

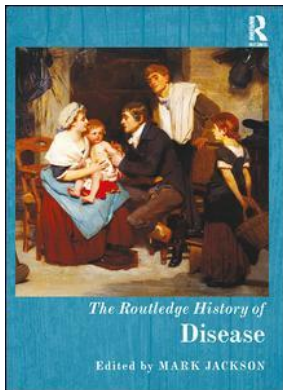
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Mark Jackson

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Richard A. McKay

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BEFORE HIV

Venereal disease among homosexually active men in England and North America

Richard A. McKay

The transmission of sexually transmitted infections among homosexually active men would not regularly command headlines in England and North America until the emergence of the Acquired Immune Deficiency Syndrome (AIDS) epidemic in the early 1980s. Yet this topic had, by then, been a developing social and public health concern for over 30 years; it remains a pressing issue today, over 30 years later. This chapter aims to sketch the contours of this pre-AIDS history, one which has languished in the shadow of HIV and has received relatively little attention from historians.¹

This overview presents interim findings from an on-going historical study of venereal disease (VD) – the term most often employed before 1980 for infections spread through sexual contact – and sexual health among men who had sex with men. In describing these men, I follow the work of other historians of sexuality by employing the word ‘gay’ for those individuals who organized their personal identities to a significant degree around their sexual attraction to other men. I use ‘queer’ as a more broad descriptor, a category which included gay men as well as those who might not identify as gay but who were attracted to and had sex with other men. The project concentrates on three predominantly English-speaking countries – England, the United States, and Canada – in the twentieth century’s middle decades, and the current chapter reflects these geographic and temporal foci.² Though these countries present obvious differences in terms of their populations, health-care delivery systems, and immigration patterns, among other variations, they share a number of important similarities. Common religious and legal traditions generated similar social and legal prohibitions on same-sex relationships. In response, first homophile and later gay-rights activists drew encouragement and assistance from supportive transnational networks.³ Furthermore, each country also had an established corps of health-care professionals dealing with a growing venereal disease problem, many of whom were attentive to international developments. A working assumption, therefore, is that sufficient similarities exist to justify drawing together examples from these three countries to illuminate shared phenomena and chronologies. My hope is that interested readers will pursue the cited sources for more detailed study, and to determine the extent to which local conditions might complicate the general picture I present here.

Earlier awareness and tacit knowledge

An awareness that same-sex sexual practices could communicate infection circulated within European medical and forensic communities – and, of course, among those men unfortunate enough to become so infected – as early as the 1490s.⁴ As cities across Europe prosecuted individuals for sodomitical practice and assault, and confessions by torture gradually gave way to the use of forensic evidence in trials, medical professionals' testimony assumed greater importance in the courtroom. Paolo Zacchia, a prominent seventeenth-century medico-legal authority, consolidated and disseminated a body of logical knowledge about anal intercourse which medical experts could then read onto the bodies of those accused of such crimes. Over time, venereal maladies like condylomous bumps, chancres, and foul discharges joined penile traumas, traces of anal inflammation, tears, and excretions – or a smoothed rectal passage in the case of habitual sodomites – as suggestive signs of anal intercourse.⁵ In London, a Turkish man was convicted of sodomizing a Dutch youth in 1694; the surgeon testifying in this assault case pointed to the victim's anal venereal ulcers and corresponding chancres on the accused's penis as evidence of the crime.⁶ Just over a decade later, John Marten, another London surgeon, wrote that, 'in this dissolute Age', sex between men transmitted venereal infections 'very frequently'. Marten noted disapprovingly that one patient he treated had become sick with the clap and the pox after another man with mouth ulcers sucked his penis – an act which, before the onset of a venereal distemper, brought both men 'great Pleasure'.⁷ The surgeon later highlighted, in an expanded version of his treatise, the tensions experienced by medical men treating such individuals, their loyalties divided between a professional duty to aid these patients and a legal responsibility to report them to a magistrate.⁸ Marten's contemporaries viewed him as unusually scandalous, however, for his explicit mention of sex between men in print; most practitioners maintained a well-practised silence on the topic.⁹

Perhaps the dissolute relations that Marten's contemporaries avoided discussing, and which dismayed urban reformers in the eighteenth and nineteenth centuries – in London and other large cities of Western Europe, and later in North America – stemmed from the disruptive agricultural improvements linked with the industrial revolution's onset. Thousands of young workers, displaced from their traditional rural employment, streamed to urban areas. Young people in their teens and twenties dominated London's population in the late seventeenth and early eighteenth centuries.¹⁰ Uprooted from their familiar work, religious, and familial environments, which normally served to police sexual behaviour, ever-greater numbers of young men were able to find others interested in same-sex contact. In London, these increased numbers supported the formation of a core group of 'mollies', men whose non-normative gender performance and semi-public displays of sexuality placed them most visibly at the centre of many loosely overlapping networks of queer men. These men would continue to seek each other for sex and sociability in the marginal spaces – parks, latrines, and certain taverns – of their growing cities.¹¹

Although English secular law had prohibited sodomitical relations since the sixteenth century – a tradition transferred to the North American colonies – a series of laws passed over the course of the nineteenth century codified the 'unnatural' relations that were not to be named under offences like 'gross indecency' and 'indecent

assault'.¹² In conversation with these legal attempts to demarcate the actions of men who sought sex with men as deviant, late-nineteenth-century sexologists – practitioners of a scientific study of sexuality that drew on such diverse specialties as public health, forensic medicine, and psychiatry – attempted to classify the abnormal sexual behaviours they witnessed, attributing them to an inherently deviant mental state. In doing so, they moved away from a history of analysing bodies for physical signs of infection. Previously, medico-legal authors such as Ambroise Tardieu in Paris and Johann Ludwig Casper in Berlin had considered whether infections like syphilis and growths around the anus constituted typical signs of those who practised anal intercourse.¹³ Shifts away from physical signs towards psychological understandings of homosexuality may have contributed to a relative loss of the association between same-sex encounters and VD by the beginning of the twentieth century. Later, the work of some twentieth-century public health practitioners would represent a return of sorts to this positivist tradition, with attempts to define 'the homosexual' by appearance and comportment, by occupation, and by the presence of venereal lesions.

In the late nineteenth and early twentieth centuries, physicians, surgeons, and specialists in syphilis and other diseases drew on increasingly sophisticated techniques to differentiate between sexually transmissible infections, namely syphilis, gonorrhoea, and chancroid. In isolated reports and case studies, practitioners published examples of such infections being passed through 'unnatural' or 'perverted' practices. Gradually, experts attributed fewer cases of venereal infection to 'casual' contact, instead viewing syphilitic chancres in the mouth or around the anus as a product of oral-genital and penile-anal contact. Nonetheless, with VD a difficult topic for public conversation, many were very reluctant to acknowledge sexual practices other than vaginal intercourse. This silence contributed to a burgeoning belief on both sides of the Atlantic that oral and anal sex could not transmit infections and were therefore safer than vaginal intercourse.¹⁴

A growing problem? Political and public health surveillance

The 1930s and 1940s brought increased political and public health scrutiny to non-normative forms of sex, through a retrenchment of gender conformity during the Great Depression, enhanced VD prevention drives, and a heightened attention to commercialized sexuality amid mobilization for war. *Sexual Behavior in the Human Male* (1948), by Alfred Kinsey and his associates, further concentrated public attention on the 'homosexual outlets' of American men – which appeared to exist in far greater numbers than previously imagined.¹⁵ In synchrony with this increasing research and discussion of homosexuality, public health physicians increasingly reported outbreaks of VD spread through same-sex contact, or, as some saw it, 'from perversion'. The 'hitherto unsuspected source of the spread of venereal disease', as two Vancouver physicians referred to homosexuality in 1951, gradually drew more attention.¹⁶ A subsequent shift occurred in the way observers discussed the same-sex transmission of VD in the 1950s. From earlier descriptions of isolated transmission incidents, where practitioners suggested the uniqueness and rarity of such events – particularly in the Anglo-American world – increasingly public health workers emphasized that such exposures appeared to be occurring more frequently and accounting for more cases

than before.¹⁷ In part this stemmed from the success of penicillin treatment in reducing cases of infectious syphilis from a post-war high in 1946 to sufficiently low levels that disease surveillance work could quickly detect new outbreaks; it was also due to a socio-political climate that was increasingly hostile towards homosexual behaviour.

The late 1940s and 1950s witnessed growing concern about the dangers posed by 'the homosexual', particularly for child protection and national security. In North America, legislators moved to address the perceived threat of dangerous sexual offenders in the 1930s and again in the immediate post-war years; these laws notionally targeted child molesters, yet in practice were often applied against gay men. Fears of homosexual men being Cold War security risks, either as members of socialist organizations or as blackmail targets, sparked high-profile media stories and purges of gay men from government departments, first in the USA, then later in England and Canada. In the 1960s, Canadian researchers – supported by the Royal Canadian Mounted Police, the Department of National Defence, and the National Research Council – attempted to create a 'fruit machine' that measured interviewees' pupillary responses to visual stimuli in order to determine their sexual orientation. The technology repeatedly failed to deliver conclusive results, and eventually the project was abandoned.¹⁸

Discussions of VD compounded these politicized concerns, and incorporated similar language suggesting a pervasive, secretive, and largely veiled threat. Drawing on recent research from one of its city clinics, the director of New York City's Bureau of Social Hygiene informed attendees of a 1953 conference that the homosexual contact was an 'important agent' in VD transmission who 'must be sought zealously'.¹⁹ Homosexual men seemed to locate each other through some secret code, had sexual liaisons that transcended social strata, and were reluctant to name their partners. In articles for their peers, VD specialists sought to establish their expertise by explaining the difficulties of discerning a homosexual man and locating his hidden infections. One physician, who emphasized the 'highly organized' degree of the homosexual network on North America's West Coast and the widespread anal intercourse this facilitated, urged colleagues to perform a dark-field examination on every anal ulcer found in a male patient. Recasting an old epithet for syphilis with a new Cold War resonance, and linking the disease's renowned mastery of disguise with the homosexual's ability to evade detection, he wrote: 'We must be ever wary of the "great imitator" in dealing with lesions in the anorectal area.'²⁰

Amidst the upswing of reported cases of venereal disease among homosexually active men in the late 1950s and early 1960s, some asked whether this was a real or apparent increase. One physician who had worked in a Baltimore syphilis clinic in the years leading up to the Second World War recalled how he and his colleagues had treated many early infectious syphilis cases, but had only occasionally noticed queer men in attendance. 'Is male homosexuality significantly more common to-day than 5 or 10 years ago?' he wondered.

Is there more venereal disease in male homosexuals than there was in the past, or is it simply that venereal disease is more frequently diagnosed in such patients? Is it possible that male homosexuals attend [VD] clinics in greater numbers than in the past and are therefore subjected to a greater extent to contact interviews which reveal the existence of additional venereally-infected

homosexuals? Is the male homosexual to-day more promiscuous than he was in the past? And finally, since one is most likely to find what one is looking for, is the male homosexual with venereal disease more frequently identified to-day as a homosexual because of a higher index of suspicion?²¹

Other medical workers echoed and debated this physician's questions, as did members of the growing homophile movement. Some described their surprise in learning, following an infection, that syphilis and gonorrhoea could be spread between men.²² The editor of *ONE*, a leading homophile journal, stated emphatically that this was a new development:

We can remember the day when a venereal disease contact from an homosexual experience was highly unlikely – when, in fact, no one even remotely known to us, no matter how promiscuous, had ever picked up a disease through a homosexual source.

One writer suggested that gay men, for whom pregnancy was not a concern, were less likely to use condoms, particularly due to their reduction in erotic sensation, and thus experienced a commensurate reduction in their protection against disease. He also posited that gay men were likely to forego attending public clinics, expecting to find them lacking in understanding or confidence.²³ *ONE*'s editor advocated just such avoidance, advising readers that as long as laws against homosexual acts existed:

Under no conditions, or for any reason, should a homosexual set one foot inside a public health office. If anyone of us needs a doctor, let him go straight to a private physician whose ethics should hold that which is between the doctor and his patient in confidence.²⁴

Drawing on the work of historians tracing the post-war growth of lesbian and gay communities, we might hypothesize that the rise in reports *did* describe a real increase in syphilis, caused by an intersecting combination of factors. Urban gay communities experienced transformative boosts from the remarkable disruptions of mass-mobilization for the Second World War. Millions were uprooted from small towns, thrown together in all-male environments, and stationed far from home in their own countries and overseas. Many men who might previously have felt isolated by feelings of sexual difference were able to find others like themselves and participate in thriving war-time gay scenes in major cities like San Francisco and New York, Montreal and London. Many would choose to remain in these cities at war's end, or maintain connections with other gay men in their new networks. These men would have had a sense that they were part of a growing community of like-minded individuals, gained an increased awareness of that community's diversity – beyond enduring stereotypes that focused on 'the fairy', for example – and in many cases fostered a communal sense of normalcy in opposition to prevailing psychological theories of homosexuality as deviance. In many cities, more men were having sex with others in more tightly connected networks, with increased opportunities to meet more frequently, albeit in a less permissive social environment than during war-time.²⁵ The chances of an individual transmitting an asymptomatic infection to others increased, likely with a

correlated rise in clinic admissions. Similarly, as a result of a delicate yet growing sense of communal confidence and solidarity, greater numbers of men were more likely to admit to sexual contact with other men when seeking treatment.

**The male homosexual and the female prostitute:
rivals for sexual partners, public space, and public health attention**

In an unpublished training manual written in 1951, an experienced American VD investigator explicitly compared the male homosexual and the female prostitute in an aside emphasizing the need to maintain confidentiality with teenaged VD patients:

It will take only one breach of confidence with a youngster to ruin your reputation as a keeper of your word . . . Young people have a very efficient grapevine ranking second to homosexuals and prostitutes tied in first place. You play ball with them; they'll play ball with you . . . It is not your job to correct sex patterns already fixed or to save souls. It is your job to find cases of venereal disease.²⁶

This brief comparison hints at a common association made by many individuals active in the fields of law enforcement, moral reform, and VD control: that the male homosexual and the female prostitute were roughly equals of one another in terms of their disregard for conventional morality and gender norms, habitual lack of consideration for laws regulating sexuality, and cause of public nuisance. In England, the grouping of the two in the Wolfenden Committee's deliberations in the mid-1950s most clearly demonstrates this connection – although the Committee's report and the evidence upon which it was based paid very little attention to VD transmission among men.²⁷ While a remarkable late-twentieth-century shift in public favour towards gays and lesbians has largely severed these conceptual links, their traces can be detected most easily in a shared argot, and become much more visible in the historical record prior to the 1970s. Frequently those responding to the threat of VD in earlier periods would equate the two in an uneasy binary.²⁸

Historians have shown how queer men and female sex workers shared similar haunts and interacted with each other at the margins of respectable society, often in bars, cafes, and taverns with some criminal element, and that a common language emerged to describe sexual practices (for example, 'frenching' for oral-genital intercourse), sexual partners ('straight' for those preferring vaginal intercourse), and ways to meet them ('cruising' through public spaces looking to meet men). Furthermore, this sharing sometimes intensified into competition for the same men as sexual partners. For example, the sailor – a quintessential representative of working-class bachelor culture, often with extra money to spend while on shore leave – was a favourite of female prostitutes and also featured heavily in gay men's fantasies and real-life sexual culture.²⁹ Sailors also frequently featured among international efforts to regulate VD, although contemporaries tended to focus on the risks they faced from their contact with female prostitutes.³⁰ From the 1930s onward, expert and popular views of sexual orientation increasingly enforced a dichotomy between a majority of 'normal'

heterosexuals and a minority of 'deviant' homosexuals. Before then, however, men – particularly working men – who slept with women could also have sex with men without necessarily losing social status nor their own sense of themselves as normal.

These sexual dynamics would evidently affect VD transmission patterns, and also, in times when infections were overwhelmingly associated with female prostitutes and vaginal sex, impressions of relative risk. Thomas Painter, a New York gay man studying male homosexuality and hustling in the late 1930s, indicated how this sexual economy might operate during wartime with reference to another mobile representative of the bachelor class – the soldier:

Prostitutes are seldom very desirable . . . [and] are likely to be diseased, especially the kind that can be picked up on the streets, and finally they cost money, of which no soldier in the ranks ever has much. The homosexual then presents himself, providing free entertainment, drinks, and company, and offering a momentary fondness to the lonesome boy desperate to forget the weary boredom or the terrifying horror of the war or army life. And the homosexual offers the boy a form of sexual release without cost, and relatively free from the danger of disease. He often will pay the boy something in addition – which the boy then can, and often does, spend on the young woman or female prostitute of high quality, whom he really wants. No one will ever know – he is away from home – and anyhow, what the hell . . . he'll probably be killed day after tomorrow anyway. It is [for] these reasons that the soldier . . . succumbs to, and even seeks out, the advances of the homosexual – in 1865, in 1918, and in 1941 equally.³¹

Painter's class biases are expressed in his denigration of street-walking sex workers and assumptions about homosexual men's disposable income. Yet his description of shifting sexual dynamics draws attention to the 'normal' working man – not the female prostitute, nor the homosexual – as a lynchpin in VD transmission, and emphasizes the view, widespread before 1950, that homosexual men were 'relatively free from the danger of disease'.

During the 1950s, as word spread among health workers about the prevalence of VD infection among male homosexuals, some asked whether a double standard was at work in the legal system. Herman Goodman, a physician who worked for New York City's Bureau of Social Hygiene, had investigated a syphilis outbreak among a network of queer men in 1943. By the mid-1950s he was convinced that the male homosexual population bore responsibility for a considerable amount of VD transmission. Based on his interpretation of statistical records from the 1957 city magistrate's report, Goodman concluded that roughly 1,000 female prostitutes and 6,500 male homosexuals were largely responsible for the city's current early syphilis and gonorrhoea infections. He pointed out, however, that while female sex offenders were charged under a penal code section that required them to receive a physical examination, blood test, and antibiotic treatment, none of the male sex offenders received this attention. 'No discrimination', he argued, 'for or against the sex offender either male or female', calling for an equitable application of screening and treatment measures to those in custody.³² The jails of some cities, like Vancouver, had implemented routine testing of male inmates in the late 1940s, based on their older programmes'

successes in finding VD cases among female prisoners.³³ Others, like Los Angeles, demanded mandatory blood tests and treatment specifically for gay men sentenced in city courts as a VD reduction measure in the 1960s. This was shortly after one LA public health official announced to an international syphilis conference that ‘the white male homosexual has replaced the female prostitute as a major focus of syphilis infection’,³⁴

Where health measures ended and law enforcement began was often unclear to individuals on both sides of the equation. For example, the official responsible for VD control in Vancouver in 1942 protested the police department’s efforts to obtain the names of those infected through illegal sexual acts. Just over a decade later, his successor promoted the value of extensive interdepartmental cooperation, to ‘insure the exchange of all available information, to the advantage of both.’³⁵ As exemplified above by the 1962 *ONE* editorial, many gay men were, understandably, deeply concerned that information requested by public health clinic workers – the names, descriptions, addresses, and phone numbers of their sexual partners – might be transmitted to the police department, whereupon they and their partners risked entrapment, arrest, loss of livelihood, and registration as sex offenders. From their perspective, and that of health workers tackling VD, maintaining the confidentiality of this information was vital. All community-based VD education leaflets produced in the 1960s emphasized the commitment of public health agencies to meet this requirement, often in large, bold letters.³⁶

‘Perpetual spirals of power and pleasure’: health workers and venereal disease

Michel Foucault’s phrase linking pleasure to power neatly characterizes certain aspects of the relationships between health workers and queer men with VD in the mid-twentieth century – with the former working to seek out, examine, and apply diagnoses to these men, and the latter often attempting to evade and resist the effects of that gaze.³⁷ Although numerous health workers contributed to the emergent bureaucracy underpinning successful VD diagnosis and therapy – receptionists organizing their clinics’ patients, nurses administering treatment, lab workers testing samples, and secretaries managing the expansive paper records detailing clinical and contact-tracing histories – this section concentrates on two professionals with whom these patients interacted: the contact tracer and the physician.

Contact tracing aimed to locate all sexual contacts of infected patients seeking treatment; the practice began in the United States in the mid-1930s, later spreading to Britain and Canada.³⁸ Initially a predominantly female workforce composed of nurses, almoners, and social workers, its ranks in some large North American cities eventually included male public health advisers.³⁹ At first, contact tracers focused almost entirely on locating male patients’ female partners, reflecting widespread assumptions that VD was spread mostly by the professional female prostitute or by ‘the amateur’. Following the widely discussed Kinsey Report, and the increasing acknowledgment of same-sex contacts by men attending VD clinics in England and North America, greater emphasis was placed on ‘the homosexual’.⁴⁰ Refinements to VD investigators’ interviewing techniques continued; by 1962, training courses instructed contact tracers how to identify homosexuals and encouraged them, through their questioning,

to 'establish the fact that the patient is a sexually promiscuous person and that this promiscuity has developed into a continuous pattern from early in life'.⁴¹ By providing examples of how homosexual men might respond to evade certain questions, and explaining that '[c]ertain known occupations may suggest deviant sexual activity', the instruction of contact tracers continued the positivist nineteenth-century sexological project of defining and identifying 'the sexual deviant', and succeeded in locating many cases of VD.⁴² One Vancouver newspaper described a local epidemiologist, who had travelled to the US for his VD training, as being 'proud of his ability to flush out the "gay ones"'.⁴³

Contact tracers lamented the fact that many private physicians failed to report the VD patients they treated; the detective trail often ran cold at the private clinic door. Sometimes this represented a potentially catastrophic spread of infection: reports suggested that certain practitioners' clientele consisted mainly of gay men, some of whom amassed dozens of partners while infectious. Often public health workers suspected that private physicians were shielding their patients, or were too busy for the time-consuming and unpaid task of interviewing them for information about their sexual partners. Health departments expended much effort educating private physicians about the value of their contact tracers and their absolute commitment to confidentiality.⁴⁴ It is also true that many physicians remained unaware of the possibility of same-sex VD transmission. Formal education about sexual matters was minimal – a persistent problem throughout the twentieth century – and if doctors learned about homosexuality at all it was often as a foreign perversion, or a practice that conferred a protective effect compared to sex with a female prostitute.⁴⁵ In some cases physicians may have held suspicions about certain patients' sexual orientation, yet were hesitant to ask prying questions or suggest rectal examinations for fear of losing clients.⁴⁶ It seems likely, though, that a Czech émigré physician accurately summarized the American situation in the mid-1950s when he wrote that 'the nearly total lack of reports of primary syphilis in the mouth and rectum due to homosexual practices can only be explained by the lack of awareness of this possibility by doctors'.⁴⁷

From the mid-1940s onward, physicians were advised to suspect homosexual relations and overcome a reluctance to conduct oral and rectal examinations for hidden lesions. One doctor urged his colleagues to look further: 'Because homosexuals are notoriously imaginative in their sexual behavior, the varied lesions of venereal disease may be found anywhere on the body.'⁴⁸ Under the dominant sun of Freudian psychological theories, physicians learned that homosexuals' immature development made them self-loving, vain, cruel, amoral, risk-seeking, and untruthful, all of which fostered their characteristic promiscuity and propensity for VD infections.⁴⁹ These characterizations evidently shaped some practitioners' understanding of their patients, bringing mixtures of sympathy, disapproval, and disgust. One venereologist, who in 1965 took up a consultant position in a mid-sized English town, viewed most of his homosexually active patients as 'apprehensive and fearful persons desperately seeking sympathy and succour'. He recalled a middle-aged man from a small local town attending his clinic 'in tears':

He was unable to sit down and almost unable to walk from pain. He had had little sleep for several days and had restricted his intake of food and drink for more than a week as his venereal condition caused intense pain on passing

urine and opening his bowels. The whole of his genital area was ulcerated as part of a widespread syphilitic rash and pus poured from his rectum which was infected with gonorrhoea. Trembling and humiliated he had almost lost the desire to live. A homosexual partner had driven him but only supported him as far as the threshold, lacking the courage or concern to stay with him.⁵⁰

Increasingly vocal and visible lesbian and gay rights activism came to the fore in the late 1960s, drawing energy, inspiration, and individuals from the civil rights, women's health, and anti-war movements. Gay liberation's spirited activism fostered the development of more publicly apparent and politically active communities in many cities, some of which sponsored their own clinics and health outreach programmes. The Los Angeles Gay Community Service Center's VD clinic, Chicago's Howard Brown Memorial Clinic, New York City's Gay Men's Health Project, and Toronto's Hassle Free Clinic were among the better known of these new health initiatives. As part of this expanding medical infrastructure, gay and gay-friendly medical professionals, who were themselves occasionally VD patients, targeted poor physician training. They drew attention to the differential presentation of disease among homosexually active men, emphasizing the importance of oral and anal examinations. They also elucidated how different sexual practices, like oral-anal intercourse, had given rise to a new category of enterically spread VD, including amoebiasis, giardiasis, shigellosis, and hepatitis A. Sites of queer sex, like bathhouses, which had since the 1950s faced public health and civic scrutiny for facilitating VD transmission, saw gay doctors making new outreach efforts to test and treat those who attended, although some owners saw these efforts as bad for business. Perhaps the most significant outgrowth of the 1970s gay liberation health movement was the collaborative work between a number of gay VD clinics, the Centers for Disease Control, and the pharmaceutical company Merck to study the prevalence of hepatitis B and conduct clinical trials for a vaccine.⁵¹

Patient experiences: from 'terribly embarrassing and terribly pitiful' to 'red badges of courage'?

In addition to enduring the widely felt stigma of medical conditions often associated with dirt and moral depravity, and often the need to pay for and juggle medical visits with work without raising employers' or family suspicions, men contracting infections through sexual liaisons with men encountered other significant challenges extending beyond their immediate physical health concerns. Few men with family doctors would previously have confided the specifics of their sexual attraction to their physicians; thus, they would have faced what for many would have been a humiliatingly frank conversation with their primary health-care provider, or the stress of concealing the source of their infection. Those who had gained access to networks of other gay men could inquire about local physicians who might be amenable to treating patients discreetly. In many cities, certain doctors – whether themselves closeted, non-discriminating, entrepreneurial or perhaps a combination of the three – became renowned for their expansive gay practices. For those who could not afford a private physician, the public clinic presented a mixed blessing. From the early twentieth century onward, these clinics increasingly provided affordable and sometimes free care with a minimum of moral condemnation, although even within the same clinic a

patient's reception might differ drastically from one physician or nurse to another.⁵² Nonetheless, significant numbers sought treatment from sources where disclosure could be minimized: as late as the 1960s, authorities would complain of patients seeking fraudulent cures from quacks and disreputable pharmacists.⁵³

The location of a patient's physical complaint also coloured his experience, and to a considerable extent dictated the degree to which he might evade the health worker's scrutinizing gaze. While little about patients presenting with penile chancres or gonorrhoeal urethritis suggested homosexual contact, those with oral ulcers and certainly with anal disturbances would have aroused considerably more suspicion. That being said, the latter two locations would frequently go unexamined unless specifically prompted by the patient, so men with low-grade signs and symptoms might easily pass unnoticed – leading a Scottish committee reporting on sexually transmitted diseases to declare that 'passive homosexuals' were 'reservoirs of infection'.⁵⁴ One gay observer of the homosexual scene in 1930s New York remarked that, while certainly not widespread, among anally receptive homosexual men 'syphilis of the anus' was 'a really pitiful affliction, being terribly embarrassing and terribly painful at once'.⁵⁵ To this man, embarrassment was closely tied to the physical seat of the pain, a confirmation of one's demasculinization. Such humiliation caused some patients to delay seeking treatment, to their considerable distress, complicating the notion that venereal diseases were essentially minor irritations between penicillin's rise and the appearance of AIDS.

At public clinics, and to a lesser degree with private physicians, patients faced the ordeal of disclosing their infection's likely source. Many were deeply concerned about trusting government-employed contact tracers. In the 1950s, physicians realized that a good number of these patients reported female names for male sexual contacts. In some cases this was an ingenious balance between honesty and concealment whereby gay men provided the investigators with the widely employed feminine camp names used by their partners.⁵⁶

In a letter to Donald Webster Cory, the pseudonym of one of the most widely read American authors on homosexuality in the 1950s and 1960s, one anonymous gay man in his early twenties wrote at length of his experience being diagnosed with syphilis at a New York City public clinic. Both he and Cory wished to highlight 'an old problem in a new form', one which had risen dramatically in importance since the Second World War, and Cory reprinted the letter in full. Several of the young man's points bear emphasizing here. First, the primary importance of personal networks over official channels: before attending the clinic, he consulted a gay friend who told him 'there was a lot of VD going around in New York, and that you can get it by having almost any kind of sex with an infected person'. Horrified that VD might have caused his anal discharge and spots on his torso, he visited a library to consult an encyclopaedia, but 'it didn't say anything about sores in the back'. Second, his lack of awareness: he admitted that he and most of his friends were 'pretty ignorant about it. How was I to know that that spot on that sailor's pipe was going to put me through such an ordeal?' Finally, he repeatedly expressed feelings of 'anguish and humiliation' in having to admit the source of his infection and submit to anal examinations by an intern and subsequently a team of medical students. It is likely that his sense of being scrutinized as 'a model specimen for their instructional purposes' was due in no small part to penicillin's success in reducing the prevalence of syphilis in

the 1950s.⁵⁷ With clinical instruction on VD so limited, and infectious syphilis cases in such short supply, a number of forces compounded the scrutiny the young man received, and contributed to his sense of mortification.⁵⁸

In many cases the availability of antibiotics reduced patients' concern about VD, and gay-run clinics succeeded in diminishing the stigma associated with infections during the 1960s and 1970s. With gay liberationist ideologies proposing that multiple sexual partners were the ties that bound the gay community together, some, like author Edmund White, were later quoted as saying that 'gay men should wear their sexually transmitted diseases like red badges of courage in a war against a sex-negative society'.⁵⁹ Still, the experiences of men whose sexual lives straddled these therapeutic innovations, and who fell ill with other diseases like hepatitis, invite more complicated interpretations. Samuel Steward, an American gay man whose remarkable career trajectory took him from university English professor to tattoo shop owner and artist, is one telling example. In his early twenties, Steward contracted syphilis from a casual male partner; the shock of the infection, his sense of pollution, and a lengthy and painful treatment experience scared him from sex for some time. Having returned to a vigorous pursuit of sexual encounters, the unsettling shock revisited him once more with a gonorrhoea diagnosis in 1950. Later he was scared by the prospect of police and health department investigation when one of his sexual partners was diagnosed with syphilis and named him as a contact, and he fell very ill with hepatitis shortly after a sexually active holiday spent in San Francisco in 1953. Though he never followed through with his occasional ideas to give up sex completely, Steward would go on to think of the trauma of venereal infection as being an important example of a 'dividing point', one of a series of ruptures organizing the lives of all homosexual men.⁶⁰

'VD is no camp': education and prevention

Widespread reluctance to publicly discuss homosexuality fostered an environment where official efforts to address the transmission of VD generally ignored the possibility of same-sex transmission. This silence manifested in several ways. Many physicians, most of whom received very little education on sexual matters, remained unaware of this route of spread. Such ignorance of the possible risks of same-sex contacts also extended to queer men. Indeed, in times and places where the threat of VD was tied so closely to vaginal intercourse with female prostitutes, some interpreted the silences surrounding homosexual activity and male prostitution as suggestions that engaging in these realms conferred a *reduction* in risk, in the same way that they helped men avoid unwanted pregnancy. For instance, Richard von Krafft-Ebing, the Viennese psychiatrist who established himself as a late-nineteenth-century expert on homosexuality, interpreted cases and compiled editions of his *Psychopathia Sexualis* at a time when syphilis and fears of the disease were widespread. He hypothesized that among the reasons why some men might seek sexual contact with other men was a 'hypochondriacal fear of infection in sexual intercourse; or on account of an actual infection'.⁶¹ Similarly, the expression 'Better a little shit than a chancre', which circulated in New York's Harlem district during the 1920s – an area with many unmet social and health needs during a period of more relaxed social mores and widespread prostitution – suggests how some men rationalized this safer-sex belief.⁶² In the 1950s and 1960s, public health physicians continued to express concern that homosexual men were

unaware that sexual contact could bring VD. Many seemed to view this particular consequence of sex, like pregnancy, as a concern solely affecting heterosexuals.⁶³

As public health workers became more aware that sex between men could transmit disease, they were cautious in their attempts to promote this understanding. Information leaflets distributed by health authorities might cover all bases by indicating that syphilis or gonorrhoea could be spread from one infected ‘person’ to another, without specifying the sex of the persons involved – though of course this risked readers projecting their own assumptions onto the documents. As long as laws banned same-sex sexual contact, many health workers felt compelled to exercise caution, since there was a fear in some quarters that open discussion risked promoting the taboo – and illegal – practices. In 1963, at a time when the VD Program of the Communicable Disease Center (later the Centers for Disease Control) was otherwise encouraging its public health advisors to be assertively resourceful in their efforts to reduce VD transmission, its director chastised an advisor who spoke publicly, without prior clearance, on the issue of VD and homosexuality at a North Carolina medical society.⁶⁴ Although in 1957 the VD Program had relocated from Washington to Atlanta, the political reach of the capital remained strong over this stretch of distance and time. ‘Washington is regarding VD education and behavioral studies as sensitive areas and screening for policy’, wrote a representative of the CDC’s Information Office in 1964.⁶⁵ There is no doubt that these political misgivings impeded the promotion of this knowledge, and required agencies seeking to make inroads to exercise strong discretion. That same year, as part of the nation’s drive to eradicate syphilis by 1972, representatives of New York City’s Department of Health teamed up with the Mattachine Society of New York, the nation’s largest homophile organization, which sought to promote public understanding of ‘sexual variants’. Their collaborative effort led to one of the earliest health leaflets created by and for gay men, entitled ‘VD is No Camp’. Ten thousand copies were printed for distribution, though city workers were careful to insist that their assistance went uncredited.⁶⁶

In the absence of official information and before homophile organizations began filling this void in the mid-1960s, queer men adopted numerous strategies to protect their health and safety. Many undoubtedly read official guidelines against the grain to find information that they could adapt to their own sexual circumstances.⁶⁷ Tabloid gossip columns, often the earliest published sources of community information, would occasionally warn readers of VD outbreaks.⁶⁸ Given their shared positions as sexual outlaws in overlapping social spaces until the mid-twentieth century, it is unsurprising to see queer men drawing on techniques employed by female prostitutes to reduce their risk. ‘Frenching’, a commonly employed phrase denoting oral-genital sex, was deemed by many sexually active individuals to be safer than vaginal or anal intercourse, not least because it allowed for close inspection of the partner’s penis for chancres or discharge.⁶⁹ Experienced female prostitutes were known to reduce their infection risk by refusing partners who failed such visual examinations; similarly, some gay men carried small penlights with them to allow quick partner check-ups in a city’s dark corners.⁷⁰ Among those familiar with the risks, men who enjoyed being the receptive partner in anal intercourse were deemed, like the female prostitute, to be at higher risk of acquiring venereal infections. Another technique some of these men borrowed from female prostitutes was the practice of post-intercourse douching with an antiseptic solution.⁷¹

Millions of enlisted men learned of the benefits of condom use and post-coital prophylactic disinfection through their Second World War training. It is not known how many would have thought to use condoms for protection in their same-sex encounters, though it seems plausible that some would have done so in the post-war years. Certainly the practice was rare by the 1970s; VD investigators remembered gay men laughing at the suggestion that they might consider using condoms, and one queer-identified man recalled thinking that men using condoms before the AIDS epidemic were fetishists.⁷² By contrast, post-encounter genital washing formed part of standard healthy sex guidelines that gay men encountered in community-produced literature in the late 1960s and 1970s.⁷³ Finally, from the early 1960s some doctors regularly recommended their gay patients practise pre-exposure prophylaxis by taking penicillin pills if they foresaw the chance of an exposure with an infected partner. The fears of drug-resistance and sex without consequences raised in the ensuing conversations would presage many that would follow in the course of the HIV/AIDS epidemic decades later.⁷⁴

Conclusion

At the close of the Second World War, and throughout much of England and North America, many health workers and queer men were unaware that same-sex contact could transmit VD. This changed significantly between the late 1940s and the 1970s, as queer men gradually became the focus of heightened political and public health surveillance, and the incidence of VD among them appeared to rise. The increasing visibility of lesbian and gay communities and the rise of gay liberation had mixed results. By the 1970s gay men managed to shake off the shackles of medically defined deviance with a successful campaign against psychiatry's classification of homosexuality as a mental illness. On the other hand, much older links between same-sex activity and physical sickness were at the same time being reinscribed. These associations would become cemented for decades with the emergence of the HIV/AIDS epidemic in the 1980s.

Three brief concluding observations bear emphasizing here, to link with themes emerging elsewhere in this book. First, the shifting connections made between sexual activity among men and VD – ranging from tacit awareness to impressions of relative safety and then to increased risk – highlight the markedly contingent nature of beliefs about disease over time. Disease ecology, population movements, fears about prostitution amid rapid urbanization, changing axes of sexual orientation and identity, and shifts in physician education – these were but some of the factors whose changing configurations affected the comparative visibility or obscurity of same-sex VD transmission. Second, during a Cold War period that saw the widespread growth of highly developed technological systems in health and medicine, the bureaucratic technologies that rendered queer men most readily visible were remarkably simple. Developments in contact tracing and refined interviewing techniques were ultimately far more successful than failed hi-tech screening efforts like the Canadian fruit machine, and harkened back to administrative advances from earlier decades. This relates to the third observation: in the context of risk-factor epidemiology for chronic diseases, the dominant medical research paradigm of the Cold War period, there was something decidedly old-fashioned, even *déclassé*, about efforts to identify homosexual men and link them to the spread of VD. As the investigation of disease

risk became focused on multifactorial webs of causation, health workers who concentrated on the social webs of well-established VD transmission moved to the periphery of professional practice; they remained there until the dramatic re-entry of infectious disease with the rise of the HIV/AIDS epidemic.⁷⁵

Some issues from this earlier era would continue to feature strongly as HIV took hold. Gay activists' concerns about the confidentiality of their health information became one key battleground, and organised resistance to attempts to enact quarantine measures and mandatory testing for those infected with HIV ensured a legacy of special care given to the results of tests for the infection. Medical and popular understandings cast both queer men and female prostitutes as groups at risk for the new disease. However, the strength of the old conceptual and social affiliations linking the two groups together was rapidly dissolving. As the tide of public opinion against homosexuality peaked then began to fall in the twentieth century's last decade, those middle-class representatives of the lesbian and gay communities who survived the epidemic would see their social capital grow. Perhaps most importantly, in the absence of meaningful official assistance, and amid suggestions that they abstain from sex to avoid disease, gay men drew upon a historical legacy of pragmatic self-help. They appropriated the condom and developed a safer-sex ethos that built upon gay liberationist ideas while at the same time acknowledging the risks of acquiring infections through frequent partner exchange. By 'queering' the condom and pushing back against an often hostile world, gay communities ensured that same-sex encounters could continue, empowering pleasure and connection just as HIV presented a devastating new dividing point to the lives of many queer men.

Notes

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- 2 'Before HIV: Homosex and Venereal Disease, c.1939–1984', Wellcome Trust grant no. 098705, Department of the History and Philosophy of Science, University of Cambridge, 2013–17.
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 - 9 K. Siena, 'The Strange Medical Silence on Same-Sex Transmission of the Pox, c.1660–c.1760', in Borris and Rousseau (eds), *Sciences of Homosexuality*, pp. 115–33; C. Berco, 'Syphilis and the Silencing of Sodomy in Juan Calvo's *Tratado Del Morbo Gálico*', in Borris and Rousseau (eds), *Sciences of Homosexuality*, 92–113.
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