

## **An Interview with Alfred E. Bacon, III, MD**

Elizabeth Healy, MPH

Dr. Alfred Bacon, III (Figure 1) is an infectious disease specialist at Christiana Care Health System, and is affiliated with multiple hospitals in the area. He has been in practice for over 20 years and received his medical degree from Jefferson Medical College.

Figure 1. Alfred Bacon, III, MD



***LH: Why did you decide to go into medicine? I understand your father was a physician as well, did that affect your decision at all?***

AB: Well yes, I think it did affect my decision significantly. He enjoyed what he did, and was rewarded for it on every level...I found it fit me from an early age. He was driven by medicine as an art and the enjoyment of it. For me, I had done some laboratory based research in college which made me more interested in infectious disease for example. So I think we had a similar view of things and that is what led me in that direction.

***LH: Other than the research you took part in, was there anything else that led you to specialize in infectious disease?***

AB: Yes, I thought it was a really an intellectual field, it was stimulating and interesting, I thought I'd spend my days walking around the halls of the hospital pontificating about stuff... then HIV came along and we had to actually see really sick people. And infectious disease has changed some much. It's gone from being this sort of academic approach to patients, to part of the inpatient world where you have to contribute to the efficiency of medical care and the corporatization of medicine.

***LH: One of the things we've perceived over time is that HIV has gone from being essentially a diagnosis that supports prognosis of death, to now being a chronic disease that is managed. Do you think it'll remain in that place? Do you think there's the potential for HIV to become drug resistant like gonorrhea has?***

AB: I do think it will remain in that place, and you're exactly right with what you said, it used to be that you had HIV, you died. And actually the meds we used were almost useless, in retrospect, monotherapy was not very helpful, and combination wasn't adequate.

I saw my first case of HIV in 1983, and from then until 1995 when the combination drugs came out, the most beneficial thing we could do would be to put someone with HIV disease on bactrim

suppression and antiretrovirals and we could treat their infections when they got them. There were often bizarre presentations of infections.

HIV has so many sequelae down the chain of science; if it wasn't for HIV, we wouldn't have Hepatitis B, Hepatitis C treatments, and all these other agents for antineoplastic agents. In fact, and when HIV hit and all the science started going in that direction, it was really very impressive. A lot of money went into HIV research, really good money, going to good places, and they found the key to managing this disease. Keep in mind what HIV did to the US; look what it did to sub-Saharan Africa. In Africa it was the middle income groups that were the entrepreneurs that traveled and they had HIV and brought it back to their villages and so many of the productive people were killed as a result and their economy is still suffering. But that's a global discussion.

***LH: What do you find public perception of STIs is like now? And how has that changed over time?***

AB: So we'll group a number of them together, we'll talk about STIs like syphilis, HSV, HIV disease... the public has become blasé about most of the STIs in my perception, and that's a reflection of the medical field also being blasé about STIs. I think we view them as quick, easy things to take care of, except for HIV disease, which now is easy to take care of, so there's a resurgence of syphilis we haven't seen in a while, within the HIV population. Part of that is we're seeing this swing- remember HIV went through an aggressive educational component in the gay male population, and then there was the IV drug abuse population, then the female population- so they all went through these phases...and then unprotected sex became okay at one point in time.

In fact, there were even comments made by activists in California, saying... people think it's very treatable so they don't care about things like having unprotected sex now. Unprotected sex allows many things other than HIV to occur, and I think people got very blasé about it for a while. And now that HIV is treatable, I'm seeing patients for pre-exposure prophylaxis for HIV, which is a whole separate discussion which becomes almost political, about taking a pill, but keeping in mind it doesn't protect you from other diseases...the sooner you get into that preventive arena the better.

***LH: Are there any local trends you have seen with HIV in Delaware?***

AB: No, but there is a comment that has to be made about HIV in Delaware, and that is the absolute incredible dedication from the people who have worked on this from the get go, and who continue to work on it. It cannot be understated. Throughout the years some of these professionals have totally embraced the management of these patients, in every facet of the population, from the IV drug abusers and different socioeconomic groups, they were unwavering; it is really to be admired. And they have maintained the same philosophy and structure and competence. They bring really good people in to work with these patients. I did leave that arena, but I'm thrilled to see people doing well there. I think the continued effort is phenomenal and very unique.

The thing about HIV in Delaware, the disappointing thing, is that I'm seeing the continued waves of noncompliant patients. What I'm also seeing is the sons and daughters of my patients I saw in the 80's and they're the same as their parents. There was a patient I would bring to Jefferson with me in fact, to talk to second year medical students about HIV, and her daughter

was also completely noncompliant. So I'm seeing the sons and daughters generationally with similarities.

With any disease, not just HIV, the psychosocial factors translate into how patients do, and if they're going to follow management, whether it's HIV, or hepatitis C, or a brain abscess, and that plays a role in how they do. For any disease, a lot of your upbringing and how you are raised, and the support you have, and your nutrition all become manifested with age.

***LH: What advancements do you hope to see in medicine, and if I can tie that into HIV specifically, what advancements do you hope to see specifically with this disease?***

AB: I think we've seen HIV go from determining what is the bug, to how do you kill the bug, to how do we kill the bug better, to how do will kill the bug cheaper and better. I would like to see the cost come down for treatment. Once these drugs get to generic form, think what that would do for so many people in the world. Seeing the cost come down for vaccination would be good. The thing we're seeing with HIV disease is we can control the disease, and now my patients get what everybody else gets, but they get it earlier. People age faster. So for example if you have cardiac disease, and your dad had a heart attack at 70, you're going to have yours at 60. Same for osteoarthritis, or dementia, it's happening earlier. So, that means ongoing inflammation driving this, so I think the best step might be to deal with the ongoing inflammatory issues, that promote early aging and promote comorbid disease, osteoarthritis, cardiac disease, atherosclerosis, and I think that actually is a current HIV issue- where are we going to take the disease to see we can minimize everything else so you do lead a normal life.

What's really interesting is I had all of these patients in 1992, 1993, who were going to die. Their T counts were very low, 20, 30, 40, and then new drugs came in, we got them to these patients. For example, I had a woman who was blind from CMV, who was going to die before, but is now normal. Some patients had so few T cells, they thought they were going to die, and watching them go from being prepared to die, to saying "I'm not going to die," was really great. In 2000, things were getting better and better. T counts were going from 10 to 500. This is a reason they have to keep investing in science, and we want more money going to the NIH, because all the things discovered for HIV are applicable to so many other diseases. The scientific validation and use of other things shows that good science begets good science, and competing to find treatments, it's phenomenal and unique.

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