBONS: Yeah, but I had another guy who came into the hospital. He was low
sick with pancreatitis, and he was comatose for several reasons. His wife was
there, and I asked her, had he had any other medical problems?

“Oh, yes, Doctor. He had cancer of the esophagus.”

I said, “Oh, well, that’s a surgical disease, so when did he have his
operation?”

“Oh, he hasn’t had an operation. He’s just been getting office treatments.”

“Oh, from Dr. Gustafson?”

“No, Dr. Shah.”

He had been telling his wife that he had cancer, and he had been telling
Dr. Shah that he got the infection from a blood transfusion.

I got to tell the entire extended family in Spanish what exactly was going
on, and they took it surprisingly well. His brother-in-law said, ”Well, I can see
why he’d want to keep it quiet.”

So that spread out. Now it’s anybody and everybody. We had the
Committee for HIV for several years, and I started the practice of making it part
of the tests that we did on pregnant women simply on the grounds that if you’re
pregnant, you have clearly been having unprotected sexual intercourse. We got a
few shocks, but we picked up a few that way too. It wasn’t good, but maybe the
babies made it through. I think it’s about a 50 percent transmission rate, and you
can treat the mothers through the pregnancy and reduce the chances that the baby
will get it. It’s still horrible. And maybe the daddy can get tested and get some
treatment.

SCHWARTZENBURG: In thinking about all of your experiences, how do you feel about your place in that?

FITZGIBBONS: Well, I think I managed to give a lot of aid and comfort to patients and families. I felt it much more rewarding working with HIV patients than taking care of sore knees and people who wouldn’t take their pills for diabetes.

They were pretty well ideal patients. The fact that they had something serious wrong with them just was a challenge, and doctors like that.

SCHWARTZENBURG: It sounds like philosophically you were open-minded enough and compassionate to be a source of comfort for so many people.

FITZGIBBONS: Well, I just thought they were interesting. One of the first patients I saw came swishing in, if you’ll excuse the expression, and I said, “I need to do a little bit of blood work. Why don’t you walk this way?”

And he said, “Oh, I don’t think I can. You’ve got higher heels than I do.”

One of the best defense mechanisms and healthiest defense mechanisms for all the problems gay people have is a good sense of humor, and my patients had that in spades, all of them. It was fun to work with them and very nice. They liked me, and I liked them.

SCHWARTZENBURG: That’s one thing I’ve noticed in doing this project. It’s amazing to me that the people who showed up to address this, at least from the medical standpoint, were just the right people. Maybe it’s because nobody else would, or maybe it’s just because it was the right person, right time, right place kind of a thing, but it’s very comforting to me to realize that there were many, many safe places for people to go because of people like you.
FITZGIBBONS: Well, Omega House is still in operation. In defense of my colleagues who were not taking care of HIV, these were time-consuming patients. You had to be right on top of the latest developments. They were complicated medicines with a lot of side effects and interactions, and you had to go to a lot of extra effort in order to take care of it. It was better for the patients for somebody who sees the problem regularly to take care of them than even the most well-meaning family doctor who didn’t open the journals any more than he could help.

It was a whole subspecialty for a while. The American College of Physicians puts out an update program every three years for internal medicine, and you have a magazine-like syllabus for each of the divisions like cardiology, lung diseases, infectious disease, and so on, and they had, one year, a separate syllabus for HIV disease. That was how rapidly the knowledge was expanding, and that was a lot to keep up with. Concentrating it on a few doctors was really a very effective way of dealing with it.

SCHWARTZENBURG: And it’s not just one body system; it’s every body system.

FITZGIBBONS: Oh, it’s all the body systems, yeah.

SCHWARTZENBURG: Lots of collaboration among the specialists, where you had to work together in a holistic model that I think everyone would like to have for themselves; not only an internist, but also these other specialists, working together and communicating. You don’t find that in many disease states these days.

FITZGIBBONS: I don’t think so, but it was challenging, and I think we all got our reward just from working with these patients. Yeah, I’d do it over again in a minute.

SCHWARTZENBURG: How did they change you?
FITZGIBBONS: Oh, I don’t know. I guess I got a little bit better at — one of the problems Dr. Shah and I agreed on was that it made us feel extremely maternal towards gay men. I was one of the doctors who came along when Hawkeye Pierce [from M*A*S*H] was a role model, so going against the expected things was just something I thought was part of the job.

SCHWARTZENBURG: Bucking the system a little bit to get things done?

FITZGIBBONS: Yeah, and actually — I don’t know if you’ve read And the Band Played On — it was kind of like a snowball rolling down the hill. It was really tough getting the snow on there and building it up, and it moved really slowly at first, but by 1985 and 1986, things were starting to move faster. The more we knew, the more we were able to know, and the research methods that produced the antiretroviral drugs, just research into how the virus reproduces, and then that expanded over into other viruses like the herpes viruses and cytomegalovirus. The more we knew, the more we were able to learn is the best way to put it. That was very challenging to watch, and I’m very grateful to all those scientist types because I hate research. I do not do research. I take care of patients.

SCHWARTZENBURG: What are you doing now?

FITZGIBBONS: Now I have part-time jobs. I moonlight at Memorial Hermann in The Woodlands, helping out the hospitalist group. I also work in a small-volume ER at St. Luke’s Lakeside, which is owned by cardiologists and orthopedists. It’s usually not that busy, so I get to spend a little more time with patients. I also help out at Interfaith Community Clinic just across from The Woodlands Mall one morning a week. And I review cases for lawyers. What else do I do? I think that’s all. Every now and then, I write something, but it doesn’t always get
accepted.

SCHWARTZENBURG: And you play the piano?

FITZGIBBONS: Oh, yeah. Well, that’s not medical.

SCHWARTZENBURG: I know.

FITZGIBBONS: Yeah, but I play the piano professionally, and I do an occasional wedding and open house and parties and things like that. Our church, St. Luke’s Methodist downtown, which is huge, it also has a huge music department, and numerous gay members involved with that. The senior pastor has decided that don’t ask, don’t tell is the best way to keep peace in the church, so I figure he’s been pastoring as long as I’ve been doctoring, so maybe he knows what he’s doing.

SCHWARTZENBURG: That’s good. Anything else that we should know?

FITZGIBBONS: No, I don’t think so. I think that’s covered everything.

SCHWARTZENBURG: Thank you so much for your time today.

FITZGIBBONS: Well, I appreciate it.

SCHWARTZENBURG: I very much enjoyed talking to you.

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