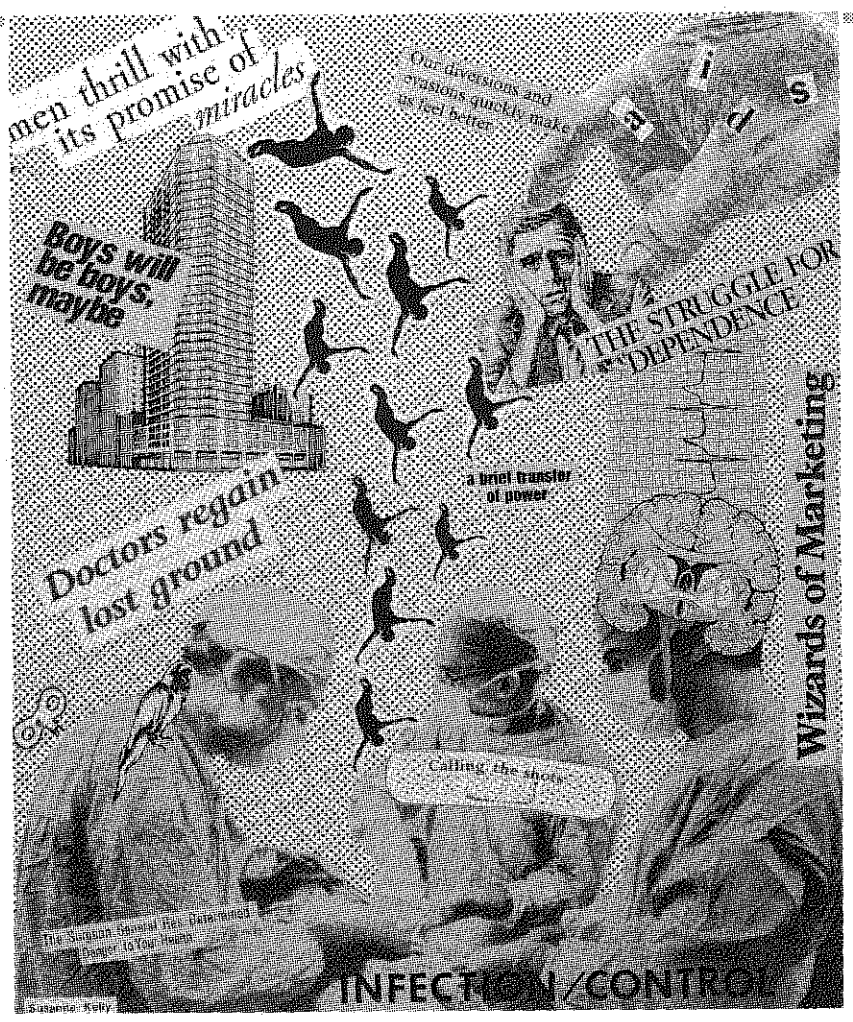
INFECTION/ CONTROL

Gays And Medicine In The Age Of AIDS

by Evan Collins

Illustrated by Susanne Kelly



EXCURSIONS

Western medicine has long been viewed as an institution of social control, rivaling religion and law as a major regulator of behaviour and purveyor of social values. This control is exercised in a variety of ways, such as: the labeling and treatment of that deemed abnormal (the medicalization of deviance); the transmission of ideological messages which reflect the values of doctors' privileged class; the discouraging of certain sick roles like the injured worker; and the expanded professional management of sex, stress, pregnancy and other aspects of daily life.

The maintenance of this social control relies on a power relationship in which the patient-consumer is passive and dependent, surrendering autonomy and deferring completely to the professional. The inequality is legitamized on the basis of doctors' expertise, and protected by the mystification of knowledge through technical language — rendering it inaccessible to the layperson. In short, not only does doctor know best, the doctor is given complete power in exercising that knowledge.

Historically, the homosexual's relationship to medicine has been somewhat different: one of alienation and mistrust), less susceptible to doctors' dominance. This arose out of medicine's view of homosexuality as illness, as medicine succeeded the church and courts as the state's agency dealing with sexuality. What had first been viewed as a sin, and then a crime, became a condition to be treated; modalities like psychoanalysis, aversion therapy and psychosurgery were used in the belief that homosexuality could be "cured". Even once struck from the American psychiatric classification of diseases in 1973 (it is still listed in the international classification), the spectre of homosexuality as a treatable condition lived on. With it lived on a basic mistrust of the health care establishment on the part of the gay community.

Although this alienation pertains to both gay men and women, lesbians have more often been completely invisible to doctors. A recent survey of gynecologists uncovered that not one believed there was a lesbian woman in their practice (could it be all gay women stay away from physicians?). As well, there have never been stated guidelines on pap smears for lesbians. Unfortunately, what they might be spared in their invisibility, they gain back as women, a group traditionally alienated from the male domain of medicine.

The occurence of the acquired immune deficiency syndrome (AIDS) has significantly altered the relationship between the homosexual community and the medical system. This devastating disease, of which gay men are but one affected group, has been inextricably linked to homosexuality by the media and public at large. Even if no longer slandered as "the gay plague", it continues to be viewed as a gay disease. In Belgium, where the majority of cases are heterosexuals of central African origin, the media still portray AIDS as a gay phenomenon, milking from it the moral metaphors that come so easy with this disease.

A number of things contribute to how AIDS is perceived by government, the health care system, media, public and groups at risk. As an incurable disease seemingly out of control, a plague mentality has developed. In addition, because the causative virus can be transmitted sexually it, like all venereal diseases in history, is viewed as a punitive consequence of sexual activity and a symptom of society's moral decay. Lastly, that the original affected groups (homosexuals, intravenous drug users, Haitians) are socially marginalized, has allowed the mainstream to see AIDS as a threat perpetrated on them by deviants. Even the publicization of AIDS among the rich and famous has done little to humanize the attitude to this disease; the desire to attach blame is still present, if not always admitted to.

In the face of the AIDS crisis, have doctors become more enlightened in their approach to homosexuality? Willingly or not they have had to acknowledge gays' existence and deal more openly with them. Doctors have been forced to ask after sexual orientation and take sexual histories, which their training never equipped them to do, or to feel comfortable about. Now that homosexuals have become objects of interest to clinicians and Nobel Prize-seeking researchers, it is questionable whether medical attitudes to homosexuality have changed at all. Certainly in the past, the celebrated scientific objectivity of doctors has not kept them immune to moral interpretations of disease.

For their part, gay men have turned to doctors for testing, treatment, information and reassurance as never before. They have been encouraged to come out to their physicians and to be open about their activities. In addition, they are told to place faith in government health officials' handling of the crisis, to take part in experimental treatments and research and to wait patiently for medicine to solve the riddle of AIDS. Unfortunately, this is part of a wholesale and uncritical deferral to the physician as expert, and goes on despite mounting examples of mismanagement in research, treatment and public health planning, and increasingly evident attitudes of anti-gay moralism. With current talk of quarantining and computer registries of test results, there is a dangerous vulnerability to this submissive, unquestioning posture.

The gay community would do well to look to the women's health care movement for an example of how a relationship between medicine and a patient population has been changed. In the 1970s feminists documented how women were being treated by medicine (in particular psychiatry and gynecology) and how this reflected and reinforced sexism. A major focus of feminism in this period was aimed at changing women's consciousness through health education, encouraging women's exploration of their bodies and the development of alternative health services run by and for women. The strategy was direct: doctors have the knowledge; take the knowledge and with it will come control over women's bodies.

THE homosexual's relationship to medicine has been one of alienation and mistrust. Medicine succeeded the church and courts as the state's agency dealing with sexuality. What had first been viewed as a sin, and then a crime, became a condition to be treated.

This movement has had far-reaching effects and is not often given its due. It informed an enlightened consumer approach to medicine that went beyond women's health care. It helped legitimize a number of non-physician sanctioned health alternatives, and influenced a demystification of doctors' power and previously unchallenged power base. Over the years it has forced dramatic changes within and outside the medical establishment, not the least of which is that patient-consumers tend now to be more critical and skeptical in their approach to medical practitioners.

This reclamation of knowledge and struggle for control should be a model for the gay community's relationship to medicine. In the midst of a health crisis like AIDS, when anti-sexuality and anti-gay attitudes are propagated so easily, gays cannot afford to defer so uncritically to a professional body whose best interests are not always with whom they treat.

Of added interest is that these issues of autonomy and control may have ramifications beyond the socio-political arena of AIDS. Slowly, western science is recognizing that determinants of illness entail social and psychological factors as well as biology. Psychosomatic research into the connection between stress and illness shows that certain psycho-social variables are associated with diminished resistance to disease. Specifically, the experiences of "loss of control" and "helplessness", as best as those can be measured, seem to impair the part of the immune system responsible for defending against viral illnesses and cancer (and the part that the AIDS agent undermines). It is too soon for anything conclusive to be drawn, but it appears that autonomy and striving for control, as well as focused anger, are import ant in maintaining health and in fighting disease. That these are also appropriate responses to oppression show how the personal and political can be linked.

In this frightening time for the gay community, when beleagured by both AIDS and its political uses, it seems prudent not to submit uncritically to the medical and scientific establishment. As AIDS is being defended against it is best to keep a healthy sense of skepticism, and retain a measure of control regarding all agencies of the state — especially towards medicine which professes to help and heal, but whose agenda has always been broader.

Evan Collins
is a Toronto physician working in mental health and sexually transmitted diseases

P

BROAD-CAST-ING WATCH

By
Marc Raboy

erceptive readers of **border/lines** may have noticed an apparent discrepancy in our report on the crisis in Canadian broadcasting policy, published in issue no.3. In that article, it was stated that the federal government's scenario for broadcasting policy review was seriously compromised by the nature of the vehicle it had chosen for beginning the review process: a ministerial task force, which would reflect on the problem and consult the milieu, but without necessarily providing a mechanism for public input.

Of course, by the time **border/lines** hit the stands, the Caplan-Sauvageau task force was into the final stages of a coast-to-coast tour, highlighted by a series of public meetings at which interested parties presented their views on the problems of the Canadian broadcasting system.

In fact, as we had stated, public hearings had been explicitly excluded from the task force's *modus operandi*, in the interest of expediency, by communications minister Marcel Masse. Somewhere early on in the task force's work, however, some sage in its entourage must have pointed out the all-too-evident anomaly of such an approach, for in midsummer the task force abruptly announced that it would be touring the country and meeting, in public, with interested petitioners. I heard of this development on the CBC's "World at Six" one August evening while cruising on a houseboat on the Lake of the Woods, and I imagine it was close to Labour Day before most public interest groups and concerned individuals were in a position to respond.

As it turns out, the task force's consultations were not formal public "hearings" in the sense usually meant by a parliamentary committee or royal commission. What the task force was in fact doing as it traveled around the country was meeting *in private* with selected groups during the day, and then holding a public meeting in the evening at which other, or if they so wished, the same groups, could summarize their positions. The result was undoubtably fruitful for the enlightenment of the task force, but not necessarily beneficial for the level of public debate, as groups with private interests to promote could do so in private, while groups speaking in the name of some aspect of the public interest played their cards in public. A further quirk was the fact that the private meetings were scheduled to last for three-quarters of an hour each, while at the public meetings speakers were restricted, at least in principle, to five minutes.

But let's not quibble. The task force has a monumental job to do, and I'm perfectly prepared to give it the benefit of the doubt...for now.

The single most important service the task force could perform would be to reaffirm the essential first principle of Canadian broadcasting, to wit, that it is above all else a public service, to be operated in the public interest. Everything else — ownership, structures, regulation, even content — must flow from this source.

In order to make such a reaffirmation, and support it with concrete proposals, the task force will need to overcome a variety of pressures, beginning with its own mandate from the Minister of Communications (which, incredibly, fails to mention in the first instance the public interest or public service as a criterion for guiding policy development), and extending to the very private and often arcane pressures from the "industrial" sector. It will also need to overcome the unfortunate myth that public service can only be thought of in terms of a mammoth, centralized, bureaucratic institution several reference points removed from the public it is intended to serve.

If the task force can find its way clear to surmounting these obstacles and bring down a report with proposals which reinsert the public into the system, it will have performed a major, lasting service to the multitude of communities that make up this thing we call Canada. But if it fails, it could very well go down in history as the gravedigger of the Canadian broadcasting system.

Marc Raboy
is in the Graduate Communications Program, McGill University, and Journalism Program, Concordia University and is a corresponding editor of **border/lines**

THE single most important service the task force could perform would be to reaffirm the essential first principle of Canadian broadcasting, to wit, that it is above all else a public service, to be operated in the public interest.

EXCURSIONS