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Study Abroad Final Project

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June 26th, 2015

The "Problem" of Queerness

Exploring the History of LGBTQ People and Medicine

One of the toughest aspects of being a prospective medical student and eventual doctor is accepting that your field of study has been historically used to justify violence against marginalized groups, especially groups that you consider yourself to be a part of. The past cannot be undone, but it is essential to learn about it to make sure that marginalized groups don't have to suffer to gain access to basic healthcare. When I signed up for this study abroad, I was primarily interested in the history of the AIDS crisis; I would not have attended if that was not covered. Yet as we journeyed through different countries and explored the history, I found that there was much more to the relationship between queer (queer being used as a catch-all term for those in the LGBTQ community, not to imply that all members identify as queer) people and medicine than AIDS. On the trip I explored the origins of said relationship, studied the role of the medical community in the Nazi era and the AIDS crisis, and reflected on what can be done to make healthcare more accessible and friendly to LGBTQ people.

The pathologization of queerness was a relatively recent development in queer history. In Western European history, homosexuality was condemned and gay men were oppressed under the justification that their behaviors were animalistic, akin to incest and child molestation, offensive against nature, and defiant of dominant gender expectations (Boswell 138). It was not until the latter part of the nineteenth century when medical professionals began to analyze

homosexuality as not just "abnormal" behavior, but rather a health condition that can and should be treated. In the classroom we examined historian George Chauncey work on early modern New York City's culture of gay men, and I found that the medical community had a large role in shaping institutionalized homophobia. He wrote that "medical discourse was one of the most powerful anti-gay forces in American culture" (5), and it led to many doctors in the era attempting to "treat" homosexuality. Yet to doctors' surprise, many gay men refused to believe that they were degenerate and resisted medicalization. It was then that reluctant consensus was reached that most of their gay male patients saw nothing wrong with their attractions, and that "it was this attitude… that threatened to make the 'problem' of homosexuality so intractable" (Chauncey 6).

Unfortunately, Chauncey's piece did not mention lesbians (I should note I am using the term lesbian to refer to all women who are attracted to women, as the Lesbian Herstory Archives does, and gay for all men attracted to men regardless of self-identification), which initially did not surprise me because many historians wrote off lesbian history as between women with really close friendships. Yet as we entered the Lesbian Herstory Archives in Brooklyn (see Figure 1) I was pleasantly surprised at all of the material that focused on lesbians. Just in one shelf were books filled with lesbians' experience with the medical community, most of it was directed at the historical psychoanalytic approach to lesbians. I found an essay written by psychoanalyst and colleague of Freud Helene Deutsch written in 1932 on female homosexuality. Unsurprisingly, she examined her lesbian subjects using Freudian concepts as she states that "not one of my cases failed to have a very strong reaction to castration complex; a complete Oedipus with exceedingly powerful aggressive reactions could be demonstrated in very case" (Ruitenbeek 127). She also makes assumptions that penis envy is the cause of homosexuality between women,

which aligns with the popular notion at the time that the only real form of sex is penetration with a penis. Despite Freud's theories being illegitimatized as the twentieth century progressed, gay men and lesbians alike had their attractions labeled as a mental illness by the Diagnostic and Statistical Manual of Mental Disorders until 1973 (Datta), and many today still see people who experience same sex attraction as mentally ill. So while the medical community did not create homophobia, it was a main force in making it an oppressive system. As someone who will have to put up with the institution of medicine to keep a career, I found that horrifying.

Fig. 1. "Lesbian Herstory Archives". Photograph.

Despite the pivotal role the medical community has in establishing societal homophobia, there were some doctors who sought to justify and legitimize homosexuality. For example, as written in Chauncey's *Gay New York*, Dr. William Howard in 1904 argued that homosexuality in men was a normal feeling because "although the inverts had male bodies, they had female brains, and… that the brain, rather the anatomy was 'the primary factor' in classifying the sex of the person" (49). Chauncey then goes on to explain how intellectuals viewed effeminate gay men (known as fairies at the time) as a third sex and people who were attracted to both men and women (nowadays known as bisexual people) as having male and female traits simultaneously.

However, one of the key figures in early gay activism was physician and sexologist Dr. Magnus Hirschfeld. He began to popularize the idea of a third sex in hopes of expanding traditional views on gender and sexuality and advocate for minority rights by founding the Scientific Humanitarian Committee, which is accredited to being the first official organization that advocated for gay rights (McFatridge). Yet his activism was short lived, as Adolf Hitler and the Nazi Party rose to power in Germany and initiated the Holocaust.

Fig. 2. *Magnus Hirschfeld.* Photograph.

In Nazi Germany (1933-1945) a large emphasis was placed on Aryan racial superiority and the cleansing of impurities that threatened it. Among the targets were homosexual men as five to fifteen thousand were incarcerated in concentration camps, and it is estimated that about sixty percent of those incarcerated perished (“Homosexuals”). There has not been as much

research done on the persecution on gay men and even less research on lesbian women as there have been of other targeted groups of the Holocaust. Having traveled to three different cities in different countries (New York, Paris and Amsterdam) examining queer history, I have no doubt that this is because of the constant erasure of queerness in history. After all, the Homomonument in Amsterdam (Figure 3) was not created until 1987, and it took *eight years* to raise just 180,000 euros ("Sinds 1987"), and even then it was still the first of its kind. Yet there was plenty of evidence of science and medicine being used to justify the persecution of homosexual men.

Fig. 3. *Homomonument in Amsterdam.*
Photograph.

The Nazis saw gay men as degenerate human beings rather than ordinary criminals, as historian Geoffrey J. Giles writes that within the German population and many Nazi-supported psychiatrists "a widespread belief was gaining ground that adult homosexual offences were the result of an inborn predisposition" (52). Some believed that they could have been cured by having them assimilate into heterosexual relationships, but Giles notes in his article that prominent Munich psychiatrist Professor Theo Lang asserted that heterosexual activity would not cure homosexuality and it would rather create children with the same chromosomal abnormalities that caused the deviance (52). So, like any other genetic degenerate, gay men had to be exterminated under Nazi policy. Interestingly enough, the policy only seemed to take strong hold in Germany, whereas historian Michael Sibalis claims that Vichy France did not make a large effort to deport gay men to concentration camps unlike it did with Jewish people (313). This is likely because the cleansing of homosexuality under Nazi policy was prioritized for the Aryan (German) race.

For those in Nazi Germany, however, the persecution was swift, as we found in the visiting exhibit on gay men and the Holocaust in the Museum of Jewish Heritage in New York. Before the Nazi takeover, Magnus Hirschfeld had created a movement to decriminalize and destigmatize homosexuality which began to take hold in the intellectual community in Europe. The Nazi party relied on the affirmation of the medical community to validate their policies, so this was an obvious threat. So on May 6th, 1933, Hirschfeld's Institute of Sexual Science's library – which held invaluable research conducted on gender and sexuality – was raided and burned to dispose of positive views of homosexuality ("Nazi Persecution"). This forced Hirschfeld to take refuge in France, where he died a year later. This left only the "consensus"

that homosexuality was a disease and gave the Nazis the apparent right to remove them from the German population. The medicalization also convinced doctors to perform experiments on them. One notable experimenter was the SS major Dr. Carl Vaernet (Figure 4), who performed experiments on exclusively homosexual men in the Buchenwald camp. Author Richard Plant wrote that Vaernet would "castrate several homosexuals, inject them with huge doses of male hormones, then wait to see whether they would begin to exhibit signs of interest in the opposite sex" (177). Two of the subjects died from the hormone injection, according to Plant, and no record survived that contained the results of the experiment (179).

Fig. 4. "Carl Vaernet". Photograph.

When we delved deeper into the history of the Holocaust in the Deportation Memorial and the Shoah Memorial in Paris, and the Dutch Resistance Museum and the Homomonument in Amsterdam, I was once again reminded of the horrors that took place. Many hope that remembering this tragedy would prevent others like it in the future. But I knew that because of the erasure of gay history that not the same could be said for queer people. Because of the destruction of Hirschfeld's work, queer people continued to be stigmatized and labeled mentally ill until said otherwise by the DSM as mentioned before. To add to that, I knew that the medical institution will again fail the LGBTQ community on the onset of the AIDS crisis.

In the classroom before the trip, we watched the documentary *How to Survive a Plague*, which discussed the history of ACT UP and their efforts to gain proper healthcare for a disease that was quickly killing men who have sex with men (shortened to MSM, and is forcibly applied to transgender women). Admittedly I knew very little about why the AIDS crisis was initially so severe, but my eyes were opened. The documentary taught me a lot about the government's deadly indifference, but what shocked me the most was how the medical community treated the AIDS patients, both on a micro and macro scale. Hospitals gave incentives for doctors to *not* diagnose a patient with AIDS because of the mass panic, the National Institutes of Health (NIH) excluded people with AIDS from research committees until forced by ACT UP, and doctors' homophobia prevented them from treating their patients ethically and effectively. In the film Dr. Anthony Fauci of the NIH admitted that "There is a feeling among members of a number of professions or just the general populations, that patients with AIDS, many of whom are homosexual are a little bit different. I think that has led to a little bit of complacency on how to approach the disease" (France).

The documentary was enough to have us in tears, especially since many of us could not imagine losing many of our friends to a disease that your country was ignoring for the most part. Yet I do not think we fully empathized with the victims until we talked to ACT UP members and veterans of the origins of AIDS activism. One of said veterans Jim Eigo told us about the history of ACT UP in a first person narration and how people in his community had to choose between taking illegally distributed medicine or going bankrupt taking azidothymidine (AZT), which was the most expensive drug at the time (Eigo), while suffering from the debilitating side effects. In his time, people with AIDS only had the community to depend on due to the failure of medical institutions. Yet often that was not enough, as AIDS was considered a death sentence.

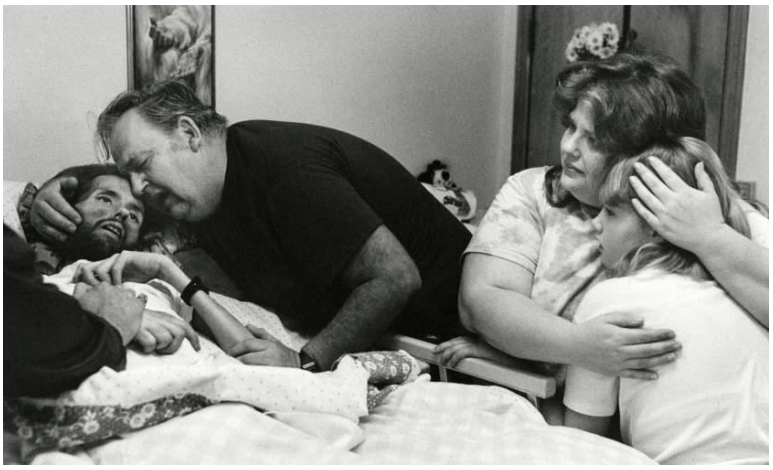

Fig. 5. “David Kirby on his Deathbed.”
Photograph.

We then spoke to activist Brandon Cuicchi who went into more detail about the politics behind the AIDS crisis. He noted that one of the reasons the medical community failed patients was not just because of homophobia, but also because the medical community did not prioritize AIDS patients because the overwhelming majority of medical professionals were negative and did not see AIDS as a very pressing issue. To add to this, medical academia did not realize that doctors were not effectively doing their jobs, despite the queer community insisting that they were (Cuicchi). In a way that could also apply to today, since many believe that high ranking medical officials do not consider LGBTQ issues a significant problem simply because it does not affect cisgender heterosexual people. However, since the presence of the queer community and their support has been growing stronger each day, the medical community is beginning to look at LGBTQ specific issues.

A couple of those issues that plagues the queer community today still stem from HIV/AIDS, as we discussed with the members of ACT UP. In the United States alone, there are about a million people above the age of 13 who are HIV positive (“HIV in the United States”).

Two major predicaments of the prevalence of AIDS are the accessibility of treatment and the lack of effort by local and state governments to help prevent further spread of the virus.

The pharmaceutical company Gilead has developed the current treatments to HIV: Truvada/Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP). However, putting aside the fact that many people at risk for HIV do not know about PrEP (Eigo), the drug may not even be accessible to many people since the cost is $1,300 per month ("Truvada"). Given that people of color (especially trans women of color) are disproportionally infected by the virus (Krellenstein) and given that queer people are more likely to live in poverty (source), the medicine is in no way accessible, and it leaves many people without treatment. At Purdue University we are fortunate enough to have PrEP and PEP covered in the student healthcare plan, but this is not the case at most American universities and Purdue students appear to be unaware of this. The accessibility of PrEP does not just affect the United States, as we learned in our time in Paris, the EU has not yet subsidized PrEP for use, leaving European people at risk for HIV without the same prevention methods that Americans do. This could once again be associated to the fact that since many believe that HIV/AIDS is a "gay problem", it is not prioritized. Although plenty of heterosexual people do get infected with HIV (Krellenstein), something should not have to affect the privileged majority to be merely recognized as an issue.

Another issue is the handling of the epidemic by American government. Coincidentally at the same time we met with ACT UP the only free STD clinic in Chelsea had closed without any warning, with the nearest alternative clinic being 70 blocks away according to Jim Eigo ("Chelsea"). New York's Department of Health and Mental Hygiene (DOHMH) have known about this since 2007, yet

Fig. 6. "Protest Sign". Photograph

have offered no alternative for locals. Due to ACT UP's persistence and protests (Figure 6), the DOHMH are just now starting to address the issue, but the delayed response means that many more infections could have occurred, especially since Chelsea is considered to be the epicenter of New York City's outbreak. Again, this is an issue regarding the prioritizing of the majority while ignoring issues plaguing the minority, which we have seen is a common theme in healthcare. Now, the Chelsea clinic is only one example that we have seen up close and personal. I have no doubt that similar cases are happening throughout the U.S., especially in states that are much less "progressive" than the State of New York.

Now, since this trip, I have thought a lot about what I can do as a physician in order to make healthcare more accessible for LGBTQ individuals. In my experience, many people, especially youth, in the community have experienced discrimination from healthcare officials because said officials still hold on to the pathologization of homosexuality even though it was abolished 40 years ago. In an article about discrimination against LGBTQ individuals in healthcare, Christine Moyer writes that said discrimination "involves inappropriate comments by healthcare staff about a patient's sexual orientation or gender identity and refusal to treat individuals because of their LGBT status" (Moyer). However, she notes, many comments made were not meant to be malicious but rather stem from ignorance. Since healthcare often starts with physicians themselves, it is essential to start incorporating LGBT related curricula in medical schools. With proper education, doctors can make more of an effort to make queer patients more comfortable with accessing healthcare. I discussed this issue with Stephen Helmke, who is a geriatric cardiology lab manager at Columbia University Medical Center. He referred me to the resource that Columbia used to modify their medical school curriculum: The Association of American Medical Colleges's *Implementing Curricular and Institutional Climate Change to*

Improve Health Care for Individuals Who Are LGBT, Gender Nonconforming, or Born with DSD. I would like to see LGBT material when I attend Indiana University School of Medicine, but there needs to be a lot of advocacy before that can happen.

The path to LGBT-friendly healthcare may begin at medical school, but it sure does not end there. It is crucial that each and every doctor knows how to work with a patient who identifies with a marginalized sexual orientation and/or gender identity. Notice how I said work with, and not treat. I choose this specific wording because I learned how doctors and patients get the most out of their relationship when discussing harsh issues like AIDS at the Spencer Cox Health Center (Figure 7). During social worker Terri Wilder's presentation on how the health center operates she introduced a man who had contracted AIDS during the crisis to talk about his personal experience with the healthcare system. One aspect of his recollection that stood out of me was that he stressed how important it was for doctors to show respect for their patients. When he was trying to obtain healthcare he talked about how dehumanized it felt when the physicians he saw just threw a prescriptions at him without fully informing him on what exactly the drug does and its side effects. When he decided to take a stand for himself, he found a new physician and explicitly told him that for their doctor-patient relationship to work, the doctor must inform him as much information available about treatments and their side effects and allow him to decide what is best. That way, instead of being treated like a problem, he was treated like a person. If more doctors approached their patients like that, along with LGBTQ cultural training, so many barriers can be broken down for queer people. The Spencer Cox center has taken this step; it is time for health centers across the country to do the same.

Fig. 7. “Visiting the Spencer Cox Center”.
Photograph.

I do not believe this is necessary to add, but medicine has not been kind to the LGBT population. I knew that even before I attended the study abroad, but the trip has given me new perspectives on what my responsibilities are as a doctor. The many people we have met on this trip showed me that there is hope, but only if we as a community step up and make a change. It has also inspired me to do as much as I can to advocate for the health of queer students at Purdue University, because ACT UP has taught me that I do not have to be a doctor to make a lasting change.

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