

Brother, Help Thyself: The Construction of a Gay and Bisexual Men's Health Movement before HIV/ AIDS

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This project traces the formation and development of a gay and bisexual men's health movement before HIV/AIDS (1981-1996). The project is an effort to consider the lives and contributions of gay and bisexual men between the Second World War and the HIV/AIDS period. The creation and management of health and clinical programs formed by and directed toward gay and bisexual men are examined. There is particular attention given to the Whitman-Walker Clinic in Washington, DC, and to similar clinical and community outreach programs in selected urban communities in North America. Through archival research methods, the project addresses the intersection of postwar science, public health, and biomedicine with human sexuality, gender, class, and race. This draws from research and publications in a number of humanities and social science disciplines to critique health politics and activism in response to medical discrimination, health disparities, and the pathology of homosexuality. The work of philosophers Michel Foucault and Guy Hocquenghem offers insights into a larger context of sexuality and Western political and health social movements. The project is intended to place the gay and lesbian health movement alongside the histories of the women's health movement and African-American health initiatives of the postwar decades. This work contributes to a growing dialogue among historians about this overlooked period of medical history and establishes new points of intersection between gay health activists and the association of disease to this stigmatized population.

Dedication

I sat down to write hundreds of pages about a time that predated disfigurement and death. It is a time that precedes the episode that now overshadows it in both chronicles and perspectives. It was a longer, slower period that lay a broad foundation for the later ones including the health care entities that exist today. The immediate successor to this earlier period is a time so short in terms of years and so powerful in its delivery; a time so specific to its people and so certain in their fate.

The era of HIV/AIDS that followed the earlier period constitutes one of the ghastly decades in human history where people and science failed a population so vulnerable and happy. I recall the era as one of sadness and frustration and sometimes bewilderment. Those were the years when you might see a friend on the street one day and then days or weeks or months later meet the same unrecognizable friend. The perished disappeared from conversations; the stricken gradually did the same.

But, before that sadness, these same people lived. They had ambitions and cheerful gatherings and a sense of progress that it would be better. That is the period that interests me here.

I owe this work to those who enjoyed their time. Who relished good health and sought solutions to our lives. This work is for those men who wrote poems, marched in the streets, formed organizations of vision, and asked that their health care be a right, not a privilege.

I dedicate this work to my friends, Jim, Tom, and Milo, and all the others who vanished. I give this work to the men who established health care opportunities for their friends and strangers and who sought relief for the anonymous figures who loved in darkness.

Acknowledgements

This is essentially my thanks to people who made this possible. To my committee led by Dr. Arlene Macdonald who never wavered in her belief that I could do this enormous intellectual project, Dr. Kristen Peek who led me out of deep spots through my clumsiness in academia, Dr. Jerome Crowder who willingly explored every intellectual route with me no matter how bizarre, Dr. Walter Meyer who is truly one of our great angels to a disenfranchised and vulnerable people, and Dr. Wesley Phelps who took me on without hesitation and offered guidance through LGBT history. Thanks as well to Dr. Jeffrey Farroni and Dr. Paula Summerly who stepped in to cover essential academic roles when I was in a desperate pinch. A special thanks to Dr. Rebecca Hester who unknowingly first sparked the idea of this project and then supported it, and Dr. Jason Glenn who challenged my conventional thinking about history and other things all the time. A final thanks to the faculty of the Institute of Medical Humanities and especially Dr. Anne Jones for her channeling me through many aspects of this endeavor.

A note of thanks to my friends and colleagues of the Galveston Historical Foundation especially Denise Alexander, Will Wright, Jami Durham, Waris Mustafa, Mark Scibinico, Brett Harrington, Brian Mitchell (and John Wes Stuart), Renee (and Landon) Tallent, Kane Toler, and Michael Guillot. And other friends who offer encouragement: Alice Wygant, Ellen Beasley, Larry Wygant, Lisa Lowry, Camille Warrington, Joel Burns and J.D. Angle, Kevin and Lauren Scott, Shannon Guillot Wright, Veletta Lill, Jim Kane, and Mark Doty. And my family of two extraordinary aunts (Billie Harris and Tommie Crenshaw) who always offered encouragement in my many endeavors. And, to my friend and former partner, Lance Hartmann, who seemed startled that I even did this and left this world just before it was complete. I should recognize Don Kelly who befriended me as I searched for documents and has set up a wonderful research archive at Texas A&M University now named for him. Finally, to my gracious four legged companions who share my life each day and are both grateful and accepting.

Although I finish this while we are in a pandemic with thousands suffering and dying from COVID-19, I hope the message of this project is not overlooked and is instead viewed as yet another era where lives were challenged and lost, but hope eventually emerged.

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Introduction

Brother, there's somebody to help you make it through. Brother, that somebody is based on me and you. (Advertisement in *Washington Blade*, c. 1983)

Antonius said to a monk: "Brother, help thyself, otherwise neither I nor God will ever help thee."¹

"Our history remained thin, often depending on intimations, suppositions, and telltale signs of cover-up." (Jim Kepner, 1996)²

By 1981 gay and bisexual men in North America and Western Europe met an untimely fate. For those of us who were there and faced the barriers of western political and health care establishments, our perspectives of self-care and personal health moved to center stage when we began to question our sexual practices and partners. A new dynamic of sexuality engulfed gay and bisexual men as we looked for signs of disease among us. A bruise might be a Kaposi's sarcoma lesion, a dry cough an indication of pneumocystis, a flutter of the eye the indication of cytomegalovirus, or flu-like symptoms the beginning of an unknown journey to death. Suddenly, all around us, we observed friends and colleagues as the dying and dead in a new plague of unknown proportions. It seemed impossible for the opportunistic diseases and mounting deaths to slow down, much less stop. It was a time of uncertainty and fear; it was the era of HIV/AIDS (1981-1996).

This dissertation is a critical history of how gay and bisexual men engaged with our bodies in a pre-HIV/AIDS era. It is a history that predates our awareness of the words human

¹ Henry Suso, *The Life of Blessed Henry Suso*, trans. Thomas Francis Knox (London: Aeterna Press, 2015), 105.

² David W. Dunlap, "Jim Kepner, in 70's, Is Dead; Historian of Gay Rights Effort," *New York Times*, November 20, 1997.

immunological virus (HIV) and acquired immune deficiency syndrome (AIDS). It was the era when we built isolated gay ghettos with our support services, and before we understood that we could be abandoned by the very forces that we supported and believed in as citizens of postwar progress. It was a period when we turned to familiar religious institutions and sought support or acceptance of who we were. It was the time when we learned through activism that if we objected and stood up for ourselves, we would be recognized. If we organized and banded together, we would mobilize forces to combat a multitude of social issues including racism, sexism, and a new term, homophobia.

Through the emerging homophile movement and the gay activism of the Gay Liberation Front and other emancipatory efforts around sexuality, gay and bisexual men reaching adulthood in the 1940s through the 1970s defined our postwar world through other social movements contemporary to our “coming out.” We coupled our nascent activism with a postwar progressive confidence in science, technology, and biomedicine. Alongside the black civil rights efforts, the women’s movement, and anti-Vietnam War rhetoric, we positioned the revolution of our sexuality through scientific studies, innovative birth control techniques, space technologies, and advances in medical ethics. During this postwar era and within the urban gay world, gay and bisexual men began to construct a unique health movement long before HIV/AIDS appeared. Physicians, Bopper Deyton and Walter Lear, would later place this development in context:

The lesbian and gay health movement in the United States resulted from several important political and social forces in our country; specifically, the civil rights movement of the 1950s-60s, the modern feminist movement of the 1960-70s and the newly visible gay and lesbian movement following the Stonewall riots in 1969. In addition, the movement for better health services, particularly for minorities, low income people and others grossly underserved because of immoral and inhuman

reasons contained many lesbian and gay individuals. The way these forces and their antecedents interacted so as to produce the gay and lesbian health movement remains for students of the history of social change to explicate.³

Construction of a Gay and Bisexual Men's Health Movement

Science and technology became so central to our everyday life in the pre-HIV/AIDS era that we expected biomedical researchers, public health agencies, physicians, and the technologies of clinical medical care to resolve any new health crisis. We believed that our health as gay men was reliant on easy clinical fixes like penicillin and antibiotics because advances in biomedicine supported our sexual freedom. We believed that our own childhood illnesses such as polio and rubella, could be prevented by vaccinations produced through postwar research. The future, as at least it seemed for some, appeared so promising that a gay and lesbian health care movement formed in the 1970s. For the first time, gay and bisexual men and lesbians could initiate their own professional affiliations and set up their own health care facilities. When the board of the American Psychiatric Association removed the mental health diagnosis of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973, we were granted a new freedom to acknowledge our own sexuality and identify publicly and professionally with those like us. Deyton and Lear would quote the first openly gay health commissioner in New York City, Dr. Howard Brown when he reflected on this period:

“Since it is doctors who ultimately determine whether people are mentally ill or well, the board’s vote made millions of Americans who had been officially ill that morning

³ Bopper Deyton, MD, MPH and Walter Lear, MD, MS, “A Brief History of the Gay/Lesbian Health Movement in the U.S.A.,” in *The Sourcebook on Lesbian/Gay Health Care*, eds. Michael Shernoff, MSW, ACSW and William A. Scott, MSW, ACP (Washington, DC: National Lesbian/Gay Health Foundation, 1988), 15.

officially well that afternoon. Never in history had so many people been cured in so little time.”⁴

At the same time, health professionals began to recognize a growing crisis of social disease among gay and bisexual men. Beginning in the late 1950s, the reported incidences of venereal disease and sexually transmitted diseases steadily increased. In response, a new and evolving gay activist movement began to equate political and social achievement with the need to address health inequities and social disease. This connection between the late 1950s and 1981 became apparent in a number of urban communities and led to an optimism among many gay and bisexual men, lesbians, and transsexuals that both mental and physical health could be improved, both inside and outside existing health care establishments. Despite the optimism and measured successes in addressing health care, the public appearance of HIV/AIDS in the last two decades of the twentieth century would in time overshadow these early efforts. The HIV/AIDS service organizations and direct action politics became a familiar presence in the gay and lesbian community in the late twentieth and early twentieth-first centuries. This familiarity led some historians, social scientists, and journalists to consider the HIV/AIDS era as a period that first established a broader unified political agenda and created an energy never before known in gay and lesbian communities.

The intellectual premises of health care for gay and bisexual men developed in the late twentieth and early twenty-first centuries suggest that the epidemic or plague of HIV/AIDS (beginning in 1981 and continuing through 1996) stimulated a previously unknown interest in self-care. It also established a path toward larger and more comprehensive health care

⁴ Deyton and Lear, 17.

practices and institutions for gay and bisexual men, both within the gay and lesbian community and in the larger health care establishment of government and biomedicine. This premise further suggests that HIV/AIDS solidified an amorphous and disjointed urban gay community and moved it toward addressing its own community health issues. This line of thought also attributes the direct action of ACT-UP and Queer Nation that formed in the late 1980s and early 1990s as the beginning of health activism for gay, lesbian, bisexual, and transgender community.

The premise that the HIV/AIDS era solidified an urban gay world in western countries is questionable in other ways. For example, George Chauncey's work on gay New York from 1890 to the Second World War uncovered "a highly visible, remarkable complex, and continually changing gay male world" that is arguably similar to the foundation for a postwar urban community in the pre-HIV/AIDS era. Just as Chauncey noted that historians have overlooked this early period, historians also have described the pre-HIV/AIDS era in the same myths of "isolation, invisibility, and internalization."⁵ Historians have tended to describe every gay achievement across the twentieth century and prior to HIV/AIDS in a similarly conservative perspective resulting in an uninformed analysis.

This critical history will show that in the decades after the Second World War and before HIV/AIDS, gay and lesbian community organizations expanded and grew to support a variety of special interests and social issues much like they did in the late nineteenth and early twentieth centuries. For example, gay men, lesbians, bisexuals, and transsexuals broadened

⁵ George Chauncey, *Gay New York: Gender, Urban Culture, and the Making of the Gay Male World, 1890-1940* (New York: Basic Books, 1994), 1-2.

communication within the community through alternative newspapers and newsletters that established a network of community groups and activities. Specialized bookstores appeared in newly formed gay ghettos as a resource for the community. Liberal Protestant churches established outreach programs to gays and lesbians as each denomination debated the place of sexuality in its denomination and congregations. While mainstream churches and synagogues debated, gay and bisexual men and lesbians formed an evangelical church for themselves, the Metropolitan Community Church (MCC), and it spread rapidly across North America. Other social groups formed to bring like-minded gays, lesbians, bisexuals, and transsexuals together. There were gay cowboys and rodeos, community marching bands and choral groups, sports teams, and fetish organizations of all kinds. Drag queens performed regularly in clubs and discotheques and formed their own support groups and pageants. Gay and lesbian business owners opened establishments of all types and congregated their bars, bathhouses, and retail stores in major urban centers that fostered the gay ghettos. Above all, gay and bisexual men, lesbians, and transsexuals in the postwar decades recognized that they must help themselves within their own gay community and organizations. Karla Jay, an early lesbian activist and writer, noted in 1975 the formation of supportive communities as well as the need for such:

It is not enough to complain about oppression or even to combat various aspects of oppression; we must, in addition create alternatives and a culture of our own. We must build our own community, one in which we will be able not only to survive but thrive.⁶

This attention to helping ourselves within the gay community encouraged some gay men and lesbians to focus on specific health care issues among gay and bisexual men and to challenge

⁶ Karla Jay and Allen Young, eds. *After You're Out: Personal Experiences of Gay Men and Lesbian Women* (New York: Links Books, 1975), 171.

prejudices and stigma of health care for gay and bisexual men among their professional health care colleagues. Their efforts included establishing clinics that offered venereal disease testing and treatment, mental health and counseling programs, and substance abuse (namely alcohol at this time) support groups. In some locations, sensitive medical centers set up gender identity clinics to counsel gender conflicted men and women. Even the growing pornography industry, largely directed at gay and bisexual men, included health care and medical advice amid the lurid stories of adventure and sex. Gay switchboards and hotlines formed in almost every urban community. These communication centers offered information on community programs and organizations as well as providing directions to sensitive physicians and mental and physical health centers. This period in the 1960s and 1970s that began to focus on self-care and health, however, also built on late nineteenth and early twentieth century interests in science and medicine as a means to explain divergent sexualities.⁷

The gay and lesbian urban communities of the pre-HIV/AIDS era had other precedents. Chauncey described the gay world in New York from 1890 to the Second World War as consisting of “men who participated in that world forged a distinctive culture with its own language and customs, its own traditions and folk histories, its own heroes and heroines.”⁸ Similarly, gay and bisexual men, lesbians, and transsexuals of the pre-HIV/AIDS era created their own communities of support and families of trust. The attention to self-care and the health care establishments that formed the gay and lesbian health movement, however, began

⁷ This is addressed by several historians with one of the most thorough discussion by Henry L. Minton, *Departing from Deviance: A History of Homosexual Rights and Emancipatory Science in America* (Chicago: University of Chicago Press, 2002).

⁸ Chauncey, *Gay New York*, 1.

to attract more attention and become foundational efforts within the gay communities of North America and western Europe in this postwar and pre-HIV/AIDS era. During this period, a number of health care professionals organized membership groups including the National Coalition of Gay STD Services and hosted four National Lesbian/Gay Health Conferences. The more localized gay communities also moved into health alliances. For example, in 1978, four leather and Levi motorcycle clubs in Washington, DC, worked together on a fundraiser to save the Gay Men's Venereal Disease Clinic.⁹ The collective non-profit organization that they formed, *Brother, Help Thyself*, began an annual event to raise funds for health care that continues today. The undercurrent of mutual support, steady and strong within the gay male, lesbian, and transsexual community in the pre-HIV/AIDS era, would do what the former executive director of the National Gay Task Force, Urvashi Vaid, wrote years later in the middle of the HIV/AIDS era:

A basic reality of gay lives is that we take care of our own. AIDS service organizations at once grew out of, and depoliticized, the pre-AIDS gay and feminist health movements. AIDS activists did not so much invent a gay health movement as reinvent it.¹⁰

In spite of the interest among many gay and lesbian leaders in health care and politics to address the overall "community," a significant number of gay and bisexual men and transgender men and women were marginalized from the gay health movement. Men and women of color, sometimes referred to as "Third World", were either excluded or not accommodated in many of the programs and facilities of gay and bisexual men and lesbians. Few health leaders addressed the specific characteristics or geographies of these marginal

⁹ Brother, Help Thyself, "About Us," *Brother, Help Thyself*, <http://brotherhelphthyself.net/about-us>.

¹⁰ Urvashi Vaid, *Virtual Equality: The Mainstreaming of Gay and Lesbian Liberation* (New York: Doubleday, 1995), 86.

populations who shared many of the same mental and physical health concerns. Jim Graham, director of the Whitman-Walker Clinic in Washington, DC, would say his clinic was never successful in addressing the health care of black gay and bisexual men.¹¹ Men and women of color certainly sought health remedies and recognized the inequalities of health care and biomedical research, but they had to find other avenues to address their health and well-being.

Despite the growth and formation of the gay community in the postwar era, there is a certain form of amnesia that exists about the decades that preceded the public awareness of HIV/AIDS in late 1981. It is a form of amnesia that is selective about what we choose to recall and what we intentionally forget. It happens with the passage of time and a diminished urgency. In contemporary writing and research, it is as though everything that mattered in the health and lives of gay and bisexual men began and ended with the HIV/AIDS era. Examples of this begin with the early journalistic writing of Randy Shilts in *And The Band Played On: Politics, People, and the AIDS Epidemic*, to Elizabeth Fee and others essays of history in *AIDS: Burden of History*, to Cindy Patton's sociological perspective in *Inventing AIDS*, to cultural theorist Paula Treichler in *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS*, to medical anthropologist Steven Epstein in *Impure Science: Aids , Activism, and the Politics of Knowledge*, and more recently to David France in his historical perspective *How to Survive a Plague: The Story of How Activists and Scientists Tamed AIDS*. These writings suggest that gay and bisexual men were unconcerned with self-care and health prior to HIV/AIDS and considered their bodies simply as sexual vehicles.

¹¹ Jim Graham (director, Whitman-Walker Clinic) in personal communication with author, November 5, 2015.

Most writers and researchers on HIV/AIDS in the late twentieth and early twenty-first centuries believe that gay men were consumed with sexual freedom and equated promiscuity with liberation politics regardless of sexually transmitted diseases. This amnesia of self-care and health care in general has been mentioned by a handful of historians and writers in recent years with an interest in revising historical interpretations and correcting troubling statements. The work by Jim Downs, one of these revisionist historians, provides the greatest challenge to others who focus on promiscuity in the pre-HIV/AIDS era. Downs offers a straightforward critique and seeks a balanced perspective on the lives of gay and bisexual men and their communities in the pre-HIV/AIDS decades.

The explanation that promiscuity leads to the spread of HIV not only was medically and scientifically significant, but also had a profound, uninterrogated effect on how the history of the 1970s was narrated: the nuanced social history of the 1970s got pushed aside in favor of a narrative that emphasized sex.¹²

The significance of my research and this dissertation is that I hope to redirect the origins of social disease and health care initiatives for gay and bisexual men away from sexual practice and perceptions of promiscuity toward important accomplishments in health care and health awareness within the gay community prior to 1981. My work expands on the writing of Downs to include health activism and establish its place beside other topics in gay men's social history. I also add a health dimension to the pre-HIV/AIDS histories so that a broader understanding is presented about the period between the Second World War and 1981.

¹² Jim Downs, *Stand by Me: The Forgotten History of Gay Liberation* (New York: Basic Books, 2017), 5-6.

Research Methodology

This history project is an effort to connect how gay and bisexual men addressed their bodies and health as well as the role of health care and disease in the pre-HIV/AIDS decades. It will reveal how gay and bisexual men developed and expressed their knowledge of the male body and how that knowledge constructed a platform for the gay and lesbian health movement during the HIV/AIDS era that continues today. It redirects the origins of gay health care toward an earlier postwar period and broadens the timeline that considers how political activism and social movements arose and were at play in North America and western Europe at the time of HIV/AIDS. In doing so, it extrapolates from records and archives of the period, achievements, discussions, projects, and events that illustrate my thesis and contrast those more recent intellectual interpretations. Thus, this is a critical history that seeks to challenge prevailing historical concepts and add another layer to the historiography of gay and lesbian history.

I construct a chronological line of inquiry through archival documents, community publications and newspapers, dissertations, secondary sources, and medical and public health journal articles that begin after the Second World War. The purpose of this inquiry is to develop an argument against prevailing historical interpretations that promiscuity and social disease deterred the gay and bisexual men from achieving full social and political citizenship in the pre-HIV/AIDS era and that such citizenship was achieved in the HIV/AIDS era between 1981 and 1996. I am interested in the graduated construction of gay and bisexual male health over the long wave from the nineteenth century to the end of the twentieth century, but will focus on the post Second World War decades up to the early 1980s.

I illuminate a narrative of how gay men responded to their health care and how pervasive it was within the gay community via two data sets. First, by identifying through the writings of physicians and public health officials in North America and Great Britain the gradual association of venereal disease to gay and bisexual men by the 1950s and early 1960s. Second, I trace the response to the medical and public health officials by homophile organizations, gay liberation leaders and entities, and organizational and community publications contemporary to the period. These organizations and publications attempted to turn advances in activism into a form of pride in good health. Activism, in other words, most often using the word “pride,” included quality self-care and regular testing for venereal disease.

Traditional and Counter/Alternative Archival Sources

This project uses both traditional and counter or alternative archives. Traditional archives include collections at universities, public libraries, and institutional (government) facilities. Counter or alternative archives include privately-owned and managed collections and online collections. All archival work follows contemporary queer theory research methods or is undertaken in what is described as a “queer archive” that focuses on the production of knowledge and perspective that emerged from within the gay and lesbian community rather than from without.

Amy Stone and Jaime Cantrell identify some of the special features of “queer” or LGBTQ archives:

Indeed, in the attempts of historians to “document the history of homosexual repression and resistance,” many scholars “have recovered a history suppressed almost as rigorously as gay people themselves.” Thus, LGBT archival research becomes queer when it becomes part of a process of recovery and justice for queer past and present—

shifting the presence of LGBT lives and histories within archival scholarship from margin to center.¹³

LGBTQ collections, largely drawn from personal donations, are sometimes randomly collected, cataloged, and dated, as well as being located outside of an institution or academic center. Community-based archives or “counter archives,” however, often contain some of the most important data and may be difficult to access and in some disorder.¹⁴ Stone and Cantrell reflect on this:

The peculiarity of archival time is inseparable from that of archival space; queer lives, often marked by their ephemeral, nonlinear, and nonsequential nature, are contained in archival spaces that are equally textured and complex.¹⁵

These counter archives are popular locations for donations from gay and bisexual men, lesbian, and transgender donors, and contain critical data from both individuals and organizations from the late twentieth century to the present. Such repositories also are unique aspects of marginalized communities and for the LGBTQ communities in North America and western Europe that formed in the 1980s and 1990s.¹⁶ These archives and the queer aspects of their donation and research are key to insights into the early gay and lesbian health movement. The archives consulted and their collection focus are listed at the end of this proposal.

I primarily work in archives that contain either an individual’s papers or collections that offer insights into healthcare or those of an organization operating health facilities or programs.

¹³ Amy Stone and Jaime Cantrell, eds. *Out of the Closet, Into the Archives: Researching Sexual Histories* (New York: State University of New York Press, 2016), 3.

¹⁴ Stone and Cantrell, xvii

¹⁵ Stone and Cantrell, 5.

¹⁶ Stone and Cantrell, 7.

Sometimes these are the same location, but in other cases they are not. For example, the papers of Jim Graham contain organizational material on the Whitman-Walker Clinic of Washington, DC, when he was executive director, but are mostly his personal papers when he served on the city council of the District of Columbia.

Another significant resource for research will be the gay and lesbian community newspapers and alternative revolutionary or liberation focused newspapers produced either within a city or region (Los Angeles, New York City, Washington, DC, and other major North American cities) and newspapers with a national or international readership. Most of these newspapers date to the 1960s and 1970s with a few exceptions being the homophile publications of the 1950s. The key terms that focus my search in these newspapers are descriptions or references to venereal diseases, clinics, community health outreach programs, and health care professionals or entities organizing and operating health programs. An example of a community newspaper is the *Washington Blade* that began in 1969 and continues today. Examples of a national newspaper or magazine are *The Advocate* produced in Los Angeles or *The Body Politic* produced in Toronto, Canada. Alternative newspapers that are sometimes referred to as “revolutionary” also carried gay and lesbian news in the 1960s and early 1970s. Examples include *The Rag* (Austin, Texas) and *Quicksilver Times* (Washington, DC). Many of the community and alternative newspapers are now digitized and available online. Other newsletters or newspapers focus on certain segments of the gay male or lesbian population and be useful such as *RFD*, a publication for rural gay men and lesbians, or the newsletters of gay Levi/leather motorcycle clubs. In other cases, special health organizations or professional groups published materials including newsletters, conference programs, and

standards for health care. These all provide different points of intersection with the health and health care opportunities, as well as perspectives of gay and bisexual men.

The archival material used in this project took several formats with different processes of access. In the more traditional archives, archivists closely managed access to boxes and folders restricting the number and location of all material. Photocopying, with permission in some cases, and imaging through the cellular telephone became the only means of capturing material for use later. The counter archives operated in a much more flexible setting and with fewer restrictions, if any. The most accessible of all, however, proved to be selected digitized materials accessible through public websites that usually requested some acknowledgement. These archives and the focus of each are listed in Appendix I.

The rather large set of online archives available today proved especially helpful in locating outlying documents that would have been difficult to find before this period. The archival placement and format yielded material that corroborated other historical records but also expanded understanding the particularly nuanced roles of individuals or sequenced events.

In all of the archives, other than obvious search terms associated with the clinics, I employed search terms that included “gay clinic,” “gay health,” venereal disease, VD, and when appropriate syphilis, gonorrhea, and hepatitis B. I used other contextual searches and followed the lines of “gay liberation,” “homophile,” and “gay activism” as related to the project. If appropriate to an archive, I searched lines such as public health, medical schools, and community organizations. In several archives, I followed individuals in leadership positions either employed or volunteers. For example, in searching for Whitman-Walker, I searched

through its longtime director's papers at George Washington University, but found more documents in the files of Frank Kameny, a nationally significant gay activist and community volunteer.

These archives pulled from various parts of North America provided a geographic diversity. The major locations contrasted from East Coast, namely Washington, DC, to West Coast Los Angeles. I uncovered papers relating to other areas of the country like New York in both the east and west coast archives. The geographical spread picked up in online archives also offered access to other areas of the country and were typically based in a university or LGBT historical project.

Largely, I have focused my research on the health politics and healthcare developments in Washington, DC, because health initiatives began relatively early in the nation's capital and covered a broad population all within the context of politics, race, gender, and sexuality. The particularly active communities in Washington, DC, today provide more extensive archives and records that illuminate health care for gay and bisexual men in particular. My familiarity with the city also allows me to go deeper into the archives of the Washington gay and lesbian community and to have some personal communications with former volunteers and activists. Recent scholarly research on the gay and lesbian history of Washington helps to provide context to my interest on health is not covered in such research. The work of the Rainbow History project of Washington and increasingly accessible digital material make this much easier than would have been possible a few years ago. The Mattachine Society of Washington (1961), the Gay Liberation Front (1970), and the Gay Activists Alliance (1972) all have accessible material related to health politics. Other material from radical lesbians of the period (Off Our

Backs) also is available to augment research on gay and bisexual men. Similar archival material exists to expand a discussion of black gay and bisexual men. I added context from archival materials from Los Angeles, Milwaukee, New York, Houston, and San Francisco that are easily accessed from recent digital online community history projects.

An unexpected and valuable source found mostly in traditional archives was the folders of correspondence between gay and bisexual men writing to individuals or organizations. These letters and notes occasionally shed a deeper perspective on chronology of events. The depth of emotion and breadth of concerns appear in these personal forms of communications where disease or the education about a disease often appear through desperate inquiries.

Ephemeral material also became important in this project. This included items like objects relating to health education such as a fan, advertisements, brochures, programs, and announcements that appeared as loose items in collections. Some of these tended toward erotic using images to attract attention to gay or bisexual men but most reflected the skills and underlying beliefs of the writer as well as available technology for communication. Almost all the ephemeral material and much of the correspondence is typewritten or handwritten carrying typical errors in misspellings and sentence structure as well as spellings meant to inform the reader of a particular time period or influence. For example, “Amerika” and “sister and brother” typically appear in the writings of gay activists in the late 1960s and 1970s. It is only in the early days of HIV/AIDS that digitized material was found in early dot-matrix formats.

The shortcomings of this archival work are that what was kept as a record of an individual, organization, or event, or what was saved because of space or relocation,

automatically reflects an individual's bias. That became obvious in the papers of Jim Graham at Whitman-Walker. That collection contrasts to that of Frank Kameny, who lived in the same house in Washington, DC, most of his life and kept virtually everything. All of these archives are further streamlined by the processor of the material. What the processor chose to keep and how items were catalogued. The most challenging aspect of the archives is the selection of items to digitize and then open to the public online. Inherent in any collections management, however, is a bias of what is of "value" for broader researchers who might randomly search for material now or in the future.

Finally, the archival research is very useful and reveals a largely unbiased database for my work, but it also is limiting. As time and resources limited what might have been used in this project, outside of some personal communication or my own experiences, I did not collect oral histories. Oral histories would have been useful in making additional connections or weaving a deeper narrative. However, many of the key players of the events I discussed died in the HIV/AIDS era or are now scattered across North America. The timeliness in this project became even more of an issue as I sketched out the possible sources for such interviews, so it was not feasible to collect the oral history interviews that might have been helpful.

Positionality

One of the most important aspects of my methodology is my positionality or voice in this research. Esther Newton said it best regarding her research on *Cherry Grove, Fire Island*. "Like other anthropologists, I believe there is no substitute for what Clifford Geertz called "being there." I heard, saw, and participated in many aspects of the intensely social Grove life

of the eighties.”¹⁷ Like Newton, I joined a handful of gay men in a Protestant church near Dupont Circle in the early 1980s for a volunteer training program at the Whitman-Walker Clinic in Washington, DC. I volunteered for more than one year and served on an operations committee. I also interacted with volunteers and patients each week before beginning graduate school. While there, I experienced caregiving with my fellow volunteers in the small clinic open on Thursday evenings and Saturday mornings. As a gay man who grew up in the pre- HIV/AIDS era, my perspective and voice also broadens the discussion in this project by using the terms and circumstances that we knew and used at the time. These are reflective of my own experiences as both a patient and volunteer in a healthcare facility for gay and bisexual men.

With my perspective in mind, the methodology for this project is decidedly different from the memoirs now being published by gay men who survived AIDS. Some of the older gay and bisexual men who lived through the HIV/AIDS era are offering reflective writings while others have retired from active research and publishing. This leaves the history of gay men and lesbians to be researched, interpreted, and written by a new generation of queer scholars. These youthful and curious researchers bring a great deal to the dialogue of our collective history, but are sometimes overly interpretive using contemporary references and terms to LGBTQ and social theories developed since the HIV/AIDS era. These interpretations distort what really happened or critique the period rather than acknowledging the complexities that existed around such issues of sexuality as “coming out”, as well as race, gender, and class. My

¹⁷ Newton, “Appendix,” 303.

goal is to counter these contemporary interpretations, informed by vantage points of the present, with the perspective of “being there.”

Theoretical Frameworks

One of the challenges of writing about gay and lesbian history is that descriptive terms changed over time. For the purposes of this critical history, I intend to use terms appropriate to the decade as they would be understood or used especially by gay and bisexual men. The binary terms of homosexual and heterosexual are late nineteenth century medical terms that in the twentieth century became acceptable words to distinguish sexuality. Although these terms are problematic for some and do not recognize the fluidity of sexuality, they were in use by many public health and medical researchers by the middle of the twentieth century. Men interested in same-sex liaisons, however, would refer to themselves in a number of ways. The term “gay” was a common term by the Second World War, and certainly by the 1960s, for men interested in same-sex relations replacing earlier terms, including derisive ones, such as “fairy,” “queer,” “sissy,” and “fag” or “faggot.” The term “gay” alternatively is used to be inclusive of women interested in the same sex, though for the most part, it is more accurate to identify such women as lesbians as they tended to self-identify as lesbians separating themselves from women who associated with men. I intentionally distinguish between gay men and bisexual men as many of the latter met the same challenges to health care as those gay men “out of the closet” by the 1970s. When the National Lesbian and Gay Health Foundation, Inc. published the second edition of *The Sourcebook on Lesbian/Gay Health Care* in 1988, the introduction delivers a full explanation of why they added chapters on bisexuality. With this in mind, I observed that many recent publications and research on the pre-HIV/AIDS era excluded

bisexual men believing that gay men were the only individuals served in the special community clinics or participating in the biomedical research trials. I choose to use a more inclusive language as my research uses broader resources and archival material that illustrate why bisexual men were as affected by disease and health care as were gay men.

Another important consideration in this project is the focus on health care for gay and bisexual men to the exclusion of lesbians, transsexuals or transgender. This focus is narrowed because gay and bisexual men of all ethnic groups and classes experienced unique issues in health care. Venereal diseases and later HIV/AIDS and testing technologies for those diseases differentiate them from lesbians or most transsexuals in the postwar decades. At times the relationship between gay men and lesbians fostered separatism in social, political, and health care. Sometimes this relationship proved contentious and even hostile. Lesbians sometimes associated with larger issues of the women's health care movement and then at other times isolated their concerns from both heterosexual women and gay and bisexual men.¹⁸ This separation also depended on where one lived and positioned oneself in the hierarchy of sexuality and feminism. Regardless, lesbians rarely encountered venereal diseases and HIV from sexual practices and never met the same type of stigmatization as gay and bisexual men from health care professionals or biomedical researchers of sexually transmitted diseases.

While lesbians typically did not share the health issues of gay and bisexual men, transsexuals or transgender sometimes did. I generally use the term transsexual to refer to men and women conflicted in gender before the 1980s. This is somewhat of a misnomer as

¹⁸ Karla Jay and Allen Young, *The Gay Report: Lesbians and Gay Men Speak Out About Sexual Experiences and Lifestyles* (New York: Summit Books, 1977, 1979), 41-82 and 301-338.

“transsexual” generally means men or women who undergo a surgical sex change and not just hormone treatment. When referencing contemporary health issues, I try to use the term transgender as it has been developed since the early 1990s. Transgender may refer to a number of different gender issues from surgical intervention, hormonal treatment, or any assortment of individual choices. With that said, transsexuals (male to female and female to male) might experience the same health issues as gay and bisexual men depending on sexual practices and personal identification.

Finally, this project is largely focused on the physical health care issues of gay and bisexual men. Although I do not limit discussion solely to physical issues, most of the gay men’s clinics addressed the growing perceptions or realities of venereal disease in gay and bisexual men separately from mental health or substance abuse programs. Mental health and substance abuse programs, however, often shared space and participated in a larger health care programming, including outreach to and within the gay and bisexual community. In time, programs for lesbians and transsexuals/transgender have become part of the overall health care programs and facilities for a more comprehensive or queer health care initiative. This last observation is the product of many years of discussion and adaptation within the broader gay and lesbian network, and while more common today, is far from being universally accepted.¹⁹

¹⁹ Kevin L. Ard, MD, MPH, and Harvey J. Makadon, MD, “Improving the Health Care of Lesbian, Gay, Bisexual and Transgender (LGBT) People: Understanding and Eliminating Health Disparities.” The National LGBT Health Education Center, The Fenway Institute, Brigham and Women’s Hospital; and Harvard Medical School, Boston, MA, <http://lgbthealtheducation.org>.

Secondary and Popular Literature

Since the 1980s, historians, social scientists, journalists, and medical writers released a large number of publications that evaluate HIV/AIDS as a historical and health event in North America and western Europe. These come from various academic disciplines including history, sociology, anthropology, education, theater and performance studies, queer studies, women and gender studies, and public health and medical fields. Some of these projects are the work of gay or bisexual men, some who did not live at the time of the HIV/AIDS era, and lesbian scholars active in the direct action politics of the era and post-HIV/AIDS era.²⁰ These studies mostly emerged out of academia and are published in academic journals, but others come from gay and lesbian political leaders and journalists through popular books and non-academic periodicals. Beginning with the writing of Randy Shilts and later John-Manuel Andriote and David France, these journalists assumed the role of community historians of the HIV/AIDS era. Others, like Urvashi Vaid and Gabriel Rotello come from the political activist leadership and offer a broader view of the impact of HIV/AIDS. All of these works are well documented in the literature from the 1980s to the present, and form the basis for the current interpretations that typically conclude that HIV/AIDS established a new political and biomedical or health care environment with increased access to the mainstream health care establishment for the gay and lesbian health movement. Steven Epstein captures the general consensus in this regard:

The AIDS crisis is a case in which the normal flow of trust and credibility between experts and laypeople has been disrupted. The autonomy of science has therefore been challenged; outsiders have rushed into the breach. But something else has happened as

²⁰ Some of the projects include Sarah Schulman, *My American History* (New York: Routledge, 1994); Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley and Los Angeles: University of California Press, 1996); Paula Treichler, *How to Have Theory in an Epidemic: Cultural Chronicles of AIDS* (Durham: Duke University Press, 1999); Cindy Patton, *Inventing AIDS* (New York: Routledge, 1990).

well: some of those outsiders, particularly groups of AIDS activists, have constituted themselves as a new class of “lay experts” and put forward their own claims to speak credibly about the epidemic.²¹

There are relatively few studies that place transgender or bisexual men and women in that conversation. Likewise, these studies avoid the considerations of the intersexed and asexual populations that are often combined with the issues of gay men and lesbians today. Thus, for some, the use of the word “queer” is a much more inclusive consideration for those who are gender non-conforming and captures a broader audience that extends contemporary health care practices to a larger community:

There is no monolithic experience, no simple narrative, no easy way to lump and slice the incredible diversity that characterizes queer and trans identities, communities, and lives...“queer” and “trans” are imperfect shorthand for sexual orientations and gender identities including and certainly not limited to lesbian, gay, bisexual, queer, asexual, pansexual, Two-Spirit, transgender, transsexual, intersex, and so many more.

You need to understand this context in order to understand why trans folks tend to fare worse than cisgender folks, and why trans women experience the health impacts of transmisogyny. Why all of this is a result of health being rooted in complex structures of privilege and oppression, and not because being queer or trans is inherently bad for your health.²²

Despite a contemporary movement within health care professions and centers of medical education to be more inclusive, the current gay and lesbian health movement still marginalizes men and women who are young, those of color, and those with class limitations.

²¹ Steven Epstein. *Impure Science: AIDS Activism, and the Politics of Knowledge* (Berkeley/Los Angeles: University of California Press, 1996), 17.

²² Zena Sharman, ed. *The Remedy: Queer and Trans Voices on Health and Health Care* (Vancouver, BC: Arsenal Pulp Press, 2016), 14-15.

The predominance of literature addressing the HIV/AIDS era overshadows a small number of scholars and writers reflecting on the pre-HIV/AIDS decades. There are several of note in this area. Richard McKay, an English medical historian, is keenly interested in the pre-HIV/AIDS era in North America and western Europe. His work builds a strong historical perspective regarding venereal disease and includes various health care initiatives to address gay men prior to HIV/AIDS. His most notable work is to discredit the stigmatization of “Patient Zero” established by journalist Randy Shilts in his book *And the Band Played On: Politics, People, and the AIDS Epidemic*. McKay’s recent book *Patient Zero and the Making of the AIDS Epidemic* provides a broad introduction to the HIV/AIDS era with thoughtful interpretations of the pre-AIDS decades.²³ Catherine Batza is an American historian whose dissertation, now reformatted and released as a retitled book, *Before AIDS: Gay and Lesbian Community Health Activism in the 1970s* addresses the establishment of several gay men’s health clinics prior to the early 1980s. She connects these clinics to liberation politics, the post-1969 Stonewall gay rights movement, and the programs of the Great Society that established community health centers.²⁴ Michael Brown addresses the pre-AIDS health care as a geographer. Through a geographical perspective, using a Foucauldian model, he examines the dispersion and effectiveness of the Kings’ County Venereal Disease Clinic in Seattle.²⁵ Finally, journalist Gabriel Rotello in *Sexual Ecology: AIDS and the Destiny of Gay Men* constructs an aggressive history of promiscuity before HIV/AIDS that condemns a long-held stereotype of gay men. While Rotello’s

²³ Richard A. McKay, *Patient Zero and the Making of the AIDS Epidemic* (Chicago: University of Chicago Press, 2017).

²⁴ Catherine Batza, *Before AIDS: Gay and Lesbian Community Health Activism in the 1970s* (PhD diss., University of Illinois at Chicago, 2012).

²⁵ Michael Brown, “2008 Urban Geography Plenary Lecture—Public Health as Urban Politics, Urban Geography: Venereal Biopower in Seattle, 1943-1983,” *Urban Geography* 30, no. 1 (2009), 1-29.

arguments and perspective of sexual ecology discusses the pre-HIV/AIDS era, it is not of the caliber of the other mentioned works that show a more circumspective historical and social view of gay and bisexual sexual practices and disease.²⁶

My project researches and discusses contributions to this scholarly investigation of gay and bisexual men's health care across the postwar decades that saw the rise of associative sexually transmitted diseases, homophile and post-Stonewall health activism, health care responses from within the community, and the transitions that followed leading up to the HIV/AIDS era. I add to earlier literature, particularly the work of Batza and McKay, by moving to an earlier time period of the homophile movement and bringing health activism up through various community entities and geographies to the brink of HIV/AIDS. In addition, I connect the development of a hepatitis B vaccination and its protocol testing among gay men to HIV/AIDS in the early 1980s. I also explore health activism in Washington, DC, through the Whitman-Walker Clinic to the emergence of HIV/AIDS in the nation's capital.

Chapter Descriptions

Chapter One: Postwar Health Care for Gay and Bisexual Men

Through a review of pertinent secondary literature, this chapter presents some of the major and most relevant social, economic, and political achievements that influenced populations in North America and western Europe. In particular, the postwar ideals of health and health care are considered in light of the value of the nuclear family, development of vaccinations to address infectious diseases, rise and then diminished role of religious

²⁶ Gabriel Rotello, *Sexual Ecology: AIDS and the Destiny of Gay Men* (New York: Penguin Books, 1997).

denominations, and social and political efforts to enforce anti-obscenity laws. The chapter also addresses the growth of medical and scientific authority and the counter response to authority directed to patient rights and medical ethics. Of particular note, I will address Alfred Kinsey's two publications on the sexual practices of men and women (1948, 1953) and how these works influenced public health research and stirred public debate about sexuality for the first time.

Chapter Two: Pride in Health: Shame of Disease

This chapter develops the translocation of venereal disease in the postwar decades from association with female prostitutes and black men to include Mexican immigrants, gay and bisexual men, and urban/suburban teenagers. The association of social diseases with gay and bisexual men grew steadily until reaching a critical point in the late 1970s. Gradually, more diseases, some not typically attributed to sexual transmission, became associated with gay and bisexual men. By the late 1970s, the stigma and accompanying shame of social diseases for gay and bisexual men reached an unprecedented level within and outside the gay community. This chapter overall constructs a biomedical dialogue between health officials, public health agencies, and gay men about shared responsibility and concern for management of venereal diseases within the gay and bisexual male population, particularly in urban communities of North America and Great Britain.

Chapter Three: Lavender Health Initiatives

This chapter begins with the work of Vernon C. Mitchell in Los Angeles who organized the Committee for the Eradication of Syphilis in conjunction with the Los Angeles County Public Health District and offered testing for gay and bisexual men (and teenagers) in West Hollywood beginning in 1967. Mitchell's community education work continued into the early 1970s

making it the earliest outreach program on venereal disease for gay men in the United States. The chapter then outlines the development of several community clinics that specifically targeted gay and bisexual men for testing and in some cases treatment and concludes with larger accomplishments of gay and lesbian health professionals forming organizations and several national gay and lesbian health projects.

Chapter Four: "Brother, help thyself"

The establishment of clinics and health care programs within the gay male community led to public campaigns to educate and test gay and bisexual men for venereal diseases and for outreach within the community as well as partnerships with other organizations or entities. This chapter identifies a number of specific health outreach programs for gay and bisexual men from the 1960s through the late 1970s. Several of these programs emerged from gay venereal disease clinics including the SAFE program in Denver, Colorado; leather and Levi motorcycle clubs in Washington, DC; drag shows and organizational support; and a variety of mobile testing efforts in bathhouses and community events across North America. This chapter also will examine the role of the Metropolitan Capitollites of Washington, DC, a black gay male social organization, that developed alternative health care services and educational opportunities for gay black men and the larger black community. In addition, the chapter addresses the initial partnerships between gay health care professionals (often in these community clinics) and public health officials drawn from newsletters and reports of public health officials and clinic records. I will consider the motives behind such relationships and the preliminary benefits or problems that defined these relationships. Ultimately, the chapter sets the stage to answer

questions on whether the gay health professionals were complicit or resistant to public health initiatives in the pre-HIV/AIDS era.

Chapter Five: HepB Vaccine Development and Clinical Trials

By the middle of the 1970s, biomedical researchers resurrected technology to develop a vaccine for Hepatitis B. Hepatitis B troubled special populations worldwide and led increasingly to lifelong health issues or death. This chapter explores this important biomedical achievement and addresses the ethical issues surrounding the acquisition of Hepatitis B antibodies from gay and bisexual men and the field trials of the new vaccine in the same study population. The example of the Hepatitis B vaccine and its use in the gay and bisexual male populations illustrates the overall purpose of this project to address health awareness and activism.

Chapter Six: Like Water through a Funnel: Inside the Whitman-Walker Clinic

This chapter focuses more directly on the clinic operations and leadership in the 1970s. From 1978 to 1981, Whitman-Walker experienced a number of major shifts that put it in order for the upcoming crisis of HIV/AIDS. The chapters addresses a collective approach to health care and positioning of the clinic both physically and financially.

Conclusion: Five Critical Years 1977-1982: Get out of the fast lane!

The five years between 1977 and 1982 may be viewed today as a final development in this period for the health care of gay and bisexual men in North America and western Europe. A quickened pace among these gay male communities both in health care provisions and social/political life became a platform for the public awareness of HIV/AIDS about 1981-1982. My analysis of these years as the conclusion of a long postwar process within and outside of the gay and bisexual male community contributes to a growing awareness among historians that

the HIV/AIDS era did not initiate the widely held conceptions of a politicized and health educated gay male population.

At the same time, my research suggests that like several other recent historical narratives the gay male leadership among health professionals and political activists overstated and misused the claims of promiscuity among gay men. This contrasts with a number of memoirs and publications of the HIV/AIDS era that over-burden the urban gay culture with excessive behavior and describe a gay male culture that is devoid of community support and commitment.

Finally, this chapter employs work from two early social or queer theorists: Michel Foucault and Guy Hocquenghem. These two French philosophers offer two separate approaches to the concluding years before HIV/AIDS. Hocquenghem suggests the function of venereal disease in “managing and limiting” gay and bisexual men, while Foucault offers insight into the role of biopower as well as “friendship as a way of life.”

Chapter One

Postwar Health Care and Medical Authority

The position of gay health activists at the onset of the HIV/AIDS era in 1981 was not set in one preceding decade. The tensions held at that point developed gradually in a dynamic play during the postwar decades that started with worldwide changes. Science and medicine had assumed unprecedented values and authority to address almost all aspects of our lives. Such values and authority supplanted for many the role of religion in guiding human existence. With these new positions, largely accepted across North America and western Europe, physicians and biomedical researchers moved to answer complex human problems that heretofore seemed undefinable. This became the landscape for gay and lesbian health activism. Through these decades, incredible grassroots leadership emerged that would define the methods and definitions of sexuality as well as public health.

Postwar Science and Biomedicine

Following the Second World War, science, technology, and developments in biomedicine earned a broad level of public trust and positivism. In particular, the postwar ideals of health and health care rose in value as it strengthened or reinforced the nuclear family, developed vaccinations to address life-threatening infectious diseases, and ameliorated social and political efforts to enforce an array of discriminatory laws to regulate personal lives.

It was an age of confidence and a time of vision and an epic story of defiance against tyranny and inhumanity that materialized at the end of the Second World War. The atrocities of the Nazi human experimentation and the unprecedented use of newly found nuclear weapons reshaped the views of Americans and instilled in them a belief in world-wide dominance in

politics, military power, and human achievement. In particular, science, namely medical science, defined cultural aspirations and focused ambitious, variously funded, public and private projects toward addressing every human challenge. Americans became increasingly willing for medical science, previously serving at a dispersed and more modest scale focused on chronic diseases, to address therapeutic health as well as social problems. This shift formed in two ways: first it moved traditional family clinical practices into large-scale hospitals and research institutions, and second it relocated medical research, once funded primarily by private foundations, to public funding sources and bureaucracies that willingly addressed an array of diseases and social problems.²⁷

Coupled with the paradigmatic shift in focus and funding, the American social landscape began to change in the postwar decades. The Second World War released American men and women from traditional familial bonds allowing greater mobility for economic goals and flexible social engagements. With such movement, the American population congregated in large urban areas for jobs and leisure opportunities. For instance, what historians call the Great Migration of the 1920s moved black families from the south to growing urban centers like Washington, DC, Chicago, and Los Angeles before the Second World War; in turn in the postwar decade, opened up permissive urban enclaves to gay and bisexual men and lesbians as well as other special populations. At once, large urban areas absorbed these new populations and expelled dominant (often heterosexual and white) populations toward a newer urban phenomenon called the suburbs. This horizontal demographic movement led to new housing and

²⁷ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 335-338.

neighborhood forms in the suburbs that emphasized conformity. An equal push-pull reaction appeared in social and religious institutions. Within large urban centers many religious entities contracted in size and social services, and their programs opened up to these new populations in heretofore unthinkable ways.

All of this movement accumulated in cities like New York, Boston, Philadelphia, Chicago, and Washington, DC, and west coast cities such as San Francisco and Los Angeles. In the Cold War competition with communism in Cuba, the Soviet Union, Southeast Asia, and China, Americans felt the need to reinforce the ideals of a nuclear family and advance the country through an emphasis on science and biomedicine. Conformity seemed paramount to many political leaders who engaged public and private forces against pornography (more often called obscenity) and venereal disease. In the wake of those political interests, medical researchers produced and implemented impressive public health advances mostly consisting of vaccines for conquering poliomyelitis, smallpox, and measles, and reducing incidents of tuberculosis. Health in this era also meant choices. Margaret Sanger's long effort to develop an easy contraceptive for women other than the condom or cervical block matured as an option for couples to have sex but avoid pregnancy. "The pill," as it was commonly known opened new life experiences for women through choice in spite of religious and social controversies. All of these accomplishments fell in line as the Soviets launched a competitive Sputnik in 1957 and the United States sped up its space program while cautioning that a nuclear war lay just over the horizon and bomb shelters were an essential part domestic home life.

Medical Authority

Liberal minds, as Paul Starr says, were comfortable with medical science addressing social problems that lingered from at least the 19th century.²⁸ Certainly the curious mental state of homosexuals (increasingly labeled pathological) fell within those problems as did the social hygienists concern with venereal disease among undesirables.

As Starr notes in his term “the liberal years,” meaning the post Second World War decades, the development of the Office of Economic Opportunity (OEO) authorized neighborhood health centers or community clinics that by 1967 included eight clinics with the first one in rural Mississippi. The idea of two community health professors in Boston (Dr. Jack Geiger and Dr. Count Gibson, Jr.), these community clinics maneuvered through the late 1960s bureaucracies of OEO and the United States Department of Housing, Education, and Welfare to offer neighborhood-based ambulatory health care for all types of disease or wellness. Employing local residents with free medical services (that eventually became fee-based) the health centers grew in number to address multiple health concerns including mental well-being and malnutrition. In this manner of operation and funding, the centers implemented a key component of President Lyndon Johnson’s War on Poverty where the poor were enabled to “help themselves.”²⁹

Outside of government health programs for the poor, a surge of “revolutionary” clinics began to appear in urban centers in North America. These dynamic volunteer-based, free clinics (usually without trained medical professionals) arose to address specific needs in special under-

²⁸ Starr, 336-337.

²⁹ Starr, 370-372.

served communities that had relocated to urban neighborhoods. The most notable clinics (and best researched) are the work of the Black Panther Party. Historian Alondra Nelson recently examined their medical projects in *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination*. Nelson traced the health activism of the Panthers from 1966 to 1980 identifying testing for sickle cell anemia programs and public health education and health treatments as unique to poor, black, urban communities. The Panthers' health care programs are significant as mentoring entities to other political entities in both politics as well as social services. The overlap of Panther's unchallenged revolutionary leadership into other special communities should not be discounted. These (mostly) black men risked great personal well-being for their cause and would inspire community leadership in a number of urban settings including the gay and lesbian radicals of the late 1960s and 1970s.³⁰

The Black Panther outreach services were not alone nor were they really the first revolutionary health care initiatives. Progressive Era free clinic movement for tuberculosis, venereal diseases, and other health concerns have existed since the late nineteenth century. Also in the late nineteenth century, a group of mostly urban black women organized similar health care programs largely focused on family planning, pregnancy, and child care. The 1960s produced fresh leadership and programs that would challenge the authority of medicine in new health care facilities and bureaucratic programs. There are a handful of examples from the 1960s. One program is the Young Lords Organization (Chicago) and Young Lords Party and Health Revolutionary Unity Movement (New York) who formed neighborhood clinics directed

³⁰ Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2013), 4-5.

to Puerto-Rican communities of poverty. The Young Lords felt compelled to develop a ten-point health program and issue statements about their revolutionary health care initiatives.³¹ The Young Patriots, a white, Appalachian off-shoot in North Chicago that companioned the Black Panthers, organized clinics for poor whites.^{32 33 34} In New York, the I Wor Kuen (IWK) and, in San Francisco, the Red Guard Party identified overlooked Chinese communities with special health care concerns and opened similar neighborhood clinics.³⁵ A much smaller organization, East Wind, in Sacramento, California, developed its own free clinic for Asians making health care for the city's Chinese and Japanese residents affordable and emulating health care practices in the People's Republic of China.³⁶ In East Los Angeles, the Brown Berets organized the El Barrio Free Clinic as part of a Chicano movement giving substantive leadership roles to women.³⁷ In almost all cases, these revolutionary clinics selected storefront or church facilities that allowed them to address a number of issues including work force poverty and job placement, anti-draft counseling, housing accommodations, mental health services, nutritional guidance, pregnancy and child care assistance, and in several clinics tuberculosis testing and treatment. While rarely a principal focus, all the clinics seemed to educate and test for venereal diseases as well. Without exception, the leadership of the revolutionary clinics aligned

³¹ Darrel Enck-Wanzer, ed., *The Young Lords: A Reader* (New York: New York University Press, 2010), 188-191; Theresa Horvath, PA-C, MPH, "The Health Initiatives of the Young Lord's Party: How a Group of 1960s Radicals Made Health a Revolutionary Concern," <http://www.hofstra.edu>.

³² Dave Strano, "Young Patriots and Panthers: A Story of White Anti-Racism," <http://redneckrevolt.org>.

³³ "Evicted Group Reopens Free Medical Center," *Chicago Tribune*, January 17, 1970, N2

³⁴ Robert Enstad, "Council's Hearing on Clinics Erupts in Disorder; 3 Ejected," *Chicago Tribune*, June 2, 1971, 5.

³⁵ Paul Saba, trans., "History of I Wor Kuen," in *Statements on the Founding of the League of Revolutionary Struggle (Marxist-Leninist)*, 1978.

³⁶ "Community Free Health Clinic," *People's Community News* (English/Chinese) 1:2 (February 1972), 1-4.

³⁷ Allison M. Lyons, "El Barrio Free Clinic," US Department of the Interior, National Register of Historic Places Registration Form, August 16, 2016.

with Marxist-Leninist political theory and the perceived successes of Mao Tse Tung in China. The latter offered political and social inspiration for most of these revolutionary leaders, but Mao's barefoot doctors and efforts to eradicate Colonial-introduced venereal disease became major visions.³⁸

Political leaders, most notably in Chicago, were troubled by the outreach to undesirable sectors of the community, and physicians and public health officials objected to undocumented health care providers and probably the idea of sharing their medical authority. All of these clinic initiatives, wherever based, faced scrutiny by public health officials and political forces while struggling with funding and supplies. All, however, embarked on sufficient public relations campaigns by publishing newspapers (usually in the voice and language of the community served) that alerted locals to health care and social-political developments. Despite the odds against each of them, most seemed to have survived for a few years if not longer by forming and reforming and building popular support from their constituencies and allied liberal-minded leaders. Their success is evidenced in a number of ways. One example is the collaboration of several revolutionary political parties in New York who reversed the shutdown of Gouverneur Hospital on the Lower East Side and reset its intention to serve poor needy local residents.³⁹ The revolutionaries connected to each other as familiar minds with similar programs and built a base at the grassroots level that would be emulated over and over again.

³⁸ T. Hesketh, XJ Ye, and WX Zhu, "Syphilis in China: The Great Comeback," *Emerging Health Threats Journal* 1(2008), e6.

³⁹ Saba, *Statements*.

In a similar focus, a number of special clinics appeared in the 1960s to address urban social issues. Two of these formed in and around San Francisco. The Haight-Ashbury Free Medical Clinic started to address drug abuse in that neighborhood as well as issues of venereal disease. The Haight-Ashbury is significant because of its pioneering formula of leadership and inspirational stories.⁴⁰ The other nearby free clinics include the Berkeley Free Clinic and Black Man's Free Clinic both with population focuses on university students and residents of nearby neighborhoods. Similar free clinics appeared in Los Angeles and in New York the specialized clinic known as the Lincoln Detox Drug Program of Dr. Richard Taft.⁴¹ The overwhelming growth in the free clinic movement prompted Dr. David Smith and David Bentel to write "A New Phenomenon Appeared on the American Health Care Scene," in 1970. Smith presented credible arguments for the free clinic movement: "Despite Medicare, the poor or the socially "disenfranchised," particularly in ethnic and racial ghettos, do not receive the health services they need."⁴² Smith stressed "Established community medical centers select their clientele, putting up subtle barriers to those who are not acceptable for ethnic, political or social reasons."⁴³ He listed some twenty-five to thirty free clinics in the United States mostly in California and the East Coast and recognizing none in the South.⁴⁴ Within two years, Irene

⁴⁰ David E. Smith, M.D. and John Luce, *Love Needs Care: A History of San Francisco's Haight-Ashbury Free Medical Clinic and Its Pioneer Role in Treating Drug-abuse Problems* (Boston: Little, Brown and Company, 1971), 4-35.

⁴¹ "People's Doctor Murdered," *White Lightning*, <http://www.freedomarchives.org>.

⁴² David Smith, M.D. and David Bentel, M. Crim., "A New Phenomenon Has Appeared on the American Health Care Scene," *California's Health* 27 (1970), 1-4.

⁴³ Smith, "New Phenomenon."

⁴⁴ Smith, 3.

Turner would identify 175 free clinics, and still state it was a growing and new concept of health care.⁴⁵

Organized shortly before and energized by the March on Washington in 1963, the Medical Committee for Civil Rights developed through professional physician's organizations to become the leading spokesmen for more inclusion of black physicians in the American Medical Association and leading opponents of the discriminatory Hill-Burton Act that funded separate but equal hospital construction. The leaders of the Medical Committee included physicians Walter Lear, Montague Cobb, and John Holloman. Lear, originally born in New York but living in Philadelphia, became something of the organizer.⁴⁶ A white, Jewish, gay man, he focused his organization toward the summer March on Washington in 1963. At the time of the momentous march, the Medical Committee consisted of some two hundred members mostly from New York and most of them showed up on that August day in Washington.⁴⁷ The success and now visibility of the Medical Committee attracted more members and Lear organized more events as well as a health survey of medical facilities in the South. As quickly as the Medical Committee grew it began to decline just as the civil rights movement did.⁴⁸ Lear became interested in public health and would eventually turn his attention to a gay and lesbian health movement and organizing within medical professional groups for gay and lesbian health professionals.

⁴⁵ Irene Turner, M.T., "Free Health Centers: A New Concept?," *American Journal of Public Health* 62 (1972), 1348-1353.

⁴⁶ John Dittmer, *The Good Doctors* (New York: Bloomsbury Press, 2009), 10-12.

⁴⁷ Dittmer, 21.

⁴⁸ Dittmer, 24.

The follow up to the March on Washington was a series of freedom marches in southern cities. To accompany the marches, health professionals needed volunteers to provide first aid along the route. The existing Medical Committee failed to respond to this need so a new group, the Medical Committee for Human Rights, formed in 1964 under a broader banner. This group quickly established medical aid centers or clinics in ten southern cities around each projected March.⁴⁹

The new Medical Committee for Human Rights (MCHR) flourished led mostly by activist physicians (and some nurses) with a common understanding “that health care in the United States was inadequate, unjust, racist, and in need of a major overhaul.” These physicians would be active in some of the clinic formations mentioned earlier and in neighborhood clinics of urban areas as well as engaged in the debates of public health care and national insurance.⁵⁰ They were also at the forefront of newly founded causes for women’s reproductive rights, anti-Vietnam war protest, and gay and lesbian rights.

In addition to Lear, another gay physician soon emerged as a leader in health care and human rights. Dr. Howard Brown of New York rose quietly but deliberately among medical activists. In 1962, Brown served as director of Ambulatory Care at the Gouverneur Hospital on the Lower East Side and there established a model neighborhood health center. This work led him to chief medical adviser to the Office of Economic Opportunity in Washington involved him in the formation of health centers in Watts, California and Mound Bayou, Mississippi. Following that, and in conjunction with, the assorted revolutionary parties mentioned earlier, Brown

⁴⁹ Dittmer, 36-37.

⁵⁰ Dittmer, xi.

became influential in setting up the new Gouverneur Hospital in the late 1960s.⁵¹ Brown's most significant contribution would soon emerge as New York's Mayor John Lindsay appointed him as chief medical officer for the city of New York. This extraordinary move may seem rather banal but it placed a gay man in the early 1970s in charge of the largest municipal health care programs in the nation.⁵² Brown brought great medical and administrative experience, but his place in the human rights and gay and lesbian health movement overshadows that work. He is still today recognized in New York City and honored in his home town of Chicago in the name of the city's gay men's health facility the Howard Brown Memorial Clinic.

Wedged between medical civil rights, human rights, and gay and lesbian rights, a strong movement emerged to recognize freedom of reproductive systems and the unique characteristics of women's health care. Generally framed within the second wave feminist movement, the women's health care movement invigorated other revolutionary and radical health care efforts. The community programs of women often provided a model for other organizations. The historian Jennifer Nelson broadly covers the development of women's health care in *More Than Medicine*. Nelson offers the most comprehensive treatment of feminist health care yet written and contextualizes its placement as follows:

Geiger, MCHR activists, and many feminists, both international and those in the United States, and particularly many women of color feminists, have understood that health rests on the "social determinants of health – housing, and food, and income and education, and employment, and exposure to environmental danger—and their consequences." Thus, while medicine and technical intervention to cure disease is important, it is also fundamental to transform social formations and hierarchies that

⁵¹ Howard Brown, M.D., *Familiar Faces, Hidden Lives: The Story of Homosexual Men in America Today* (New York: Harcourt Brace Jovanovich, 1976), 5-6.

⁵² Howard Brown, 3.

disempower certain groups on the basis of race, class, sex sexual orientation, and/or gender so that all humans have access to the means to live healthy lives.⁵³

Starr's acknowledgement of a significant shift in the 1970s is a deeper reference to a medical crisis in health care in North America.⁵⁴ Called the "generalization of rights," it may also be called the "democratization of health care" and with that the diminished authority of medicine and medical science. As health care professionals organized specialized communities of care by race, gender, and sexuality; the authority of a dominant class of physicians and researchers declined. Two community health professors at Tufts University in Boston are often mentioned as the leaders of early efforts. Dr. Jack Geiger and Dr. Count Gibson, Jr. established what would become model health care centers at several Boston housing projects.⁵⁵ Their work inspired others with similar ideals to step out of familiar roles in health care and care about all races, classes, and special interests. These challenges to traditional medicine and clinical practice would open the doors to others, even laymen and laywomen, through volunteerism and vision. This was very easily seen in the parallel development of health social movements and especially in the trajectories of the gay and lesbian health movement.

Alongside health social movements in the decades following the Second World War, medical authority manifested itself in two areas that were destined to affect gay and bisexual men and lesbians. First, psychiatry expanded as a medical specialty. In part, this expansion developed because of the decisive role that psychiatry assumed during the mobilization for the

⁵³ Jennifer Nelson, *More than Medicine* (New York: New York University Press, 2015), 5.

⁵⁴ Starr, 379-388.

⁵⁵ Starr, 371.

Second World War as psychiatrists constructed diagnoses for what constituted mental illness and fitness to serve in the military. This authority began with a group of prominent psychiatrists including Dr. Karl Menninger at the Menninger Hospital in Topeka, Kansas; Dr. George Henry with Alfred Gross at the clinic operated by the Civil Rehabilitation Committee of the Quaker Emergency Service in New York; and Dr. Winfred Overholser and Dr. Benjamin Karpman at St. Elizabeth's Hospital in Washington, DC. These men developed medical questionnaires that were used to identify homosexual men and women at the point of entrance to military service.⁵⁶ By establishing an exclusion from military service for homosexuals, psychiatrists were able to observe gay men and sexual behavior and label it as deviant. The work of these psychiatrists both challenged and supported homosexuality as a pathological disease. Throughout their professional and medical careers, these men offered sympathetic analyses of homosexuals that influenced activists in opposition to their pathology, but their work collectively and individually remains questionable and in need of contemporary analyses. This diagnosis of behavior attracted the angry protests of most gay and lesbian activists; for them it was the single most illegitimate example of medical discrimination in the postwar decades. These protests culminated in the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973. The history of the development and dismissal of homosexuality as a disorder is thoroughly covered by Dr. Ronald Bayer in *Homosexuality and American Psychiatry: The Politics of Diagnosis* published in 1987. Dr. Abram J. Lewis recently revisited the antipsychiatry issue in a slightly different approach with an article in the *Journal of the History of Sexuality*. Lewis argues that the protests from gay activists

⁵⁶ Hugh Ryan, *When Brooklyn was Queer: A History* (New York: St. Martin's Press, 2019), 228-229.

continued for some time after 1973 and until full clarity existed within the psychiatric and counseling professions.^{57 58 59}

The second important struggle over medical authority in the issue of gay health centers on the Public Health Service (PHS). After the mid-1950s, the PHS began to slowly increase surveillance among prostitutes, urban ethnic and sexual minorities, and suburban adolescents. As a complement to more interrogation and field work, the PHS funded research on communicable and infectious disease, but maintained a strong moralist position with its partners in the social hygiene movement. In 1961, the United States Congress directed the PHS to appoint a task force to study and address syphilis. One year later, President John Kennedy (and reaffirmed by President Lyndon Johnson) directed a ten-year program to eradicate syphilis. Efforts persisted to locate and eradicate syphilis as suggested, but by 1972, the deadline for eradication, a new National Commission on Venereal Disease reported that all venereal diseases were increasing and new programs and efforts were needed.⁶⁰ Accompanying the rise in political and bureaucratic interest in venereal disease, medical researchers and public health officials stepped up their work. Researching venereal disease began to open up new sources of funding, and publishing on that research in major medical journals helped build medical and biomedical research careers.

⁵⁷ Committee on Nomenclature and Statistics of the American Psychiatric Association. *Diagnostic and Statistical Manual: Mental Disorders*. (Washington, DC: American Psychiatric Association, Mental Hospital Service 1952).

⁵⁸ Ronald Bayer, *Homosexuality and American Psychiatry* (Princeton, NJ: Princeton University Press, 1987).

⁵⁹ Abram J. Lewis, "We Are Certain of Our Own Insanity: Antipsychiatry and the Gay Liberation Movement, 1968-1980 o," *Journal of the History of Sexuality* 25 (January 2016).

⁶⁰ John Parascandola, *Sex, Sin, and Science: A History of Syphilis in America* (Westport, CT: Praeger, 2008), 133-142.

The association of mental illness in gay men and lesbians and venereal diseases in gay and bisexual men constituted two different health problems that separated gay men and women from the larger population. These distinctions gave credence to long-held social stigmatization within a broader context of medical discrimination shared with other special populations seeking human and civil rights. Within the course of thirty years from 1950 to 1980, gay health activists and allied medical professionals attempted to discredit medical authority and remove the stigmatization from a number of different areas. The research and roles of “unbiased” medical or science professionals provided critical arguments against the prevailing medical authority.

The Kinsey Revolution

Few postwar developments in science and medicine altered the gender and sexuality civil landscape more profoundly than Alfred Kinsey’s published research on male and female sexual behavior. The 1948 W. B. Saunders Company release of *Sexual Behavior in the Human Male* and, in 1953, *Sexual Behavior in the Human Female* expanded common perceptions of sexual interests and behavior releasing conventions and enabling public discourse. The concept that human sexuality was complex was not new. What was new, however, was that sexual behavior could be quantified and thus used for multiple purposes. Scientists, physicians, sociologists, psychologists and activists, among others, took great liberty in applying the quantified results produced by Kinsey and his research team.

By the 1940s, Kinsey, a professor of biology, had developed a reputation for rigorous scientific methods of taxonomy in his study of the insect gall wasp. What he sought to do in his largest project was the application of quantified methods to diverse human sexual behavior.

The gall wasp was every bit as diverse as humans, but the field methods differed. For the first time Kinsey developed interviewing techniques that he in turn quantified through statistics.

Kinsey elaborates on this cross over of taxonomic methods:

The techniques of this research have been taxonomic, in the sense in which modern biologists employ the term. It was born out of the senior author's long-time experience with a problem insect taxonomy. The transfer from insect to human materials is not illogical, for it has been a transfer of a method that may be applied to the study of any variable population in any field.⁶¹

Not all scientists and physicians agreed with Kinsey and challenged both the value of his study, as well as his methods and results. Kinsey faced many of these challenges that led him to compare his research experiences: "objections to this study have offered more hazards than the deserts and the mudholes [*sic*], the mountain walls and the chasms, and the sometimes hostile native whom we had to deal with in the course of the insect surveys."⁶²

The complicating element in the new taxonomy became the interview as well as the interviewer. Kinsey again elaborated on the difficulty of the interviews:

In lieu of direct observation and experiment, it is necessary to depend upon verbally transmitted records obtained from participants in the activities that are being studied, then it is imperative that one become a master of every scientific device and of all the arts by which any man has ever persuaded any other man exposing his activities and his innermost thoughts. Failing to win that much from the subject, no statistical accumulation, however large, can adequately portray what the human animal is doing.⁶³

⁶¹ Kinsey, Alfred and Ward B. Pomeroy, Clyde E. Martin. *Sexual Behavior in the Human Male* (W.B. Saunders Company: Philadelphia and London, 1948), 9

⁶² Kinsey, 13

⁶³ Kinsey, 35.

Successful interviews required a certain finesse by the interviewer. A rapport must be established, some degree of privacy ensured, and other techniques added to the promising stories that Kinsey insisted were volunteered.⁶⁴ The assembled interviews then provided data turned into statistical sampling. The procedures for interviewing and the mechanism for manipulation are the subject of several chapters in Kinsey's publication and are curiously similar to techniques developed within a few years by public health officials investigating venereal disease transmission through cluster testing.

There was reason for concern among those who challenged his research methods and his conclusions. Kinsey reported his intention in his dedication to continue the interviews into an unknown point in the future and left open the opportunity to reconsider his conclusions: TO the twelve thousand persons who have contributed to these data AND TO the eighty-eight thousand men who, someday, will help complete this study.⁶⁵

To his credit, or discredit, Kinsey shattered concepts of "monosexuality" --essentially the idea that every male or female stayed "within his own lane." He complicated an unfounded popular belief that sexuality followed gender and vice versa. But, perhaps even more to form, sexuality that did not remained firmly in line with biblical structure now troubled personal and religious counselors. Kinsey's statistics and the popularity of his studies opened the doors to counselors and new approaches to counseling, strengthening arguments that recognized sexual fluidity and not rigorous conformity to sex roles and sexual behavior.

⁶⁴ Kinsey, 47-50.

⁶⁵ Kinsey, introductory page.

The Kinsey Scale and Population Percentages

The research and writing of Kinsey and his colleagues clearly influenced millions of Americans and beyond. Two aspects of his printed research, however, are most significant to the project of gay men's health in the pre-HIV/AIDS era. In describing what Kinsey called the "heterosexual-homosexual balance," he alluded to psychiatric terms like "the homosexual personality" and popular personality testing mechanisms such as the Terman-Miles 1936 scale of masculinity and femininity.⁶⁶ Within this structure, he elaborated on what we might call stereotypes of behavior; for instance, the stereotype that homosexual men are rarely athletic and expressed themselves in certain voice pitches, hand movements, walking gaits, and carriage of hips.⁶⁷ He elaborated:

Concerning patterns of sexual behavior, a great deal of the thinking done by scientists and laymen alike stems from the assumption that there are persons who are "heterosexual" and persons who are "homosexual," that these two types represent antitheses in the sexual world, and that there is only an insignificant class of "bisexuals" who occupy an intermediate position between the other groups. It is implied that every individual is innately—inherently—either heterosexual or homosexual. It is further implied that from the time of birth one is fated to be one thing or the other, and that there is little chance for one to change his pattern in the course of a lifetime.⁶⁸

To illustrate this important and influential perspective, Kinsey constructed a visual straight diagonal line in some ways a metaphor for life choices.⁶⁹ This graphic scale would be used frequently to illustrate the sexual fluidity so inherent in Kinsey's research. The scale moved from left to right in a straight diagonal form from exclusively heterosexual to exclusively

⁶⁶ Kinsey, 637.

⁶⁷ Kinsey.

⁶⁸ Kinsey, 636-637.

⁶⁹ Kinsey, 638.

homosexual. The diagonal line crossed ratings from 0 to 6 (left to right) allowing considerable interpretation for placement.

The visual image earned great respect and could and would be mental information applied by oneself as well as a demonstration of relationships by others. For instance, Kinsey's scale created relational positions that allowed each person a place on the continuum or diagonal. The figurative scale granted freedom to move or change or reposition with no real hardship to explain. Despite the obvious contemporary criticism of the binary presentation—either homosexual or heterosexual— and despite the obvious but undefined bisexual position, the Kinsey scale became a sensational visual to illustrate sexuality in males. The opportunity to move up or down or left or right throughout one's life seemed revolutionary as well as accurate. Other sexuality studies devised alternative images, but none became both a part of casual dialogue as well as scientific explanation as Kinsey's scale did.

Kinsey valued the scale for another reason. It allowed men to have experiences with other men, but one experience did not make him a homosexual:

Everywhere in society there is a tendency to consider an individual "homosexual" if he is known to have had a single experience with another individual of his own sex. Under the law an individual may receive the same penalty for a single homosexual experience that he would for continuous record of experiences. In penal and mental institutions a male is likely to be rated "homosexual" if he is discovered to have had a single contact with another male. In society at large, a male who has worked out a highly successful marital adjustment is likely to be rated "homosexual" if the community learns about a single contact that he has had with another male. All such misjudgments are the product of the tendency to categorize sexual activities under only two heads, and of a failure to recognize endless graduations that actually exist.⁷⁰

⁷⁰ Kinsey, 647 and 650.

Kinsey's statements here reflect his research but also his personal life. Historian James H. Jones, author of *Bad Blood: The Tuskegee Syphilis Experiment* and one of several biographers of Kinsey, reveals the researcher's interventions in the gay community in Chicago in the 1930s. While conducting early research, the scientist seems to have had relations with other men. He was relatively happily married, but it would seem he also engaged in homosexual liaisons at times.⁷¹

Second, Kinsey's taxonomy—the classification — became applied to human sexual behavior in many ways and for many purposes. His percentages of firm homosexual men and women eventually became narrowed to roughly ten percent of the overall human population. For the next forty years, perhaps longer, Kinsey's percentages, quantified interviews, and visual descriptions found a place in virtually every scientific and medical article or book about human sexuality. With even greater impact, however, Kinsey's work found a place in the records and research of public health agencies where the statistics justified public policy and public finance. The force of Kinsey's work also served as a strong influence among gay and lesbian activists who used Kinsey's numbers to simplify rhetoric, leverage public policy and judicial cases, and instill among the vernacular communication percentages that brought a degree of legitimacy. It would become common to hear "I'm part of ten percent." No other minority group could quantify its place against a majority rule so succinctly than the gay, bisexual, and lesbian community.

⁷¹ James H. Jones, *Alfred C. Kinsey: A Life* (New York: W.W. Norton & Company, 2004), 384.

Kinsey's extraordinary contribution to science and sexuality studies drew a flurry of responses. Alternative opinions challenged his methodology and resented his elevation to "father of sexuality" and his celebrity status, but no one could unseat him. The fanfare that followed each release of research attracted more would-be participants with seemingly everyone ready to share his story and interest in sexuality. It did not help alternative efforts to counter the legitimacy of his work by religious leaders and conservative scientists when Kinsey's face appeared in artistic form with a fluttering gall wasp and pink roses on the cover of *Time* magazine under a title "Reflections in the mirror of Venus."⁷² He had through the most conventional avenues of field research and statistics liberated many average men and women trapped in postwar conventions of family, culture, and medicine.

There are several important strains of development that began to converge in the postwar decades relating to gay health issues. As Paul Starr noted, the liberalization of Americans toward medicine and science released a ground swell of protests through civil and human rights channels.⁷³ Gay and lesbian activists recognized this and through their own organizations and protests began to claim a unique space for themselves. Concerns around mental health diagnoses of illness and associations of social diseases festered among gay men and lesbians and forced them into direct action to seek change. For gay men and lesbians, two researchers offered them voices of change. First, psychologist Evelyn Hooker of Los Angeles provided the first significant research and became a respected authority to challenge the

⁷² "Alfred Kinsey: Reflections in the mirror of Venus," *Time: The Weekly Newsmagazine*, August 24, 1953.

⁷³ Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982), 388-389.

association of homosexuality with mental illness.⁷⁴ Second, sexologist Alfred Kinsey in Indiana, offered a new perspective and a credible challenge to the norms of sexuality that had prevailed for decades. Efforts to prove that homosexuals were not “sick” dominated almost every communication from gay activists as psychiatric diagnoses influenced employment, religious and secular counseling, civic and political affairs, and personal and familial relationships. The recognition that venereal diseases were centered on gay and bisexual followed a longer trajectory that would unfold rapidly before 1980.

⁷⁴ Hooker of the University of California at Los Angeles is discussed later, but she is most noted for her groundbreaking paper that challenged conventional mental health understandings of gay and bisexual men. Evelyn Hooker, “The Adjustment of the Male Overt Homosexual.” *Journal of Projective Techniques*, 21 (1957), 18–31.

Chapter Two
Pride in Health: Shame of Disease

Lament

All I ever look for is attention and affection

All I ever get is a venereal infection.

Leo McAlbert⁷⁵

The association of social diseases with gay and bisexual men steadily increased after the Second World War until it reached a critical point by 1980. The increase in reported cases in gay and bisexual men contributed to the translocation of venereal disease in the postwar decades from its association with female prostitutes and black men to include homosexual men, immigrants, and teenagers. In response, PHS officials honed their field research techniques such as cluster testing in order to identify and track venereal disease transmission virtually exploding issues of privacy and confidentiality typically maintained by physicians and public health agencies. Gradually, more diseases, some not typically attributed to sexual transmission, became associated with gay and bisexual men. By the late 1970s, largely within the enclaves of gay and bisexual men in urban communities, the stigma and accompanying shame of social diseases for gay and bisexual men reached an unprecedented level within and outside the gay community. At the onset of the HIV/AIDS era in the early 1980s, reports from within the gay community and public health agencies offered a broader description of sexual practices of gay and bisexual men that served to further stigmatize this population. The construction of a biomedical dialogue between public health officials, public health agencies, and gay men would bring about a shared responsibility and expressed concern for management of venereal

⁷⁵ Leo McAlbert, *ONE*, January 1963: 14

diseases within the gay and bisexual male population. This was particularly in urban communities of North America and western Europe. This occurred through a progression of medical research and investigations into the lives of gay and bisexual men who were at the same time “coming out of the closet” and experiencing more public awareness, if not acceptance. This progress, however was slow and shadowed by the sense of shame and conflict in the lives of many gay and bisexual men. The development of this is the subject of this chapter. The following narrative traces in a long trajectory the characteristics of venereal disease and how associations attached to gay and bisexual men began a shift from internalizing the shame of disease to health activism toward pride of health.

The Scourge

For centuries syphilis infected human populations around the world. Hundreds of notable men and women in our history contracted and often lived their lives with syphilis. Scores of others from all social classes suffered with symptoms of syphilis. As a byproduct of colonialism the disease quietly ravaged unknowing communities spreading its spirochetes through the most basic of human pleasures: sex. The introduction of venereal disease in China is one powerful example. The spread would be attributed to colonialism by the middle twentieth century and become the political rallying cry in Mao Tse Tung’s eradication campaign initiated in the 1950s. Radical revolutionaries in the United States in the 1960s and 1970s would point to the success of Mao’s campaign, as would public health officials, as the ability to control venereal disease if the government so chose to do so.⁷⁶

⁷⁶ T.Hesketh, XJ Ye, and WX Zhu, “Syphilis in China: The Great Comeback,” *Emerging Health Threats* 1 (2008), 1.

When German researchers, Fritz Schaudinn and Erich Hoffman, finally discovered the spirochete in 1905, they named it *Treponema Pallidum*. However, it is more commonly referred to it as *Spirochaeta pallida*.⁷⁷ Despite the understanding of disease causation and the germ theory purported by Louis Pasteur in France and Robert Koch in Germany (1860s-1880s), respectable men and women continued to associate the disease with immoral behaviors exchanged by “others.” The cruel disease of syphilis would take on various symptoms sometimes hiding for decades as it coursed through the human body from primary to secondary to tertiary levels of infection before ending in a hideous and often disfiguring death. During its early history, physicians employed two remedies: mercury and guaiacum. Mercury, long the most popular treatment, carried serious side effects including mercury poisoning. Guaiacum, the other known treatment made of ground wood, offered another alleged cure that was sometimes used in conjunction with mercury.⁷⁸ Forensic evidence today from syphilitic deaths suggests that neither treatment really cured the disease.

In 1907, the German bacteriologist August von Wasserman developed a test to identify the spirochetes in the blood. What became popularly referred to as the “Wasserman” successfully identified the early appearance of syphilis, but it was years later that it became more effective for the late stages of the same disease.⁷⁹ In 1910, another German researcher, Paul Ehrlich, presented a cure (or rather a predictable palliative treatment) to the progressive disease. Ehrlich enlisted a drug company to produce a curative compound and named it

⁷⁷John Parascandola, *Sex, Sin, and Science: A History of Syphilis in America* (Westport, CT: Praeger, 2008), 21.

⁷⁸ Parascandola, 18.

⁷⁹ Parascandola, 21.

Salvarsan. The Salvarsan treatment of arsenic injections took days, if not weeks, and sometimes up to a year to be complete. These injections required a patient to be injected in a clinic for hours each week. It was a slow and painful way to be rid of the scourge. But desperate sufferers would try its saving therapy anyway? Salvarsan and its improved compound Neosalvasan (sometimes combined with mercury) would be the only reliable treatment as late as the Second World War until the trials of penicillin conducted during the war.⁸⁰

As a note, Hideo Noguchi, a biomedical researcher at the New York Rockefeller Institute developed a second test for syphilis in 1910-1913. His laboratory test --an inactive solution of the syphilis spirochete injected under the skin-- seemed to detect the presence of syphilis. Over the next decade, Noguchi's human experiments on himself and children, in an attempt to perfect the lutein skin test, erupted in an uproar among antivivisectionists and the press.⁸¹ Noguchi's test, however, effectively detected latent syphilis in humans and often was used in conjunction with the Wasserman to determine a diagnosis of syphilis.⁸²

While Ehrlich's amazing Salvarsan treatment received the most attention; it did not halt the vicious spread of talk by moralists. The moralists continued to associate the disease with marginalized men and women with unrestrained sexual drives. This association resulted in powerful expressions of race and promiscuity. The moralists of the twentieth century arose from a Progressive Era movement known as social hygiene that formed and reformed until the 1960s. The American Social Hygiene Association in New York with chapters across the country

⁸⁰ Parascandola, 21-22, 77.

⁸¹ Parascandola, 76-77.

⁸² Susan Lederer, "Hideo Noguchi's Lutein Experiment and the Antivivisectionists," *ISIS*, 76 (1985), 31-48.

addressed venereal disease of all classes and sexes as well as instituting community policing of degenerates—prostitutes and homosexuals-- during two world wars. The social hygienists typically shared a common moralistic purpose, sometimes religious, but they also drew leadership from medical fields and philanthropic bases that evidently saw their role as humanistic and altruistic. The common factor among their work was the focus on the diseases themselves rather than attending to the circumstantial evidence that female prostitution might result from economic and capitalist forces rather than promiscuity. In addition, they ignored the men who patronized them who were also perpetrators as well as perhaps victims in some odd way. A popular term for all venereal disease social outcasts was “social deviant.” Such men and women were products, the hygienists argued of broken homes, lax sexual mores, and declining religious values. God and church leadership could help the situation, but government and medical intervention offered a more complete therapy.⁸³

Female prostitutes caught most of the blame for spreading syphilis until black men were seen as accomplices. The moralists further argued that impoverished blacks of all types used sex as a manipulator against whites. Again, rather than associating syphilis with structural forces, the moral leaders who had economic and political social standing met the moralists of science and medicine to research syphilis and its effects on black men and women. One young physician and biomedical researcher in Galveston, Texas, would test 1,200 new black inpatients at John Sealy Hospital only to determine that the incidence of syphilis was more common in lower-class blacks than for medical students at the same hospital. He used two methods of

⁸³ John Parascandola, *Sex, Sin, and Science: A History of Syphilis in America* (Westport, CT: Praeger, 2008), Introduction and 1-22.

testing for the disease, one that involved actual spirochetes injected into the subcutaneous black skin in order to observe the effects a week later. The injections in some cases actually infected subjects as well as providing a test for the presence of spirochetes. McNeil would die an untimely death a few years later from the Spanish influenza in a First World War hospital in France, but not before publishing his ghastly results in a prominent medical journal.⁸⁴ This was only one of many associations of blacks and venereal disease rendered by physicians researching the diseases. In Washington, DC, a few years earlier, a black professor of dermatology at Howard University separated blacks by class (he was himself a well-respected successful black man) and associated syphilis with lower working class blacks in the city and elsewhere.⁸⁵ Race and class were not consistent indicators of venereal disease, but would be a popular research subject for most of the 20th century.

Syphilis, however, was not the only social disease social hygienists associated as a byproduct of sexual practice by allegedly immoral men and women. In the early 1890s, another German researcher Albert Neisser, identified a bacterium (*Neisseria gonorrhoeae*) that caused other symptoms. This would become commonly known as gonorrhea. Unlike its sister disease, gonorrhea rarely led to death but its manifestations were painful reminders of what moralists deemed sexual promiscuity that spread easily from the penis to welcoming receptacles of the vagina, throat, or rectum. Finding gonorrhea however was not always easy. An informed physician had to locate it not only in the body, but through laboratory technology, and then

⁸⁴ H.L. McNeil, "Syphilis in the Southern Negro," *Journal of the American Medical Association* 68 (September 30, 1916), 1001-1004.

⁸⁵ H.H. Hazen, M.D. "Syphilis in the American Negro," *Journal of the American Medical Association* 63 (no. 6)(August 8, 1914), 464-466.

prescribe an appropriate treatment. Testing in the laboratory took time and in between the test and test results meant the possibility of more transmissions. It was not until the Second World War that a more reliable biomedical approach emerge through the research of Dr. Alexander Fleming for treatment of gonorrhea as it did for syphilis: penicillin. The incredible story of penicillin is described by Eric Lax in *The Mold in Dr. Florey's Coat: The Story of the Penicillin Miracle* (2005). Penicillin was a wonder drug, a product of advances in science and medicine. Many within the social hygiene movement, public health agencies, and medical circles believed that penicillin would lead to an end of venereal disease, and in some ways it did. For men and women without allergies to penicillin, physicians prescribed the drug for a relatively quick recovery typically with few side effects. Many patients could return to normal lives and resume sexual activity.

Public Health Initiatives

Social hygienists and public health agencies eventually developed a shared responsibility for public education as well as testing and treatment. This combined effort promoted all aspects of health awareness including cleanliness, sex education, and moralist constructs. A healthy body and domestic and civic cleanliness became equated with a higher moral and sometimes religious position. In time, the pride of good health challenged the shame of disease in the population. The role and authority assumed by public health leaders and agencies became paramount to the social hygiene movement and conjoined medical authority in everyday life.

While the United States Public Health Service (PHS) traced its roots to 1798, the modern day agency formed in the late 19th century in response to threats and outbreaks of bubonic

plague in American cities. The paramilitary service worked in coordination with the Marine Hospital Service taking a joint name in 1902 and the new Public Health Service name in 1912.⁸⁶ The administrative history of the PHS is addressed by a number of historians, but it is essential to understand that the agency vastly increased its scope of work in the First and Second World Wars because of the threat of military troops engaging with prostitutes. In 1918, the PHS formed a special unit for venereal diseases named the Division of Venereal Disease. This division set about organizing local clinics and distributing educational pamphlets, sometime sensationally promoting stigmas of disease. Despite the moral popularity of eliminating venereal disease and the seriousness of the disease, not until President Franklin Roosevelt appointed Dr. Thomas Parran as United States Surgeon General in 1936 did the agency progress.⁸⁷

Parran initiated the most aggressive campaigns against venereal disease ever attempted in our history. He used his position of surgeon general to direct personnel and funds for the eradication of the disease. Parran wrote in his own words about the scourge of venereal disease, penning *Shadow on the Land: Syphilis* in 1937. Despite his popularity and compassion for disease eradication, President Harry Truman replaced Parran as surgeon general in 1948. He left public service and entered another long career at the head of the University of Pittsburgh's public health department where the university named its building in honor of him. Despite the obvious respect for Parran in the field, under his leadership the PHS conducted the now famous Tuskegee experiments and subsequent ones in Guatemala. He also oversaw the

⁸⁶ Parascandola, *Sex, Sin, and Science*, 68-69.

⁸⁷ Parascandola, 69-70.

equally offensive program to incarcerate female prostitutes for syphilis treatment during the Second World War, a program he called “rapid treatment centers” under the American Plan.⁸⁸ Had it not been for Tuskegee and Guatemala, namely, Parran’s record as surgeon general might have been unblemished even heralded. But, today, in part because of the research and publications of historians Susan Reverby and James Jones, the university that once recognized Parran’s leadership voted to remove his name from the Graduate School of Public Health building.^{89 90 91}

Under Parran, PHS researchers improved testing and ultimately treatment for syphilis and gonorrhea in 1943. Dr. John Mahoney at the Venereal Disease Research Laboratory (VDRL) in New York perfected the treatment of both diseases with penicillin. At the same time, the VDRL created a new test for syphilis that was more accurate than those used in the early twentieth century. This test referred to as the VDRL for syphilis became the standard for clinical tests until the early 1980s.⁹²

In 1947, another health incident occurred under the management of PHS. Eugene Le Bar, who worked briefly in Mexico, allegedly infected thousands of New York City residents with smallpox following a bus trip from Mexico across Texas and the Midwest and into the nation’s largest urban community. Within days, Dr. Smadel of the New York Public Health moved swiftly

⁸⁸ Parascandola, 128.

⁸⁹ James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Free Press, 1993).

⁹⁰ Susan Reverby, “‘Normal Exposure’ and Inoculation Syphilis: A PHS “Tuskegee” Doctor in Guatemala, 1946-1948.” *The Journal of Policy History*, Vol. 23, No.1, 2011: 6-28.

⁹¹ Jeffrey Benzing, “Pitt to remove Dr. Thomas Parran’s name from university building. Here’s why.” *PublicSource*, www.publicsource.org (accessed June 19, 2019).

⁹² Jones, 128-129.

and inoculated six million residents against smallpox.⁹³ Several years later in 1949, residents began to exhibit signs of smallpox in Mercedes, Texas, along the Mexican border. Again, within days, residents of two counties lined up for inoculations of smallpox. In each case, public health officials took costly, timely, and rather dramatic steps to halt an outbreak of the dreaded and deadly smallpox. These were the last two incidents of smallpox in the US. The PHS's rapid response to these two incidents was recalled years later as the epidemic of venereal diseases escalated.

The aggressive policies and funding employed by Parran faded quickly when Truman dismissed him as surgeon general. Having risen from the ranks of the PHS, Parran carried a personal dislike for venereal disease and an unyielding commitment to eradicate it. He had met with some success. By 1954, with penicillin, public education, and the end of the Second World War; the reported rates of syphilis dropped to its lowest recorded point in United States history. Under now President Dwight Eisenhower, funding for a national venereal disease program virtually stopped. His appointment of a Texan, Oveta Culp Hobby, as the first secretary of the Department of Housing, Education, and Welfare (HEW) resulted in a reduction in venereal disease research and services to a frightening low level forcing local health departments to address venereal disease as only each could administer and afford programs. At this point, under new federal leadership and programs, the reliance of public health on penicillin and public education created a false level of management suggesting that while social disease remained morally objectionable to people like Eisenhower and Hobby, the

⁹³ Israel Weinstein, M.D., "An Outbreak of Smallpox in New York City," *American Journal of Public Health* 37 (November 1947), 1376-1384.

responsibility of government to mitigate the crisis was over and now remained with the individual citizen guided by prideful hygiene and shame of diseases.

Public Health in the Nation's Capital

While federal leadership's management of social disease shifted from funding to broad oversight of social diseases, these decisions forced responsibility onto underfunded state and local public health agencies and ignored public health issues just down the street in the District of Columbia. Washington and regions of the American South contained pockets of race discrimination and poverty that resulted in virtual cesspools of diseases with few medical resources and struggling populations. By the late twentieth century, the city of Washington, still with legislative oversight, faced growing issues of public health and social disease that would eventually reach near catastrophic proportions. This development lay the foundation for the problems among gay and bisexual men in the 1970s which were exacerbated by race and sexual practices.

Washington, grounded in racial and class disparity, addressed venereal disease by geographic sector. Public health facilities, typically a storefront clinic, offered walk-in examinations and treatment, but tended to focus on acute symptoms and illness. Venereal diseases often led the list of transmissible diseases to be faced in the clinic. Thus, the city's public health officials focused on diagnosis and treatment by sector which revealed several important characteristics in the postwar decades. The majority of syphilis cases by the 1940s came from the clinic known as Polk Public Health Clinic in Polk School at Seventh Street and Avenue P in the mid-city now referred to as Shaw (in the northwest quadrant). Polk functioned mostly as a poor African-American neighborhood, but also, as the cultural hub of Washington's

Harlem. The journalist Bert Kemmerer noted in 1943 that one half of all the districts venereal cases came from within one mile of Polk Clinic. He opined, "Squalor, poverty, congestion and disease" made the neighborhood attractive to disease just like other world centers of disease such as the waterfront of Rio and the wharfs of Marseille. The neighborhood of "Jerry built structures and unsanitary conditions" helped to spread venereal diseases. Kammerer noted that the city supported twenty clinics mostly with day-time hours and under the supervision of black physicians like Dr. R.G. James, a Howard University Medical School graduate.⁹⁴

Within two decades, between 1940 and 1970, the center of disease shifted to the west and south of Shaw to the downtown. The streets of Avenues K and I (Eye) attracted a growing middle class postwar population described as "well to do" in a 1964 article. A District of Columbia Public Health official initiated out of the Northwest Central City Clinic a new clinic he described as "an unmarked downtown office for the higher socio-economic groups" at 18th Street and Avenue K. Philip Donahue, chief epidemiologist noted that was "so they could slip in for treatment." A growing alarm, however, focused on the homosexual population when 40 percent of the males with syphilis interviewed in 1963 told officials of "one or more male sex partners." This report suggested the need for a "separate clinic services for such patients."⁹⁵ The District of Columbia Health Department reported at the same time that local cases of infectious syphilis increased from a low in 1956 of 36 cases to 702 in 1962. Washington, they reported, now ranked fourth among large cities in syphilis and first in gonorrhea cases.⁹⁶

⁹⁴ Bert Kemmerer, "Vicious Circle: Half of City's Venereal Cases Come From One Squalid Area," *The Washington Post*, June 1, 1943, 1.

⁹⁵ Jerry Doolittle, "White-Collar Workers Get VD Clinic," *The Washington Post*, March 26, 1964, E20.

⁹⁶ Doolittle, E20.

Beginning in the 1960s and through the next decade, public health officials initiated intensive campaigns to reduce venereal disease through education and access to testing. In 1963, Dorothy Youtz completed a study of the local venereal problem. Washington with a population of 800,000 reported a gonorrhea case rate that was more than three times the national average from cities of 200,000 or more. Syphilis rates also exceeded the national average at almost twice the national rate of same-sized cities. Moreover, those figures only represented *reported cases from public health clinics*. The study showed that private physicians reported just over 1 percent of gonorrhea cases and 15 percent of syphilis cases.⁹⁷ Under the leadership of Dr. C. Wendell Freeman, another black physician from Howard University Medical School, the District of Columbia Health Department targeted high school students in sex education classes while aggressively investigating reported cases and trying to make patients at ease in the interrogation. With Washington ranking first in United States cities with venereal disease rates, Freeman faced an uphill battle.⁹⁸

The increase in social diseases in the postwar decades paralleled a significant growth in the homosexual population in the nation's capital. Many of the young men and women involved in the Second World War migrated to Washington to pursue jobs in the growing federal bureaucracy. This pursuit of perceived "safety" in a large city was elusive for some gay and bisexual men and women. Expulsions from government work encouraged by federal and executive officials in the 1950s was coupled with Public Law 615 or the Miller Act passed by

⁹⁷ Robert H. Conn, M.P.H., "Venereal Disease Education in Washington, D.C.," *Public Health Reports* 80 (no. 8)(August 1965),746-749.

⁹⁸ "D.C. Fights Venereal Epidemic By Educating Its Young Citizens," *Daily Press* (Newport News, Virginia), November 13, 1964, 25.

United States Congress in 1948. The Miller Act connected “illegal” sexual acts with increased prison sentences. The Act, however, also defined homosexuals as “sexual psychopaths” and therefore mental ill. Two psychiatrists at St. Elizabeth’s Hospital in Washington, Dr. Winfred Overholser and Dr. Benjamin Karpman, assisted in the development of the term and diagnostic characteristics of the patient.⁹⁹ Jean White, a *Washington Post* staff writer, took up these issues of mental health and venereal disease in a series of articles in 1965. Rather than presenting an objective view of homosexuality, White asserted herself as the expert on homosexuality and reinforced broad stereotypes. She was particularly impressed with the writings of Dr. Charles Socarides, a psychiatrist, who supported aggressive intervention to cure homosexuals.¹⁰⁰ Well into the 1960s, gay and bisexual men and women lived secret lives stigmatized as psychopaths with a propensity toward promiscuity and spreading venereal diseases. The writings and programs of Dr. Socarides served as a prominent medical authority that some journalists and politicians relied on as a means of encouraging stigmatization.

The Stigmatized Gay and Bisexual Man

By the 1960s, gay and bisexual men were aware of the strengthened relationship between mental health and sexual behavior among the public. Newspaper and magazine articles, medical conferences, and politicians, and community leaders often expanded on the mental health of homosexuals. While many gay and bisexual men and lesbians did not consider themselves mentally ill, an oppressive medical, political, and religious authority constructed this paradigm. The homosexual, particularly gay and bisexual men, earned a disreputable place

⁹⁹ Genny Beemyn, *A Queer Capital*, 134-138.

¹⁰⁰ Jean M. White, “Center to Treat Homosexuals Urged,” *The Washington Post*, September 25, 1967, A3.

often because of legal and police entrapment and associated promiscuity. This stigmatized position and the connection to venereal disease actually developed over several decades following the Second World War and became the primary focus for gay and bisexual men and lesbians to challenge in the 1960s and 1970s.

The first medical articles to associate homosexual behavior with the spread of venereal disease were penned by two physicians in New York in 1944 during the Second World War. Dr. Robert S. Westphal, the assistant state health officer from Albany, New York, addressed a gonorrhea “outbreak at a boy’s school for delinquent” black boys. These cases involved what we would consider today “minor” boys institutionalized by a magistrate judge in New York City.¹⁰¹ The second article more specifically addressed gay and bisexual men with venereal disease (genital chancres from syphilis). Dr. Herman Goodman, assistant director of the Bureau of Social Hygiene, which oversees epidemiology and education, discussed an alleged “cellar social club” of homosexuals in New York City in 1944. He identified eighteen young men (ages 17 to 28) partaking in perverted activities (fellatio) that he determined extended from the last interviewed case (number 18) who showed evidence of secondary syphilis. The eighteen appeared to be working class men often living with extended families. Several interesting details highlight this public health event.¹⁰²

In seven of the cases Goodman interviewed every member of the household, sometimes over several months, and tested each for syphilis. (Interesting methodology since syphilis is

¹⁰¹ Robert S. Westphal, M.D., “Report of an Outbreak of Gonorrhea at a Boys’ School,” *New York State Journal of Medicine* (March 1, 1944), 493-496.

¹⁰² Herman Goodman, M.D., “An Epidemic of Genital Chancres from Perversion,” *American Journal of Syphilis, Gonorrhea and Venereal Disease* 28 (1944), 310-314.

spread through sexual contact, not household living.) Though a majority of the men tested negative, he required follow-up testing and interviews as well as treatment of each. Goodman's reaction and management of his "homosexual club" is indicative of how public health and medical research associated shame with venereal disease among the affected and unaffected. His research protocol of testing and subsequent writing in a medical journal reinforced associations of shame with public health as well as humiliated the victim and his family.¹⁰³

Fifteen years later, Goodman published a second article repeating his earlier findings and expanding on his work with related reports from physicians and homosexual males. In this article, he more clearly associates the homosexual with threatening public health and encouraging promiscuity as he described the homosexual man as "victim and transfer agent of venereal disease" with the proceedings of the magistrate's court.¹⁰⁴ Goodman recommended in this article broadening the association of sexual behavior and venereal disease calling for all arrested homosexual men to be tested for venereal disease, like female prostitutes, and treated before release from incarceration. Most important, however, he described methods of interviewing to elicit the best information that often included homosexual men who had sex with women:

In addition, exposure to female companions is frequent. This is another facet of homosexual existence. It is important in the search for exposed persons. It is equally important to begin an interrogation of the homosexual with well selected, studied words. Ask the patient to name the person he was with rather than the woman from whom he acquired the infection. This brings the results not otherwise obtained. Allow the patient to exaggerate his sex conquests. In this manner, one of the patients stated

¹⁰³ Goodman.

¹⁰⁴ Herman Goodman, "The Male Homosexual and Venereal Disease," *Acta Dermato-Venereologica* 38 (1958), 274.

he was exposed to the members of the group --all 19 of them. He had a girl friend (sic) too.¹⁰⁵

Goodman's interrogations foretold of similar research methods on perceived carriers of venereal disease. Dr. William Brown, chief, Venereal Disease Branch at the Communicable Disease Center in Atlanta, Georgia, published in 1961 an in-depth report on the latest technique for health department investigators called "cluster testing" or "cluster surveys." This interviewing process extended "contact tracing" long in use by public health officials tracking down an original source of a venereal disease epidemic. Cluster testing identified "suspects" noted by the positive syphilis victim and added "associates" who may be friends or social acquaintances of the victim. This inquiry expanded the circle following the assumption that "birds of a feather" would identify other carriers. Summarizing cluster testing, Brown offered this: "First, you interview a patient, win his confidence, and get his sexual contacts. Then ask him for suspects—people he thinks may need a test. Next, check all sexual contacts named by the patient and try to pin down their associates."¹⁰⁶

Brown's cluster testing yielded a great deal by conducting a blood test one evening of everyone at local bar frequented by the victims. This additional step is referred to as "mass blood testing" that for this study produced "bonus results." Brown's enthusiasm for cluster testing seems quite clear but he added:

If you don't like to talk, talk, talk, don't cluster. If you don't like hard work and long hours, don't cluster. But if you want to find and bring to treatment as many cases of

¹⁰⁵ Goodman, 275-276.

¹⁰⁶ William J. Brown, "Cluster Testing—A New Development in Syphilis Case Finding," *American Journal of Public Health* 51 (July 1961), 1048.

syphilis as you possibly can, and don't mind talking your head off, and working like the very devil, try cluster testing. It works!"¹⁰⁷

Public health field officers honed the technique of cluster testing interviews. In 1961, at almost the same time, Dr. W.V. Bradshaw, Jr. used similar techniques to ferret out a Fort Worth, Texas, homosexual ring. From "interrogating and reinterrogating" the first patient (a sixteen-year-old black man) documented with syphilis, the interview yielded 135 contacts. Bradshaw explained how the homosexual community was a "fraternity" and that through cluster testing the investigators uncovered not only the first carrier but "all the people like me in town."¹⁰⁸ This probably was not true, but it did seem to deter Colonel Bradshaw (later an Army surgeon from Fort Polk, Louisiana) from further investigations for the Department of Public Health in Fort Worth as he seemingly had caught all the homosexuals in town. Bradshaw's article contained one of the first epidemiological diagrams using stick figures for each cluster-tested victim or suspect and those treated up to the total 135 he found in his work.¹⁰⁹

Cluster testing, however, appeared to many gay and bisexual men as more than just a concern for public health. In the postwar tension of the Cold War, rightly inherited from the Second World War, several events made cluster testing seem suspicious. In 1953, President Dwight Eisenhower issued Executive Order 10450 as a step to remove all homosexuals from government positions.¹¹⁰ Stymied by a scandalous publication by journalists Jack Lait and Lee

¹⁰⁷ Brown.

¹⁰⁸ W.V. Bradshaw, Jr., M.D., "Homosexual Syphilis Epidemic," *Texas State Journal of Medicine* 57 (November 1961), 909.

¹⁰⁹ Bradshaw, 908.

¹¹⁰ Genny Beemyn, *A Queer Capital* (New York: Routledge, 2015), 129.

Mortimer under the title of a series called *Washington Confidential*, that alleged “a continuous soprano symphony of homosexual twittering” in Lafayette Park, part of Pierre L’Enfant’s plan in front of the White House.¹¹¹ They reportedly uncovered a plethora of homosexuals employed by the federal government, many, but not all, living in Washington. So much attention, they said, was devoted to the issue that the Department of State set up a “Homosexual Bureau, manned by trained investigators and former counter-espionage agents, whose duties are to ferret out pansies in Foggy Bottom.”¹¹² Eisenhower’s directive would authorize the establishment of a “homosexual bureau” with the responsibility for interrogation of hundreds of federal employees (including the ones named by Lait and Mortimer), many who lost their jobs, careers, family, and friends. The type of one-on-one questioning about your past initiated by the federal government intent on removing homosexuals from government positions was remarkably similar to public health officials seeking former sexual partners and Kinsey’s now famous interviews.

Accompanying the threatening and devastating inquiries into the personal lives of federal employees, another journalist Vance Packard investigated emerging invasion into the privacy of all Americans. In *The Naked Society*, Packard recounts observing a lie detector test for “Bill” who was applying for a sales position with a firm. Interviews conducted by trained individuals with expensive machines became common practice in the early 1960s. One of the five most important areas of the interview focused on whether or not the applicant was a homosexual or had tendencies toward being a homosexual. While strapped around the chest

¹¹¹ Jack Lait and Lee Mortimer, *Washington Confidential* (New York: Crown Publishers, Inc., 1951), 19.

¹¹² Lait and Mortimer, 97.

with electrodes attached to his arm and fingers, the interviewer pleasantly asked about Bill's former performances in the theater. Did this avocation affect his job? Probably not, but it did stir Bill's anxieties to have him ineligible to be hired. The lie detector and popular personality written tests of the same period moved frighteningly into personal lives and appeared similar to efforts to interrogate the homosexual in cluster testing by public health officials.¹¹³

Across the country by the 1960s, public health officials advocated and perfected the methods of cluster testing as it applied to venereal disease. Alleged "clusters of homosexuals" emerged in almost every major city resulting in a number of medical and public health articles that further associated gay and bisexual men with spreading venereal disease. At various times, these clusters moved from medical journals to newspapers and magazines causing great anxiety and fear among gay and bisexual men. In some cases, men identified in writings by public health officials led to loss of employment, family, and friends. The epidemiology of cluster testing and its important consideration for gay and bisexual men continued for almost a full decade and became such commonplace practice that gay and bisexual men began to assert themselves as a community, both directly and indirectly, toward public health agencies and physicians. The debate over the role of public health agencies and officials raged most actively in California. In part, gay men's longstanding conflicts with city police and elected public officials fueled suspicion of motives. Donald Slater, editor of *ONE*, an early and popular advocacy and education publication from Los Angeles, heightened the discussion about confidential venereal disease testing through his organization and publication in late 1962. First

¹¹³ Vance Packard, *The Naked Society* (New York: Pocket Books, Inc., 1965), 50-54, 57-58.

in an editorial and later a membership meeting, Slater argued that cooperation with the health department in any city left open the opportunity for legal action when homosexuality was illegal in every state except Illinois. For the next few issues of *ONE*, staff editors and writers, public health officials, and readers debated the value of such cooperation in letters to the editor. Slater held firm in his opinion that gay men should resist cooperation with public health officials, but his counterparts in New York and Washington, DC, took a different stance.^{114 115 116 117}

In the November issue of *ONE*, Slater prepared a lengthy article that he asserted took five years to prepare. He outlined the status of venereal disease with statistics and elaborated on the assortment of venereal disease being transmitted and how it moved through the human body. It was a lengthy article that tried to address all aspects of venereal disease for a largely invisible readership of gay and bisexual men and lesbians often isolated in communities across North America. Slater saved his viperous comments, however, for his own theory of how the transmission moved from bisexual men to homosexual men who he referred to as the “real perverts.” In this language it is evident he projected sexuality in a binary of homosexual and heterosexual leaving little space for fluidity.¹¹⁸

In 1966 Mike Kinghorn and Jim Kepner again sparred over the confidentiality of patient records collected in public health clinics. Kinghorn, a gay motorcycle enthusiast and founder of the Circle of Themis, a pagan organization in Los Angeles, argued that any government record

¹¹⁴ Donald Slater, “Editorial,” *ONE* 10 (no. 10)(October 1962).

¹¹⁵ “The Price of Promiscuity,” *ONE* 10 (no. 11)(November 1962).

¹¹⁶ Letters to the Editor, *ONE* 11 (no.1)(January 1963); *ONE* 11 (no. 4)(April 1963).

¹¹⁷ Marvin Cutler and Robert Gregory, *ONE Confidential* 8 (no. 11)(November 1963).

¹¹⁸ Slater, “Editorial,” *ONE* 10 (no. 10)(October 1962).

was open to investigation for security and background checks with the government or employers. Kepner, a well-established gay activist, historian, and writer, countered that cooperation with the health officials was necessary in order to curb the spread of venereal disease and treat gay and bisexual men.^{119 120} Kinghorn served as legal advisor for Personal Rights in Defense and Education (PRIDE) and represented a smaller circle of activists who long distrusted public health professionals from prior incidents. Kepner served as the community advisor for PRIDE and reflected the opinion of “accommodationists” in Los Angeles who already worked with county health officials.

In the 1960s in Southern California, a discussion of homosexuals and venereal disease festered among gay activists, medical professionals, and public health officials, Dr. John Tarr and Robert Lugar published an article stating that male homosexual relations “played a large part” in the spreading of syphilis in Los Angeles. By tracing reported incidents of syphilis in five West Coast urban areas, the writers narrowed down the major culprits as homosexual men.¹²¹ Tarr, a family medicine physician, returned to this reasoning soon afterwards in another published article, but he expanded his theory of the homosexual male spreading venereal disease to reports of increased syphilis in urban areas. Tarr offered informed hints on how to recognize the male homosexual, observing “this clear-cut type is not representative of the wide spectrum of behavior which results from varying admixtures of homo-heterosexual

¹¹⁹ Lilian Faderman and Stuart Timmons, *Gay L.A.* (New York: Basic Books, 2006), 154.

¹²⁰ “Can Homosexuals Trust the Health Dept.? Two Views of the VD Danger: Mike Kinghorn says ‘No!’ ‘We Must!’ says Jim Kepner,” PRIDE Newsletter, September 9, 1966, 2.

¹²¹ John D.F. Tarr, M.D., and Robert R. Lugar, B.A., “Early Infectious Syphilis: Male Homosexual Relations as a Mode of Spread,” *California Medicine* 93 (July 1960), 35-37.

orientation.”¹²² The misinformed homosexual, he states, believes that venereal disease is like pregnancy and exclusively heterosexual.¹²³

Dr. Warren Ketterer of Berkeley, California, issued a much broader and arguably more conciliatory communication in 1964. Ketterer served as the head of the venereal disease division of public health for the state of California and was included in the public debates staged by Donald Slater and ONE in 1962-63. His position granted him authority over the state’s clinics and the records of thousands of patients seen in those clinics. By 1964, he knew of the growing problem of venereal disease within the homosexual communities. He also knew that revealing a patient’s sexuality could destroy his professional and social life. As an overture to the homophile organizations of California, Ketterer stressed confidentiality in epidemiological procedures for gay and bisexual men. In an unprecedented statement, he asserted that medical examinations for venereal disease in homosexual men should include more than genital tests and should add oral and rectal exams.¹²⁴

Certainly the decade of the 1960s amidst its varied social issues inherited as part of those issues the connection of syphilis and other venereal diseases to gay and bisexual men. If the public wanted to look the other way, major newspapers carried regular articles to remind readers of the connection of disease to perceived perversion.¹²⁵ Physicians and public health

¹²² John D.F. Tarr, M.D., “The Male Homosexual and Venereal Disease,” *General Practitioner* 25 (June 1962), 93-97.

¹²³ Tarr.

¹²⁴ Warren A. Ketterer, M.D., “Venereal Disease and Homosexuality,” *Journal of American Medical Association* 188 (June 1964), 111-112.

¹²⁵ The *New York Times* frequently carried articles on venereal disease. Some examples: Morris Kaplan, “\$10,000,000 Federal Aid Urged to Fight Rising Syphilis Threat,” March 7, 1962, and Jane Brody, “Teen-Age Incidence Up,” March 2, 1967; Jane E. Brody, “Venereal Disease Rising; Many US Young Afflicted,” June 1, 1970.

officials especially could not have overlooked the association of venereal disease with a simultaneously more visible male homosexual population. In 1964, the British medical journal, *The Lancet*, stated what now seemed apparent to public health and medical professionals in North America and Western Europe:

For those concerned with the control of venereal disease, practicing homosexual males –like prostitutes, migrants, itinerant workers, and delinquent adolescents – are a “problem group”. The characteristic that members of these groups have in common is a tendency to sexual promiscuity. Promiscuity among homosexuals is determined by a combination of factors, including powerful urges, a lack of the stability and responsibility that come from a settled home life with a dependent family, an awareness of society’s condemnation, and in some instances a deep sense of guilt. Among practicing homosexuals, as in all promiscuous groups, the incidence of venereal disease has probably always been high; but of late years certain developments have combined to focus attention on it. For one thing, the existence of homosexuality is now more widely known and freely discussed, and this has led homosexuals to admit their deviations more readily, especially to the understanding and sympathetic physician. For some years, too, infectious syphilis has been relatively uncommon among heterosexuals, but it has remained common within the closed circles of homosexual practice.¹²⁶

If venereal disease spread through the gay and bisexual male urban population during the 1960s, it exploded across the same communities in the decade of the 1970s; and everyone knew about it. Public health officials wrote articles and conducted research from their observations at community and gay-oriented clinics. Some interested in public health attempted to profile the gay and bisexual patient or quantify types and qualities of venereal disease in gay men. Other writers encouraged medical professionals to be considerate of the unique qualities of the gay male and listed ideal clinical practices for the homosexual patient.

¹²⁶ “Homosexual Practice and Venereal Diseases,” *The Lancet* 1 (no.7331)(February 29, 1964), 481-482.

Several public health officials, however, stepped out farther from the fray. Dr. Ralph Henderson wrote a unique article for the journal *Sexually Transmitted Diseases* based on a presentation he delivered to public health officials. Henderson spoke from his director's position in the Venereal Disease Control Division of the Center for Disease Control. In an effort to improve health services for gays, he outlined a national perspective. Neither being gay, nor having multiple partners, nor the choice of partners was responsible for higher venereal disease rates, Henderson argued.¹²⁷ Instead Henderson penned some of the most observant words yet related to the association of gay men to venereal disease:

Male gays, then, emerge as a high risk group for sexually transmitted diseases in part because they are male, but not simply because they are gay or have multiple sex partners. Yet our society exerts powerful antigay pressures, and these pressures foster anonymous sexual contact among gays while inhibiting them from using the health care system to the extent that straights with the same health care values would use it. High disease rates ensue, and these can serve to reinforce society's anti-gay (sic) attitudes and continue the cycle.¹²⁸

The news of venereal disease (and now the euphemism "sexually transmitted diseases") found popular coverage in every gay community newsletter and newspaper in North America. On the flip side, some newspapers and medical journals explored prophylactics that might apply to gay and bisexual men. The *Body Politic* in Toronto published a lengthy series on prophylactics that could have been developed to slow the spread of venereal disease.¹²⁹ Other articles noted various educational efforts to reduce disease through prophylactics as well. Most

¹²⁷ Ralph H. Henderson, MD, "Improving Sexually Transmitted Disease Health Services for Gays: A National Perspective," *Sexually Transmitted Diseases* 4 (1977), 58-62.

¹²⁸ Henderson, 62.

¹²⁹ Merv Walker, "The Clap Trap: A Venereal Catch 22," *The Body Politic* (April 1977), 15-16.

of these writers concluded that assorted prophylactics existed and were available for distribution, but research and development stopped in the 1950s. Arguably, the availability of penicillin made such research obsolete. The ability to stop or minimize the spread of sexually transmitted diseases existed, but no-one wanted to do it.¹³⁰

The availability of prophylactics did not stop physicians and medical researchers from building professional vitae on the existing accumulation of sexually transmitted diseases within the gay and bisexual male community. Several early publications focused on incidences and practices at gay-sponsored venereal disease clinics working closely with public health officials in Los Angeles and Denver. Dr. David Ostrow broadened similar discussions from his viewpoint at a gay operated clinic in Chicago. Other writers dealt with public health outreach programs such as the one in Cincinnati, Ohio. In 1977, a number of medical and public health articles discussed success and failure at gay bathhouses in urban areas. The outreach to gay bathhouses as a location for venereal disease transfer was well known, and the satellite projects usually conducted at night by clinic volunteers yielded some success. At the same time, physicians began to accumulate reports of enteric diseases associated with active gay and bisexual men. Dr. Selma Dritz in San Francisco reported on these in 1977 as did other physicians across the country. These collective diseases (shigellosis, amebiasis, sometimes with viral hepatitis A and B) became euphemistically called “gay bowel syndrome.” This term spread among health professionals despite its stigmatizing and subjective perspective, its assumption of sexual orientation as causative rather than correlated, along with a related failure to fully

¹³⁰ Edward M. Brecher, “Prevention of the Sexually Transmitted Diseases,” *The Journal of Sex Research* 11(4) (November 1975), 318-328.

appreciate the many variables of that correlation. Beth Goldman, a public health professional at the Center for Disease Control, issued an independent report that “profiled” the gay patient with sexually transmitted diseases, a now common assumption among health officials and physicians that undergirded the stigmatization of gay and bisexual men as disease carriers without substantial research documenting it. Her presentation, gathered from six venereal disease clinics, indicated the gay men were older than heterosexual patients, with twice as many partners, and an underrepresentation of black men.¹³¹

Several publications in the late 1970s and first two years of the 1980s presented a capstone to the incredible spread of venereal diseases (now known as sexually transmitted diseases) and the stigmatization of gay and bisexual men. In the most significant article, Dr. William Darrow joined with a unique band of non-medical researchers to publish *The Gay Report*. Darrow, now with the Centers for Disease Control in Atlanta stated that he located the researchers and asked for their collaboration because of the depth of their published findings. He wanted access to a broader gay and lesbian data base than Kinsey had developed. The findings of *The Gay Report* offered a large number of responses from gay and bisexual men as well as being more current one than Kinsey’s thirty-year old data.¹³² The “evolution” of the gay and bisexual man as a carrier and contributor to the spread of venereal disease seemed complete by 1980. Despite the presence of syphilis, as only one venereal disease, for centuries among all classes and races of people, medical professionals and public health officials

¹³¹ Beth Goldman, M.P.H. “Profile of the Gay STD Patient,” abstracts for the American Public Health Association, 138.

¹³² Oral Interview with Dr. William Darrow by Dr. Mary Chamberland, <http://www.globalhealthchronicles.org>.

commonly assumed that gay and bisexual men contributed the most and sometimes led the spread of venereal disease resulting in record numbers of cases as documented by public health agencies by the early 1980s.¹³³

Gay Health Activist Contributions to Stigmatization

There are many examples of public health officials and physicians furthering or accepting the stigmatization of gay and bisexual men. While it may be easy to place the obligation of this stigmatization on those entities, gay health activists also contributed to the stigmatization of gay and bisexual men through their own writings and public education announcements. Gay health activists through community newspapers and organizations often borrowed from and cooperated with public health officials and agencies to define the gay and bisexual male as promiscuous and venereal disease carriers. At times, gay health activists invoked their own experiences with venereal diseases and added new diseases to public health watch lists through innocuous methods. This role of furthering stigmatization, whether intentional or not, isolated gay and bisexual men as disease hosts and carriers as discussed here in contrast to the medical community's stigmatization.

As the rate of venereal disease escalated and percentages of gay men infected increased, gay men in health care leadership positions in urban communities began to write more about the diseases and increased their educational efforts. Sometimes, in disbelief about the role of gay men's sexual behavior, gay homophile leaders blamed a number of sources on transmission of venereal diseases including bisexual men who "crossed over," gay men who did

¹³³ Marc M. Solomon and Kenneth H. Mayer, "Evolution of the Syphilis Epidemic Among Men Who Have Sex With Men," *Sex Health* 12 (2), April 2015, 96-102.

not wash, and men who lurked in dark spaces of parks and public restrooms. In many ways, these homophile leaders reinforced stereotypes of gay and bisexual men as disease carriers and furthered the medicalization of these men. Though studies of sex variants for the last century noted the relationship between venereal disease and homosexual men, many active and informed gay men ignored those subtle messages.

While health care professionals, both gay and straight, published in the 1970s, a few gay journalists who were not in health care explored health care issues. At some point the gay-oriented newspapers and magazines almost all carried articles on venereal diseases, clinics, and ethics of medical care. The progressive *Gay Community News* published for the New England states offered a series of articles on venereal disease in 1974.¹³⁴ On the West Coast, a gay newspaper in San Francisco published information on venereal disease health care as did the University of California in San Francisco in its gay student publication.¹³⁵ *The Advocate* out of Los Angeles, California, soon eclipsed most other national publications. Journalist Randy Shilts, a recent graduate in communications from the University of Oregon, moved to San Francisco and became the publication's major health writer. Shilts researched and penned several health-related articles, including articles on syphilis, gastro-intestinal diseases, and hepatitis B, for that publication with its broad circulation and presence on newsstands. These now are considered classics of health-related literature.¹³⁶ Shilts' last health article rambled in title,

¹³⁴ Donald M. Klein, D.D.S. "The Gay Person and Venereal Disease," *Gay Community News* 1 (no. 30), January 19, 1974.

¹³⁵ "VD Care: Quality is Uneven," *Contact*, April 16, 1975, 1, 6-7, 9.

¹³⁶ Randy Shilts, "VD," *The Advocate*, April 21, 1976, 4-6, 8; "The Decades Best Kept Medical Secret Hepatitis Doesn't Come From Needles, It's Sexually Transmitted, It's a Killer, It's Epidemic," *The Advocate*, January 12, 1977, 23-25; and "A New Plague in Our House: Gastro-Intestinal Diseases," *The Advocate*, April 20, 1977, 12.

“The Decades Best Kept Medical Secret Hepatitis Doesn’t Come From Needles, It’s Sexually Transmitted, It’s a Killer, It’s Epidemic,” but set the tone for his forceful and informed discourse that began to mature into his later writings.¹³⁷ All of these articles served as preparation for his largest contribution to the gay and lesbian health movement, *And the Band Played On*. This book, long considered important as a chronicle of the first five years of the AIDS pandemic, rests today as important non-fiction despite its creation and stigmatization of Patient Zero.¹³⁸ After Shilts separation from *The Advocate*, a New York journalist from Texas, Nathan Fain, took up the early health concerns of AIDS. Fain’s now important work in health-related journalism highlighted the often confusing story of the early AIDS pandemic in “Is the Urban Gay Male Lifestyle Hazardous to Your Health?”¹³⁹ He also addressed a new introduction to the second printing of *The Advocate Guide to Gay Health* just as the AIDS crisis began to unfold.¹⁴⁰ Fain, a founder of New York’s important Gay Men’s Health Crisis, later succumbed to AIDS-related illnesses while abandoned by his family in a nursing home in East Texas in 1987. Shilts also died of AIDS-related complications in California in 1994.

Gay and bisexual men across North America would begin to understand that their sexual behavior facilitated the transmission of venereal disease. That was certainly no surprise. Public education within the gay community through various publications and organizations steadily increased education programming before 1980. The PHS through its own sources of

¹³⁷ Randy Shilts, “The Decades Best Kept Medical Secret Hepatitis Doesn’t Come From Needles, It’s Sexually Transmitted, It’s a Killer, It’s Epidemic,” *The Advocate* 338, January 12, 1977, 23-26.

¹³⁸ Richard McKay, *Patient Zero and the Making of the AIDS Epidemic* (Chicago: University of Chicago Press, 2017), 1-41.

¹³⁹ Nathan Fain, “Is the Urban Gay Male Lifestyle Hazardous to Your Health?” *The Advocate* 338 (March 18, 1982), 17-21.

¹⁴⁰ R.D. Fenwick, *The Advocate Guide to Gay Health* (Boston: Alyson Publications, 1978, 1982).

information and sometimes aggressive field techniques (cluster testing) cast a wide net over both the association of disease and moral interpretations. The PHS, coupled with others in medicine and biomedical research, accumulated evidence that would stigmatize gay and bisexual men. While this stigmatization was in no way a local or regional occurrence, urban communities and the gay enclaves that held large concentrations of gay and bisexual men and the accompanying social spaces like bars and public parks. The culmination of such social and physical factors stimulated gay activists to find solutions to improve public perception and offer testing and treatment. Those solutions would become “lavender health initiatives” that activists sometimes borrowed from other social groups and at other times invented new approaches.

Chapter Three

Lavender Health Initiatives

Gay men and lesbians used the color “lavender” as its associated public image long before the now ubiquitous “rainbow” of colors. Perhaps borrowing from the work of Oscar Wilde in the late 19th century, lavender infused gay activism in politics and health served as a means of identifying a under-recognized community. Early gay health activists used the color to focus health services and public education in the decades before the HIV/AIDS era. Recent research in the history of gay health activism often points to the decade of the 1970s or more often the HIV/AIDS era as the beginning of health initiatives to this special community. This chapter relocates the beginnings to an even earlier decade and builds an awareness by decade to the early 1980s.

First Initiatives

Postwar Los Angeles teemed with gay and bisexual men released from military duty in the Second World War and living in the largest, fastest growing city in the country. Next to San Francisco and its unbridled urban growth during the freedom decade of the 1960s, Los Angeles stood as the beacon of the west to young gay and bisexual men in North America. The strong postwar economy, temperate climate, and dazzlingly handsome men and beaches lured young gay men to areas like West Hollywood. As the city’s population grew between the 1950s and 1970s, so did the legal and social issues including venereal disease and related health problems. This growth within the gay community of Los Angeles also led to the formation of some of the earliest organizations and publications directed towards this emerging gay community and its sexuality that were then distributed across North America.

Harry Hay is recognized for organizing the first “permanent” organization in Los Angeles in 1951. (A German immigrant Henry Gerber attempted a short-lived group in Chicago in 1925 called the Society for Human Rights.)¹⁴¹ Hay initiated a similar group in the late 1940s called Bachelors Anonymous, but with the help of others the new Mattachine formed as a “secret society” to sponsor discussions and challenge mental health stigmatization as well as other problems facing homosexuals. Named for court jesters who wore masks during the Italian Renaissance and were thus able to “speak the truth,” the Mattachine society developed into a modest, but stable, group with significant influence.¹⁴² Meeting in the basement of the First Unitarian Church of Los Angeles, the members only invited sympathetic guests and kept a rigid hold on personal information.¹⁴³ Other Mattachine organizations formed around the country (San Francisco, Chicago, and Washington, DC) initially as off-shoots of Los Angeles but by the late 1960s the “chapter” form disintegrated, and each city typically operated independently.¹⁴⁴ The Mattachine published the Mattachine Review (starting in 1955) in a newsletter or pamphlet format, but the later version of the Mattachine Society of Washington and New York Mattachine Society only wrote newsletters intermittently. In a somewhat competitive atmosphere ONE, an organization to educate and advocate for homosexuals, formed under Don Slater in Los Angeles in 1952 and issued the small magazine *ONE*.¹⁴⁵ The circulation of

¹⁴¹ Lillian Faderman and Stuart Timmons, *Gay L.A.: A History of Sexual Outlaws, Power Politics, and Lipstick Lesbians* (New York: Basic Books, 2006), 109-110.

¹⁴² David K. Johnson, *The Lavender Scare: The Cold War Persecution of Gays and Lesbians in the Federal Government* (Chicago: The University of Chicago Press, 2004), 169.

¹⁴³ Faderman and Timmons, 111-112.

¹⁴⁴ Johnson, 172.

¹⁴⁵ “ONE, Oldest Homophile Group, To Celebrate 15th Anniversary,” *The Los Angeles Advocate* 1 (No.1) (September 1967), 1.

both California publications went across the country to readers in cities of all sizes and to rural areas.¹⁴⁶

Historians typically refer to these membership organizations that predate the formation of more radical direct action organizations within the gay community as “homophile.” The homophile movement in the United States borrowed heavily from ones formed in the late 19th century by Dr. Magnus Hirschfield in Germany and Edward Carpenter in England.¹⁴⁷ By the early 1960s, the word homophile was increasingly popular among gay men and lesbians and defined as:

The word is not synonymous with homosexual, **homophile**: adj., pertaining to the social movement devoted to the improvement of the status of the homosexual, and to groups, activities and literature associated with the movement; and, homophile organizations, homophile conferences, homophile publications.¹⁴⁸

The use of the term homophile soon emerged across the country and proved useful to uniting gay and bisexual men and lesbians under a common umbrella. Organizations of similar interests joined together to host regional and later national conferences and shared publications. The term also allowed for men and women who did not identify as homosexual to join in leadership positions or to form support organizations. This proved especially helpful in addressing the mental health diagnoses by psychiatrists and by progressive religious clergy and liberal Protestant denominations.

¹⁴⁶ ONE 171.

¹⁴⁷ Donald Webster Cory, “History of the Homophile Movement,” *East Coast Homophile Organization (ECHO) Conference '64* (1964), John V. Dowdy, Sr. papers, Accession Number 7, Box 143, Folder 4, , Baylor Collections of Political Materials, W.R. Poage Legislative Library, Baylor University.

¹⁴⁸ Cory.

While never materializing into large entities by today's standards, most of these groups organized in the 1950s and 1960s were instrumental in connecting gay men and lesbians and building a foundation for a social movement. These other homophile organizations arose across North America and Western Europe all with similar goals. In the United States, many homophile organizations formed in urban areas, but the largest and most influential ones came from the most prominent concentrations of homosexuals in North America and include the Mattachine and later ONE in Los Angeles; Mattachine Society of San Francisco and later Society for Individual Rights (SIR); Mattachine Society Inc. of New York; Daughters of Bilitis, Inc. in San Francisco, Chicago, and San Francisco; Janus Society of Philadelphia; and The Mattachine Society of Washington.

The homophile organizations are best understood as educators for a relatively small membership generally issuing a publication that in some instances reached a broad geographic readership. The publications announced relative legal issues, unjust arrests and raids on bars and public spaces, new books on homosexuality that were both positive and negative, poetic verses from gay poets, history of gay men and lesbians, and reported on medical and public health concerns. Typically, a companion set of sponsored lectures interspersed with organizational meetings featured sympathetic legal, medical, and academic speakers. Most homophile organizations maintained some type of lending library for members to stay abreast of issues related to improving the status of homosexuals in society. Many of these organizations offered public speakers and spoke on radio and television. Almost every organization published a newsletter or newspaper that also carried a set of letters from readers. These letters provide a deep insight into how the homophile movement progressed in

these years but also notes special interests and regional events that might be unknown. These letters, not published, but included in the archives of the entities, indicate that the homophile organizations served as informal referral boards to sympathetic physicians for physical and mental health problems and also offered information and advice on venereal disease.¹⁴⁹ Letters to the Mattachine Society of Washington sometimes requested information on what they thought might be a venereal disease, who might be helpful for a rectal problem, and who might provide counseling both written and in person around the country. These letters reflect often emotional pleas for help and reveal stories of entrapment and arrests, legal frustrations, loss of jobs and careers, and abandonment by family and friends.

The Formation of Special Health Clinics

While the homophile organizations served a valuable role for connecting gay and bisexual men and lesbians prior to 1970, they were neither organized for the purpose of health care referrals nor in a position to offer health advice on mental illness, counseling, or venereal disease. The leaders of the organizations certainly understood these concerns among homosexuals but their primary purpose was advocacy and education. Regardless, most of the organizations felt compelled to answer the desperate calls for advice on health care and began to identify these requests with the fear and anxiety of gay and bisexual men who could not be open about their sexuality for fear of discrimination inside and outside traditional medical establishments. Age, class, and race added another layer to the distrust of medicine and health

¹⁴⁹ I uncovered many letters requesting support or advice regarding health issues encountered by gay or bisexual men. The Mattachine Society of Washington records in Frank Kameny's Papers, Manuscript Division, Library of Congress, Washington, DC, as well as the ONE Archives, USC Libraries, University of Southern California, suggest this was common for most of the homophile organizations.

care facilities. Many young men and those with limited incomes and aware of racial and sexual discrimination avoided clinics, hospitals, and physicians. Other than the occasional public health clinic, exposure to or symptoms of venereal disease or rectal complications left the gay and bisexual men with few alternatives. By the 1960s, however, the challenges to traditional American life in almost every aspect including medicine and health care opened the door to clinics, often free clinics, to address special populations systemically discriminated against by American physicians and health care institutions. Out of this phenomenon an incredible period of creativity and funding came forth initially in the west coast cities and then the east coast ones, and later the north and south urban areas. This grassroots urban effort resulted in special medical clinics answering the health concerns of a disenfranchised population.

The Committee for the Eradication of Syphilis, Inc. (CES) seems today an unusual organization to form in the growing city of Los Angeles when incorporated on December 29, 1966. The original board involved men and women drawn from medical professions or public health agencies in the area all solicited by an unlikely man, Vernon Clarence Mitchell. Mitchell, an administrative employee at Hughes Aircraft (1955-1980) in Long Beach, lived in San Marino, in south Los Angeles. He was a former Navy enlisted man discharged in 1946, who learned how to read and write after entering the military. Born in Albuquerque, New Mexico, he lived an almost transient life with his mother and landed in Southern California in 1933 well before the Second World War. The war, however, connected Mitchell with other gay men whom he

befriended after the war. Mitchell left a small collection of documents to piece together the formation of CES.¹⁵⁰

From the material we can access, Mitchell seems to have been comfortable with his sexuality, and as an attractive young man he moved easily within the growing underground of gay West Hollywood and Los Angeles. In response to the warnings and propaganda of the public health officials, Mitchell recognized the growing problem of syphilis among his friends and the forming gay community. He organized a team under the guidance of Dr. Walter Smart Chief of the Division of Venereal Disease Control for the Los Angeles County Health Department. On December 15, 1966, the original board signed the charter documents in the Lantern Room of the Beverly Hilton Hotel. The photograph of that day shows a posed board of mature men and women standing around a seated Mitchell clearly recognizing his leadership in forming the committee.¹⁵¹

The first clinic opened almost a year later on September 19, 1967 at 921 North San Vicente Boulevard in West Hollywood. Mitchell's colleagues at Hughes Aircraft volunteered to put in hours to operate the free clinic, but he later recruited trained medical professionals as volunteers. Advertisements issued by the committee encouraged young men and women to come in and be tested. The clientele was mostly men in their twenties. The formal announcements from the CES never mention homosexuals or the special emphasis that

¹⁵⁰ Obituary, *ONE Letter* 37 (3)(March 1992).

¹⁵¹ "Photographs 1966-1972," (Handwritten date of December 15, 1966), Box 1, Folder 7, Committee for the Eradication of Syphilis Records, Coll2012-129, ONE National Gay and Lesbian Archives, USC Libraries, University of Southern California.

Mitchell envisioned for the clinic. An article in the newly formed *The Los Angeles Advocate* the communications vehicle of the PRIDE organization announced its opening.¹⁵²

It is unclear how much the founding board knew about Mitchell's real interest of outreach to young gay and bisexual men, or to what extent it was recognized among gay men, but the new clinic provided a needed service in a convenient location and welcoming environment. There is no evidence that it was a "gay men's clinic," however, it was organized and directed by a gay man motivated to help other gay men reduce the fully understandable venereal disease problem. Mitchell recounted some of the clinic's success in a press release in 1971 after five years of operations:

In the summer of 1966, a group of volunteers known as the Committee for the Eradication of Syphilis (CES) set their sights on the eradication of diseases with far more debility rates than ever achieved by polio.

Among their numerous accomplishments was the opening of the first volunteer night-time venereal disease clinic tailored specifically to meet the needs of the young disestablished person, who found within the atmosphere of this free clinic, a rapport not easily obtainable in established health department-run installations. From the time this clinic opened its doors to the present, in excess of 15,000 patient visits have been processed.

Through the support it mustered among citizens, medical associations and the media, legislation was enacted which permitted the treatment of minors 12 years of age and over without the need of parental consent.¹⁵³

¹⁵² "CES To Open Evening VD Clinic in West Hollywood," *The Los Angeles Advocate* 1 (No.1)(September 1967), 1.

¹⁵³ Vernon C. Mitchell, Press Release from CES, Committee for the Eradication of Syphilis, Inc. (1971), 1-2, Box 1, Folder 1-2, Committee for the Eradication of Syphilis Records, Coll2012-129, ONE National Gay and Lesbian Archives, USC Libraries, University of Southern California.

The CES operated the clinic for at least ten years in various formats and location before the lack of funds and probably volunteers forced it to close. Mitchell became a spokesman for syphilis education in Los Angeles speaking at high schools and civic groups. He traveled to Europe at the request of Dr. James Elias of Adolph's Foundation in Burbank, California, to deliver a presentation on "Behavioral Aspects of Venereal Disease," in 1972.¹⁵⁴ Mitchell set up an awards program to recognize success in syphilis eradication typically announced during VD Awareness Month each April. In 1970, Mitchell awarded Aerojet Medical and Biological Systems of El Monte, California, for their research to develop a "fast and accurate automated device for the detection of syphilis" replacing tests that might take a week or more to get results.¹⁵⁵

Mitchell eventually moved on to other activist roles in Los Angeles. He became a leader in Gay Pride events and later in AIDS awareness and education. His legacy is generally unrecognized. When he died in 1992 of AIDS-related complications, Mitchell's obituary noted his vision and leadership factually though most of its contextual value remained silent: He was the first, and perhaps only gay man, to organize a clinic for testing and treating venereal disease.¹⁵⁶

Proliferation of Venereal Disease Clinics

As late as 1970, the leaders of the homophile organizations in many major cities did not organize for health care of gay men or lesbians. They did, as I noted, share information and

¹⁵⁴ J.E. Elias, "Letter authorizing Mitchell to speak at the International Symposium in May 1972," Box 1, Folder 1-2, Committee for the Eradication of Syphilis Records, Coll2012-129, ONE National Gay and Lesbian Archives, USC Libraries, University of Southern California.

¹⁵⁵ "Firm Wins Award for Syphilis Device," *The Sacramento Bee*, April 16, 1970, 41.

¹⁵⁶ Obituary, *ONE Letters*, 1992.

occasionally offer referrals for counseling more than venereal disease. These groups struggled between raising money, political infighting, threats of legal actions as pornographers, and a steady surveillance by police and bureaucrats. In some cases the organizations kept offices (like the Washington Mattachine Society), but rarely did they manifest their mission and purpose in physical storefront locations. After the turn to more radical activism in the late 1960s, this began to change. The fear and uncertainty of being arrested as an illegal sexual deviant began to wane and the willing confrontation in urban areas and “gay ghettos” allowed a visible street presence.

In 1971, Leonard Ebero, originally from Brooklyn, decided that gay and bisexual men needed to address their health issues of venereal disease and sexual organs much as women were initiating for themselves. Probably influenced by Boston Women’s Health Book Collective who published *Our Bodies, Ourselves* in 1971, Ebero, a non-medical volunteer, recruited Perry Brass and Mark Rabinowitz to start a clinic and health education programs in the basement of the Washington Square United Methodist Church. Programs on rectal sex, the male sex organ, and venereal diseases drew a good crowd. (The importance of this clinic is explored in a subsequent chapter.)

The Gay Men’s Health Project, Ebero’s initiative, appears to be the first clinic on the east coast and perhaps the first in North America by openly gay men for gay and bisexual men. It operated independently until it merged with the older and more “liberal” St. Marks Community Clinic (that also saw gay patients) and that catered to patients based on need. The new clinic moved to a less prominent role after the formation of the well-known Gay Men’s Health Crisis in the early 1980s. Today, the merged clinic is recognized as the founding entity for the Michael

Callan-Audre Lorde Community Health Center in 1983 and moved into a 27,000 square foot facility on 18th Street in Chelsea offering medical, dental, and mental health services.¹⁵⁷

Over the next few years after Ebero's clinic, other gay activists began to become health activists, specifically, assuming the continued role as health educator but putting into practice a clinical presence to address specific health needs. In Los Angeles, the Men's Clinic (Gay VD Clinic) formed as part of the Gay Community Services Center at 1614 Wilshire Boulevard in 1971.¹⁵⁸ The Community Services Center later moved to 1213 North Highland in West Hollywood.¹⁵⁹ As an outgrowth of the Los Angeles' Gay Liberation Front "liberation houses," the center developed a comprehensive set of programs that worked independently from a central location. The Center housed job placement services, a draft and military program, legal services program, prisoner assistance initiatives, peer counseling, alcohol and drug abuse services, medical services, twenty-four-hour hotline, transvestite/transsexual programs, parents of gays group, and a speaker's forum.¹⁶⁰ In a unique and certainly unprecedented step, the clinic leaders secured \$1,182,000 in government funds from the US Department of Health, Education, and Welfare, Los Angeles County Health Department, and the California Regional Medical Program.¹⁶¹ This funding did not get replicated in other parts of North American gay venereal disease clinics, but in Los Angeles it put the initial effort on sound footing to grow rapidly.

¹⁵⁷ Eileen McDermott, "Callen Lorde Celebrates Three Years," *Gay City News* 47 (November 20-26, 2003), "City/Health" Section.

¹⁵⁸ Katie Batza, *Before AIDS*, 28-29.

¹⁵⁹ Batza, 31.

¹⁶⁰ Karla Jay and Allen Young, *After You're Out*, 248-251.

¹⁶¹ "LA Center Gets \$1,182,000 in Grants," *Gay People's Union News*, University of Wisconsin at Milwaukee, November 1974, 2.

In Berkeley, California, activists offered a separate clinic within the Berkeley Free Clinic as the Gay Men's Health Collective. In San Francisco proper, however, the City Clinic at 356 Seventh Street became the almost exclusive center for gay and bisexual testing and treatment. The City Clinic is still operated and continued through the HIV/AIDS era with a strong responsible outreach to needy men and women regardless of sexuality.

Chicago and Boston developed in different ways. Two social and service organizations in Chicago set up the first testing and referrals for treatment for gay and bisexual men. Gay Horizons, Inc., and the Chicago Gay Medical Students formed the Howard Brown Memorial Clinic for evening testing in 1974 on the second floor above a grocery store. Dr. David Ostrow, a gay physician, assumed medical oversight at this clinic and continues to have a presence.¹⁶² Now the Howard Brown Health, it offers an array of services to gay men, lesbians, bisexual, transgender, and queer patients and conducts research in the Uptown neighborhood and a handful of sites scattered around the region.¹⁶³ In Boston, two clinics formed for different aspects of the gay and lesbian community. The Homophile Community Health Service organized for mental health counseling about 1974. Fenway Community Health Center, now a large operation called Fenway Health, first operated in 1971 for both gay and straight neighborhood residents and developed specialized services for venereal disease within a few years including outreach to gay bathhouses.¹⁶⁴ The mostly volunteer leadership of Fenway is responsible for several health guides and a history of its operations entitled *For People, Not For*

¹⁶² David G. Ostrow, MD, PhD and Dale M. Shaskey, BS, "The Experience of the Howard Brown Memorial Clinic of Chicago with Sexually Transmitted Diseases," *Sexually Transmitted Diseases* 4 (April-June 1977), 53-55.

¹⁶³ Howard Brown Health, <http://www.howardbrown.org>.

¹⁶⁴ "Healthcare is a Right, Not a Privilege," <http://www.fenwayhealth.org>.

Profit (2009). Historian Katie Batza covered both of these facilities in the publication, *Before AIDS: Gay Health Politics in the 1970s* (2018).

The Gay Peoples Union (GPU) at the University of Wisconsin Milwaukee started the GPU Examination Center (Clinic) for V.D. for gay and bisexual men in October 1974 at 225 E. St. Paul Avenue in a rented storefront of the Third Ward with a small grant (\$2,500) from the City of Milwaukee Health Department.¹⁶⁵ After cooperating for four years with the Social Hygiene Clinic, the activists of the GPU felt a specialized clinic would attract a larger number of gay and bisexual men to curb what the GPU newspaper called a “syphilis emergency” among local gay men.¹⁶⁶ Three years later, the GPU moved its testing and education center to the gay community center, the Farwell Center, on North Farwell and added a physician for testing and treatment.¹⁶⁷ The GPU developed a number of outreach programs in the university and community newspapers for education on venereal disease and details on prevention and detection.¹⁶⁸ In 1981, the clinic relocated and renamed itself by its location as East Brady STD Clinic, Inc. with an all-volunteer staff.¹⁶⁹ In 1972, non-physician volunteers opened a clinic in Minneapolis called The Red Door. It does not appear to be an exclusive venereal disease clinic for gay and bisexual men, but The Red Door intended to serve residents of the city who could not afford a private physician or chose more anonymous testing and treatment. From the statistics presented by Dr. Charles Mahan, after two years, the clinic saw mostly men (and

¹⁶⁵ “Homosexual Clinic to Deal with VD,” *Milwaukee Sentinel*, October 6 and October 8, 1974.

¹⁶⁶ “GPU Opens VD Center,” *GPU News*, October 1974; “Syphilis Emergency in Milwaukee,” *GPU News*, August 1974.

¹⁶⁷ “VD Clinic Expanded,” *GPU News*, September 1977, 7.

¹⁶⁸ Various *GPU News* advertisements from 1977-1979.

¹⁶⁹ “BESTD Clinic,” <http://www.bestd.org>.

mostly homosexual men) and a large number of adolescents for gonorrhea and syphilis.¹⁷⁰ In Seattle gay activists initiated in 1979 a Wednesday evening and Saturday morning clinic through the Country Doctor clinic at first and subsequently named it the Seattle Gay Clinic. While separate from the Seattle-King County Department of Public Health, the department conducted some surveillance of the gay clinic.¹⁷¹

Gay activists in Denver developed an interesting association with public health officials and operated the Denver Metro Health Clinic.¹⁷² This clinic would partner with Denver gay organizations and businesses in aggressive campaigns for venereal disease testing. A similar organization seems to have appeared in St. Louis. In Tucson, Dr. Alfred (Al) Obermaier started the Tucson V.D. Clinic under the auspices of the Gay Community Services at a popular bar the Toole Box that operated until the early 1980s.¹⁷³ Philadelphia gay men and lesbians formed the Gay Health Consortium of Philadelphia in 1973. In addition to a broad set of services in counseling, the consortium opened services at 60 North Third Street that included a Gay Health Clinic for venereal disease and urological problems in men, and obstetric/gynecological problems in women.¹⁷⁴

¹⁷⁰ Charles Mahan, "The Red Door: A New Venereal Disease Clinic Concept," *Minnesota Medicine* 58 (1975), 493-497.

¹⁷¹ Michael Brown and Larry Knopp, "The Birth of the (Gay) Clinic," *Health & Place* 28 (2014) 99-108.

¹⁷² Franklyn N. Judson, MD and Frederick C. Wolf, BA, "Tracing and Treating Contacts of Gonorrhea Patients in a Clinic for Sexually Transmitted Diseases," *Public Health Reports* 93, No. 5 (September-October 1978), 460-463.

¹⁷³ "Tucson V.D. Clinic Moves to New Quarters," *Arizona Gay News* (AGN), February 1980, Vol. 5, Issue 6, 14.

¹⁷⁴ Keith Clark, "Gay Health Consortium of Philadelphia, Press Release, June 25, 1973, Box 123, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

In Washington, DC, the Gay Men's VD Clinic organized as an offshoot of the Washington Free Clinic largely under the leadership of the Gay Liberation Front in 1973. From the basement of the Georgetown Lutheran Church, the clinic grew and later reformed with multiple health care services as Whitman-Walker Clinic. Today, Whitman-Walker Health is a full service clinic in several locations in the city and region. Lesbian health care often overlapped with women's care in general though a lesbian health group joined the Whitman-Walker Clinic group but later separated. A seemingly successful project, however, operated in the 1970s and early 1980s called *Off Our Backs*, a collective that published a very regular newsletter. (This is discussed in depth in the next chapter.)

As gay led and operated clinics formed around the country, very few organized in the South until late in the 1970s. In Houston, the Medical Committee of the Gay Political Caucus (GPC) started soliciting endorsements and funds for the Montrose Health Center for the "screening of venereal diseases and other standard transmissible diseases" in 1979.¹⁷⁵ ¹⁷⁶ What became the Montrose Clinic really got underway by 1981-82 when it was certified by the Texas Hospital Association.¹⁷⁷ The clinic, funded in part through the popular Zap Clap Revue Show at local bars, soon relocated to 803 Hawthorne in the Montrose neighborhood and offered expanded services that covered the emerging HIV/AIDS crisis.¹⁷⁸ ¹⁷⁹ In 2005, the Montrose Clinic and The Assistance Fund merged and renamed itself Legacy Community Health Services

¹⁷⁵ "Houston Group Seeks Federal Funds," *Gay Community News*, December 8, 1979.

¹⁷⁶ "Proposal from Gay Political Caucus," under "Montrose Clinic/Legacy," <http://montroseclinic.org>.

¹⁷⁷ "Montrose Clinic Certified by Texas Hospital Association," *Montrose Voice*, August 20, 1982.

¹⁷⁸ "Zap Clap," *This Week in Texas*, November 18, 1983.

¹⁷⁹ "Clinic Moves," *This Week in Texas*, August 23, 1984.

on Westheimer.¹⁸⁰ There is some archival evidence that gay leaders in New Orleans toyed with the idea of a local clinic, but never organized. Some years later Atlanta tried to set up a clinic with limited success. But for the most part, gay and bisexual men turned to local public health clinics for testing and treatment as they did in Dallas, Austin, and San Antonio, rather than gay-led and operated clinics. The Dallas homophile organization, Circle of Friends, first started educational efforts on venereal disease as early as 1969, they referenced the public health clinic for suspected cases among gay or bisexual men.¹⁸¹ Although the primarily gay-organized Metropolitan Community Church would initiate a gay men's clinic in the early 1980s, it did not materialize into a full-scale operation in Dallas.¹⁸²

By 1981, gay health activists organized more than twenty urban storefront clinics across the nation. Despite this impressive number, these clinics do not represent all the health initiatives available for gay and bisexual men. The vast majority of gay and bisexual men simply went to a sympathetic private physician.¹⁸³ It is impossible to document the extent of private physicians who tested and treated gay or bisexual men. The homophile organizations and gay activists who followed and built upon early homophile efforts always recommended using a private physician when affordable and available. When a sensitive and informed private physician existed, many gay and bisexual men of means would have availed themselves of their facilities. Gay men in urban areas, through referral by friends or organizations, knew of understanding physicians and took advantage of their attitude and familiarity with venereal

¹⁸⁰ Nancy Ford, "New Name for Clinic and Assistance Fund," *txt newsmagazine*, December 23, 2005.

¹⁸¹ "If You Got It, Don't Flaunt It," *Personals, The Ampersand* (1), No. 1, June 29, 1969, 23.

¹⁸² "MCC Announces VD Clinic Plan," *Dialog: The Newsletter of the Dallas Gay Political Caucus* (3), NO. 5, June 1979, 3.

¹⁸³ *The Official News letter of the National Coalition of Gay STD Services*, November 1981, 7.

diseases. Much to the chagrin of public health officials, private physicians rarely shared positive results of syphilis or other testing. Patient confidentiality most often trumped reports to the public officials.¹⁸⁴ We will never know the extent of health service provided through such physicians nor the number who judged their patients and contributed to their personal anguish or uncertainties about their sexuality.

The proliferation of special clinics across North America led to the formation of the National Coalition of Gay Sexually Transmitted Disease Services (NCGSTDS) in 1979. Choosing the name “sexually transmitted disease” recognized the diversity of disease now prevalent among gay and bisexual men. While syphilis and gonorrhea were clearly the most common infectious diseases, the litany now included venereal warts, chlamydia, panniculosis (crabs and lice), various gastrointestinal issues now called “gay bowel syndrome,” and hepatitis B. The list was growing it seemed, and the need for a steady dialogue among interested medical professionals and researchers was needed. Mark Behar, a physician’s assistant student at George Washington University in Washington, DC, and veteran organizer of the GPU Examination Center in Milwaukee, led the initial organizing meeting and agreed to edit a periodic newsletter. Representatives of the clinics usually met in conjunction with a professional health care association and occasionally toured each other’s clinics. They exchanged ideas on management, patient services, and educational programs. A key to their organization lay with an open non-competitive relationship that focused on the health of gay

¹⁸⁴ Local public health officials collected and published reports on venereal disease through the twentieth century as required by ordinances. This count served a number of purposes including funding requests, but it primarily offered a way to track venereal disease patients and contact them about sexual partners. This became a major concern for many gay and bisexual men. This practice continues today.

and bisexual men. At some points, a constructive debate emerged about medical practice, ethics of management and patient care, and the details of diseases and treatment.

The newsletter, published in a rudimentary format by today's methods, contained impressive information unique to the patients and often attached professional journal articles related to their interests. Behar edited the newsletter and eventually moved back to Milwaukee where he continued his career in medical services. Though sometimes reluctantly overseeing the newsletter, he managed to continue it until late 1983. The importance of this group should not be understated, because without them the network of specialized health care to gay and bisexual men would not have existed. Moreover, the existence of this group prepared a significant number of medical professionals and public health officials for the crisis of the HIV/AIDS era that soon appeared.¹⁸⁵

The members of the National Coalition (NCGSTDS) were not the only gay health activists to emerge in the 1970s. Other leaders filtered their interests through existing national and regional health entities creating access within traditional medical establishment circles of communication and education. Walter Lear in Philadelphia was one such activist. Lear, now relieved of his duties with the Medical Committee for Human Rights, organized his latest campaign under the Caucus of Gay Public Health Workers in 1976. This new role gave Lear a place to introduce an unprecedented symposium on venereal disease and gay men at the annual meeting of the American Public Health Association in Miami Beach, Florida, on October

¹⁸⁵ *The Official Newsletter of the National Coalition of Gay STD Services*, September 1979-August 1983. Accessed December 30, 2019, <http://www.chodarr.org>.

18, 1976. Co-sponsored by the Caucus and the American Venereal Disease Association. Lear would expound on the significance of this symposium:

It is a deeply appreciated privilege for me to open this symposium--the first of its kind in this country and possibly in the world at a major national health conference. This symposium is sponsored by gay health workers and chaired by a high-ranking, openly gay public health official. During this symposium openly gay health workers will present summaries of their experience in gay-sponsored clinical facilities for gay men ... These sessions are an important beginning of our effort to implement the educational component of the resolution on "Homosexuality and Public Health" which was adopted overwhelmingly by the Governing Council at the Annual Meeting of the American Public Health Association last year.¹⁸⁶

Lear would reorganize creating the National Gay Health Coalition in May 1976 that enlisted gay men and lesbians within existing medical entities that included "eighteen caucuses, organizations, or subgroups of virtually all major health professional associations."¹⁸⁷ The eighteen, he stated, included the Caucus of Gay Public Health Workers of the American Public Health Association and the Caucus of Gay Psychiatrists of the American Psychiatric Association.¹⁸⁸ He spoke at the hearings in opposition to the confirmation of Dr. C. Everett Koop at Surgeon General in 1981. Koop, Lear argued, believed gay men and lesbians were "anti-family" and a threat to the nuclear family. Lear added, "My concern is for the very health of at least ten percent of this nation's population."¹⁸⁹

¹⁸⁶ Walter J. Lear, M.D., "Opening Remarks," *Journal of the American Venereal Disease Association* 4 (April-June 1977), 1.

¹⁸⁷ "Testimony of Walter J. Lear, M.D. National Gay Health Coalition House Subcommittee on Health," April 3, 1981, 1-2; Bopper Deyton, MPH, and Walter Lear, MD, MS, "A Brief History of the Gay/Lesbian Health Movement," in *The Sourcebook on Lesbian/Gay Health Care*, Second Edition, edited by Michael Shernoff, MSW, ACSW and William A. Scott, MSW, ACP, National Gay/Lesbian Health Foundation, Inc., 1988, 18.

¹⁸⁸ Lear.

¹⁸⁹ Lear, 2.

Lear envisioned the now visible coalition as the maturity of efforts to reeducate the American health system for a better understanding of gay and lesbian patients. A number of focused committees and caucuses formed within the major health care professional organizations starting with the Gay Nurses Alliance of the American Nurses Association (c.1975); followed by the Caucus of the Gay Public Health Workers of the American Public Health Association; the gay, lesbian, and bisexual caucus of the American Medical Student' Association; and the Association of Gay Psychologists of the American Psychological Association. Within three years, virtually every national professional health organization recognized a group of gay men, lesbians, and bisexuals.¹⁹⁰

The National Gay Health Coalition set up its first cooperative project to organize the First National Gay Health Conference in the basement of All Souls Unitarian Universalist Church near Dupont Circle in Washington, DC, on May 19-21, 1978. Organized by local volunteers, the conference attracted more than four hundred gay and lesbian health workers from around the country and presented the first award for "outstanding contributions to the health and welfare of gay people," (the Jane Addams-Howard Brown Award) to Dr. Evelyn Hooker.¹⁹¹ A second and third conference followed and a fourth occurred in Houston, Texas, in June 1982.¹⁹² The National Gay Health Coalition formed The National Gay Health Education Foundation in 1980 and five years later changed its name to The National Lesbian/Gay Health Foundation.¹⁹³

¹⁹⁰ Deyton and Lear, 17-18.

¹⁹¹ Deyton and Lear, 18.

¹⁹² "Welcome to the Delegates of the National Lesbian/Gay Health Conference," *Montrose Voice*, June 2, 1982 in Don Kelly Archives, Texas A&M University.

¹⁹³ Deyton and Lear, 18.

The “lavender health care” that existed by the early 1980s is noted primarily as care conceived, formed, and managed by and for gay and bisexual men and lesbians. Most of these services were located in major urban neighborhoods where an open gay community already existed and a clientele of patients operated and felt comfortable. They organized in liberal Protestant churches, gay and lesbian community centers, and neighborhood storefronts when affordable. These were the early health activists often not trained in medical work but committed to serving people like themselves. The lavender health services reduced anxieties and discomfort for gay and bisexual men by communicating in a friendly understanding voice and operating within comfortable and familiar urban enclaves. The gay health activists understood uncertainty and fear of disease as well as the ramifications of ignoring critical sexually transmitted diseases. By the early 1980s, venereal disease was firmly identified with gay and bisexual men and that separated them from a dominant class of men and women. They wanted to rectify their status as a way to reduce differences between classes and approach acceptance or understanding by others. Despite the breadth of acceptance and non-judgmental services generally among these health activists, their programs rarely reached related sexual communities of color or class. Virtually without exception, educated gay white men led these clinics and organizations. Race, class, and physical disabilities of gay men were virtual barriers to accessible health care and these prospective patients rarely passed through the doors of the clinics even when welcome. It also was true that the “gender non-conforming” struggled for a place. Alternative health care for transsexuals, or what is now called transgender, developed in a parallel line to these services generally under medical authority,

but would wait almost twenty more years before being included in many of the same clinics that formed in the 1970s.

Chapter Four

"Brother, Help Thyself"

The establishment of clinics and health care programs within the gay community led to public educational campaigns, testing and treatment of gay and bisexual men for venereal diseases, and partnerships with other organizations or entities. This chapter identifies a number of specific health outreach programs for gay and bisexual men from the 1960s through the late 1970s by locating the discussion in the nation's capital, Washington, DC. Washington provides an informative landscape because of its connection to national politics and federal agencies as well as its unique geographical position at the center of many other national progressive and activist projects. The chapter also introduces a look into the complex role of race and class within the gay and bisexual male and lesbian community. This leads to a discussion of the role of the Metropolitan Capitollites of Washington, DC, a black gay male social organization, that developed alternative health care services and educational opportunities for gay black men and the larger black community. These are set within a larger personal and community expression of "coming out" that so radically differed from the earlier homophile organizations. In addition, the chapter addresses the initial partnerships between gay health care professionals in these community clinics and public health officials drawn from newsletters and reports of public health officials and clinic records. Ultimately, the chapter sets the stage to answer questions on whether the gay health professionals were complicit or resistant to public health initiatives in the pre-HIV/AIDS era through the examination of Washington's gay and lesbian history.

Washington's Gay Center

Stretched along P Street between Dupont Circle and Georgetown in northwest Washington, DC, is the P Street Bridge. This strategic location makes the bridge the official entrance, or exit, to the Dupont Circle neighborhood and a forced separation from the posh and more historic community of Georgetown and its immediate neighborhood of row houses along the streets of 26th, 27th, and Dumbarton. The bridge is a 1930s concrete arched structure that forms one side of a large sloping greenspace bounded by woods on another side and Rock Creek Park and Rock Creek Parkway on the lower one. Known as P Street beach, it is not a beach, of course, in the true sense of Atlantic beaches, but it is a long acknowledged community public space that is sunny and open, inviting and obscured from 23d Street above it.

But the center of Dupont Circle is just that, the circle. Dupont Circle is one of French engineer Pierre L'Enfant's original circles in the plan for the nation's capital from 1791. Once the hub of the neighborhood and a gathering place for generations, the circle includes a large fountain contained within a concrete wall and concentric rows of park benches starting at the fountain and trailing out. Underground public restrooms (now closed) are set just outside of the circle and spokes of streets that contain vehicular and pedestrian traffic and highlight the circle. In the late 1970s the city's subway system, the Washington Metro, began to offer alternatives to these pedestrian and vehicular routes and today brings millions to Dupont Circle each year.

From the 1950s to the 1980s, at least, Dupont Circle, Dumbarton Street, Georgetown, and the parks contained within the area constituted the public center of the gay and bisexual male community of Washington. The area also supported the lesbian community but for the most part the row houses, commercial spaces, parks, and churches based there constituted the

world of the largely white gay and bisexual male. While once an upper middle-class neighborhood with foreign embassies and prosperous community facilities, by the middle of the twentieth century the areas seemed run down and the low rents attracted Washington's emerging bohemian or alternative lifestyle residents, both of which encompassed gay and bisexual men.

The "world" of gay and bisexual men included businesses like The Community Bookshop at 2028 P Street that carried an array of progressive and controversial books and offered an upstairs meeting space for antiwar activists and poetry readings. Michael Lally, a poet and instructor at Trinity College, who self-identified as bisexual, collected around him emerging Washington poets many who were gay or bisexual. Lally's protege went on to develop respectable names as poets including Tim Dlugos, Ron Morgan, Terrence Wench, and Simon Schuchat. Under a loose organization called MASS TRANSIT, The Community Bookshop served as a private space for weekly poetry readings. MASS TRANSIT gatherings might include a spontaneous reading of a poem or poems written by the speaker. Some of these eventually were published in small chapbooks sold at The Community Bookshop and elsewhere. These chapbooks offered opportunities for new poets to be published in the monthly series through Lally's own press he called Some of Us Press (SOUP). Lally noted years later that the community served by the press and MASS TRANSIT brought in a mixed generational crowd from the "teens and the oldest, as far as I knew, was in his seventies, and it was equally male/female with gays and lesbians and African-Americans and several handicapped poets as regulars."¹⁹⁴

¹⁹⁴ Michael Lally, "DC poetry," <http://www.dcpoetry.com/history/lally>.

Other row houses along P Street and surrounding areas rented to gay and lesbian bars such as the Georgetown Grill at 1239 Wisconsin and Janus 2 at 1660 Connecticut Avenue. Popular restaurants like the 1832, coffee houses, and service businesses dotted the streets around Dupont Circle serving a mostly local, but at times a regional population or out-of-town visitors. In Georgetown, the Georgetown Lutheran Church and Grace Episcopal Church offered space to community organizations while in the Dupont Circle area the Friends Meetinghouse, All Souls Unitarian Church, and St. Margaret's Episcopal Church (aka "the Ruins") regularly opened their facilities for community meetings and ongoing services for both spiritual and community purposes. Almost everyone knew that the area hosted residents and visitors with alternative views and practices and gay and bisexual men often chose to live nearby or found their way there for a social and political life.

When Ed Cox died in 1992 he left a quiet legacy of achievement in both social and political circles. This young gay poet, who grew up in Washington, captured the decades of change within the gay male community in Dupont Circle. By all accounts he was a mild-mannered, soft-spoken perfecter of words who created evocative poetry about the lives of gay and bisexual men in his community and, in particular, his neighborhood. His obituary and all records since describe Cox as a dedicated clerk typist for a number of public interest entities including Common Cause, the Indochina Refugee Action Center, and the National Center for Urban Ethnic Affairs. He was a Navy veteran committed to the anti-war movement and GI counseling and an organizer of the MASS TRANSIT poetry collective. He is noted here because he was a community activist especially in the area of health care at the Washington Free Clinic where he volunteered for the "Saturday Clinic" that would become the Gay Men's VD Clinic and

then Whitman-Walker Clinic.¹⁹⁵ Despite this interest in health care, Cox died from complications of endocarditis that, while treatable, remained untreatable because he lacked health insurance and had no money for health care.¹⁹⁶

Cox exemplifies the formation of a movement in health care for gay and bisexual men that emerges in Washington during the early 1970s. By examining his life accomplishments, we can see the evolution of gay health activism prior to the HIV/AIDS era. The breadth and depth of this evolution would serve as a community platform that attracted volunteers to address venereal diseases in the gay and bisexual men of Washington. Cox was young, idealistic, an activist on multiple causes, and had no experience or education in a medical field. Befriended by Tim Corbett, most likely from The Community Bookshop or the Washington Gay Liberation Front, Cox became one of the regular volunteers for the first health services outreach to gay men in the city that was first known as the Gay Men's VD Clinic at the Washington Free Clinic. Cox would later dedicate a poem to Tim Corbett "From the City" where he notes their exploratory years living in Dupont Circle and "coming out."¹⁹⁷ Corbett, today, is less well known but arguably more significant in the formation of health care for gay and bisexual men. As one of the founding members of the Washington Gay Liberation Front he "crashed" at the collective housed at 1620 S Street in Dupont Circle one evening, was arrested in a brawl at the Zephyr Bar on Wisconsin Avenue, and then stayed in Washington for a number of years. He is photographed with other members of the collective on S Street in a circa 1970 image. Corbett's

¹⁹⁵ Ed Cox, *Blocks* (Washington, DC: Ary Press for Some of Us Press, 1973), inside cover; Ed Cox, *Waking* (San Francisco: Gay Sunshine Press, 1977), 48; "Ed Cox Papers," Biographical Note, American University Archives, <http://www.american.edu/library/archives>.

¹⁹⁶ Ed Cox, *Collected Poems* (Arlington, VA: Paycock Press, 2001), 150-151.

¹⁹⁷ Cox, *Collected*, 56.

early activities and recollections of the GLF collective are some of the best accounts of the newly formed Washington Gay Liberation Front and the first health care initiatives for gay and bisexual men.

Washington's "chapter" of the Gay Liberation Front formed on June 1970 at Grace Episcopal Church at 1041 Wisconsin in Georgetown not far from Dupont Circle. Despite objections from a few parishioners, the church continued as the community meeting space for several months until a row house in Dupont Circle became its headquarters.¹⁹⁸ The initial Gay Liberation Front publication consisting of a single typed sheet that offers many insights into the organizational structure, priorities, and goals of the young organization. These publications help to understand why health care emerged as another priority in a few years.

Unlike both the staid Mattachine Society of Washington (that focused on discrimination practices and restricted membership for security reasons) and the Homophile Social League (designed for creating a social environment for gay men and lesbians), the Gay Liberation Front organized through a community-wide and open call for members and quickly aligned itself with other human rights efforts such as the Black Panthers, anti-war and peace organizations, and the women's movement and feminists. Established in 1969 as an offshoot of the Mattachine Society of Washington, *The Gay Blade* reported on the formation of this third homophile organization in Washington. The newspaper stated that the Gay Liberation Front (as a new organization) was seeking its place to participate in the "established DC gay community" and

¹⁹⁸ "FACT SHEET for the Washington Gay Liberation Front," June 1970, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

some members were joining in the marijuana smoke-in on the Fourth of July at the Washington Monument to “zap” liberals into accepting gays.¹⁹⁹

Nancy Tucker, a lesbian and first editor of *The Gay Blade*, reported that the Gay Liberation Front formed to “overcome the oppression and repression that has been shoved down our throats for so many years.” She added that “At the first meeting on Tuesday, June 30 at the Grace Church... About 40-50 people gathered to rap for three hours on the formation of the new group.” The following confirms the concurrent social movements of the time as the sources of inspiration of DC’s GLF, Tucker noted: “for a long period of time blacks were niggers and women were broads and we have been queers, faggots and dykes. Well, the blacks got their heads together and the women have begun to get their heads together. We have to start now.”²⁰⁰

The Gay Liberation Front quickly chose to not organize in a traditional way but to form small consciousness-raising cells for discussion of personal problems and oppression by the straight community. These cells would form around special interests and be referred to as “glonks” rather than committees. The first set of glonks identified political action, publications, social events, public education, ways and means, new members, and women. Later, while not referred to as a glonk, gay men’s health care emerged as a special interest from the Gay Liberation Front.

From the ways and means glonk, David Aiken emerged as the “ring leader” to secure an office and phone number for the Gay Liberation Front. Aiken would report at the August

¹⁹⁹ *The Gay Blade*, Vol. 1 No. 10, August 5, 1970.

²⁰⁰ *The Gay Blade*, Vol. 1 No. 10, August 5, 1970.

gathering that he secured a row house at 1620 S Street in Dupont Circle for small meetings and a communal collective. Aiken and eight other men committed to each other for a daily life of consciousness raising and shared living.²⁰¹ Photos of the collective show that black and white, gay and bisexual men formed the nucleus that then cooperated in leading the local movement. The racial mix of the GLF collective seems somewhat unusual and does not appear to reflect the racial distances that existed among the larger gay and lesbian community. Two of the gay men residing at the GLF collective would later help form a national organization known as Black and White Men Together. The racial diversity of the commune probably reflects commonly held progressive concepts among these liberation activists and opened communication to a broader audience of locals and visitors. The phone number for the commune began to prove especially helpful to the broader audience and provided a contact for gay men and lesbians visiting or living in Washington who were searching for a social outlet, religious center, or health needs. A later Gay Liberation Front newsletter noted that “the Commune will be listed in the Yellow Pages as a social service organization.”²⁰²

Within a short time in 1971, another collective formed taking a couple of members from the S Street collective and located first at 1614 S Street and later at 1733 Q Street both in Dupont Circle. Known as the Skyline Faggots, the new collective included Tim Corbett and seven others such as Tim Tomasi (Timothy J.) a medical student at Georgetown Medical School

²⁰¹ *GLF Newsletter*, Volume I, No. 2, Washington, DC, August 11, 1970, 1-2, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

²⁰² *GLF Newsletter*, Volume I, No. 9, Washington, DC, September 29, 1970, 2, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

and later resident at DC General Hospital.²⁰³ A third collective, Breadbox, formed for gay street people and workers in 1971 and began its own newspaper, *The Breadbox*, at its headquarters at 1861 California Street in Dupont Circle. The new collective took a more militant approach to gay liberation led by Edward Scott “Randy” Coleman who was arrested in October 1971 for allegedly placing a bomb at a Dupont Circle bank. Coleman, interestingly enough, is described as “a fully committed gay revolutionary. He is well-known as a street organizer, community medical worker, and one of the founders of Breadbox Collective, the revolutionary gay paper he worked on for the first two issues.”²⁰⁴

At the center of each collective and of the members of Washington Gay Liberation Front are the concepts of self-identity, later referred to as “coming out,” community volunteerism, and consciousness- raising cells. “Coming out of the closet” and the self-identification of being a gay man or lesbian became a central tenet of the Gay Liberation Front in North America and western Europe. “Coming out” provided a vehicle with which to confront the straight world and the establishment, as it was called, while freeing up the opportunity to meet other gay men and women in the formation of community organizations both political and social. What is often excluded in the discussions of the Gay Liberation Front, however, is the financial aspects of collective living and programming, the purview of the “ways and means” group. In time, challenges around who earns income for the collective’s rent and who pays for communication and other efforts, stalled further development of the Gay Liberation Front. By the middle of the 1970s, the three collectives of mostly gay men dissolved into a broader community spread

²⁰³ Rainbow History Project, Tim Tomasi in *Faces of the Front/Members and Associates*, also referenced in “Tim Corbett on the Gay Liberation Front House,” <http://rainbowhistory.org>.

²⁰⁴ *Quicksilver Times*, Washington, DC, October 13, 1971, 9.

across Dupont Circle and in a few other areas of Washington. The concentration of the community in Dupont Circle eventually manifested into various locations and a more regional community that catered to gay men and lesbians and would attempt to supplant gay bars as the only social outlet and legitimate meeting place.

These methods became important to the ad hoc nature of community organizing that prevailed in the outreach of the members to other organizations and served as the guiding principles for the organizations they created for the next two decades in Washington. As I will discuss, within a few years, the Gay Activists Alliance (GAA) of Washington would replace the Mattachine Society of Washington and the Gay Liberation Front, sometimes with the same leaders, and take on a broader concept of “community” than what was possible before its formation. At its core, however, the Gay Activists Alliance recognized political activism, the election of sympathetic DC officials, and funding mechanisms from within and outside of government as key pathways to direct its policies and leaders. One of the policies and goals most influenced by the Gay Activists Alliance is its commitment to health care for gay and bisexual men.

The Gay Activists Alliance typically did not pursue the same care for lesbians or people of color, although it did not exclude either group, but the Alliance held early and fast to the need to address the emerging health care issues within the gay and bisexual male community. In tandem, what is notable here, is that when health care issues for the community arose there was often an absence of professionalism or medical training. The lack of medical professionals, however, did not deter any of the gay leaders from organizing out of a perceived need. This volunteerism defined many of the health care initiatives of the gay and lesbian community from

this era through the HIV/AIDS era. At the same time, the same financial constraints faced by the Gay Liberation Front and others limited effectiveness and placed the organizations under undue financial challenges and they eventually ran afoul of public health laws.

A key description of the concerns of the gay men and women in these volunteer health care initiatives, however, is that “health” meant a number of things for a strong and politically active community. Health included, mental health and acceptance or “coming out” as a gay man or lesbian, as well as alcoholism and drinking behavior, sometimes women’s health in alternative deliveries, a switchboard to communicate and respond to health and social issues, and, finally, a growing concern among public health officials and gay men about the increasing presence of venereal diseases or diseases transmitted through sexual contact including syphilis, gonorrhea, hepatitis B, scabies, and crabs.

Other issues are noted in the early newsletters that would develop into internal challenges to the Gay Liberation Front of DC. Topics emerged often through consciousness raising rap sessions such as women’s liberation and their attitude toward lesbians and GLF, sexism of gay men, racism, Black Panthers and their constitutional convention (gay groups were excluded), and male chauvinism within the movement.²⁰⁵ A regular point of discussion and consternation became the poor showing of gay women and blacks. The editor of the newsletter, probably David Aiken of the S Street collective, associated the discontented women with the ongoing antagonism between gay women and women active in Women’s Liberation. He noted under a heading of “Dykes Split” that “gay women are not nearly as active or radical

²⁰⁵ *GLF Newsletter*, Volume I, No. 3, Washington, DC, August 18, 1970, 2, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

as gay men.”²⁰⁶ In another note, the editor recognized the Gay Liberation Front’s opposition to an ongoing “Groovy Guy” competition at a local gay bar as a “gay version of the Miss Amerika and therefore vulgar, ludicrous, offensive, superficial and exploitative.”²⁰⁷ The Gay Liberation Front gronk on political action would find this event and similar ones as sexist and aligned with the racism and “imagism” rampant in Washington’s gay community.

The separation evident in the Gay Liberation Front newsletters in its first few months foretold the future domination of white, educated gay and bisexual men who led the early liberation efforts from the Mattachine Society of Washington, to the Homophile Social League, and the Gay Liberation Front. The exclusion of lesbians, and sometimes hostility toward women in general, and the separation of the gay liberation movement from men and women of color would become clearly evident in the formation of health care issues within a short time. White gay men and a few women, like Nancy Tucker, owned or managed the Dupont Circle businesses and the community newspapers and newsletters. Nevertheless, Tim Corbett, one of the collective members, would much later recall what role the first collective on S Street and the Skyline Faggots collective assumed for the movement:

The Gay Community Services House offered information on where to crash, which often was with us, information on VD, on “coming out” (a role now assumed by the Gay Men’s Counseling Collective), the gay switchboard, and living gay in Washington. It offered assistance to gays coming to Washington for leftist activities like the Revolutionary CC, Mayday, and the Franklin County Campaign. GLF led to groups who separated out for different interests.²⁰⁸

²⁰⁶ *GLF Newsletter*, Volume I, No. 5, Washington, DC, September 1, 1970, 2, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

²⁰⁷ *GLF Newsletter*.

²⁰⁸ “Tim Corbett on the Gay Liberation Front house,” Rainbow History Project Digital Collections, <https://archives.rainbowhistory.org/items/show/211>.

The Gay Liberation Front did not dissolve overnight or even within a year. It remained effective at least in some way to establish a key set of community priorities, develop young leaders, and present a community face to the awareness of gay and bisexual men, lesbians, and to some degree, gender non-conforming residents of Washington. Two critical junctures for the Gay Liberation Front happened in the fall of 1970 and the spring of 1971. First, the Black Panthers staged their Revolutionary Peoples' Constitutional Convention (R.P.C.C.) in Washington in November 1970. At the August 1970 meeting of the Washington Gay Liberation Front members reportedly discussed a number of topics including a letter to the Dupont Circle bars about discrimination against women and blacks, protests to the "Groovy Guy" contest, and "The Black Panthers and their relationship to Gay Liberation."²⁰⁹ A week before the GLF Newsletter carried a copy of Black Panther Huey Newton's now famous letter to other Panthers about the Gay and Women's Liberation movements. A short discussion followed that questioned or perhaps rationalized the Washington Gay Liberation Front's relationship with other radical groups leaving a consensus that the Panthers were welcome to speak to the members if requested.²¹⁰ In response, the members drafted their own letter to Newton expressing support and camaraderie.

Dear Huey Newton:

The Gay Liberation Front of Washington says "Right On" to your article in the Black Panther Party newspaper, 8-21-70, concerning the oppression of women and homosexuals. For centuries, homosexuals, like other oppressed people, have been

²⁰⁹ *GLF Newsletter*, Volume I, No. 5, September 1, 1970, 2, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

²¹⁰ *GLF Newsletter*.

singled out for abuse and exploitation. The intolerant, inhuman, racist, sexist, material-oriented society is the common enemy of all oppressed people.

Like Black People, Gay People have been taught since birth to hate themselves. Both have been the targets for scorn, derision, and malicious acts of intolerance. While both Black People and Gay People have made significant contributions [*sic*] to civilization, the racist, white, male supremists [*sic*] attempt to withhold this fact from our people. In fact, our enemy [*sic*] does everything possible to increase our feeling of failure and worthlessness [*sic*], but we will spread the truth and fight for the liberation of all our people.

GAY IS GOOD !!!

ALL POWER TO THE PEOPLE.....

Gay Liberation Front
Washington, DC.

It is unclear if Newton responded to the chapter's letter, but in late October 1970 the GLF Newsletter carried a lead article about the Revolutionary Peoples' Constitutional Convention outlining what the Washington Gay Liberation Front members would offer. The collective or commune as it was now called would serve as the information center for all Gay Liberation groups attending the convention. The Radical Caucus, or glonk, formed to address a more radical membership and the commune would provide all necessary services for the convention including food, legal aid, medical aid, and transportation.²¹¹ The newsletter identified food and housing as the most critical needs of conventioners, but added a full paragraph on medical aid:

MEDICAL AID: A volunteer team of medical workers—doctors, nurses, and medical aides—is being organized. First aid training will be available for those who want it. First aid supplies and cash donations are also needed. Check the attached form or call Tom

²¹¹ *GLF Newsletter*, Volume I, No. 12, October 27, 1970, 1, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

through the Commune and leave your name and telephone number so he can return your call.²¹²

The “Tom” referred to in the newsletter is Tom Tomasi of the Skyline Faggots collective, the only health professional involved in any of the communes. The newsletter went on to discuss fundraising initiatives with a Halloween Party at the S Street commune after a long scheduled community party held by Mattachine Society of Washington (now interested in social events) and the Homophile Social League.²¹³

In early November the Washington Gay Liberation Front members joined other local groups to discuss ways to support and interact with the Black Panthers.²¹⁴ Most of the planning for the convention fell short of expectations as did the actual event. The spirit of the convention, however, permeated the gay and lesbian community of Washington who likened the rally experience in Malcolm X Memorial Park a few blocks from Dupont Circle to what overtook crowds at the Christopher Street Liberation Day in New York and San Francisco a few months earlier (these are the first Stonewall annual celebrations).²¹⁵

About 300 gay people who were representing various national GLF’s took part in the RPCC gathering in Malcolm X Memorial Park. The rally, the first actual manifestation of a peoples (sic) convention as called by the Panthers to show Pig Amerika that although they had prevented the actual physical site of the convention from materializing, the will of the People is and always will be greater than the frustrations Amerika can

²¹² *GLF Newsletter*.

²¹³ *GLF Newsletter*.

²¹⁴ *GLF Newsletter*, Volume I, No. 14, November 10, 1970, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC. (Other groups included YIP, *Quicksilver Times*, DMZ, CRV, and Panther Defense Committee)

²¹⁵ *GLF Newsletter*, Volume I, No. 16, Washington, DC, December 1, 1970, 1, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

produce. The cry that the convention would be held on the streets, if necessary, became a fact.²¹⁶

The gay contingent became more forceful and united as it marched to the front of the rally chanting “Gay power to the Gay People,” and “Be Gay, Be Proud.” They added more specific chants “Go left, Go Gay, now pick up the gun,” and “Out of the closets and into the streets.” The group then formed a huge circle chanting and urging the crowd to support the gay brothers and sisters.²¹⁷

While the convention fell short, and it is unclear how much services of any kind the communes offered, the day’s celebration and enthusiasm later in the evening created one of the city’s most significant liberation events. At the Zephyr Bar on Wisconsin Avenue, twelve gay brothers were arrested after four of their friends were denied service. This interesting mix of color (two Puerto Ricans, one black and one white) were challenged by security guards who targeted black gay men most aggressively. The resulting arrests included seven brothers staying at the commune at 1620 S Street. By court order, the seven could not leave Washington until the trial concluded. Tim Corbett from the Chicago Gay Liberation Front was among the seven stranded, and this event would begin his residence in Washington and leadership in establishing health care for gay and bisexual men. For the next few months, the Zephyr incident dominated the discussions of the Gay Liberation Front members particularly how to pay for the increased number of residents at S Street and the legal fees.²¹⁸

²¹⁶ *GLF Newsletter.*

²¹⁷ *GLF Newsletter.*

²¹⁸ *GLF Newsletter, 2-3.*

A number of unpredictable outcomes to the Washington Gay Liberation Front membership followed the festivities of the Revolutionary Convention. Theodore (Ted) Kirkland of the commune on S Street developed a list of issues and reports from the various cells of the Washington group. One issue raised became the role of “3rd World Gay Brothers and Sisters.”²¹⁹ Kirkland defined “3rd World” as the following;

We are oppressed 3rd world men and women. Oppressed because we 3rd world people being those who make up 4/5 of the population who are not North American whites or of European descent. Oppressed because we are gay. Gay people: being those who the developed capacity to love members of one’s own sex.²²⁰

The role of Third World gay men and lesbians in liberation and their inclusion in the Gay Liberation Front’s membership challenged the largely white gay men who lived at the commune, led rap groups, publicized events, and decided a political action agenda. This issue continued well into the 1980s leading some of the Third World gay community to create separate social circles and take political action on different, but related, oppressive forces in Washington. In health care, this distinction would resurface most genuinely in practices, programs, and promotions of the early gay men’s clinics and HIV/AIDS era responses. In most of the gay men’s clinics, the board and volunteers largely drew from the educated white gay community giving an appearance that these programs catered to white gay patients. Promotional and educational advertisements also typically featured only white men and were posted only in community-wide sites rather than in ones developed with gay communities of color.

²¹⁹ *GLF Newsletter*, 3-4.

²²⁰ *GLF Newsletter*, 3.

On another matter, the Washington Gay Liberation Front members faced a more threatening and perhaps more insidious problem which arose at the S Street commune during the convention. This issue led the Boston Gay Liberation Front members to “walk-out” from the commune and leave Washington alleging “sexist attitudes” of other Gay Liberation Front members and their being “forced” into compromising sexual roles.²²¹ In a direct and descriptive letter to the Washington Gay Liberation Front, the Boston gay men shared their humiliating experience during the convention:

In the past 3 months we have given ourselves to each other in Boston. We have to learn how to love men fully, now to talk and criticize with love to hold and touch with love. It was such a beautiful beginning. ... Each one of us has had to endure 48 hours of cruising, of constant pressure to get a piece of ass for the night, or to allow ourselves to become meat for anyone who chooses. ... We cannot stay and be treated as sexual objects by our own brothers and we are not yet strong enough to change you.²²²

The tension between members of different Gay Liberation Front communes would characterize distinctions among gay and bisexual men of like sexual orientation but not shared views or practices. As Gay Liberation Front members identified under different perceptions of class, sex, race, and sexuality, the outreach for venereal diseases and even clinic management developed differently. The earlier discussion of lavender health initiatives illustrates how these clinical health care programs followed very different paths at times with varied points of origin.

In a final note, the newsletter recounted a long public statement by “Sister Martha” of the Washington membership. Sister Martha challenged the Black Panthers on their practices

²²¹ *GLF Newsletter*, 4.

²²² *GLF Newsletter*, 4.

and organization. She continued by stating that gay men and women did not need Black Panther Huey Newton's "seal of approval" in order to be valid. In response, the Washington members disagreed with Sister Martha and acknowledged that at the end of convention no one felt validation by the Black Panthers was necessary; it was instead simply a matter of "coalescing" with other like-minded groups.²²³

The Gay Liberation Front newsletter in December noted that reactions to the Revolutionary Convention were "strong and mixed." The Radical Caucus (referred to as a "gronk") succeeded in getting a large number of gay liberation men and women to Washington. One brother asked: "Didn't the GLF group really fall apart at the convention? The radicals evidently had no program. And Gay Lib was subservient to Pantherism."²²⁴ Others noted: "The weekend was a successful experience in unstructured, collectivist living, and third world people took an important role in the leadership."²²⁵

The event would eventually foretell a separation within the Washington Gay Liberation Front between a more radical membership, which aligned with identity movements, and one committed to furthering the social and political interests of the gay community. In the concerns of the event, the presence of a medical aid cell and the collaboration among health care professionals, gay and straight, and gay activists added a new dimension to the revolutionary health care initiatives that began in North America in the 1960s. Among these revolutionary initiatives is the work of Medical Committee for Human Rights, the Black Panther

²²³ *GLF Newsletter*, 5.

²²⁴ *GLF Newsletter*, Volume I, No. 17, December 8, 1970, 3, Box 92, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

²²⁵ *GLF Newsletter*, 1(17).

Party clinics and educational programs, the national Free Clinic movement, and the spin-off street clinics of the Young Lords, Asian groups, and Young Patriots. (See Chapter One, 40-41)

The Revolutionary Convention, however, appears to be the first time gay activists connected first aid and health care in general to their own political and activist interests and united with other revolutionary people for change.

Revolutionary Health Care in Washington, DC

Although the Gay Liberation Front of Washington would take direct action in the health care of gay and bisexual men (and others), earlier steps by local gay leaders established networks of communication that actually undergirded these later health programs. The Mattachine Society of Washington (MSW) recognized the public health concerns of venereal diseases and developed methods to educate unknowing gay and bisexual men in the city with public health officials. The members also established close contacts with the American Red Cross in Washington and frequently concluded their meetings with a visit to the blood donation center. This connection to blood donation and the health and well-being of gay men and lesbians is a small glimpse into how the members valued health, as well as a shared interest in gaining acceptance among more dominant social groups. Frank Kameny's papers of the MSW reveal important steps in the growth of revolutionary health care in Washington.

There was nothing revolutionary about Frank Kameny contacting the DC Public Health in 1962. Or was there? Only a year after the founding of the new MSW, the group formed a Venereal Disease Committee to address a growing concern in the city now mentioned regularly in the city and national newspapers. Most of the members of the MSW operated at meetings using pseudonyms to avoid detection by DC police. Frank Kameny, as the exception, easily

moved around the city bureaucracy and felt no threat at this point because his identity was already disclosed. Kameny would describe the meeting with the DC public health department as “open” but later say the health officials were “uncomfortable.” He mentioned the uneasiness around patient confidentiality at the city’s public health clinics and discussed the importance of nonjudgmental testing and treatment. While there is no mention of a final outcome, it must have been positive as Robert King (not his real name) became head of the VD Committee and began to draft a brochure on venereal disease. The following year (1963) MSW published with the DC public health department the first informational brochure on VD and homosexual men.²²⁶ shortly afterwards and for the next few years, members of the MSW began to distribute more than five thousand brochures at local bars, parks, and washrooms known to have homosexual patrons.²²⁷

The N.Y. Mattachine Society inspired by Washington (they were in regular communication) prepared its own brochure in 1964.²²⁸ These two publications constitute the first efforts of written information, but the proactive approach of the MSW is clearly the first. A few years earlier, the NY MS invited Dr. Herman Goodman to speak on homosexuals and venereal disease. Speakers on a wide range of topics in New York was customary as the organizations believed education to be key to changing perceptions of homosexuals. Topics on mental and physical health periodically appeared, but so did the topics of literature, history, politics, and sociology.

²²⁶ Mattachine Society of Washington, “Homosexuality and Venereal Disease,” Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

²²⁷ “Homosexual VD Rate Alarms Officials Here,” *The Washington Post*, March 24, 1966, F8.

²²⁸ New York Mattachine Society, “V.D. is No Camp,” and “V.D. Information for Homosexuals,” Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

On the platform of the success of his VD Committee, Robert King ran for MSW president against Kameny. Kameny's overbearing personality and at times unrealistic expectations made him difficult to work with in the business of the organization. King was elected and served as president for several years but only with a steady reminder that Kameny's vision and determination were the strength behind the venereal disease program and other initiatives. In 1965, MSW began its best known awareness program with protests and signs in front of the White House and later the Pentagon and Independence Place in Philadelphia. The significance of these protests, while largely symbolic, is addressed in a number of works by historians.²²⁹

As the MSW acknowledged the venereal disease problem among homosexual men, across town another group began the Washington Free Clinic in the basement of the Georgetown Lutheran Church on Wisconsin Avenue. The new clinic rapidly grew as an alternative to public clinics and private physicians; and, centered in Georgetown, it was easily accessible to the bohemian population that haunted Dupont Circle and Georgetown. The Washington Free Clinic offered a number of health programs including women's health care and venereal disease testing and treatment.

Gay Activist Alliance and Venereal Disease Campaigns

Despite the racial mix and an inclusiveness within the voice of Washington's Gay Liberation Front about sexism, racism, and antiwar imperialism, gay and bisexual men largely split along color lines. David Aiken would establish Black and White Men Together a few years later, and a number of entities banded together to challenge the discriminating practices for

²²⁹ David K. Johnson, *The Lavender Scare: The Cold War Persecution of Gays and Lesbians in the Federal Government* (Chicago: University of Chicago Press, 2004), 199-202.

blacks and women at a new gay bar called Lost and Found. Gay Activists Alliance, now replacing the homophile organizations and the Gay Liberation Front, organized campaigns to boycott the Lost and Found until some concessions were made. But black men and other men of color maintained a community meeting separate from the white gay activists. This is not to say that the color lines did not unravel at times, but the portrayal of a unified gay community is misleading. For instance, the Gay Activist Alliance's increased its effort to eliminate entrapment by plainclothes policemen in the Dupont Circle and Georgetown areas and recognized that most of the arrests were of black gay and bisexual men. Likewise, in the health care initiatives of the Gay Men's VD Clinic, leadership was usually white and well-educated men, and the majority of the patients also were white. A sizable percentage of black men chose to seek treatment at public clinics often denying sex with other men that fostered the transmission. During the HIV/AIDS era, a decade or more later, this huddled safety around race rather than sexuality camouflaged the presence and ongoing transmission of HIV and AIDS complications in Washington's black gay and bisexual underground. The well-shared awareness that few black men visited the Gay Men's VD Clinic and the unspoken relations between and among black men became even more pronounced in the early days of AIDS. The leaders of the Gay Men's VD Clinic recognized the problem and quickly developed special outreach to the black gay community through programs and advertising in bars and publications.

Through the work of Nancy Tucker and others of the *Washington Blade*, the gay community's only newspaper began to carry a number of stories about venereal disease and the growing activists' community. The editors mixed venereal disease with stories on Christopher Street Liberation Day in 1972 and a new bar for Third World gay and bisexual men

outside of Dupont Circle opened by black gay organizations like the Washington Capitolites.²³⁰ Metropolitan Capitolites, a social and civic group of gay black men, earlier in the year reportedly expressed interest in health care for their community by raising money for sickle cell research the same year.²³¹ The *Washington Blade* writers also covered a gay rap session forming at the Washington Free Clinic in Georgetown and the formation of the first gay switchboard to direct local and national calls for gay Washington.²³²

One of the *Blade* stories set the stage for the relationship between DC Public Health and the gay activists for the next few years. Following the report of the National Venereal Disease committee in 1972 and realizing the disturbing statistics on reported venereal disease cases in Washington, the DC Public Health Department set up its own committee and a subcommittee referred to as the Homophile Committee. Officials appointed Kameny, Nancy Tucker of the *Washington Blade*, and others. The minutes of these meetings show a gradual loss of interest and attendance despite early enthusiasm.

After the first few meetings of the homophile sub-committee, activist Frank Kameny grew tired of the fears and threats of the public health officials. Don Culver of the Lost and Found bar proposed distributing fliers, Nancy Tucker promised a story in the *Blade*, and almost everyone committed to a month long campaign of education.²³³ Kameny's typewritten and long letter to officials, as was typical of him, proposed a number of strong steps. If the city was in an

²³⁰ *Washington Blade*, May 1972 (VD Clinic Opening); June 1972 Christopher Street; June 1972 VD Rectal Exams; August 1972 Third World Bar.

²³¹ *Washington Blade*, February 1972.

²³² *Washington Blade*, Free Clinic, October 1972, 2; "Gay Switchboard Organizes," November 1972.

²³³ *Washington Blade*, front page Homophile Subcommittee of Metro VD Campaign July 1972; "Call for Gay Public Health, Big VD story," September 1972, 3.

epidemic of venereal disease, he reasoned, then drastic steps should be taken. In 1948, he recalled more than six million residents of New York were vaccinated for smallpox in six months. If public health officials could do that, why could they not give every gay man in Washington a penicillin injection?

It was again mostly true. While Kameny might have exaggerated somewhat, in two instances in the late 1940s public health officials inoculated thousands of residents in New York and South Texas in the last two major smallpox health scares. But things were different in 1972. The Public Health Service recently received harsh criticism about its decade's long program in Tuskegee, Alabama, and there was a growing awareness of clinical and medical ethics in general. The ethical complexities of consent and treatment without test results and the inherent costs for this widespread treatment gave pause to everyone but Kameny. Moreover, health officials held a concern over inoculated men who might have allergies to penicillin. Kameny's idea seemed risky despite his repeated efforts to move it forward.

These DC Public Health Department venereal disease programs made no acknowledgement of race, economics, household income, or geographical placement in the city. Their only effort was the creation of a homophile subcommittee. There was good reason for alarm and attention to this minority population as the reported incidents of venereal disease increased every year since 1957 and continued to climb.²³⁴

²³⁴ *Washington Blade*, September 1972.

The Interim Years, 1970-1980

Gay and lesbian politics and the community as a whole changed significantly in the 1970s. Stymied by the Gay Liberation Fronts direct methods of confrontation, gay activists reformed organizations and shifted messaging to the public. The emphasis that many gay men and lesbians placed on “coming out” transferred to their positioning of gay advocacy and directly working with elected officials to effect change. Within these same circles of discussion, health activists found a footing and espoused the importance of a “venereal free” population of gay and bisexual men. These collective steps increased visibility of disease, led to the development of special clinics and clinical programs, and recognized that health was an important part of self-esteem and human rights.

The editors of *The Gay Blade* continued to provide the community readers with information about health care. In early 1973 the editors announced a gay men’s counseling service forming with an unrelated effort to create a gay Alcoholics Anonymous meeting.²³⁵ They launched a major story about venereal disease in the early summer and reported that a new group was forming to address gay men’s health and growth. Deacon Maccubbin, the owner of Earthworks (a head shop that carried gay publications) and a new entity Lambda Rising (Washington’s first gay bookstore), sought interested men to form a “medical services committee” with the new Washington Area Gay Community Center initiative and a new Gay Men’s VD Task Force.^{236 237238 239} As the written communication improved in the community,

²³⁵ *Washington Blade*, January and February 1973.

²³⁶ *Washington Blade*, June 1973.

²³⁷ “Washington Area GCC,” *Washington Blade*, July 1973

²³⁸ “WAGCC Medical Services,” *Washington Blade*, November 1973, 2.

²³⁹ See illustration, *Washington Blade*, November 1973, 4.

David Aiken and other gay activists started the Stonewall Media Collective including “Friends” radio program broadcast out of a public radio station at Georgetown University.²⁴⁰

From 1973 to 1976, gay activists created a number of significant organizations mostly centered on Dupont Circle that expressed the diversity of the gay and lesbian community. Health care programs often got top billing in newspapers and radio. The new gay switchboard centralized communications and continued to grow in impact and use. In conjunction with the Washington Free Clinic, attention to counseling and clinical care flourished in a cooperative environment. The activists addressed alcoholism in the gay community, mental health concerns like “coming out,” and venereal diseases that multiplied in number and complexity.²⁴¹

In 1975, Cade Ware and others of the Gay Activists Alliance took advantage of a newly independent District of Columbia government to ask for funding for the Gay Men’s VD Clinic for fiscal year 1976. The activists scheduled meetings with recently elected DC officials and prepared information packets that would justify an investment in the clinic. With a flier entitled “Why the New D.C. Budget Should Include Funds for the Gay VD Project,” they outlined critical facts in the development of clinical services and the need. The flier reported Kinsey’s estimates that “Gay people account for 5-10% of Washington’s adult population; we pay 5-10% of this city’s taxes, yet our special needs and problem have been totally ignored in the budgetary process until now.”²⁴² The new DC Council awarded twenty-five thousand dollars to

²⁴⁰ *Washington Blade*, July 1973, 10.

²⁴¹ *Washington Blade*, December 1973, 6; February 1974, 2; April 1974, 5; May 1974, 11; July 1974, 7 and 9; September 1974, 6 and 12; November 1974, 3; December 1974, 5 and 8; February 1975, 2. May 1975.

²⁴² Gay Activists Alliance of Washington, DC, “Why the New D.C. Budget Should Include Funds for the Gay VD Project,” typewritten flier, 1, c. 1975, Boxes 87-88, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

the growing clinic. This remained in place until in 1978 the Congressional Oversight Committee of DC removed the award. This marked the first time any gay or lesbian organization in the United States was denied federal or state tax dollars for any project but especially a health-related one.²⁴³ The flier issued one more message in its request for funding: “Services by Gay Men for Gay Men is the ONLY Effective Method to Deal with the VD Epidemic in the Gay Community.”²⁴⁴

²⁴³ Private conversation with Jim Graham, November 5, 2015.

²⁴⁴ Gay Activists Alliance of Washington, DC, “Why the New D.C.,” 1, Boxes 87-88, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

Chapter Five

HepB Vaccine Development and Clinical Trials

By the middle of the 1970s, biomedical researchers resurrected technology to develop a vaccine for hepatitis B. Hepatitis B troubled special populations worldwide and led increasingly to lifelong health issues or death. While typically associated with poor living conditions or infections among medical professionals, researchers eventually determined that hepatitis B could be transmitted through sexual practices. This information led to concentrated studies within urban gay and bisexual male populations that would indicate as much as forty percent of the population carried antibodies to hepatitis B or were infected. This percentage staggered gay health professionals as well as public health officials leading to increased interest in broad-scale development of a vaccine. One pharmaceutical company responded to the challenge and initiated within urban gay ghettos in-depth studies that increased manufacturing of vaccines and led to vaccination trials among gay and bisexual men.

The relationship of gay and bisexual men to hepatitis B is a curious reflection of how gay health activism matured by the 1970s. The widespread assumption that gay and bisexual men increased public health statistics for venereal disease transmission and typically lived promiscuous lives became exacerbated by the increasing presence of hepatitis B in gay urban enclaves. Gay writers discussed it in health articles and public health officials and physicians were aware of the growing number of cases. But, how these health factors and assumptions transferred into action by the biomedical establishment and parlayed into the gay community's relaxing of autonomy and agency are the precursors to the unfolding health drama of the HIV/AIDS era.

Hepatitis B and the Gay Men's Health Project

Leonard Ebreo created a stark contrast to the young medical doctor Dan William. Ebreo was a New York Italian convert to Judaism and a wildly experimental gay man. Lenny, as he was known, saw no reason to answer the request of the young, "polished and courtly", perhaps gay, Isaac Much when he approached them to collaborate in a study of hepatitis B.²⁴⁵ Dr. Much, a medical researcher from the Laboratory of Epidemiology at the New York Blood Center participated in a team researching hepatitis B under the direction of the Polish immigrant scientist Dr. Wolf Szmunes.²⁴⁶ The Gay Men's Health Project was barely one year old at that time and struggling for funds and supplies. It was a popular and growing specialized evening clinic for gay and bisexual men at Washington Square United Methodist Church in New York. The clinic offered patients anonymity in a "safe" environment and an affordable, relatively quick, fix for syphilis and gonorrhea without proffering judgment or requiring extensive medical histories. Much saw this as an ideal collaboration where the researchers of hepatitis B could find a supply of study participants and the clinic could get needed funding.

When approached by Much, the conservative young intern William thought differently from Ebreo. While not a founder of the clinic, he assumed the role of its first medical director, and he felt that collaborating with a large research project and eventually a pharmaceutical company could eliminate financial problems, attract other donors, and add credibility to the clinic among medical professionals. Over the concerns of Ebreo, Perry Brass, and Marc Rabinowitz, the clinic founders; the volunteer clinicians of the Gay Men's Health Project began

²⁴⁵ Perry Brass, "A Prophecy Before Our Time: The Gay Men's Health Project Clinic Opens in 1972: Controversies and Legacies", <http://www.npl.org/blog/2014/04/28/prophecy.html>.

²⁴⁶ June Goodfield, *Quest for the Killers* (New York: Hill and Wang, 1985), 53.

innocently recruiting gay and bisexual men for the study.²⁴⁷ Brass later recalled the conversations:

If we became involved with his research, he could help fund the clinic, something we desperately needed. All we had to do would be to hand over a portion of our blood samples to him; he would supply all the vacu-tainers and needles needed to do this.

Also this researcher ...made us feel that Big Daddy himself had now stepped onto the scene. In other words, he was going to be the recognized “adult” we were looking for, after scrambling around in the early months of the clinic, trying to figure out how to do everything. Dan, as one of the few professionals involved with us, had been feeling alone. So he quickly gravitated toward this proposal.²⁴⁸

For the duration of 1973 and 1974, each patient who came to the clinic, ostensibly for venereal disease testing also gave a small sampling of blood for research on hepatitis B. “We had to tell our patients that their blood would be used in research, but for the most part we were rubber-stamping their agreement. Most of the men were so eager to have STD testing done, in the kind of supportive environment we provided, that they quickly assented.”²⁴⁹ In total, four hundred gay and bisexual men gave blood samples and answered intimate questions about their sexual behavior and private lives.²⁵⁰

In 1975 the researchers led by Szmunn and Much published the first descriptive article identifying significant numbers of homosexual men with serologic evidence of hepatitis B and functioning as carriers, and more specifically, as those who “spread” hepatitis B as the title of the article, “On the Role of Sexual Behavior in the Spread of Hepatitis B Infection,” notes. The

²⁴⁷ Brass.

²⁴⁸ Brass.

²⁴⁹ Brass.

²⁵⁰ Goodfield, 54.

medical journal described the research subjects as “high-promiscuity populations” that were further identified as “patients with venereal diseases and male, not female, homosexuals.”²⁵¹

The cooperation of the Gay Men’s Health Project between 1973 and 1974 yielded data for Dr. Szmunness’ theory that gay and bisexual men were the almost ideal hepatitis B study cohort. With continued cooperation of the Gay Men’s Health Project an additional 800 to 1000 gay and bisexual men could be tested for hepatitis B antibodies and recruited for trials of a new vaccine being developed by Merck, Sharp & Dohme for hepatitis B.

A decade earlier, Dr. Saul Krugman of New York University Medical Center perfected a vaccine using live “flecks of viral protein” in hepatitis B carriers by concentrating the flecks and then purifying and sterilizing the flecks for injection. Krugman first tested his vaccine on “mentally retarded children” institutionalized at Willowbrook Hospital on Staten Island in New York.²⁵² The Willowbrook Hospital study is the subject of a number of articles on medical ethics as well as debate on the value of Krugman’s discoveries in addressing hepatitis B in the broader population.²⁵³ Nonetheless, Margot Joan Fromer, a writer in 1982, praised Krugman’s study at Willowbrook as a precursor to the hepatitis B vaccine giving his research credit for helping gay men.²⁵⁴

²⁵¹ Wolf Szmunness, M.D., M. Isaac Much; Alfred M. Prince, M.D.; Jay H. Hoofnagle, M.D.; Charles E. Cherubin, M.D.; Edward J. Harley; Gloria H. Block, “On the Role of Sexual Behavior in the Spread of Hepatitis B Infection,” *Annals of Internal Medicine* 83 (1975), 489-495.

²⁵² Goodfield, 66.

²⁵³ A number of articles appeared in the 1970s including F.J. Ingelfinger’s discussion in 1973, entitled “Ethics of Experiments on Children,” in the *New England Journal of Medicine* and revisionist discussions in the early 21st century such as Kush Fansiwala, “The Duality of Medicine: The Willowbrook State School Experiments,” August 14, 2016 in the online journal, *Medical Dialogue Review*.

²⁵⁴ Margot Joan Fromer, “Hepatitis, retarded children, and Gay men: The story of one set of experiments that helped lead to the new hepatitis B vaccine, *The Washington Blade*, October 15, 1982, Volume 13, Number 23, 1.

Merck Institute for Therapeutic Research in Pennsylvania acknowledged the success of Krugman's vaccine and initiated a program to commercially develop it. Under the direction of Dr. Maurice Hilleman, Merck invested heavily in a laborious process that would take sixty-five weeks from start to finish to produce the vaccine.²⁵⁵ The key to the process, however, began with the volunteer gay or bisexual man who carried the hepatitis B antigen and proffered his blood. Each blood donor sat for a donation of blood that was collected into an initialed bag, processed in a centrifugal instrument that separated out the antigens and red blood cells, and then the red blood cells were returned to the donor by injection; a time consuming and highly sensitive process. The Gay Men's Health Project in Greenwich Village became the vehicle between Merck and the carrier population of gay and bisexual men. A potable vaccine required three injections emerged from Merck, but needed a final course of human subject trials on uninfected patients before approval by the United States Federal Drug Administration (FDA).

The ideal research population easily appeared. Szmunn's research with the gay and bisexual male population defined the community as "sexually active, urban gay men" meeting all the criteria for the final research phase:

...they had a high rate of hepatitis B infection nearly ten times greater than the general population of the country; they were a compact homogeneous group and stood out clearly; they existed on his doorstep; they were young and presumably healthy; through their institutions — churches, synagogues, professional associations, health forums and clubs— they were accessible; they didn't tend to move around and there were a large number of them in a compact area across town in Greenwich Village in the west side of New York.²⁵⁶

²⁵⁵ Goodfield, 67.

²⁵⁶ Goodfield, 70.

With a goal of locating at least 850 gay or bisexual uninfected men for the vaccine trials, Dr. Szmunnass assembled a diverse team at the Blood Center and initiated recruitment. The team launched a public relations campaign with posters, flyers, and even a bloodmobile that appeared at popular gay sites like the piers, clubs, and bathhouses. A special brochure to answer the men's questions about the study and the disease followed. Soon the gay community of New York felt saturated in information on hepatitis B, but the number of recruits needed to increase.²⁵⁷

Although gay male participants joined the study for assorted reasons, the lead researchers reflected that "they understood the full extent of their problem, that it was an epidemic disease with no treatment, and were anxious to gain a better social image."²⁵⁸ Szmunnass, however, took extra steps to assure participants of their value. He hired all gay physicians and made sure they were noted in the study and he secured the most lucrative sources for participants in the bloodmobile and Gay Men's Health Project. For the latter struggling clinic —held in one-room makeshift quarters with curtains separating patient rooms — Szmunnass purchased wooden cubicles, couches, cushions, and decorations.²⁵⁹ He ingratiated himself to the gay male community of Greenwich Village by infiltrating their social hangouts, attending Gay Pride events, and entering the dark, under-belly of the men through their clubs and bathhouses. In return, Szmunnass guaranteed anonymity through a numbered identification

²⁵⁷ Goodfield, 72-74.

²⁵⁸ Goodfield, 74.

²⁵⁹ Goodfield, 75.

system, reassured participants that Merck employees too had been vaccinated, and offered medical treatment by the physician of the Gay Men's Health Project, Dr. Dan William.²⁶⁰

Despite the efforts to enlist the gay and bisexual men of New York, Szmunn still needed more participants. While 850 would meet research protocol, one thousand would be better. A new or revised campaign ensued. The research team kept up the usual work but added some new dimensions. One, described as a "muscle man" approach, used a very attractive and muscular male couple embracing on a brochure and presumably involved in the study. One of the researchers later commented:

The biggest job I had was to convince the gay community leaders that participation in this trial would enhance their self-image. Once that was picked up people were very responsive and helping in the hepatitis B vaccine program became their personal gesture toward their gay identity and that of the movement.²⁶¹

The team stretched their mission to convince gay volunteers that the project was not just that of the New York Blood Center but all of the gay community in Greenwich Village, and ultimately the world. One employee said: "he forced the gay volunteers to make the leap from their community to a wider family of humanity. Usually this worked. If not, he badgered them."²⁶²

In a sense, the success in convincing gay and bisexual men to participate in this study because it "helped" the self-image indicates the maturity of work begun among gay men even in the 1950s. Certainly by these interim years, most gay and bisexual men were aware of the transmission of venereal diseases among their friends and colleagues. Enhancing that

²⁶⁰ Goodfield, 76-77.

²⁶¹ Goodfield, 79.

²⁶² Goodfield.

knowledge against the goal of gay and lesbian activists to improve social standing and recognize the human rights of the community probably seemed logical to most of the research subjects. An added “trust” of physicians and research scientists to improve health for everyone easily followed. The concept of a compromised ethical position would not seem reasonable and would not fully form as a consideration well into the HIV/AIDS era.

In the fall of 1977, Merck with Bill Darrow of the Centers for Disease Control expanded the research network to other gay health clinics around the country and issued requests for clinics to assist in recruiting participants. By 1978 Darrow was working on his own research project in the urban gay communities. Having grown weary of Kinsey’s statistics, Darrow as director of the venereal division of the Centers for Disease Control asked Karla Jay and Allen Young to share their data from the gay project. Darrow knew it was not the first such request to access this special community for research. Alfred Kinsey used this community as did Dr. George Henry in his study of sexual variants.

Clinical directors considered the Darrow request, seeing an opportunity to secure much needed funds to provide their rather basic clinical services. Although syphilis and gonorrhea dominated the growing list of infectious diseases among gay and bisexual men, hepatitis B and other gastrointestinal diseases seemed to be increasing. New articles in medical journals were creating new names for health issues and identifying clusters of infectious diseases increasingly associated with gay and bisexual men.

Not all of the gay clinics saw an opportunity with the new study. In 1978, the volunteers of Washington, DC’s Gay Men’s VD Clinic initiated testing for hepatitis B among local gay men. Early results revealed an incidence of five percent with positive Hepatitis Australian Antigen

(HAA) in their blood.²⁶³ The reorganized Whitman-Walker Clinic later considered joining the vaccination trial but quickly stepped away.²⁶⁴ In 1984, in the early years of AIDS the board reconsidered administering the hepatitis B vaccine and then declined to begin such services.²⁶⁵ Clinics in Boston and other major cities also declined to join the study. While the records of these clinics do not clearly articulate a reason for not participating, the limited time, funding constraints, and staffing requirements probably contributed to their decisions.

Dr. David Ostrow, medical director of the gay-organized and managed Howard Brown Memorial Clinic in Chicago, however, eagerly joined the study as did the City Clinic in San Francisco. The City Clinic did not operate as a gay men's clinic but rather evolved from the Haight-Ashbury Free Clinic and eventually hosted primarily gay and bisexual patients. Paul O'Malley directed the San Francisco project. The VD clinic of the Los Angeles Gay Community Service Center also joined. Gay men's clinics in Denver and St. Louis became involved as well.²⁶⁶ For Ostrow at Howard Brown, the hepatitis B trials allowed financial independence with its first paid staff and put it on the "national health care map."²⁶⁷ Ostrow would later state it established a previously unknown rapport with public health officials. It also placed his name on countless journal articles and sealed his medical career.

²⁶³ Gay Men's Venereal Disease Clinic, "Overview of DHR/GMVDC Contract to Expand," 25 August 1978, 3, MS 2013, Series 1, Box 21, Folders 1-2, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

²⁶⁴ Steve Martz, "Bankruptcy Looms: Clinic in Danger," *The Blade*, February 15, 1979, Volume 10, Number 4, 1.

²⁶⁵ H. Peter Hawley, M.D. and B. Kevin Rice, R.N. "Hepatitis B Vaccine Administration Proposal," Whitman-Walker Clinic, 16 July 1984, MS 2013, Series 1, Box 21, Folders 1-2, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC

²⁶⁶ Paul Monahan O'Malley, "Interview History, The Hepatitis B Study, 1996, AIDS and Hepatitis B Vaccine Trial in San Francisco," Interview conducted by Sally Smith Hughes, PhD, in 1996, Online Archive of California, Bancroft Library, University of California Berkeley, <http://www.content.cd.lib.org>.

²⁶⁷ "Mission and Overview," Howard Brown Health Center, http://www.howardbrown.org/hb_aboutus.aspx.

O'Malley would note in an interview in 1996 that the New York trials were promising but more participants were needed and that is why they became involved. The initial plan for San Francisco and other gay clinics was to begin the trial in 1979 but it took two years to collect the data so it began in 1980. The San Francisco project screened 6,700 men with 360 actually participating in trials that began in April 1980.²⁶⁸ Among the five test centers, researchers tested some 10,000 men to find 700 qualified patients.²⁶⁹

The vaccine test results for Szmunn's team in New York proved favorable as the majority of test subjects showed the presence of antibodies after three injections of the vaccine. While the trials continued at the other gay clinics, the New York team released a research paper published on October 9, 1980 in the *New England Journal of Medicine*. The London journal *Nature* carried a similar article. The accomplishments of Szmunn's team seemed extraordinary. Celebrations followed and even gay periodicals carried the news and its community-based research methods using gay and bisexual men.²⁷⁰ In November 1981 the FDA approved licensing of the vaccine (Heptavax B) especially to be used with vulnerable populations including health professionals, drug users, and gay and bisexual men.

Little did Szmunn know that the Institute of Virology at the Pasteur Institute under the direction of Ph. Maupas, M.D. released a similar vaccine in January 1982 (Hevac B Pasteur). The French vaccine would challenge Merck's commercial claim and beat the latter to the market by six months.²⁷¹ The new vaccine offered protection for high-risk groups worldwide as well as a

²⁶⁸ O'Malley, interview.

²⁶⁹ O'Malley.

²⁷⁰ "Hepatitis B Vaccine Released, Physicians Say They're Ready," *The Washington Blade*, July 23, 1982, 4.

²⁷¹ Irving Millman, "The Development of the Hepatitis B Vaccine," in Irving Millman, Toby K. Eisenstein, Baruch S. Blumberg, *Hepatitis B: The Virus, the Disease and the Vaccine* (New York: Springer, 1984), 137.

safeguard against hepato-cellular carcinoma, making it the first anti-cancer vaccine. Despite the short time (less than a decade) in its marketable development, some scientists believed it was one of the safest vaccines ever created. Several factors, however, complicated a quick use of the remarkable new vaccine. High-risk groups, even in the United States, did not use the vaccine mostly because of the costs and need for three injections. The incidences of hepatitis B actually increased following its release. Moreover, the cost for three injections of Heptavax B typically exceeded \$100, well beyond the reach of most gay and bisexual men in need let alone the hepatitis B outreach around the world. This relatively high cost set by Merck surprised many scientists involved in the research who blamed it on the politics of commercial vaccine development.²⁷²

After the release of the vaccine, physicians and clinic administrators observed different responses among medical professionals and government public health officials. Hepatitis B became labeled a disease of “outsiders.” Gay and bisexual men and intravenous drug users were the largest high-risk groups in the North America. Thus, spending money to distribute and administer a vaccine to these groups was unpopular among politicians and some medical personnel who saw these as “lifestyle” issues.²⁷³ Ostrow of the Howard Brown Memorial Clinic in Chicago identified other significance to the vaccine (HBV) calling it the “first vaccine to be developed against an STD.”²⁷⁴ He further noted:

²⁷² William Muraskin, *The War Against Hepatitis B: A History of the International Task Force on Hepatitis B Immunization* (Philadelphia, PA: University of Pennsylvania Press, 1995), 5-7.

²⁷³ Muraskin, 7.

²⁷⁴ David G. Ostrow and Terence C. Gayle, “Viral Hepatitis,” in *Sexually Transmitted Diseases in Homosexual Men: Diagnosis, Treatment, and Research*, edited by David G. Ostrow, Terry Alan Sandholzer, and Yehudi M. Felman (New York: Springer, 1983), 129.

The significance of this latter aspect of the HBV vaccine is widely appreciated within the homosexual male community, with many of the major community STD clinics in the United States actively involved first in the clinical efficacy testing of the vaccine, then in supplying HB Ag-positive plasma for vaccine production, and now in mounting large-scale HB vaccination programs.²⁷⁵

Ostrow's comments reflected his personal interest and leadership in the vaccine trials. He also assumed for himself one of the few leadership positions among gay health activists as medical director of the Howard Brown Memorial Clinic. Ostrow would go on to pivot his own professional stature within public health and medical professionals because of the success of the hepatitis B vaccine. His position and network within gay health care services and with public health officials gave him an early authorial voice at the onset of the HIV/AIDS era.

At the founding of the National Coalition of Gay STD Services, hepatitis B and its associated vaccine ranked high among its concerns. Editor Mark Behar, a graduate student at George Washington University, emphasized the role of the coalition in "generating communication between gay VD services and the Center for Disease Control."²⁷⁶ Following several newsletters calling for speakers on hepatitis B, Behar presented a series of "point/counterpoint" articles on hepatitis B and the vaccine. The first unidentified spokesman cautioned gay health workers to question the CDC's interest in testing the new vaccine in gay clinics comparing its interest as "conjuring up a Tuskegee déjà vu [*sic*]" and that the "CDC once again found a strain of guinea pigs who "know their place"?"²⁷⁷ On the other hand, the health worker noted that "in our eagerness to procure grants from these 'interested'

²⁷⁵ Ostrow.

²⁷⁶ "Hepatitis B Virus & the Vaccine: Gay Clinics and the CDC," *The Official Newsletter of the National Coalition of Gay STD Services* 1 (March 1980), 4.

²⁷⁷ Hepatitis B Virus and the Vaccine.

institutions, we may well be compromising our major objective—the health and well being [sic] of our clients.”²⁷⁸ He continued:

My objections to the hepatitis program are as follows: The lack of provision for long term care and followup [sic] studies (i.e., at 5 and 10 year intervals); the lack of funding for trackdown [sic] of volunteer subjects who leave the program before its completion; the lack of guarantee of security for the volunteers and health providers (re: The Federal Freedom of Information Act); the lack of legal recourses available to the volunteers, i.e., methods of obtaining compensation for malpractice, injury, etc., without revealing the sexual orientation of the volunteer. Has anyone calculated the risk factors for the hepatitis vaccine? There are currently 4000 claims filed for ill effects (and death in some cases) of the Swine Flu Vaccine program. Imagine a group of homosexuals trying to get a fair malpractice hearing against the government.²⁷⁹

In conclusion, he stated “we are giving tacid [sic] approval to the CDC’s contention that the ‘promiscuous’ gay community is a veritable cesspool of disease, ripe for epidemiological studies.”²⁸⁰

Dr. Paul J. Wiesner, MD, Director of the VD Control Division, CDC, and Dr. David Ostrow of Chicago’s Howard Brown Memorial Clinic responded. Both physicians reiterated the partnerships between gay clinics and the CDC that formed a few years earlier. Ostrow would state: “Of course the CDC has not made a 180 degree turn in it’s [sic] policies—what interest they now have in gay people’s health has evolved over the past 10 years, and is largely the result of the community’s activities to enlist interest and support in our problems.”²⁸¹ He and Wiesner on similar arguments added: “In this case, the CDC hasn’t come to us with the vaccine

²⁷⁸ Hepatitis B Virus and the Vaccine.

²⁷⁹ Hepatitis B Virus and the Vaccine.

²⁸⁰ Hepatitis B Virus and the Vaccine.

²⁸¹ Hepatitis B Virus and the Vaccine, 5.

and said, 'take this.' We've gone to them and said, 'Let's work together to do something about this awful plague,' and have encouraged them to speed up progress towards developing an effective prophylaxis."²⁸² Ostrow gave the full support of the Howard Brown Memorial Clinic as a leader among the gay venereal disease clinics. He went on to question the other gay health clinics who declined to participate for whatever reason but chose to belong to the Coalition.

They say to us, "Why are you insisting on this or asking for that when such and such a gay VD clinic isn't?" If we had a common policy, and negotiated as a unit, they couldn't do this as effectively. It's interesting to note that the Washington, DC Whitman-Walker Clinic dropped out of negotiations with the CDC in regards to being clinic #6. Was this because of the red tape, problems negotiating money or protocol details, or what? Such a Coalition policy as I've suggested might make it easier for individual clinics like Whitman-Walker to get what they want and to meet the requirements of the bureaucracy.²⁸³

Over the next two years, the Coalition continued to foster debate and facilitate communications by telephone conferences and meetings. At the 1981 International Symposium on Viral Hepatitis held in New York City (March 30-April 2), David Ostrow of Howard Brown (Chicago), Dan William of the Gay Men's Health Project (New York), and Thomas Nylund of the Men's Clinic of the Gay & Lesbian Community Service Center (Los Angeles) filed a report to the newsletter after their session *Passive and Active Immunization and Treatment*:

As a direct result of the gay community's extraordinary degree of cooperation and compliance in those studies which have been reported upon today (April 1), The Merck HBV vaccine will be ready for licensure within the year. The same community, by virtue of the high rate of asymptomatic chronic infection in gay men, will be a major source of the high-titre surface antigen-positive plasma used in the manufacture of the HBV vaccine in the United States.

²⁸² Hepatitis B Virus and the Vaccine.

²⁸³ Hepatitis B Virus and the Vaccine, 6

Gay community clinics provide an optimal site for the conduct of vaccination programs aimed at high risk individuals and for follow-up studies of vaccine efficacy and the natural course of chronic infections.²⁸⁴

The debate at play in the Coalition's newsletter echoed a broader debate among gay and bisexual men: Were we guinea pigs and agents of compliance with testing by the CDC, or were we contributing to the greater good of health care that contributed to our being socially uplifted in status and value?

The development of the hepatitis B vaccine in North America would not have been possible without a number of disparate measures coming together by the late 1970s. Urban gay and lesbian communities concentrated in distinct geographies and formed their own centers of support away from discriminatory and more established institutions. This was especially true in health care. A visible gay and lesbian health movement emerged from these centers and collected trusting patients into their health care facilities and programs including venereal disease, alcohol treatment programs, mental health counseling, and community switchboards. Gay men in particular pooled their resources to address health concerns unique to their sexual behavior and disfavored by public health officials and medical professionals. Networks of communication tied the centers together to allow functional medical trials to occur.

Despite the visionary volunteers and gay health activists, the community as a whole remained vulnerable. With the noblest of intentions, gay and bisexual men served as human

²⁸⁴ "1981 International Symposium on Viral Hepatitis," *The Official Newsletter of the NCGSTDS* 2 (May 1981), 6.

test subjects offering necessary protocol variables with a great deal of personal health care and personal status at stake. The promise of an improved self-image and increased social standing among the general population certainly did not follow the contributions to medical research. In many ways, these goals were impractical as these broad links were rarely made in the minds of most people. The contributions of black men in the Tuskegee study, for example, did not improve the social position of African Americans, and neither did the trials for a hepatitis B vaccine advance gay human rights. If anything, an argument can be made that such trials and lofty research goals only confirm larger suspicions associated with disease, especially sexually transmitted ones. At the same time, the tie to public health officials in publications and trials and big pharmaceutical companies began in these vaccine trials where communication lines formed that would re-emerge in the HIV/AIDS era. Ostrow in Chicago and Dan William in New York both ascended to prominent positions and were recognized by the Centers for Disease Control. They also were prominent within the circles of the newly formed gay health organizations. Along with these leadership positions and communication lines, an underlying mistrust of government oversight, disingenuous motives of big pharmaceutical companies like Merck, and medical authority within and without the gay community reigned. These tenuous holds forged a unique place for gay health activists never before realized and perhaps not possible without the vaccine trials. However secure these holds were or were not, they facilitated communication on gay health matters by the early 1980s and they would continue until the end of the HIV/AIDS era.

Chapter Six

Like Water through a Funnel: Inside the Whitman-Walker Clinic

The impressive growth of urban gay men's clinics and the networks formed in the late 1970s foretold of even stronger connections that formed in the next decade. By the early 1980s, many of the health activists serving as medical directors or administrators of the clinics across the country knew each other and regularly communicated by letters. They often shared administrative issues, discussed funding challenges, and remarked on innovative methods of outreach to gay and bisexual men about health. Despite sharing and borrowing of ideas, we can presume, each clinic operated and chose priorities based on local preferences and what gay health activists saw as local issues and community "personalities." It was well recognized among gay men and lesbians that gay communities on the West Coast differed from those on the east and those differences manifested themselves in the Midwest and South as well. Some tended to have more "closeted" approaches to gay health care, while others used every means available to reach out to and educate their community. These differences also played out to disparities of access to funding, and even how volunteers were recruited and trained. The Los Angeles gay health activists, for example, acquired support money from local public health agencies and philanthropic entities while other clinics depended on patient donations of a few dollars per visit. Volunteers at Howard Brown Memorial Clinic of Chicago and Fenway in Boston often were medical students or medical professionals while in Washington's Whitman-Walker Clinic the volunteers mostly were not medical personnel. These same characteristics surfaced during the HIV/AIDS era. The uniqueness of each local clinic is best discussed by going deeper

into one clinic. My familiarity with the Whitman-Walker Clinic during this period helped to understand the constraints to specialized health care at the brink of the HIV/AIDS era.

The Perspective of Whitman-Walker Clinic

On September 23, 1982, Mark Behar of the National Coalition of Gay STD Services wrote to Jim Graham now president of Whitman-Walker Clinic. He wanted an update:

What is the Washington clinic doing with the Hepatitis issue? Several clinics have begun testing and treatment programs, based on a sliding scale fee... Merck is (as expected) being very strange and aloof about the whole issue. They respond to our letters when they feel like it, and frequently don't address the issues appropriately—like a giant schizophrenic! Frustrating to deal with. Dave Ostrow did get them to give money for the benefit of the "Ad Hoc Task Force on Vaccination Strategies for Sexually Transmitted Hepatitis B Infection."²⁸⁵

Graham responded within a few weeks:

On HepVax [*sic*], the short of it is that the Clinic is doing nothing in terms of distributing the vaccine. As I have told you previously, I had all sorts of conversations with Merck—with no result to speak of. I agree with you, that the company's attitude is just very puzzling in its seeming ambivalence [*sic*]. I do know that Rick DiGioia here is dispensing the vaccine at a very low cost (so low that I doubt the Clinic could do much better). Also we are distracted with various other issues of more pressing and immediate concern, such as our long-planned move to injectable penicillin [*sic*].²⁸⁶

Behar added a final set of questions for Graham:

²⁸⁵ Mark Behar, "NCGSTDS" unpublished letter of 23 September 1982 to Jim Graham. MS2013, Series 1, Box 11, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

²⁸⁶ Jim Graham, Whitman-Walker Clinic unpublished letter of 7 October 1982 to Mark Behar. MS 2013, Series 1, Box 11, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

What's going on in DC with regards to the Acquired Immune Deficiency Syndrome? Any gay community fundraisers? Committees formed? Newsletters published? Research in progress? Screening of patients underway? Etc.²⁸⁷

Graham again responded:

On A.I.D. [*sic*], there is also little to report—even though for the past month, we have been involved in discussions with physicians at Georgetown's Lombardi Cancer Center and Howard University Medical School, concerning a possible research grant on that subject. Just recently, Monday to be exact, the researchers decided that there was too little incidence of a problem in this area (thank God!) to justify a screening project at the Clinic... I am convinced that there are things to be done here in that regard, but happily we return to the basic reality that this community has been spared this onslaught to date.²⁸⁸

Looking back from Graham's letter, the clinic certainly had progressed in many respects since its founding, but not without problems and growing pains. From the informal direction of men at the Gay Liberation Front house at 1620 S Street, NW, several men formed The Gay Men's VD Task Force and started the city's first Gay Men's V.D. Clinic on Saturday, November 10, 1973, at the Washington Free Clinic.²⁸⁹

For distribution among gay and bisexual men, the Task Force typed and copied a small brochure explaining the need for a special clinic and the symptoms and treatment for syphilis and gonorrhea. The Saturday clinic, as it was sometimes called, served a growing patient load of "a few hundred patients annually (in 1973) to a service exceeding 5,000 patient visits in

²⁸⁷ Behar letter.

²⁸⁸ Graham letter.

²⁸⁹ Handwritten Announcement for Gay Men's V.D. Clinic Opening, Washington Free Clinic, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

1978.” These patient visits averaged an annual growth rate of 38%.²⁹⁰ By 1978, the clinic volunteers noted that a slight decrease of positive cultures indicated an increase of gay and bisexual men requesting routine testing as opposed to coming to the clinic with symptoms.²⁹¹

The clinic continued to be operated by volunteers some of whom were medical professionals (two or three physicians that later increased to eighteen to twenty), but most volunteers were not experienced in clinical care. This meant training programs that by 1978 included classes on venereal disease symptoms, phlebotomy, clinical screening and testing procedures, education on informed consent forms and aspects of venereal disease.

Approximately fifty volunteers staffed the clinic working every other weekend to reach a minimum of fifteen hours each month to continue service.²⁹² Ten of these volunteers completed a sign language course offered by the clinic in order to reach out to Washington’s sizeable deaf population. A few went on for further training in sign language at Gallaudet College.²⁹³

The clinic advertised regularly in the weekly entertainment magazine *Out* and in an advertisement in *The Blade*. Two pamphlets, *It Hurts Both of You* and *VD Handbook*, continued to be distributed in record numbers, but even the administrators began to acknowledge its limitations as neither covered new issues for gay and bisexual men such as enteric diseases, herpes progeneralis, and hepatitis B.²⁹⁴ In 1978, the board and staff of the GMVDC reorganized

²⁹⁰ “Gay Men’s Venereal Disease Clinic, Overview of DHR/GMVDC Contract to Expand Diagnosis and Treatment of Sexually Transmitted Disease among Homosexual Men of Washington, District of Columbia,” 25 August 1978, MS 2013, Series 1, Box 10 and 19, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

²⁹¹ Gay Men’s Venereal Disease Clinic, 2.

²⁹² Gay Men’s Venereal Disease Clinic, 5.

²⁹³ Gay Men’s Venereal Disease Clinic.

²⁹⁴ Gay Men’s Venereal Disease Clinic, 6.

as Whitman-Walker Clinic and hired its first full-time administrator, Tom Ziebold, and a laboratory technologist. It also separated from the friendly Washington Free Clinic in the basement of Georgetown Lutheran Church and entered into a lease for its first clinic at 17th and Q Streets in Dupont Circle. The board and administrator noted that the GMVDC stood at a “crossroads.” As the clinic grew, it needed this new location to expand programs and health services. It was they noted, “much like pouring water through a funnel, only so much can be forced through at a time. If more water is added, spillage occurs, and waste results.” As the clinic patient load increased dramatically in 1978, the leadership did not want to turn away patients who needed this care. A larger clinic centrally located to the gay and lesbian community needed to be established.²⁹⁵

Whitman-Walker Clinic formation constitutes the most significant achievement in gay and lesbian health activism in Washington, DC. As the political activists of the Gay Liberation Front and the Gay Activists Alliance moved to expand the community’s presence the clinic became one of its most visible entities. The GAA successfully garnered funding for the Gay Men’s VD Clinic in 1975 and annually returned to the DC Public Health Office for support. The gay community also organized to support the clinic. As funds became increasingly difficult to acquire (DC eliminated funding in 1978), the volunteer donation at the door of each clinic opening fell very short of meeting operational needs. Thus, the gay Capital Area Board of Leather and Levi Motorcycle Clubs stepped up and formed a supportive, non-profit entity called Brother Help Thyself (BHT). This group organized its first fundraiser for the clinic in 1978

²⁹⁵ Gay Men’s Venereal Disease Clinic, 8-9.

donating \$4,518 to support the struggling clinic.²⁹⁶ BHT continues today and accelerated fundraising and giving for AIDS in the early 1980s. A new board presented itself in 1978 led by Dr. John Stansell and a medical director Nathan Woodruff.²⁹⁷ The remaining board mostly came from interested gay community leaders.

While the clinic grew and expanded, other programs formed and expanded within the Washington gay community. Now veterans of gay activist organizations—the Gay Liberation Front and Gay Activists Alliance—addressed their own place in the health community. Cade Ware and Bob T. started the Gay Group of AA meeting in their homes as an alternative to Alcoholic Anonymous (AA) meetings in the city. In a rare instance of gay men and lesbians cooperating on anything, the Gay Group included both and opened its meeting through publicity in *The Blade*. Nancy Tucker, the editor, welcomed the news and reported it before joining the group herself a few years later. Ware and Tucker later joined in the publication of *The Homosexual Alcoholic: AA's Message of Hope to Gay Men and Women* in 1974.²⁹⁸

Ware also developed a companion program known as the Gay Council on Drinking Behavior in 1977. The Council provided services to gay men with drinking problems that might lead larger problems of alcohol and drug addiction. The Council operated with twenty members when it joined the clinic.²⁹⁹ It soon joined the growing Whitman-Walker Clinic with

²⁹⁶ "Our Story," BHT Foundation, <http://www.bhtfoundation.org>.

²⁹⁷ Whitman-Walker Clinic, Inc. Program for Members and Friends Dinner, 24 October 1979, MS 2013, Series 1, Box 19, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

²⁹⁸ Audrey Borden, *The History of Gay People in Alcoholics Anonymous: From the Beginning* (New York: The Haworth Press, 2007), 80-82.

²⁹⁹ "The Whitman-Walker Clinic, Inc." pamphlet on clinic services, c. 1979, MS 2013, Series 1, Box 19, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC; *OUT*, 26 April 1979, MS 2013, Series 1, Box 19, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

an increasing presence in board leadership. Tom Ziebold, the first full-time administrator, moved from being a counselor with the Council to his position as clinic administrator. He later recruited Jim Graham, first president and then administrator of the clinic, to serve on the board from the ranks of the Council. After the group renamed itself as Whitman-Walker Alcoholism Services, it published its own booklet of stories, *The Way Back: The Stories of Gay and Lesbian Alcoholics*, in an outreach to a broader audience. It then described its services as outpatient treatment for alcoholics and substance abusers and after care and co-alcoholism programs.³⁰⁰ Jim Graham noted that the Monday night services of the Council meant someone waited at the top of the stairs to see who wanted help and invited men upstairs for counselling.³⁰¹ The last publication of *The Way Back* is dedicated to Cade Ware who died March 20, 1986 from AIDS-related illnesses.³⁰²

The Gay Men's Counseling Collective also joined the Whitman-Walker Clinic as an outreach to gay men in 1978. The Collective, six years old when it joined the clinic, used thirty volunteers to offer individual counseling, growth groups, and workshops on special topics. Prior to moving into the clinic, the Collective operated mostly out of church facilities in Dupont Circle. The Lesbian Health Clinic and Lesbian Resource and Counseling Center Services both were started in 1978 by interested lesbians in Washington. The groups merged and joined Whitman-Walker as the Lesbian Health and Counseling Center (sometimes referred to as the Gay Women's Health Center) later that year. The Gay Hotline Association became one of the

³⁰⁰ Alcoholism Services,, Whiteman-Walker Clinic, Inc. *The Way Back: The Stories of Gay and Lesbian Alcoholics*, Third Edition, self-published 1981, 1982, 1986.

³⁰¹ Personal communication with Jim Graham, November 5, 2015.

³⁰² Personal communication with Jim Graham.

last entities to join the clinic. This group of volunteers provided peer counseling, information, and referrals by telephone to residents and visitors to Washington, DC. When it joined the clinic in 1982, volunteers answered some fifteen thousand calls annually from all across the country and sponsored Youth Organization of Washington (YOW) as a gay, peer-support group for gay men and women up to twenty-one years of age.³⁰³

In spring 1980, the clinic's momentum shifted. Ziebold, the administrator resigned under pressure leaving the clinic again to an all-volunteer management and leadership. An impending financial crisis, loomed over the organization. In less than a year, the medical director Nathan Woodruff wrote a letter to the new president Jaime Fernandez expressing concern over testing and patient confidentiality.³⁰⁴ He would soon resign as would several on the board. Jim Graham, a new president, then initiated means to correct the problems of funding and health care. The board relinquished an oppressive lease for its clinic on 17th Street and moved to smaller quarters at 18th and Belmont in Adam's Morgan adjacent Dupont Circle.³⁰⁵ The clinic remained at this location for more than ten years. The board hired a new clinic administrator, Larry Medley, and operated impressive volunteer training under John Conley, a gay DC Public Health employee, and David Earle, a medical professional, covering

³⁰³ "Proposal to the Board of Directors of the Whitman-Walker Clinic, Inc. by the Gay Hotline Association, Inc.", MS2013, Series 1, Box 19, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

³⁰⁴ Letter to Jaime Fernandez from Nathan Woodruff, M.D., 19 February 1981, MS 2013, Series 1, Box 11, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

³⁰⁵ Letter to Jim Graham from Key Enterprises, 12 November 1981, MS 2013, Series 1, Box 11, Jim Graham Papers, Special Collections Research Center, The George Washington University Libraries, Washington, DC.

aspects of male anatomy and physiology, sexually transmitted diseases, and clinical examination and treatment.

During this period of roughly two years, 1979 and 1981, an important volunteer structure coalesced within the clinic. As the board shared in more responsibilities for management of the clinic, volunteers assumed roles dealing with medical procedures, operations for patients, training, and public outreach. In fall 1980, I sat in a metal folding chair in the basement of a Dupont Circle church as one of these new clinic volunteers. Like many of us, I was unfamiliar with medical terminology as well as clinical procedures. I recall learning about gay men's health, but also transmission of venereal diseases, taking cultures, examining for venereal disease, and appropriate patient management. Later, I joined the Operations Committee (OPSCOM) setting up new training programs and volunteering.

At the Gay Pride Day celebration in June 1981 on P Street Beach, the clinic erected an information tent and debated the pros and cons of offering first aid to pride goers. A green fan noted "I Can't Give You Anything But Love" as an advertisement for regular screening of sexually transmitted diseases and testing at the clinic. The annual Gay Pride Day galvanized gay men and lesbians each summer, but initially started as the annual Christopher Street Reminder on the anniversary of Gay Mayday. Dupont Circle became the center of the celebration as the host neighborhood to much of the Washington gay community. Mention of AIDS still loomed as a series of small articles in public health reports and soon in American newspapers.³⁰⁶ (See Illustration 6)

³⁰⁶ Gay Pride Day Fan, Whitman-Walker Clinic, Frank Kameny Papers, Manuscript Division, Library of Congress, Washington, DC.

By 1983, Jim Graham moved from volunteer president to director of Whitman-Walker Clinic. He could no longer claim AIDS was not an issue in Washington. The clinic sponsored the first public awareness campaign with Washington physicians presenting information on the growing AIDS health crisis in Lisner Auditorium at George Washington University on April 4, 1983. Graham met his first AIDS patient, John Wittig, that night on stage.³⁰⁷ The thirty-six-year-old Wittig spoke of his illness and excruciating treatments for Kaposi sarcoma. As the former president of the gay Catholic group Dignity, Wittig's story caught everyone's attention as he spoke to a packed auditorium. Three years later Wittig died, an early victim of Washington's AIDS story.³⁰⁸ Earlier in 1983, the clinic board organized the AIDS Education Fund and through that associative entity gradually developed programs of education, testing, and support services in Washington and the Maryland and Virginia suburbs. In the initial years, the clinic borrowed heavily in educational materials from San Francisco (pamphlets of the Sisters of Perpetual Indulgence and others) and especially the Gay Men's Health Crisis (GMHC) in New York. Graham would say the GMHC started many services and other clinics followed.³⁰⁹

Graham reflected on his leadership at Whitman-Walker Clinic years later as we looked out his window at Rock Creek Park in Adam's Morgan near Dupont Circle. I could tell it was a life story for him as he traced his own visit to the Gay Men's VD Clinic in Georgetown with his former partner many years earlier. He recalled its bed sheets hanging between makeshift examination rooms to the growth of Whitman Walker Clinic in the early years of AIDS. Clinical

³⁰⁷ Personal communication with Graham, November 5, 2015.

³⁰⁸ *The Washington Blade*, April 8, 1983, 14, 1.

³⁰⁹ *The Washington Blade*.

procedures were much advanced and funding now appeared from a number of sources, both public and private, eliminating the once repeated threats to close the clinic forever.

Everyone, Graham would note, now focused on curtailing sexually transmitted diseases. The Gay Restaurant Owners (GRO) voiced some concerns but not as challenging as the owners of the gay bath establishments, particularly one of the city's oldest baths, The Regency. Some city health departments forced the closure of their gay baths while others debated the right of individual choice in sexual and health matters. Condoms that the Gay Men's Health Project once recommended to all its clinic patients, now became a thin layer between life and death. Condoms were easily available for "safer sex" or "safe sex." These two options did not constitute the same behavior. Many community organizations redirected fundraising to AIDS programs at Whitman-Walker and other organizations that appeared. Rates of syphilis and other sexually transmitted diseases fell to their lowest levels since the 1950s. Volunteer counseling and assisted living projects, supported by an often united gay men, lesbians, and others, sprang from the Gay Men's Health Crisis in New York, the Shanti Project in San Francisco and the West Coast, and AIDS Interfaith Council in Houston. North America and western Europe found their urban communities set in motion toward health care and care giving at a scale never before experienced. New York artist Keith Haring (1958-1990) used his graphic talent to design some of the most provocative images of the time. In 1986, he donated an original art piece to *Brother, Help Thyself* for an AIDS fundraiser. It captures much of the spirit that the HIV/AIDS era spawned.³¹⁰

³¹⁰ This illustration includes Haring's characteristic "cartoon" figures with six figures sitting on the shoulders of one another in two vertical columns with expressive movement around each figure, c. 1988.

The circle was now complete. Conservative religious and political leaders would associate HIV/AIDS with the promiscuity of gay and bisexual men if not the end of the world. Gay men would associate promiscuity with HIV/AIDS, while the gay community experienced a shaping and reshaping of its values and practices through the HIV/AIDS era. The stage also was set for a new wave of gay and lesbian health movements still imbedded in volunteerism but now more robustly funded and more inclusive of people of color and the gender conflicted. The clinics and health services of the pre-HIV/AIDS era would take a new leadership role in these diverse communities and in the revised health movement of the 21st century with us today.

Conclusion

Five Critical Years 1977-1982: Get out of the fast lane!

From the Second World War to the early 1980s, an extraordinary level of health activism emerged among gay and bisexual men and lesbians in North America and western Europe. This period of almost forty years marks the formation of a gay and lesbian health movement that largely has been overlooked by historians and activists. The emergence of health activism parallels civil rights and human rights activism and other achievements for gay men and lesbians in western nation states. It also follows a familiar historical path from increased mobilization of gay and bisexual men and lesbians during the Second World War, through the founding and development of a homophile movement, to the spontaneity of a radical gay liberation movement, and then matures during the formative years of the HIV/AIDS era. It is characterized by active communication networks across North America and western Europe through community-based political and social organizations, educational programs, correspondence among entities and activists, printed communications in community newspapers, public marches, poetry, radio programs, conferences, and clinics.

Considerable progress in this health activism also resulted from a corresponding conservative movement in biomedicine and medical authority. This movement served to create awareness and challenged rights among silent gay and bisexual men and lesbians who previous to the HIV/AIDS era sat quietly on the sidelines of politics and health. The result was increased communication and activism among an already agitated community. In short, this communication network, largely nonexistent prior to the Second World War, escalated within gay and bisexual male and lesbian communities and developed outside of the same

communities as a counter movement of resistance. The challenges to gay and lesbian activism strengthened the gay and lesbian health movement, and created a nascent, but viable platform on which to build a more robust and inclusive health movement than the resources that existed at the beginning of and during the HIV/AIDS era.

I identify five key components that contributed to and undergirded this health activism: (1) awareness of mental and physical disease as a underlying factor in the medicalization of homosexuality; (2) a powerful presence of medical authority that objectified gay men and lesbians and furthered medical discrimination; (3) a medical boundary that determined whose life mattered set in disease association and transmission that kept gay and bisexual men and lesbians at a managed or marginalized minority distance; (4) cooperation with sexuality and disease-focused studies that sought to improve social status within and without the gay community; and (5) the increased surveillance of gay and bisexual men by public health officials that led to an uneasy alliance with government already in place by the HIV/AIDS era.

How do we recognize that the product of this health activism is a gay and lesbian health movement in comparison to other health social movements such as women's health and environmental health communities?

First, it is fundamentally a movement characterized by a community organizing to take care of itself. Again and again, archives present demonstrations of gay activists reaching needy men and women to answer questions, provide counseling, address a common letter, and speak out in churches, rallies, and newspapers to answer a common call for help. Sometimes, such as when activists endorsed political candidates, the movement organized in traditional ways

common to their own upbringing or education. Other times, when activists confronted elected officials through direct action, the movement skirted the dark edges of the community to offer encouragement or give guidance.

Second, the movement shapes our recognition that the body is a vehicle for sexual expression as much as it is a holistic place to generate other human characteristics. The limp wrist, the lisp, or the masculine gait, whatever we may associate with characteristics of sexuality in the human body, are identified in the movement as insignificant. The human body in all its shapes and forms is a physical representation of biological forms that have certain qualities in sexuality. The movement, for example, recognizes the individuality of each person visible through the body and allows it to express sexuality. This is where the transgender, to use a contemporary term, adorns a bodily appearance that represents an underlying sexuality.

Third, the movement presupposes that sexuality and sexual expression create unique health issues. The pressures of non-conformity and relegation to sub-human existence by mental health professionals was one example of this uniqueness. But, venereal diseases and the explosive term “sexually transmitted diseases” also are unique health issues that separate some gay and bisexual men from others. Health issues of these kinds deserve professional research and training and should not be presupposed to be just like the health issues of any other male or female.

Finally, this health activism accepts a standard slogan of similar movements; that access and nondiscrimination in health care are human rights that are political. Health care is a human right not a privilege.

Periods of Health Activism

The post Second World War appearance of health activism should not be viewed as the first intersection of gay men and lesbians with medicine or science. The period follows more than fifty years of gay men and lesbians seeking the advice and counsel of physicians and scientists. Relatively little academic attention has been allotted to this period except for the work of historian Henry Minton in *Departing from Deviance: a History of Homosexual Rights and Emancipatory Science in America*. His work supports my statement that gay and bisexual men, lesbians, and transgender men and women have always cared about their health and looked to rigorous scientific methods to find answers.

Until recently, few historians researched and wrote about the second period of activism from the Second World War to the beginning of the HIV/AIDS era. Two historians of note who initiated critical work in this era are Katie Batza and Richard McKay. Their publications challenge the historical chronicles and offer initial analysis of the second period of health activism. The HIV/AIDS era, roughly 1981 to 1996, should be seen as the third period of activism and as an important prelude to our contemporary health programming that constitutes the fourth period, generally 1996 to the present.

My concern here also is with the second period of activism. Because it shares a common trajectory with other civil rights advances and because it laid a solid platform for the most critical period to follow that of HIV/AIDS, I find it most compelling.

Notwithstanding the forty years of postwar development, the five years between 1977 and 1982 may be viewed as a final and most critical development period for the health care of

gay and bisexual men in North America and western Europe. A quickened pace among these gay male communities both in health care provisions and social/political life became a platform for the public awareness of HIV/AIDS with the first mention in 1981 of a “rare cancer in gay men.” My analysis of these years as the conclusion of a long postwar process within and outside of the gay and bisexual male community contributes to a growing awareness among historians that the HIV/AIDS era did not initiate the widely held conceptions of a politicized and health educated gay male population. In fact, it is arguable that the self-care exercised by gay men in the pre-HIV/AIDS era exceeded early initiatives after the appearance and awareness of HIV/AIDS in the early 1980s. In the pre-HIV/AIDS, period venereal diseases were more visible and gay men more easily adjusted sexual practices and treatment. By the late 1970s, the stigma of venereal disease among gay and bisexual men diminished, and there was no real fear of immediate death.

At the same time, my research suggests that like several other recent historical narratives the gay male leadership among health professionals and political activists overstated and misused the claims of promiscuity among gay men. My research conclusion contrasts a number of memoirs and publications of the HIV/AIDS era that over-burden the urban gay culture with excessive behavior and describe a gay male culture that is devoid of community support and commitment. I again suggest that gay and bisexual men always cared about their health, both mental and physical, and shared a common interest in educating and supporting each other since at least the late nineteenth century. Recognizing the presence and longevity of this health ethic is an important correction to the discourse of promiscuity among gay and bisexual men. Many of the programs more richly developed during the HIV/AIDS era were

founded in projects and programs developed within the gay community many decades earlier. The fierce warnings that emerged during the HIV/AIDS era for gay men to change sexual behavior also began during the pre-HIV/AIDS era where gay men were admonished to “get out of the fast lane” by health professionals and some community leaders. Underlying these health warnings, however, lay a deeper issue of politics and economics that were structural forces that undermined gay men and compromised their well-being. The gay community’s need for and dependence on bars, bathhouses, and community gathering places also contributed to the limited success of health care programs. Nonetheless, these pre-HIV/AIDS era advancements settled deeply into the gay and bisexual community and contributed to the formation of a gay and lesbian health movement much along the lines of women’s health movement and health programs for ethnic minorities.

Gay men and lesbians have always cared about their health. At the core of their care lay the curiosity of what made them different. Was the nature of this difference biological or sociological? What formed this innate attraction to others of the same sex? After the Renaissance, these curious men and women turned to science and eventually medical physicians for answers. As science developed rigorous methods of investigation, men and women turned to scientists to help answer these questions and offered themselves as research subjects. Surely, they reasoned, the answers would reveal truth, as science was truth, and then acceptance would follow. But, the answers often were elusive and the interpretation of the results of scientific methods did not always demonstrate desirable medical practice.

Historical Perspectives

Much like George Chauncey has enlightened readers about gay New York before the Second World War dissolving common perceptions of isolation, invisibility, and internalization; this project endeavored to illuminate a health ethic that existed long before the common perceptions associated with the HIV/AIDS era. Health care and self-care always existed, but what also existed and persisted were the social constructs of disease and immorality. If you eradicated syphilis or any other sexually transmitted disease among gay and bisexual men, then you eradicated what separates heteronormative behavior from homosexual behavior. The surveillance of venereal disease sought to keep the deviant in check but it also established boundaries for heterosexuals and homosexuals. It warned bisexuals of crossing the line. Even to this day the opportunity for disease serves as a boundary between sexual practices and gay and bisexual men. The stigmatization of social disease separates sexual practice, but it also separates citizenship. Without sexually transmitted diseases, assimilation becomes more plausible and a less distinct class of men and women exist as the “other” with no stigma.

Gay health advocates stereotyped their will and offered services in part because gay men were underserved, but also to guide gay men toward assimilation. The stigma of shame associated with venereal disease placed barriers to positive self-identity and “cleanliness.” We continue to see this today in the stigma of HIV and AIDS.

The perception or reality of promiscuity (whichever you believe) separates gay from straight. There is very little documentation on the promiscuity of all gay and bisexual men, but the health barriers of sexually transmitted disease established public forms of constraint to promiscuity. This constraint also may be seen as a boundary.

We often think about boundaries in a physical perspective meaning limits to movement and transmigration. But boundaries are also human obstacles and limits imposed through or revealed in political, religious, or social discourse. For example, sexuality, one of the most debated of human boundaries, is set by a number of boundaries that we all share verbally and through performance. But disease, or the fear or threat of disease, creates the most significant boundary of all. It is not just a mental health disease, but for the gay and bisexual male it is given context through the threat of sexual transmission. It is a line, an imaginary boundary that protects the uninfected and stigmatizes the infected. The stigmatized population (largely seen as being promiscuous and exercising poor judgement) are in turn marginalized. This is supported by the practices and literature of medicine, public health, and the gay and lesbian political bureaucracy. Marriage equality is an attempt by the gay and lesbian bureaucrats to minimize the boundary and limit promiscuity.

A Theoretical Perspective

The writings of Michel Foucault and Guy Hocquenghem are useful in considering these perspectives of disease and caregiving. These two French philosophers offer two separate approaches to the concluding years before HIV/AIDS. Hocquenghem suggests the function of venereal disease in “managing and limiting” gay and bisexual men, while Foucault offers insight into the role of biopower as well as “friendship or homosocial” content. Foucault’s work is used here to address his indifference, if not opposition, to liberation politics of North America that included health politics and activism. Concepts that he later articulated suggest broad perspectives of friendship as the basis for health activism. Hocquenghem, on the other hand, is a product of French student activism that shapes his theories of the role of public health

initiatives, oppression, and the capitalist and class struggles of gay and bisexual men, in particular. These are particularly interesting early queer theorists who participated in the gay communities of North America and western Europe and would also become early victims of HIV/AIDS.

These gay French intellectuals expand the view of the gay and lesbian health movement in different directions. They create bookends to a theoretical perspective of the postwar development of this health movement. Located in a temporal world in western Europe with significant ties to North America, these two intellectuals contrast a realistic world of lived experience within the same constructs as the health movement. Hocquenghem comes from an activist role in the Paris student university riots. His writings are often forgotten today or obscured by more salient voices. Nonetheless, he shadows a richly active gay and lesbian rights movement in North America and western Europe. Foucault, conversely, stayed nestled in academia at the College de France. His ostensible absence as an activist, choosing restraint and analysis instead, camouflaged his excursions into the dark dens of the gay world where venereal disease often festered. His thoughts on friendship, however, open up a view on the leadership of gay men as health activists. The exploration of the writing of these men follows. It should not be overlooked, that while helpful to the lens on the gay and lesbian health movement, Hocquenghem and Foucault both died in the next health era, the HIV/AIDS era, in the respective years of 1990 and 1983.

Hocquenghem first wrote in 1972:

We already know about the function of the fear of syphilis in middle-class sexuality as a whole, and to what extent the fear of venereal disease acts as a barrier to sexual normality. The weakening of the free social cover against venereal disease which was

more readily available in the past than today, is known to the whole medical establishment. The shame that accompanies the disease, the repressive system by which the social worker has virtual police rights in cases of syphilis (including access to the files and his ability to force the patient to declare all sexual contacts who could have been infected) are sufficient to admit that he has syphilis. Syphilis is not just a virus but an ideology too; it forms a phantasy [*sic*] whole, like the plague and its symptoms as Antonin Artaud analysed them. The basis of syphilis is the phantasy [*sic*] fear of contamination, of a secret parallel advance both by the virus and by the libido's unconscious forces; the homosexual transmits syphilis as he transmits homosexuality.³¹¹

Hocquenghem creates an early context for what became fully realized by the early 1980s in North America and western Europe. He develops an imaginary line that separates the diseased homosexual, usually the male homosexual, through shame and interrogations, like the plague, away from heteronormativity. Much as Kinsey would argue a continuum of sexuality that moves and shifts, it is thoughtful to reflect that Kinsey's scale allows men to move up or move down or to cross over the line or choose not to do that. Using Hocquenghem's words, it may be possible to project disease as similar in movement to sexuality.

Foucault's words take a different direction focused on friendship among gay men and lesbians as a way of life. In an interview with the gay French magazine, *Gai Pied*, Foucault directs our attention to another matter:

The problem is not to discover in oneself the truth of one's sex, but rather, to use one's sexuality henceforth to arrive at a multiplicity of relationships. And, no doubt, that's the real reason why homosexuality is not a form of desire but something desirable. Therefore, we have to work at becoming homosexuals and not be obstinate in

³¹¹ Guy Hocquenghem, *Homosexual Desire*, trans. by Daniella Dangoor (Durham, NC: Duke University Press, 1993), 70.

recognizing that we are. The development toward which the problem of homosexuality tends is one of friendship.³¹²

This notion of mode of life seems important to me. Will it require the introduction of a diversification different from the ones due to social class, differences in profession and culture, a diversification that would also be a form of relationship and would be a “way of life”? A way of life can be shared among individuals of different age, status, and social activity. It can yield intense relations not resembling those that are institutionalized. It seems to me that a way of life can yield a culture and an ethics. To be “gay,” I think, is not to identify with the psychological traits and the visible masks of the homosexual but to try to define and develop a way of life.³¹³

If you replace gay activism with a quest for friendship and a “way of life,” sexual or not, then you may see that health and health care may be directed not by friendship between and among men and not by the sexual practice or promiscuity. Before the *Gai Pied* interview, Foucault lived in San Francisco at the end of the 1970s and again in the early 1980s.

His thoughts enhance our gay history in the context that we know and grew up with considering our history as one of achievements and events rather than the development of friendships and a way of life. Historians of gay history are aware of context, but typically historians discuss progression and success. In reality, our world as Foucault states, might be improved by focusing not on homosexual sexual acts or disease, but on the forms of caregiving that escalated through the 20th century and the waves of health activism expressed itself in each period. The world of gay men and lesbians (including bisexual and transgender) consisted of a back-and-forth exchange between complicity and avoidance between a straight world and a veiled gay world.

³¹² Michel Foucault, *Ethics: Subjectivity and Truth*, edited by Paul Rabinow (New York: The New Press, 1994), 135-136.

³¹³ Foucault, 137-138.

The popular idea that HIV/AIDS activated modern concepts of queerness and positioned the body into the forefront of health activism is not accurate. The HIV/AIDS era realigned questions of what constitutes citizenship based on perceptions of a healthy body and disease transmission through sexuality rather than invisible pathogens or biological germs. Thus, AIDS and later HIV (I am reversing the order here because AIDS came first in our naming of the disease and HIV came later after several names) served as exemplars of a health social movement that shared techniques for health activism from the grass roots into challenges to the stationary and intransigent biomedical bureaucracies.

HIV/AIDS did not just appear spontaneously nor did often cited community leaders arise from the populace to challenge sexuality, biomedicine, and community institutions without precedent. Instead, health activism is an early model for examining the human body and using its form, processes, and organs as political vehicles.

Why have historians and activists overlooked earlier precedents to the HIV/AIDS era? One explanation is that the latter so overwhelmed the former that it obscures earlier health activism. Another is that the records have not been as easily accessible as those of the HIV/AIDS era until the last ten years and are often obscured or filed under obscured archival research headings. The type of records accessed is also complicated by access and restrictive laws. Medical records, rightly held in privacy, rarely exist for researchers of the earlier period. A dedicated historian must look at a number of different record types and “read between the lines.”

Another factor that obscures the earlier period is the transient nature of gay and bisexual men and the understandable preference to be anonymous. Similarly, gay and bisexual male sexual activities often occurred in secrecy or in “dark corners.” These same men often did not stay within their own class or social structure for sex allowing disease transmission to cross many geographies and boundaries of race and sexuality that we often assume existed.

This project challenges the Whiggish notion that disease and health care are modern concepts because of advances in therapeutics and public health initiatives and equally questions that sexuality and gender nonconformance are advanced humanistic concepts of the 21st century. Instead this project advances a notion that the factors of health care and ethics among gay and bisexual men and lesbians transcends historians who look to the evolution of progress rather than the innate health concerns of humans, whether gay or not.

Health is politics of a different type. Access to health care free from medical discrimination is essential to human well-being.

Epilogue

On June 5, 1981, the Centers for Disease Control (CDC) released Dr. Michael Gottlieb's and Dr. Joel Weisman's article in the *Morbidity and Mortality Weekly Report* carrying the ominous title of "Pneumocystis Pneumonia—Los Angeles: In the period October 1980–May 1981, 5 young men, all active homosexuals, were treated for biopsy-confirmed *Pneumocystis carinii* pneumonia at 3 different hospitals in Los Angeles, California." Many historians attribute the findings of these two physicians in Los Angeles as being the first call to action in a crisis that formed around AIDS. Others also claim a role. Sandra Ford at the CDC answered calls from physicians for rare drugs held at the center to treat uncommon diseases. In spring 1981, she noted an increase in physicians asking for the drug pentamidine to treat *Pneumocystis carinii* mostly for young men in New York and Los Angeles. The increase prompted Ford to draft a memorandum to her chiefs at CDC make it the first trigger of awareness within the CDC that a new viral agent was at large.³¹⁴ But, it was the article by Dr. Lawrence Altman, medical editor of *The New York Times* where most Americans, gay and straight, first heard of the impending crisis. Altman's headline, "Rare Cancer Seen in 41 Homosexuals," on July 3, 1981, reached a larger audience and accelerated research and discussion among gay and bisexual men and lesbians. Aware or not, the pandemic had been long underway and would continue to expand until successful trials of antiretroviral drugs slowed or disguised HIV in the late 1990s.

Whitman-Walker Health

Whitman-Walker Clinic eventually led care of HIV/AIDS patients in Washington, DC. They established testing centers, counseling, and full services for assistance to patients. During

³¹⁴ Elizabeth W. Etheridge, *Sentinel for Health* (Los Angeles: University of California Press, 1992), 321-322.

1989-1990, lesbian health activists added another arm to the work at Whitman-Walker Clinic. The Lesbian Services Program (LSP) developed programs specifically for lesbian's interest in all aspects of focused women's care including cancer counseling and assistance, mental health counseling, and having children.³¹⁵

Today, Whitman-Walker Health is a medical and dental provider for a broad community of gay, bisexual, lesbian, transgender, and queer patients in four locations around Washington. Its principal facilities are near Dupont Circle and Logan Circle, and another neighborhood clinic in Anacostia, a historically African-American neighborhood. Services include general health care and outpatient care, wellness education, HIV/STI testing and treatment, a pharmacy, dental care, addiction counseling and treatment, and health care for queer women and youth.

The Stories of the Poets

In 2006, Jim Graham (then a DC City Council member) wanted to honor the caregivers who nursed patients in the early days of the AIDS crisis. The ideal location became the long curved granite wall that forms the escalator tunnel into the Dupont Circle metro station at Q Street. He selected two verses by gay poets. The first is from Walt Whitman's "The Wound-Dresser" reflecting on his nursing experiences in the hospitals in Washington during the Civil

War:

*Thus in silence in dreams' projections,
Returning, resuming, I thread my way through the hospitals;
The hurt and wounded I pacify with soothing hand,
I sit by the restless all the dark night – some are so young;
Some suffer so much – I recall the experience sweet and sad...*

³¹⁵ "Lesbian Health Services Meeting the Need of Women," <http://www.whitman-walker.org>.

The second verse inscribed on a granite bench near the entrance to the station is by local black gay poet, E. Ethelbert Miller:

*We fought against the invisible
We looked to one another*

*for comfort
We held the hands of friends*

*and lovers
We did not turn our backs
We embraced
We embraced*

The D.C. Commission on the Arts and Humanities dedicated these verses on July 14, 2007.³¹⁶

³¹⁶ John Kelly, "Hark, what poem leaps from yonder Metro wall?" *The Washington Post*, May 18, 2013.

APPENDIX I

Archives and Collections

Cushing Memorial Library at Texas A&M University, College Station, Texas.

This relatively new entity is called the Don Kelly Research Collection of Gay Literature and Culture. The material is varied and the vision of one individual now living in Houston. While not an archival collection of papers, per se, the collection includes ephemera, gay community newspapers, organizational and event promotions, comics, and literature related to venereal disease, and gay and bisexual men's health. The assortment of material expands the geographic basis for gay and bisexual men and health care that interests me and contains unusual items from various health initiatives from within in the gay community.

ONE National Gay & Lesbian Archives, University of Southern California, Los Angeles.

This institutional collection began as a counter archives before becoming part of the university. It includes records from the Committee for the Eradication of Syphilis (1966-1995) initiated by Vernon Mitchell in 1967-68 in West Hollywood, California; papers and documents from the Los Angeles Gay and Lesbian Center (1945-2005) that includes the Gay Men's Health Clinic, and records from homophile organizations such as the Mattachine Society and ONE from the 1950s through 1960s. This collection also includes other writings by Jim Kepner, one of the earliest historians of the gay and lesbian movement in the United States and Alan Cantwell a physician who researched the Hepatitis B vaccine trials and suggested that the vaccine was responsible for HIV/AIDS. This is the largest and most important archive for my research and may offer insights into early health care initiatives particularly in Southern California.

Special Collections Research Center at the Gelman Library at George Washington University, Washington, DC.

The principal collection includes the Jim Graham Papers, 1973-2012, former director of the Whitman-Walker Clinic. Graham's papers include the early incorporation documents for Whitman Walker and covers the years of Graham's service on the board of directors and later executive director of the clinic. This library also holds papers for leaders of a radical lesbian organization, Off Our Backs, which published newsletters for almost twenty years.

Franklin E. Kameny Papers, Library of Congress, Washington, DC.

Frank Kameny co-founded and led the Washington, DC, chapter of the Mattachine Society from 1961 until the mid-1970s. Kameny is the undisputed champion of liberation policies and positions for gay men and lesbians from his generation in Washington, DC, if not beyond the nation's capital. His papers are now catalogued and offer particularly strong insights into communications and program development for the city's homophile movement.

Lesbian, Gay, Bisexual, and Transgender People – Archives Department, University of Wisconsin, Milwaukee.

This collection holds the Gay People's Union Records (1971-1984), Brady East STD Clinic Records (1972-2007), and Mark Behar's Papers (1981-1991). These records fill out the background on the gay men's clinic in Milwaukee from the 1970s under the direction of Mark Behar, a physician assistant. Behar's works also include material on the National Coalition of STD Services as he was the editor of its publications for approximately ten years.

City of New York Public Library

This archive contains one of the nation's largest collections of gay and lesbian materials. This location houses information on the Gay Men's Health Project from the 1970s and the Gay Men's Health Crisis established in the 1980s.

LGBT National History Archives within The Lesbian, Gay, Bisexual and Transgender Community Center; Gay, Lesbian, Bisexual and Transgender Historical Society, and City of San Francisco Public Library, San Francisco, California.

These records address the early city clinic and its programs for gay and bisexual health care and the Hepatitis B trials conducted in the 1970s. In addition, the papers of Dr. Robert K. Bolen a physician involved with public health care issues for gay men are contained in the Special Collections at the University of California, San Francisco.

Baylor Collection of Political Materials, Baylor University Archives, Waco, Texas.

This archive holds the papers of Representative John V. Dowdy who actively opposed recognition of the Mattachine Society of Washington, DC. His oversight of the House District of Columbia Committee offered him unusual authority over tax exempt status for organizations. His opposition materialized into several legislative efforts to further discrimination against homosexuals in government and in the District of Columbia.

Harry Ransom Center, University of Texas at Austin, Austin, Texas.

This center holds the papers of the British Sexological Society (BSS), an early homophile organization in England, and those of George Cecil Ives, one of the founders of the BSS. Its membership consisted of leading physicians and cultured men and women in England from about 1910 to 1920. The materials are useful in connecting homophile activities to health initiatives in the late nineteenth and early twentieth centuries.

Counter or Alternative Archives

Rainbow History Project and Historical Society of Washington, DC.

This project includes both online archives and papers/ephemera from leaders and organizations of the 1960s through the present. The online material includes the Recordings of Friends Radio, WPFW (Washington, DC). These recordings are for a gay and lesbian program from the 1970s that addressed health care for the gay community of Washington, DC. (November 3, 1973 and May 18, 1974). Another online archives in joint management with the DC Public Library, Dig DC, includes publications of the *Washington Blade*, the gay and lesbian community newspaper, and *Quicksilver Times* and other alternative newspapers of the 1960s.

Houston LGBT History.org

This online resource connected to other collections in Houston can be found on the Houston ARCH Wiki. The archives offers newspaper articles and other material related to an array of subjects including health care and the formation of the Montrose Clinic.

Online Archives of California (OAC)

This online directory or statewide archives provides a focus on LGBT collections and links to in-depth catalog data. This is an excellent introduction to the more traditional archives in California. An interview with Paul O'Malley of San Francisco, who coordinated Hepatitis B vaccine trials in San Francisco in the late 1970s, is accessed through this online archive.

Community Health Online Digital Archive & Research Resource (CHODARR) Project

This project is developing an online historical archive for communities including the LGBT community. It includes the newsletters from the National Coalition of STD Services as well as some counter community newspapers and special projects. It is based in Canada.

Global Health Chronicles

This online collections includes interviews with health officials regarding various global health issues. It includes HIV/AIDS and draws from men and women involved in the epidemic from the 1970s and 1980s. One example is the interview of sociologist Dr. William Darrow and physician/researcher Dr. James Curran.

APPENDIX II

United States Public Health Bureaucracies

At the time that Acquired Immune Deficiency Syndrome (AIDS) became a named disease (1981-83), the United States supported the largest public program in the world that developed over the preceding two centuries. Historians of public health typically date the beginning of government intervention in health at 1798 with the establishment of a collection of marine hospitals. In 1870, the US government reorganized the hospitals as the Marine Hospital Service and created the position of Surgeon General. A few years later, the United States Public Health Service Commissioned Corps formed in a somewhat paramilitary format with uniformed public health officers stationed around the country. The corps assumed responsibility for public contagions and the welfare of the greater population against the containment of the fowled population. Major outbreaks of yellow fever, bubonic plague, tuberculosis, venereal diseases, and smallpox periodically were of major interest in American urban areas in the late nineteenth and early twentieth century. Corps officers exercised great latitude in containing disease agents and the “others” who were deemed responsible for bringing the germ or spreading it. Buoyed by the discoveries of the germ theory and association of living conditions in urban areas, the officers rose in authority as medical experts and military leaders to advance American principles of democracy and citizenship.

In 1944, the Public Health Service Act further entrenched the authority of the corps and became what is still the current legal basis for the Public Health Service (PHS). First included in the Federal Security Agency, the PHS then moved to the Department of Health, Education, and Welfare in the 1950s and then into the Department of Health and Human Services in 1979.

Two aspects of public health are important in the project that follows. Prior to the Second World War, a succession of surgeon generals created and expanded a division to address venereal disease out of offices headquartered in Washington, DC. It easily became the largest division of public health as it addressed the aftermath of military veterans with venereal disease returning after the First World War. Through various names, the divisions and bureaus handling venereal disease maintained statistics of the prevalence of syphilis (later other venereal diseases) collected from public health clinics and private physicians across the country. After the Second World War, Johannes Stewart, PhD, in the PHS suggested a new program to address an anticipated increase in venereal disease brought back from the soldiers serving in the Pacific and western Europe. With tacit approval in 1948, Stewart hired six trainees to begin a program of what became the Public Health Advisors (PHA). Skilled in the interviewing techniques of contact tracing and later cluster testing, the advisors moved into the field tracking down syphilitic contacts and containing the spread of venereal disease in urban and rural communities. The success of the PHAs led to a new "operations division" within the larger agency under the leadership of Dr. Lida J. Usilton. Described as "the madam," Dr. Usilton, a statistician, operated as the "wizard" behind interrogation techniques and directed the fate of every enlisted PHA. PHA veterans recalled her as a demanding poker player and authoritarian that insisted on compliance to rigid field standards by each field advisor. She seemed especially demanding in how the advisors dealt with homosexuals as a growing population with venereal disease in the postwar decades. One example is that she instructed them to use the code "HOR" for homosexuals in their reports so as to never draw attention to this segment of health enforcement. In 1957, the venereal disease division moved from Washington, DC, to Atlanta,

Georgia, and into the other major public health bureaucracy known as the Communicable Disease Center.³¹⁷

In the same postwar years that enhanced the venereal disease bureaucracy, the Centers for Disease Control also formed. The Malaria Control in War Areas (MCWA) division of the PHS stationed itself in Atlanta to be near the malaria zones prevalent in southern states. Malaria both in the states and in war zones brought debilitating effects to the war requiring special attention from the PHS. In 1946, the MCWA changed its name to Communicable Disease Center (CDC) and remained in Atlanta. The new center dealt with environmental issues but retained an interest in disease transfer of all genesis. In the postwar American landscape of the Cold War with threats of biological warfare and the Korean War, Dr. Joseph Muontin (a long-time director of the CDC) expanded services in research and scope to address the expansion of disease and military needs. This differed from another federal agency the National Institutes of Health (NIH) in Bethesda, Maryland, that focused on chronic diseases like cancer and heart ailments.³¹⁸

After an epidemic of Asian influenza (1957) and the Cutter incident when live virus got into the Salk poliomyelitis vaccine (1955), the role of the CDC began to grow. At this point, the Venereal Disease Division and the Tuberculosis Branch moved to Atlanta as related health programs to the study of malaria. Through challenges in the 1960s, the CDC shifted and realigned research priorities. First, it renamed itself the National Communicable Disease Center

³¹⁷ "Early Days of the PHA Program," Watsonian Society: A CDC Employee Organization for Public Health Advisors, <http://www.cdc.gov/watsonian/history.html>.

³¹⁸ Elizabeth W. Etheridge, *Sentinel for Health: A History of the Centers for Disease Control* (Berkeley/Los Angeles: University of California Press, 1992), xv-xvii.

and then again in 1970 as the Center for Disease Control. In 1973, the new CDC became a full agency in the PHS just as the NIH.³¹⁹

The Tuskegee experiments and swine influenza epidemic destabilized the successes of the CDC during the 1970s. Caught between the positivism projected by biomedicine and public relations, the CDC stumbled as an agency and public perceptions changed as new environmental challenges coupled with what would be called lifestyle issues like smoking and depression crept into the purview of the CDC scientists. In 1980, the Center for Disease Control became the Centers for Disease Control as it reorganized yet again into a set of bureaus with underlying divisions.³²⁰ The new CDC, coincidentally, timed itself with the forthcoming crisis of HIV/AIDS as a new infectious disease appeared with the complications of the widely held belief that homosexuality was itself a “lifestyle” choice of promiscuity and not a consequence of social factors.

³¹⁹ Etheridge, xvii.

³²⁰ Etheridge, xviii.

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