SPEAKER 1: We know that the people we care for are often moved to Express their feelings and their vulnerabilities. The most effective care givers understand that mutuality is basic to the best caregiving relationships. Mutual vulnerability means that you, the caregiver, also risk being emotionally accessible to the person with AIDS.

The largest single impediment to providing effective emotional support to a person with AIDS is the powerful distinction between us and them. It's a deeply conditioned assumption in many health care organizations, for example, that we are the proactive professionals, and they are the passive patients. This distinction undercuts mutuality and runs counter to the sense of a two-way street that's basic to the most helpful relationships.

As caregivers, we're continually forced to confront fears about our own vulnerability. And the us-them dichotomy can be a way to defend excessively against those fears. What we discover in the process of caregiving is that we are they in a very profound sense. I'm talking here, not only about the person with AIDS as a teacher for you, but as a partner in a caring relationship, a relationship where both people experience some of the best things and worst things human life has to offer.

A crucial difference, of course, is that one person has AIDS and the other, most often, does not. What is certainly the same is that we both have the same essential human needs and fears-- needs and fears triggered by living and working with AIDS. Let's listen now to two stories both took place in a hospital ward for AIDS patients. We'll hear from Michaela again, followed by Barat [INAUDIBLE] who's also an AIDS counselor.

SPEAKER 2: When I first met Richard, he had just been diagnosed with PCP number one. His lover had died a year before that. Richard was a man in his 50s, and he had been an accountant. And he'd been used to the good life at his own home, and he'd had a 20-something-- 25-year partnership, I believe, with his lover, who had died the year before.

And consequently, he felt very isolated. All his friends had died. The only person-- the only contact he had was with one woman about his age. It was his next door neighbor and the niece of his deceased lover, who was still very supportive. And he loved good food. He'd love to cook. He loved good music. And he had an incredible music collection.

Over a year's time, he had about five hospitalizations of extended time. And the very last hospitalization. I knew it was going to be his last. And I knew that several days before he was going to be sent off to a skilled nursing facility, I knew he was being sent off to die. And his lover's niece was selling off all his possessions.

And he had given his entire music collection to the San Francisco Conservatory of Music because he said he ceased to listen anymore. It didn't thrill him. I was trying to figure out what I could give him because I really considered him a friend. I had this cassette of Maria Callas, a collection that I had put together, and it was like a 90-minute tape.

And I decided that my gift to him would be that I would come into his room. He loved to be touched. Touch is one of the most important things I find, as a provider, that I can give people-- loving touch. Because in the hospital, they're constantly prodded, and poked, and hurt. All the touch that they receive is about pain.

So I said, I'm going to massage your feet, and your legs, and your arms, and your back. And he said, oh, wonderful. But I didn't tell him about the tape, and I just quietly put it on. The room was dark. I had told his nurse. But that's what I was going to do, so she was not going to come in and bother us. That's the way they are in 5A. They're great. We won't bother you.

And it was so moving to me because, in this darkened room, as I'm touching him, the room fills with Maria Callas, just that, oh, that-- I think about it. I just have goosebumps. And he opens his eyes, and he just stares at the ceiling, wondering what's happening, just-- and his eyes fill with tears. And I was just very silent. I didn't say anything. I just kept touching him.

After she finished her Aria, he said, I had forgotten how beautiful. That's all he said. And he just sobbed. And I held him and that was our last time. And he quickly went to a Laguna Honda Hospital and died a week later. I still think about him. He's one of the people that I carry with me because of what he gave me. What I regretted was that I didn't know this man before AIDS. A sweet, wonderful, gentle soul, that's Richard.

SPEAKER 3: This man who had been on the AIDS unit a number of times, and when he was much healthier, he was pretty antisocial in that he was believed to have stolen things from the unit, like people's coats, and tape players, and things like that. And so I avoided him and felt like I didn't want to be really around this person. And then, he got sicker, and it was report.

And it was my turn to take this person for the day. And I went to see him, and I thought, I hope this is brief. And he actually was very pleasant. He was watching TV. And as I have done-- sometimes, when I really want to get out of the room, I'll ask him, is there anything I can do for you? And most of the time, people say no, and I can escape.

But he said, you know, I could really use a video. I said, well, what kind would you like? He said, well, I'll go down with you. And he could barely walk, and he had this walker. I said, OK. And we walked down this long hall. It seemed interminable to get to the end. And I was so impatient to get there and get this man's video, so I could get to the next person and feel like I saw a high number of patients that day and was very helpful.

And we finally got a couple of videos for him, walked him back, got it set up. I thought, thank God that's over and went on and did my other things. And two weeks later, his mother came from Central America to visit him, and it was my turn to check in with him again. And I walked in the room. And he immediately said, mom, this is the guy I told you about that brought me the video.

Media has to do with agendas, and when I have agendas, it's pretty indicative that I am not really listening to the patient's agenda. And in that situation, I really went in there, wanting him to talk about his feelings about dying or have some emotional catharsis or something heavy and let something seemingly so insignificant.

I think my tendency, and I believe, culturally, is to really underestimate the value of simple acts like opening a window, changing the channel on a television set, sitting quietly with a person, those things mean a lot more than we're led to believe. And these people in the hospital are surrounded by people who are trained to do things all the time.

And when there's nothing left to do, they leave. So if someone's willing to sit there, even though they may feel like they're boring, they're depressing, whatever, that I've gotten such as through this man with the video a little act that I felt like I didn't do anything, really, obviously, had a big impact.

SPEAKER 1: To understand caring is a two-way street, as Barat and Michaela do, has a relationship that is mutual and reciprocal is to recognize a difference that frequently shows up between working toward cure and working toward care. Those are two related but distinct goals. Cure refers to the diagnosis and treatment of disease. Whereas, care refers to the interventions aimed at improving the welfare and well-being of the person.

Cure deals with objective aspects of the case. Care is concerned with the person's subjective experience of the disease and its treatment. Cure is often implemented by the caregiver doing things to the person with AIDS. Care is offered when we are doing something for and being with that person. Most of all, the difference between cure and care is that at the heart of the best care is reciprocity.

Barat learned how to distinguish between his agenda and that of the person with AIDS. He also learned what value a simple act of patience and kindness can have for another human being. Michaela learned that Richard was so much more than just a man with an illness. Perhaps, what caregivers, like Michaela and Barat have to teach the rest of us is how deep this mutuality really is. So deep that when such mutuality exists, we find that the experience of being cared for may help the person with AIDS more than the direct effect of the care.

These kinds of relationships and the willingness and the ability to enter into them usually take time to develop. On the other hand, the intensity of the AIDS situation can serve to propel two strangers through barriers that might otherwise take years to breach. Over and over again, we heard caregivers say, I only knew him three months or we were together only several weeks before she died. And that's followed by a description of having had a deep relationship with lasting memories.

As with any skill, the caregiving skill of building mutual relationships improves with practice. Here's another story. This one from Alice Core, where she talks of the early days of not knowing when to take a step toward more involvement, toward a more proactive and mutual relationship with a man to whom she delivered food once a week.

SPEAKER 4: There was this one man, a younger man, probably around my age, who always looked so great when he came to the door. And then, he was gone for a couple of weeks off the list. And then, we went to his apartment another time. When we got to the door-- and it took a while for him to answer-- and he opens the door, and he just stood there.

We handed him the meal, and he acted as if he had no idea why I was handing it to him or who I was. And then, we said hi and all that. And then, as we were leaving, he said, what's today, Sunday? And I always deliver on Monday. As I said, no, today is Monday. And he said, oh, OK. And then he walked back into his apartment.

And as he was walking in, I could see that the lights were off and the blinds were drawn. There was no light entering at all. And as I walked away, you know, my friend and I, we're just didn't know what to do. We felt helpless. And we both looked at each other and just said, wow. I mean, I wonder what's going on there.

And that whole week, I thought, I really said, well, I should have done something. I should have went in there with him and taken control and seen what was up. So the next week, my partner delivered to his apartment. And he came to the door, and he opened it. And he was in the same state basically.

As he was coming to the door, he fell. He heard the fall, and my partner opened the door a little and could see that he was right there at the door. So he picked him up and brought him in on his couch and sat him down. And then, the man said, put my meal in my refrigerator. And as he opened his refrigerator, he saw four other meals there.

So you knew that this man could never have left his apartment to shop or anything, and he hadn't even eaten in, at least, four days. So my friend said, will somebody come? Will somebody be helping you? And he said that somebody was going to come and feed him in an hour.

So he actually left also thinking, I hope he really means it. And after that, we both said, maybe we should do more next time, force ourselves on these people in some sort of way to help them. And then, he was off the route after that. And I assume he died.

So if I know that if I encounter somebody like that next time, then I will really make an effort. I'll call Project Open Hand immediately or myself. Come back another time and check up on the person. So at that point, it's for the people who are well to say, I need to help this person and not ask for that person to help. The situations turn at a certain point.

SPEAKER 1: Alice provides us with a strong example of how difficult it is to find a comfortable level of mutuality when we're providing a service or care for a person with AIDS. Mutuality may only extend to a friendly exchange of greetings as food is passed from one person to the other. But often, it goes much farther. When do we cross a line into caregiving as advocacy, as in taking additional responsibility for people whose medical, financial, social, or emotional resources are dwindling, responsibility that may extend beyond your normal role.

I'm not going to offer you any easy answers to challenging questions, but I will offer you a way of understanding them better. I began this segment by saying caregiving is a dynamic process. By dynamic, I mean constantly shifting, not static. Most of life is that way, fluctuating between such poles as pleasure and pain, clarity and ambiguity, hope and depression.

As you get more involved in AIDS caregiving, questions arise, such as, how much should I try to help? How much of my peace of mind can I sacrifice? Where does a relationship cross a line from professional to personal? The understanding that I would like to offer you is that the answers to such questions shift with every situation.

One woman we interviewed told us she spent her life savings of $20,000 and gained over 150 pounds in her determination to do something for people with AIDS. She had to find out the hard way what her limits were. She's slowly rebuilding her bank account and has another 50 pounds to lose, and she's still in the forefront of AIDS caregiving.

There's a long, long continuum from hanging back and not getting too involved at the one end and getting trapped in an addiction to action and the need to play savior at the other. To put it in simple terms, the head wants to instruct within rational limits. The heart wants to ignore what seem like common sense constraints, especially in a pandemic.

What you'll always be trying to figure out as you do this work is the continuing dynamic of balancing head and heart. The balancing act that's fluid. It changes depending on the person being cared for and on the circumstances going on in your life at the time. One of the more important lessons I've learned about being an effective AIDS caregiver is that, frequently, the job requires being an emotional conduit.

Regardless of what your other caregiver tasks are, giving advice on drug treatments, driving a van, cleaning the bathroom, or treating an infection, you'll find that if you have face to face contact of any kind, you'll need to be open to intense emotions. And you'll be pressed to help the person with AIDS deal with these intense emotions.

Many people with AIDS experience complex and, at times, overwhelming emotions. On occasion, they're going to feel engulfed by fear, and terror, and anger, and guilt, and despair, just like you and I would in a similar situation. And the caregivers job is simply to listen, take it all in, and thereby help the person siphon off some of those feelings.

It's just simply true for many of us that being able to share a strong emotion with the right person helps diminish its intensity much of the time. Later, we'll discuss ways to make sure you don't bottle up or excessively internalize the other person's emotion, holding it inside yourself, so you end up feeling like an emotional reverberating chamber.

Right now, let's listen to two brief stories of caregivers who served as emotional conduits while providing other services as well. First, Penny Churnow, who's an AIDS case manager at a community agency. And then Ken Shigomotso, who's a financial benefits advocate for people with AIDS.

PENNY: There's a young woman in my group who's in her mid 20s. She got infected heterosexually. She had a career, was an up and coming writer. She came home and was applying to go to a foreign country and work and had to have an HIV test to work there. It never occurred to her that was the problem. Came back positive, which was surprising for her.

And she had to tell her family. I mean, she couldn't go to the country, completely changed her plans, and she was really afraid to tell her parents. She didn't get along real well with her mother. And so, I offered to meet with all of them, the whole family, and me as a mediary for this information. And we had a really good meeting.

And she was really grateful for having the help of sharing that load, and getting her mother educated, and getting her mother connected with an agency near where she lived. And it was a big relief for her to have some support with this.

Telling is the hardest. I've got one woman with a teenage son. Everybody in her life knows but him, and she's not sure how to tell him. And probably, I'll end up doing the same thing. She will bring him in, and the three of us will talk about it.

KEN: There is a heterosexual Filipino woman who contracted HIV through her husband, and her husband subsequently passed away. And she has other medical problems. Like, she had a stroke. And we were trying to get her on SSI. It was a long, drawn out process. She had to go to medical exams and neurological exams because HIV was not disabling her, but it was a factor.

Throughout the process, I could see that she was getting more and more ragged, more and more tired of the system, but she kept visiting, and we wrote letters. We made her finances a little easier to handle. We held her hand through the system, and kept her going, and made sure that she made her appointments, and that nothing would go wrong. And we just supported her all the way.

Eventually, I made a call to Social Security. And off the cuff, they told me that she had been accepted and approved. So I gave a call, and she was just so happy. And now, she comes in, and she just had her hair done. She visits and brings us candy all the time. And she's just a much happier person.

SPEAKER 1: Ken's role is defined as advocate. But for most AIDS caregivers, deciding when it's appropriate to increase your advocacy for a person with AIDS is an ongoing judgment call. Advocacy comes naturally to Patty Rose. She's a nurse in urgent care, and she specialized in caring for AIDS patients for the past 10 years.

PATTY ROSE: I was working one night, and I just happened to go into a room of a patient, who had been left in this room by himself for about 3 and 1/2 hours. And I was actually leaving to go home. But I looked at him, and there was something about this patient that just did not strike me as being right.

And he was very effeminate and very young. It turned out he was only-- I believe he was only 16. And I took his temperature. He had 103 temperature, and he was almost gasping for breath, telling me in Spanish that he could not breathe properly. So I went up, and I looked at his chart and nothing had been done. And the doctor hadn't gone back to see him yet.

So I said, Dr. Lopez, this patient has AIDS. I want you to go back right now and look at him. And Dr. Lopez looked at me, and he goes, what are you talking about? And luckily, there are certain doctors there that respect my knowledge when it comes to HIV. I said, I want you to go look at him.

He has AIDS. I am telling you right now. His respirations are 28. He's having a real hard time breathing. It's real shallow quick breaths, and his skin color is not good. His nail beds are blue. His lips are blue, and he has 103 temperature. He's got AIDS. Dr. Lopez went back there, and I had sent the blood out. And Dr. Lopez came back to me, was very pale and said, Patty, I think you might be on to something. Why did you say that?

And I said, I don't know. I think it's just the whole picture. When we got his bloodwork back, he had under 100 T-cells. If I hadn't done that, we would have gotten his blood work. We would not have been looking for PCP. We would have gotten the X-ray. And when our radiologist read the X-ray, 2 days later, then we would know that he had PCP, or he could have died and an autopsy found out that he had PCP.

But because we weren't looking for that, I don't know if that could have been something that would have been readily diagnosed at that time or maybe 8 hours from then after they intubated him. And that's what I try to educate my patients with HIV or AIDS. You've got to tell us. It's like diabetes. Why would you not tell a doctor you're a diabetic? It affects your health care. It's part of your health information.

You don't have to tell everybody, but tell the doctor that's going to see you. That's so important. I'm telling you, it eliminates so much guesswork. And you know what, sometimes with PCP, we're talking about a matter of possibly hours. So you just tell the doctor, this patient's HIV positive. We'll know exactly what bloodwork to order. We know what to look for. We'll do this, and we've just eliminated a thousand lab tests and procedures that don't need to be done.

SPEAKER 1: It isn't hard to hear the concern, the tone of an advocate in Patty's voice. The services that Penny, Ken, and Patty provide to people with AIDS wouldn't be classified primarily as emotional support. But you can easily hear what they do also involves just that.

And each one of them understands and values the emotional support aspect of care as crucial to what they provide to people with AIDS. Each of them has to perform that balancing act, the dynamic balance of head and heart with each new client they see.

Two of the people we've already met, Penny and CJ, run support groups for women who are HIV positive. Providing emotional support is key in both places. Penny said it was difficult to get anyone to come to the support group at first. No one wanted to come to discuss their own problems.

It was only when she asked one woman to come to support another woman that two women showed up. She then used the same tactic to get other women to join the group. Please come to support so-and-so, who's having a rough time. Penny describes her group as one large hand-holding circle. Although, as in most groups, other supportive things take place as well.

PENNY: My women are interested in alternatives. My women are interested in nutrition, for example, and Chinese medicines. And those that are in drug trials are sharing with those who aren't what their experience is, and they give each other advice.

And then we talk about the fear, a lot about the fear of, I'm HIV positive. No one will ever love me. And how to get around that. And so any of the women get in a relationship with somebody who is HIV negative, the whole group takes that in and feels safer and more hopeful.

SPEAKER 1: The women in CJ's support group are also concerned with how being HIV positive is going to affect getting a man, as she put it. But CJ's group has other concerns besides AIDS, concerns which keep reminding us that you can't take a person with this disease out of the context of their everyday lives.

CJ: Something very interesting happened in one of my support groups. There was a young lady that came in, very isolated, dealing with a lot of stuff, children removed, parents isolating her, in a battered relationship. She came to the support group, and she didn't talk about, I got AIDS, and my family has abandoned me because of that.

She talked about the battered issues that were happening between her and this guy. So the following week, she fell out of four story window, trying to get away from this guy. She was trying to come out the window to get away from him. She had put the dress in front of the door and fell out of a four story window. She is in a coma to this day.

What our support group did is, we made a tape. All the women put their voices on the tape, and we put it in a room. And they played the tape continuously to try to stimulate her. She didn't get that because of her AIDS. They connected with her because of the crises that she was in, and they came to her aid. And they wanted to be with her, not because she's got AIDS, because this woman was battered and abused.

And she came in a support group and was able to talk about being battered and abused. That's part of the epidemic. You can't just deal with, let's hear about how AIDS is hurting you. What about the social things that go on in their lives? What about the things that they have to deal with every day?

They're still battered women. They're still substance abusers. They still have to deal with three or four children that they don't know how to take care of. They may abuse their children because they can't deal with the stress. My support group has to feel that they can talk about that kind of stuff.

SPEAKER 1: If you've been a caregiver any length of time, you've already begun to learn that taking on a person with AIDS means taking on the constellation of relationships in that person's family. You get to know lovers, mothers, fathers, husbands, children, and wives of the people you care for.

Sometimes, you only get to know them in their absence. They exist, but they've cut off their relationships with the person with AIDS or they simply live far away. Sometimes, you find yourself in the middle of family issues you really don't understand. Most of us have learned it's frequently best not to condemn family members and loved ones, even when the person you're caring for wants you to share their anger or rage about someone in their family.

Carol Cowan told us a compelling story about a friend of hers who had very close relationships within a large family. Most of his family lived on the East Coast, and Carol's friend was in San Francisco. He talked to his parents and siblings often. And now, this man was HIV positive for about four years when the disease moved into a phase of recurring infections.

Carol said, her friend was too ill to go visit his parents when Thanksgiving, and she encouraged him to invite his family to visit him. He said, no. He'd go home in Christmas, Christmas came and went, and he didn't go East and didn't want any family visitors. Carol said she thought it was very strange that he wouldn't want the support of his family as he was getting sicker, but she didn't push it.

He celebrated his birthday in February and was clearly very sick. When he went into the hospital, Carol and another friend decided to call the family members. They all arrived within 24 hours. Three of the four sisters were nurses, and they began requesting tests for him and force feeding him. Carol said that within three days of his family's arrival, her friend was yelling and screaming and wandering the back halls.

When the family members weren't present one morning, the young man said very directly, my sisters are driving me crazy. If you don't get them out of here, I'm going to be gone. He died within two weeks. Carol said she knew then why he didn't want his family to come visit.

He knew once they came, the end was near, not that he didn't love them, not that they didn't love him. In fact, they were undoubtedly motivated by their love for him, but they didn't know how to just be with him. They had to be doing things for him non-stop.

Caregivers must be mindful that the actions they take, no matter how well-intentioned, need to follow careful listening to the person with AIDS, listening to what the person's agenda is and to what isn't said, listening that opens up an interpersonal space and allows us to hear what needs to be done in that moment. It also allows us to hear when it's best not to act, when the person with AIDS wants our presence, not our actions.

For many experienced caregivers, professional and volunteer, listening to others requires learning how to quiet the chatter of our own thoughts. When we learn to quiet that mental chatter and really listen, we allow for a space, a space, not only for the voice of another, but for our own truest voice, what the Quakers call the still small voice within. That's our own intuition cultivated through experience about what's really best than the situation.

[MUSIC PLAYING]

HOST: OK. That was--

GUEST: That makes me jam.

HOST: Yeah, that's Diverse House doing a little kind of a PSA there for us.

GUEST: Oh yeah.

HOST: Well that tape ended a little bit early, but I still have the Pamela Stanley thing.

GUEST: Let's do it. This is my favorite. This is one of the first-- actually the first piece of gay and lesbian music I ever heard--

HOST: Oh really?

GUEST: --was Chris Williamson's Ode To A Gym Teacher, of course.

HOST: Yes, yes.

GUEST: And the very second one was this and I didn't know what it was from--

HOST: Oh.

GUEST: --or where it came from. And I didn't know who wrote it or anything about it. And later on when I started doing theater, I realized where it came from.

HOST: Oh, OK. And this is the special Buddy Johnston mix that has all the Harvey Milk stuff in it.

GUEST: It has the best stuff.

HOST: We haven't heard this in a while. And we better hurry up because it runs about 5 minutes and we're running late. So this has been after our After Hours, a continuing tradition.

GUEST: On KPFT Houston.

HOST: And we'll see y'all--

GUEST: Thanks for listening.

HOST: Yeah. See you next week.

NEWS ANCHOR: The disorders began with a routine police raid on a homosexual bar, The Stonewall, on Christopher Street in the heart of the West Village.

[MUSIC - PAMELA STANLEY, "COMING OUT OF HIDING"]

PROTESTER: All right, say it so they can hear you in the Capitol. For love and for life, we're not going back. For love and for life, we're not going back. For love and for life, we're not going back. For love for life, we're not going back.

ANNOUNCER: I want you to savor this next moment. I have the proud task of telling you that the official count of the lesbian and gay rights march, the official count is over 500,000 strong.

HARVEY MILK: We must destroy the myths once and for all, shatter them. We must continue to speak out. And most importantly, most importantly, every gay person must come out.

[CHEERING]

PAMELA STANLEY: (SINGING) Standing in the shadow too long. Waiting on the sidelines too long. Boy, I've been watching you. Now you're going to watch me too. I'm coming out of hiding. I'm coming out of hiding. It's no mystery how you missed me for so long. But that's history, you were so wrong for so long. Boy, I've been wanting you, now you're going to want me too. I'm coming out of hiding, I'm coming out of hiding. I'm coming out of hiding.

WOMAN: It's all right, you may all come out.

MAN: We're queer.

SLOGANEER: When do want it?

CROWD: Now.

SLOGANEER: What do we want?

CROWD: Gay rights.

SLOGANEER: When do we want it?

CROWD: Now.

SLOGANEER: What do we want?

PAMELA STANLEY: (SINGING) Standing in the shadow too long. Waiting on the sideline for too long. Watching and wanting you, now you're going to want me too. I'm coming out of hiding, I'm coming out of hiding. Coming out of hiding, looking for somebody like you. coming out of hiding, coming on the run, coming for nobody but you. Coming out of hiding, coming out of hiding, coming out of hiding, coming out of hiding.

DIANNE FEINSTEIN: As president of the board-- as president of the Board of Supervisors, it's my duty to make this announcement. Both Mayor Moscone and Supervisor Harvey Milk have been shot and killed.

DOROTHY: Toto, I have a feeling we're not in Kansas anymore.

PROTESTER: They've got to understand something. They've got to understand something, we are not talking about crotch politics. This is not a movement from the waist-down. We are talking about our right to love and to choose and to live. And I don't care about straight politics, and I don't care about straight understanding. You better hear me in Washington. We are demanding-- we are demanding our civil rights.

HARVEY MILK: And I ask-- I ask people all over this country to do one thing.

PAMELA STANLEY: (SINGING) I'm out of hiding, I'm out of hiding, I'm out of hiding, I'm out of hiding.

HARVEY MILK: We must destroy the myths once and for all, shatter them. We must continue to speak out. And most importantly, most importantly, every gay person must come out.

KPFA REPORTER: Harvey, do you have a few words for KPFA?

HARVEY MILK: Come on out.

[LAUGHS]

Join us.

PAMELA STANLEY: (SINGING) Coming out of hiding, looking for somebody like you. coming out of hiding, coming on the run coming for nobody but you.

HARVEY MILK: Difficult as it is, you must tell your immediate family. You must tell your relatives. You must tell your friends, if indeed they are your friends. You must tell your neighbors. You must tell the people you work with.

You must tell the people in the stores you shop in. You-- Once they realize that we are indeed their children and we are indeed everywhere, every myth, every lie, every innuendo will be destroyed once and for all. And I ask, I ask people, all over this country to do one thing. Come out. Come out, America. Come out.

[CHEERING]

SLOGANEER: What do we want?

CROWD: Gay rights.