

**Patient-Provider Teams:
Some Times the “Care Relationship”
is the Intervention**

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The Clinical Spectrum of the Acquired Immunodeficiency Syndrome: Implications for Comprehensive Patient Care

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The clinical spectrum of the acquired immunodeficiency syndrome (AIDS) is broad and presents unique challenges to the health care system. Among the challenges are the unusual presentations, unexpected complications, psychosocial sequelae, and poor outcome of patients with the syndrome. From our experience with hundreds of patients at the San Francisco General Hospital, we propose a system for optimal care for patients with AIDS that requires a high degree of planning and commitment by hospitals and health care providers. In this model, rigid subspecialization is avoided, outpatient care is stressed, and community involvement is solicited. In these ways we can hope to improve the care of patients with AIDS and learn lessons that should be important in other illnesses as well.

MEDICAL PROVIDERS and the health care system face a unique set of demands created by the acquired immunodeficiency syndrome (AIDS). The overriding concern, however, is to deliver the best possible patient care. This duty has been a complicated process, reflecting the complex nature of the disease.

This article discusses the clinical spectrum of AIDS from the clinician's perspective by presenting three typical case histories. The organization of systems for the delivery of optimal care is addressed, first in general terms, and then specifically, using the San Francisco General Hospital as a model.

weight loss; severe, constant bilateral headaches; and oral candidiasis. His erythrocyte sedimentation rate was 111 mm/h, total leukocyte count was 2.5×10^3 cells/mm³, and hematocrit was 30.3%. A cervical lymph node biopsy sample showed reactive hyperplasia. Findings of a complete neurologic evaluation were normal. The patient regularly missed follow-up clinic visits but was seen in the emergency room of the San Francisco General Hospital in October 1983 with cough, shortness of breath, temperatures above 39.4° C, drenching sweats, and severe fatigue. The patient refused full evaluation and left the hospital against medical advice.

He was next hospitalized in December 1983, again with pulmonary symptoms, recurrent severe oral candidiasis, and staphylococcal folliculitis. His erythrocyte sedimentation rate was 120 mm/h, his hematocrit was 28%, and he had severe lymphopenia. Pulmonary findings included a normal chest radiograph and pulmonary gallium scan; the pulmonary diffusing capacity was 77%. Bronchoscopic samples showed cytomegalovirus by culture, without *Pneumocystis carinii*. The patient again was poorly compliant but was rehospitalized in June 1984. At that time, in addition to all previous symptoms, he complained of hemoptysis. A small area of distal herpetic esophagitis was found that was successfully treated with intravenous acyclovir. After this hospitalization, the persistence of his disabling symptoms prompted the attending staff to recommend that, despite the absence of a definite diagnosis of AIDS, the patient be accepted into a low-cost housing program operated jointly by the City of San Francisco and the Shanti Project.

In July 1984, a bone marrow biopsy sample showed rare acid-fast bacilli that were later shown to be *Mycobacterium avium-intracellulare*. Thus, after 19 months of disabling AIDS-related symptoms, a diagnosis of AIDS was established. An

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