

Health Care for Modern Families:

Practical Suggestions Concerning Care for Families of Gay Men and Lesbians

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Abstract

This article offers a first person perspective concerning how health care providers can better recognize modern families and improve health care for them, especially families founded by gay men and lesbians in U.S. culture. It interweaves information concerning the historical, legal, and economic situation impinging on gay men and lesbians while offering personal stories in dealing with health care professionals. The article references germane scholarly literature for further reading throughout.

Keywords: *LGBT health care; health care & sexuality*

Healthcare for Modern Families:

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I. Introduction

In general, there are odd discrepancies in public and private factors in thinking about sexuality in general and same sexuality in particular. There tends to be a strong feeling that sexuality is private, even though heterosexuals routinely proclaim their sexuality through engagement notices, wedding ceremonies, anniversaries, birth announcements, and the like. When it comes to same sexuality, however, even relatively tolerant and accepting people sometimes experience a feeling that these are or should be private matters. Fortunately, medicine is an area where privacy is especially valued and protected by law. Yet, some gay men and lesbians may have misgivings about sharing information with medical providers about sexual practices, because of concerns about confidentiality or, at times, internalized worries about stigma, about being viewed as different and, therefore, deviant or deficient, not normal, even though same sexuality is a naturally occurring pattern among humankind and, yes, even among animals and birds.¹ In my opinion, it makes almost as much sense to be judgmental about another person's sexual orientation as it does to judge them based on the color of their eyes. Yet people are oftentimes judgmental of gay men and lesbians.

Although I am a Professor of communication at the University of Pittsburgh, I am offering this essay to health care professionals as a gay man of a certain race, age, and socioeconomic class: white, late 50s, and financially secure. I am not a medical professional. There might be sound medical reasons that account for some experiences with health care that I have found disquieting. As a communication scholar, I know that chasms can exist between what one person means and what another person takes from remarks or deeds. It may be productive to engage in some mutual stretching to learn how to improve health care for gay men, lesbians, and our modern

¹ For examples, Nathan W. Bailey and Marlene Zuk, "Same-Sex Sexual Behavior and Evolution," *Trends in Ecology and Evolution*, 24.8 (2009): 439-446; Marlene Zuk and Nathan W. Bailey, "Birds Gone Wild: Same-Sex Parenting in Albatross," *Trends in Ecology and Evolution* 23.12 (2008): 658-660

families. In this essay, I highlight the importance of medical professionals' attention to each patient's life history, because his or her personal biography is valuable for providing appropriate care.

As I offer some personal stories and reflections for readers to consider, I am worried about a risk of over generalizing from my limited perspective on health care. Gay men and lesbians are diverse with regard to race, economic class, age, ability, religious and political convictions, as well as human values. So I will use "I" statements to emphasize that this is one fallible human being's perspective based on specific experiences with health care providers. This essay will draw on my background as a communication scholar to highlight some factors that, from a communication standpoint, might be useful to health care professionals. For example, I will comment on the power of words, labels, and stereotypes for groups and practices. The essay begins with observations on the political and social climate for gay men, lesbians, and our families so that health care professionals may appreciate the difficult, at times precarious circumstances of our lives. Then, the essay turns to what it might mean to have a modern family with attention to problems of recognition. Last, I will offer some reflections on specific medical practices that may merit thoughtful consideration and transformation in the interest of social justice. Throughout, I will identify germane medical scholarship pertaining to particular topics so that readers can actively seek out further information of professional value. Particularly useful is Kathleen A. Bonvicinia and Michael J. Perlin's essay, which reviews scholarship concerning medical professionals' communication with gay men and lesbians. Their essay concludes with suggestions of considerable worth, many of which merit implementation.² Their essay could be coupled with my essay to generate discussions among medical professionals during their education to raise awareness and to generate ideas to improve communication with patients.

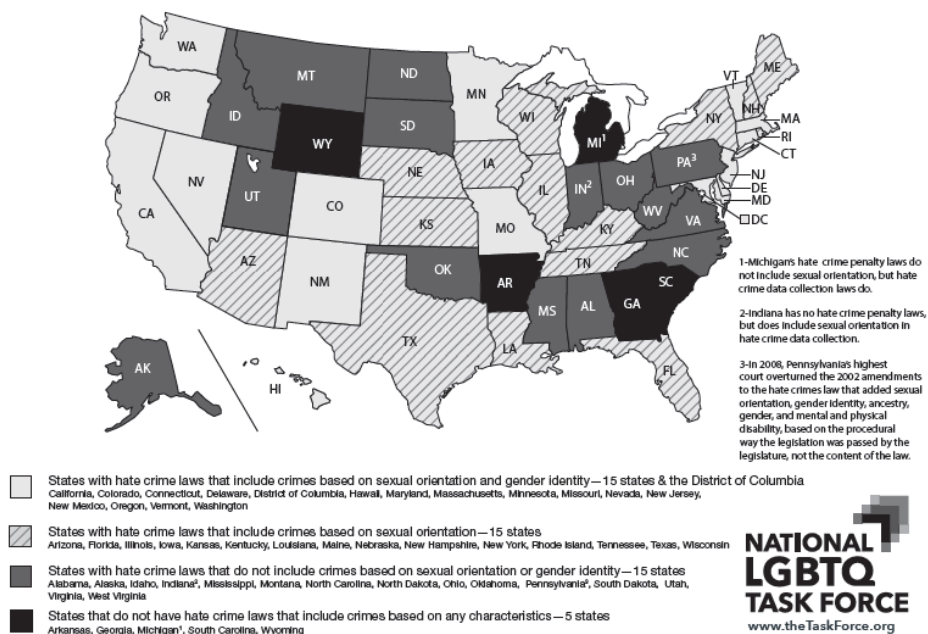
II. The Political and Social Climate for Gay Men and Lesbians in the United States

You might be surprised to learn that the political and social climate impacting gay men, lesbians, and our families is not hospitable today, though there have been some encouraging changes over the decades. A range of bias and hate offenses still impact many of us. Unfortunately in most states in this country — in 29 states, to be precise — you can be fired from your job and be told that the reason for your loss of employment is that your employer does not approve of homosexuality. This map summarises the current state of employment discrimination laws, updated as of June 21, 2013 (http://www.thetaskforce.org/reports_and_research/issue_maps).

² See Kathleen A. Bonvicinia and Michael J. Perlin, "The Same But Different: Clinician–Patient Communication with Gay and Lesbian Patients," *Patient Education and Counseling* 51 (2003): 115–122.

Hate Crime Laws in the U.S.

This map was last updated on: June 21, 2013



Pennsylvania, where I live, is among the 30 states where an employer can tell you that you no longer have a job, because he or she does not approve of your sexuality. The exceptions in Pennsylvania, to my knowledge, are certain major urban centers, among them Pittsburgh, Harrisburg, and Philadelphia, which have non-discrimination laws for sexuality and/or gender identity within

the municipality or county. Of the 22 states that do have non-discrimination laws, only 5 states include gender identity as a protected class.

I wonder how public heterosexuals would be about their families if they could lose their jobs because of who they love. Under the circumstances, it can be difficult to get dependable information about modern families founded by gay men and lesbians, because few of us can afford to lose our livelihoods. It was discouraging to me to read the chapter in a textbook on “Culturally Sensitive Nursing Care of Families,” for example, because there were only a few sentences devoted to families founded by gay men and lesbians.³ According to Bonvicinia and Perlin, research by William C. Mathews and others of medical professionals’ attitudes toward homosexuals in 1986 found, that “39.4% of physicians surveyed acknowledged that they were sometimes or often uncomfortable providing medical care to patients who were gay. In a later [1994] study by [Benjamin] Shatz and [Katherine] O’Hanlan where health providers were surveyed, 67% of respondents believed they had seen gay or lesbian patients receiving ‘substandard’ care because of their sexual orientation.”⁴

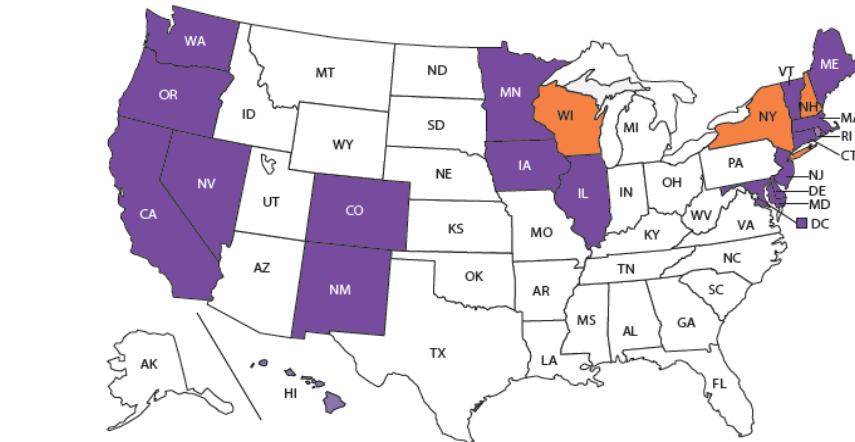
³ Joanna Rowe Kaakinen and others, editors, *Family Health Care Nursing: Theory, Practice and Research*, 4th edition (Philadelphia: F.A. Davis Company, 2010).

⁴ Bonvicinia and Perlin, 117. They cite William C. Mathews, Mary W. Booth, John. D. Turner, and Lois Kessler, “Physicians’ Attitudes Toward Homosexuality—Survey of a California County Medical Society,” *Western Journal of Medicine* 144.1 (1986): 106-110, esp. 109; Benjamin Schatz and Katherin A. O’Hanlan, *Antigay*

Although, as of 2009, there now is a federal bias crimes law that covers gay men, lesbians, and trans-people from physical harms, gay men and lesbians routinely encounter various types of bias offenses ranging from meanspirited remarks, harassment, workplace discrimination, defamation, threats of violence, bullying, hitting or physical assault, sexual assault, and even homicide.⁵ Most of these bias offenses — about 80 percent — go unreported to the police for a complicated range of reasons, among them the fact that the specific state might not have bias crimes laws for gay men and lesbians. In other words, only one out of five bias crimes against gay men and lesbians comes to the attention of law enforcement. In the United States, 20 states have no hate crimes law provisions for gay men, lesbians, and/or gender identity. This color map summarizes the current state-by-state situation for bias crimes laws as of June 21, 2013 (http://www.thetaskforce.org/reports_and_research/issue_maps).⁶

State Nondiscrimination Laws in the U.S.

This map was last updated on May 21, 2014



States banning discrimination based on sexual orientation and gender identity/expression (18 states and the District of Columbia)
 Minnesota (1993); Rhode Island (1995, 2001)¹; New Mexico (2003); California (1992, 2003)¹; District of Columbia (1977, 2005)¹; Illinois (2005); Maine (2005); Hawaii (1991, 2005, 2006, 2011)¹; New Jersey (1992, 2006)¹; Washington (2006); Iowa (2007); Oregon (2007); Vermont (1992, 2007)¹; Colorado (2007); Connecticut (1991, 2011)¹; Nevada (1999, 2011)¹; Massachusetts (1989, 2011)¹; Delaware (2009, 2013)¹; Maryland (2001, 2014)¹

Laws banning discrimination based on sexual orientation (3 states)
 Wisconsin (1982); New Hampshire (1997); New York (2002)

¹ California, Connecticut, Delaware, DC, New Jersey, Massachusetts, Nevada, Rhode Island and Vermont first passed sexual orientation nondiscrimination laws, then later passed gender identity/expression laws.

² In 1991, Hawaii enacted a law prohibiting sexual orientation discrimination in employment. In 2005, it enacted a law prohibiting sexual orientation and gender identity/expression discrimination in housing. In 2006, public accommodations protections were added for sexual orientation and gender identity/expression. In 2011, gender identity was added to the employment discrimination law.



A harmed person might not want to risk losing his or her job. He or she might not want to be blamed for bringing the harms on himself or herself, because blaming the victim is a commonplace interpretation of such harms. He or she might not want the husband or wife to know about it. The congregation or synagogue might disapprove and so

Discrimination in Medicine: Results of a National Survey of Lesbian, Gay and Bisexual Physicians (San Francisco, CA: Gay and Lesbian Medical Association, 1994).

⁵ Two extensive studies providing an broad based history of germane statistics, which have not improved appreciably, are *Anti-Gay Violence Hearings, October 9, 1986* (Washington, D.C.: G.P.O., 1987); *Inside-Out: A Report on the Experiences of Lesbians, Gays and Bisexuals in America and the Public's Views on Issues and Policies Related to Sexual Orientation* (Menlo Park, CA: The Henry J. Kaiser Family Foundation, 2001).

⁶ See, Appendix 2.

end their minister or rabbi's employment, if he or she is a homosexual. But that same person might go to an emergency room to have the injuries checked and treated, or the primary care physician's office. As health care professionals, it could be easy for you to interpret reluctance to talk about the source of sometimes severe injuries as the harmed party having done something wrong, simply because he or she does not want any public record of being gay or lesbian. It is not just internalized stigma; it is, more fundamentally, that our government has failed to assure equal protection to all citizens without distinction. As of today, that is the situation here in the state of Pennsylvania, where as recently as February 2013 there were no germane state-wide hate crimes or employment discrimination laws.

Like the rest of the population, health care professionals are diverse with a whole range of views. Your values, beliefs, and commitments are your personal business. Your judgments of others are your business, too. Yet I would ask you to entertain whether being judgmental can get in the way of your providing the best health care possible. If you recognize yourself at all in my concerns about becoming judgmental, I want you to know that you are not alone. I sometimes struggle with being judgmental, too. In fact, later in this essay, I'll give you an example of my own struggles with being judgmental in dealing with a close, gay friend's suicide attempt and, some months later, his successful suicide. In a nutshell, what I realized, even as I kept reminding myself to not be judgmental — because I was indeed being judgmental, and my judgments were severe because he was my best friend — was that my judgments were not going to be at all helpful to him. My judgments were only protecting me. I ask you to consider the possibility that your judgments only protect and serve you; they may shield you from discomfort or some difference that it is easier for you to keep at a safe distance. Yet, among all the professions, surely health care ranks among those in which it is most important to strive to withhold personal judgments in the interest of conscientious, high quality care for all harmed or unwell people without distinction.

In this essay, I ask my readers to assume primary responsibility for your own learning about “non-traditional” families or whatever differences might cause you some discomfort. I will mention resources that you could use to continue your own self-education. In addition, I would be glad to hear your specific ideas concerning how to improve health care for families of gay men and lesbians. Above all, I request that you translate your learning into speech and action of consequence in the medical profession.

I will begin with some reflections on what constitutes a modern family, traditional or otherwise, noting in the process that meanings for a modern family are changing in life enhancing ways in the United States. Then, I will share three personal stories, which I have selected to prompt your reflections and our conversations. The first story concerns my quest to identify a primary care physician to entrust with my health care, because of my firsthand experience of being treated as an untouchable. The second story concerns the nature of my health care benefits at the University of Pittsburgh, which, to my surprise, did not include some preventative health care that, in my opinion, should be available for gay men. I'll comment, too, on such specific diseases as breast cancer, HIV / AIDS and Hepatitis B, even though I have never had any of these health crises myself, because they are abiding concerns to gay men and lesbians. Finally, my last personal story concerns the death of my closest gay friend for a quarter of a century, because his suicide attempt and eventual suicide might be instructive with regard to health care provider's presumptions about family and it raises an enthralling question: Did I, if only momentarily at the hospital, become my best friend's family?

III. Modern Families Today in United States Culture

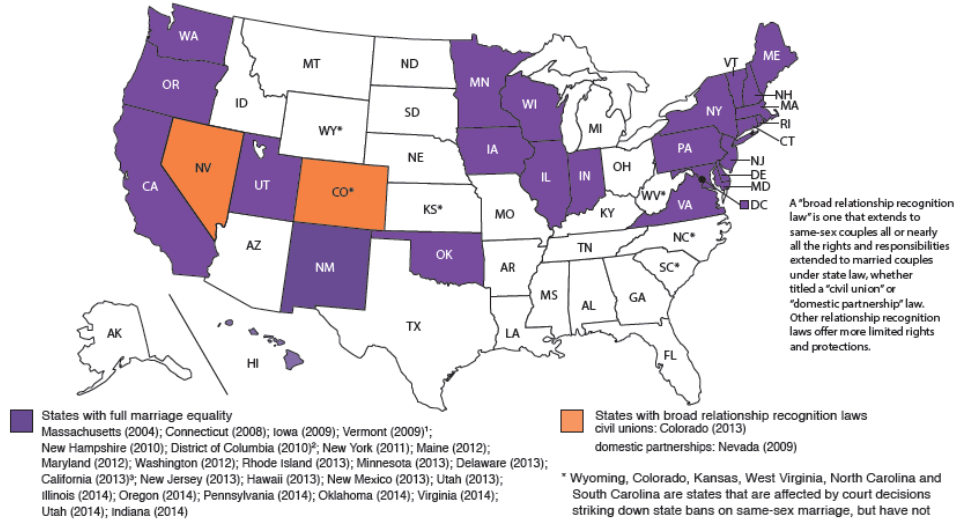
What, then, is a modern family, traditional or otherwise? How do we become families that others can recognize as families? In my opinion, it is problematic to assume that there is such a thing as one “traditional” family today. Large numbers of heterosexuals are not getting married and yet having children. Large numbers of married heterosexuals are deciding not to have children. Increasingly we see blended families where portions of so called traditional families are reconfigured in the aftermath of divorce. There are also racially and culturally blended heterosexual families. The stereotypical family with one father, one mother, and 2.5 kids may well no longer be the majority, to judge from a 2011 editorial in the *Pittsburgh Post-Gazette*.⁷ My preference would be to refer to “modern families” or “diverse families” and then to include the so-called traditional family as only one example among many, many others. Because calling one arrangement “traditional” could be understood to imply that it is somehow better or preferred over other families, which are, by implication, deviant or unorthodox or not normal. Applied to gay and lesbian households, “non-traditional” families might be an example of heterosexism, however unintended. So this language should be reconsidered and changed in educational sessions for health care professionals.

But, if we adopt that language, however false and misleading its implications, do I have a traditional family? Do I have a “non-traditional” family, too? The answer to both of these questions are yes, I believe, but whether medical professionals would have recognized my other than traditional families over my lifetime is doubtful. In other words, one baseline problem for “non-traditional” families is whether we are recognized as families by others, including the people to whom we entrust our health care. A huge part of this non-recognition and mis-recognition is a result of legal practices, which impinge on family health care and seem to be changing today, thanks, in part, to President Barack Obama, who has required that any hospital that wants to accept federal funding must recognize and provide equitable treatment for the families of gay men and lesbians. Even so, the states in this nation vary widely in their legal recognition of same sex families through domestic partnerships or marriage. Recently, there has been noteworthy trend of improvement in the situation, as can be seen in the color map for October 21, 2013 (http://www.thetaskforce.org/reports_and_research/issue_maps). As of 2013, 14 states plus the District of Columbia have full marriage equality, 5 states have relatively broad recognition of same sex relationships, plus 1 more state with limited recognition.

⁷ “Marriage of True Minds,” *Pittsburgh Post-Gazette*, Dec. 29, 2011, B-4

Relationship Recognition for Same-Sex Couples in the U.S.

This map was last updated on: October 7, 2014



All dates shown are effective dates, not dates of passage.

¹VT will honor existing civil unions but will not issue new licenses. Civil unions will not automatically convert to marriages.

²DC will continue to honor and issue domestic partner licenses and will convert domestic partnerships to marriages for those who wish.

³CA recognizes same-sex marriages following U.S. Supreme Court decision in *Hollingsworth v. Perry*.



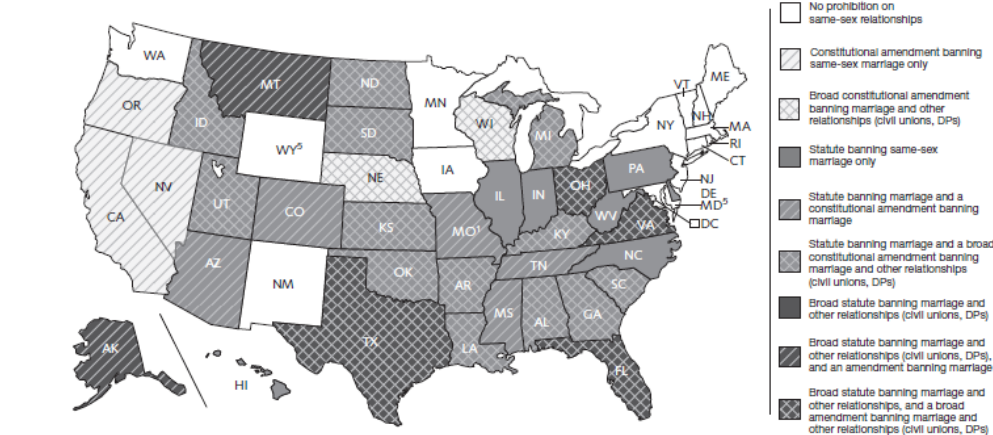
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It is particularly heartening that a certain states adopted marriage recognition as a result of state-wide votes. Still, several states have actively banned same sex relationships, as can be summarized in this black and white map, which summarized the situation as of May 15, 2013

(http://www.thetaskforce.org/reports_and_research/issue_maps).

State Laws Prohibiting Recognition of Same-Sex Relationships

This map was last updated on: May 15, 2013



¹ Missouri's 1996 anti-marriage law was overturned by its state supreme court, but another law passed in 2001.

² Hawaii enacted a state constitutional amendment in 1998 stating that "the legislature shall have the power to reserve marriage to opposite-sex couples." In turn, also in 1998, the state legislature passed a law prohibiting same-sex couples from marrying.

³ California still recognizes the 18,000+ same-sex marriages that were performed prior to the passage of Proposition 8 in November 2008.

⁴ Virginia, Texas, and Utah have both a narrow and broad statutory ban on marriage, as well as a constitutional amendment.

⁵ Maryland and Wyoming are not included here because their laws limiting marriage pre-date the 1993 Hawaii decision *Baehr v. Lewin*, which prompted many states to implement prohibitions against same-sex marriage.



What does it mean to become family? There is a lot of debate and discussion on this matter today, as people disagree over domestic partnerships, same sex marriage, and other related state and national issues. Most gay men and lesbians were raised in a “traditional” family with a mother, a father, and siblings. A maxim that conveys many biological families’ reactions to discovering their son or daughter is gay or lesbian goes like this: when a gay or lesbian youth comes out of the closet, the parents go into one. Thankfully, today there are nationwide organizations like PFLAG (an acronym for Parents, Families, and Friends of Lesbians and Gays) that can help traditional families deal constructively with the twin problems of heterosexism — the belief that heterosexual is intrinsically better than homosexual — as well as homophobia, a fear, discomfort, or disdain held toward homosexuals. As health care professionals who aspire to provide competent health care for modern families, it would be wise to learn about PFLAG for making referrals and for building your patients’ networks of support. The local chapter here in Pittsburgh has a website (<http://pflagpgh.org/>), where you can learn about its work.

However, sometimes traditional families unravel while dealing with differences of sexuality. I recall reading statistics in the 1986 Anti-Gay Violence Hearings that approximately 35 percent of the violence that gay and lesbian youths experience comes from members of their immediate families.⁸ Some traditional families disown and disinherit their gay and lesbian offspring, going so far as to throw them out of their homes. This adversely impacts the economic resources that they might have for securing competent health care. So I hope part of your education as health care professionals will consist in helping traditional families to become more functional and supportive of each other, even as you care for their members by making referrals when appropriate. Because sound, comprehensive healthcare includes both the body and the mind, another important resource here in Pittsburgh for your referrals is Persad, whose website is a useful resource for learning about its work (<http://persadcenter.org>). We are fortunate here in Pittsburgh to have Persad thanks to the courageous efforts of Randy Forester and Jim Huggins. I say courageous because both men received death threats for founding this resource for mental health care. Health care providers in other regions of the country should identify local expertise in mental health care for gay men and lesbians for making referrals whenever necessary.

Now turning to my modern family, Keith and I initiated our twelve-year partnership during Independence Day weekend in 1980. Most components of gay and lesbian partnerships were not remarkably different from civil marriages, except, of course, that it was not possible to legally marry each other. Sexual values, money management, sharing resources, maintaining health and well being, becoming helpmates, deciding whether to raise children together—gay and lesbian partners usually examine and discuss every component of their partnerships. A decision needs to be made for or against raising children. Some make the choice not to, while others make the decision to raise children. At one time, the American Bar Association estimated that about 6 percent of children in the U.S. are raised in gay or lesbian households.⁹ Commonplace patterns for having children include biologically from a

⁸ *Anti-Gay Violence Hearings*, 149.

⁹ Richard D. Mohr, *A More Perfect Union: Why Straight America Must Stand Up for Gay Rights* (Boston: Beacon, 1994), 39.

previous marriage or surrogacy, and adoption.¹⁰ There is no substantive correlation between the parents' homosexuality and the sexuality of their offspring.¹¹ The commonplace worry in medical literature that the children might be or become homosexual, which has been discredited, is nonetheless solid evidence of abiding heterosexism and homophobia in the medical profession. Evidence does suggest that children raised in gay and lesbian households tend to be more tolerant and accepting of differences than children raised in traditional families. In other words, the children are well adjusted in dealing with social differences.¹²

Same sex couples always have and always will form families — not only over the decades but across the centuries, not only in the U.S., but around the globe. In this country, gay men and lesbians have done so with dignity and courage and grace under hostile conditions. One crucial difference between our families and so-called “traditional families” that does bear scrutiny is the hostility of some, who imagine that their disdain for gay men and lesbians has something to do with virtue. If you doubt that gay men and lesbians deal with discomfort, disdain, and hatred, usually parading behind a false mask of virtue, consider this simple fact: 23 years passed between the October 9, 1986 Anti-Gay Violence Hearings, which documented that gay men and lesbians lived with the highest risks of violence and bigotry among U.S. citizens, and the 2009 Congressional passage of federal hate crimes laws explicitly protecting gay men and lesbians. Almost a quarter of a century later, Barak Obama has the distinction of being the only President in US history to sign federal laws shielding gay men and lesbians from deliberate harms — the only President. In contrast, federal exclusion from marriage laws passed rapidly in only one season, federal law aggressively assaulting our families at a time when certain states began to consider recognizing and legalizing same sex marriage. I am happy to observe that, today, increasing numbers of Americans are realizing that it is sadistic to say, on the one hand, a solid family is one key to a happy future and, on the other hand, but you cannot marry to found a family, because you are gay men and lesbians. There are encouraging signs that notions of what constitutes a family are changing in life enhancing and inclusive ways.

¹⁰ On adoption, Patrick Leung, Stephen Erich, and Heather Kanenberg, “A Comparison of Family Functioning in Gay/Lesbian, Heterosexual and Special Needs Adoptions,” *Children and Youth Services Review* 27 (2005): 1031-1044. On surrogacy, Dorothy A. Greenfeld, “Gay Male Couples and Assisted Reproduction: Should We Assist?” *Fertility and Sterility* 88.1 (2007): 18-19

¹¹ American Psychological Association, *Lesbian & Gay Parenting* (Washington, DC: American Psychological Association, 2005), 10. For commentary on criticism of the APA report concerning other aspects of children's development, see Paul R. Amato, “The Well-Being of Children with Gay and Lesbian Parents,” *Social Science Research* 41 (2012): 771-774 as well as the articles by Loren Marks and Mark Regnerus that Amato references. See also Cynthia Osborne, “Further Comments on the Papers by Marks and Regnerus,” *Social Science Research* 41 (2012): 779-783

¹² According to Jerry J. Bigner and Frederick W. Bozett, “There is no evidence of any kind that demonstrates that living with a homosexual parent has any significant negative effects on children. In fact, it appears that gay parents are as effective and may be even more so in some ways than non-gay parents.” Jerry J. Bigner and Frederick W. Bozett, “Parenting By Gay Fathers,” *Marriage and Family Review* 14.3-4 (1989): 155-175. “Same-Sex Parents Raise Well-Adjusted Kids: Researchers Say Children Who Grow Up in Households With Gay Parents Have Normal Self-Esteem,” <http://www.webmd.com/mental-health/news/20051012/study-same-sex-parents-raise-well-adjusted-kids>, downloaded June 11, 2012

IV. How Gay Men and Lesbians have Founded Modern Families

Even in my youth and young adulthood, there were some published guides for gay men and lesbians endeavoring to found families under hostile cultural conditions. Among these guides were William L Blaine and John Bishop's *Practical Guide for the Unmarried Couple*, which, according to the dust jacket, was written for people who were "straight or gay, young or old" living as an "unmarried couple"¹³; attorneys Hayden Curry and Denis Clifford's *A Legal Guide For Lesbian and Gay Couples*, which presented itself as a "practical guide" that "covers legal situations unique to gay and lesbian couples,"¹⁴ and is now going into its 14th edition; plus Eric Marcus's *The Male Couple's Guide To Living Together: What Gay Men Should Know about Living Together and Coping in a Straight World*¹⁵, which has gone into a 3rd edition with a more upbeat subtitle: *Finding a Man, Making a Home, Building a Life*. Unless gay men and lesbians who founded families took special legal measures to institute them as recognizable under law (and sometimes even if they did take special legal measures), members of biological families could show up to make crucial medical decisions or claim an inheritance, even if they had rejected their gay or lesbian offspring or sibling while alive. Today there are also resources for parenting by gay men and lesbians, such as Arlene Istar Lev's *The Complete Lesbian & Gay Parenting Guide*.¹⁶

As I mentioned earlier, I have the good fortune to have been raised in a solid family. Let me share with you one story concerning when my parents recognized my modern family, because it sheds some light on how we recognize and become families. In 1984, after I secured my job at the University of Pittsburgh, my father asked me three direct questions in my mother's presence:

When I moved to Pittsburgh, he inquired, "would Keith be moving to live there too?" "Yes," I replied, "he would."

Then he asked me, would I be "living together with Keith there the way that we had been in Madison?" We had been living in an efficiency apartment. Secretly, I hoped for a bit more space. But that wasn't what he was asking me. "Yes," I responded, "we would."

Then my father inquired, did I "think about Keith the way that another person might a spouse?" This question made me nervous. Some years earlier, I had dated a man whose family disowned and disinherited him,

¹³ William L. Blaine and John Bishop, *Practical Guide for the Unmarried Couple* (New York: Sun River Press, 1976)

¹⁴ Hayden Curry and Denis Clifford, *A Legal Guide For Lesbian and Gay Couples*, 4th edition ([Berkeley, CA:] Nolo Press Self-Help Law Books, 1985)

¹⁵ Eric Marcus, *The Male Couple's Guide To Living Together: What Gay Men Should Know about Living Together and Coping in a Straight World* (New York: Harper and Row, 1988)

¹⁶ Arlene Istar Lev, *The Complete Lesbian & Gay Parenting Guide* (New York: Berkeley Trade/Penguin Books, 2004). For an overview of changing views in psychology on lesbian parenting over the decades, Victoria Clarke, "From Outsiders to Motherhood to Reinventing the Family: Constructions of Lesbian Parenting in the Psychological Literature — 1886–2006," *Women's Studies International Forum* 31 (2008): 118-128. American Psychological Association, *Lesbian & Gay Parenting*

when they learned that he was gay. This was not likely from my parents. But we were on unfamiliar ground. I had no idea where this was headed next.

“Yes,” I replied, “I do.”

My father then turned to my mother and, demonstrably pleased, said, “It looks like we have another son.” He immediately welcomed Keith into our family as “another son.” My father only completed the eighth grade, because his family’s material circumstances meant that he needed to work on the family farm. I hope you will agree that he has set a high standard for anyone, anywhere who wants to talk about the so-called “family” values. Inclusion and acceptance, respect, honesty and openness, goodwill, generosity of spirit and resources, and, above all, love — these public values inhabit what it means both “to be” and “to become” a family.

V. Health Care for Modern Families of Gay Men and Lesbians

What are some general considerations pertaining to health care for families of gay men and lesbians? As a communication scholar, I would suggest that it can be helpful to focus attention on behaviors rather than labels for people to get at relative health risks. For example, a lot of married men and single men who seem to be heterosexual are nonetheless men who sometimes have sex with other men, but are not self defined as either gay or even bisexual. I am aware of one instance where a man has had an abiding same sex relationship with another man for more than 19 years, a relationship which began while he was married with children. It is possible that he recognized himself as gay only after he had married or that he imagined he could change his sexuality within a heterosexual marriage. I do not know. But I wonder how health care professionals would give him and his complicated family with a wife, children, plus a male partner helpful health care? That is a difficult question to ponder, and it will require creative thought and constructive suggestions by readers. Bonvicinia and Perlin rightly emphasize, “clinicians should know that sexual identity may reveal little about individual sexual behavior.”¹⁷

One part of an answer, in my opinion, would consist in focusing on behaviors more than categories for people. Another part of an answer might be to be mindful that categories for people can get in the way of providing appropriate health care. “Married family man” might still mean a need to check for HIV / AIDS. It might be helpful to ask open ended questions rather than make assumptions about sexual behaviors. Yet another alternative, which may be preferable, is routine screening for sexual health issues without regard for marital or family status within the confidential relationship between health care providers and patients.

In addition, large numbers of people marry to have children in open relationships, by which I mean not monogamous ones. Audre Lorde was a Black lesbian who married a white gay man in an open relationship, which was honest about monogamy not being a factor for them in their marriage. So, being labeled a “mother” or a “father” does not necessarily mean that one is not lesbian or gay. After her divorce, she had a lesbian partner who helped her to raise her children for about 20 years. Her partner and extensive networks of friends were there for her

¹⁷ Bonvicinia and Perlin, 116

during her breast cancer crisis, as detailed in her book, *The Cancer Journals*, which could be invaluable for health care professionals to read and discuss.¹⁸

As a communication scholar, I would suggest, in addition, that you become more aware of stereotypes and narratives that can impede competent health care (that is, presumptions about sexual values and health status, as well as attitudes toward the opposite sex). It is not unusual to deal regularly with people who presume that gay, lesbian, or homosexual means “promiscuous,” to use judgmental language. Some gay men and lesbians do have multiple partners, just like some heterosexuals do; but others are not promiscuous, just like some heterosexuals are not. Human values vary and cut across diverse social groups in intricate, complex ways. For example, some homosexuals practiced monogamy or celibacy even before HIV / AIDS was a consideration. As health professionals, it would be prudent to be careful not to judge how other people arrange their personal lives as committed partners. It is more important for partners to be honest and forthright about their sexual values with each other.

One resource for becoming more aware of stereotypes and misconceptions concerning gay men and lesbians is a documentary film entitled *The Celluloid Closet*¹⁹. Were you to view this documentary, you might be astonished at the extent to which media portrayals have cultivated a culture of negative narratives and demeaning stereotypes for gay men and lesbians. While viewing the documentary film, consider this question: which heroic figure would you most like to be like? Unless I am mistaken, you will find that there are none — no characters whom you would gladly embrace as a role model. You’ll find mentally unbalanced, emotionally unstable, and diabolical characters. You’ll find ineffectual clowns and incompetent buffoons whom you laugh at rather than with. You’ll find amoral and selfish narcissists. You’ll find shunned and extremely isolated individuals, and you’ll find a host of tragic endings by cruel sadistic murders or hopeless suicides. But there are no admirable role models in any of the media portrayals, unless I am in error.

No wonder so many people’s imaginings are crippled by harmful inherited stereotypes. I have sometimes heard individuals assert that they are entirely comfortable with gay men and lesbians, that they have no biases that impact their performance. I invariably wonder how such individuals escaped the endless torrent of harmful media images, because I know that I did not. I have devoted a lot of my life’s energy to trying to extricate the damaging narratives from my living. Frankly, I doubt that they have escaped the stereotypes either and I experience their comments as self congratulatory, not the product of serious engagement actively transforming and changing our cultural circumstances. Most of us have stereotypes that haunt our imaginings, if we are honest with ourselves about it. We are particularly vulnerable to stereotypes when we have had little contact and interaction with members of the stereotyped group.

What does that mean for health care providers? I want to encourage you to be reflexive about your assumptions and stereotypes concerning gay men and lesbians. For example, one presumption might concern health risks for HIV/AIDS among gay men and another concerns breast cancer among lesbian women.²⁰ To be sure, gay

¹⁸ Audre Lorde, *The Cancer Journals* (San Francisco: Aunt Lute Books, 1980)

¹⁹ *The Celluloid Closet* (Culver City, Calif.: Columbia TriStar Home Video, 2001)

²⁰ Bonvicini and Perlin, 116

men were among the earliest and hardest hit by the AIDS pandemic and we have had to examine and, in many cases, alter sexual practices to adopt safer sex. But even during the darkest days of the AIDS pandemic, most gay men — the vast majority, in fact — were healthy and uninfected. Some regions of the country were particularly hard hit. Gay men who preferred specific sexual practices were at much higher risk than men who preferred other sexual practices. Gay men do need to be periodically screened for HIV AIDS, to be sure, but, at the same time, you should guard against a presumption that we are unhealthy or will soon become unwell. It is a matter of using discernment as health care professionals to take sensible precautions to preserve your own health and to screen for a disproportionate risk of infection without presumptions about the entire group. Here in Pittsburgh, an important organization for supporting people who live with HIV / AIDS is the Shepard Wellness Community, which has a website, where you can learn more about the organization's work (<http://www.swconline.org>). Yet another helpful resource is the Pittsburgh AIDS Task Force (<http://pittsburghaidstaskforce.org>). Health care professionals in other regions of the country should make time to identify comparable organizations so that it is possible to make helpful referrals.

Likewise, there has been some medical research over the decades suggesting a correlation between women who remain childless (which is sometimes typed as lesbian) and a higher risk of breast cancer. Time will tell whether other factors account for the correlation, though it is interesting to me that this research has been undertaken and publicized at a time when increasing numbers of women are postponing having a child.²¹ Moreover, some lesbians do have children and nonetheless have been diagnosed with breast cancer, as illustrated poignantly in Audre Lorde's classic book, *The Cancer Journals*. Her journals give you access to one breast-cancer survivor's viewpoint on becoming a post-mastectomy woman and it sheds light on her decision to become visible to others by refusing to wear a prosthesis. Her novel gives a powerful example of a modern family, too, in that her same sex partner, her children, and her extended network of friends were present for her during and after her hospital treatments.

With these factors of language and stereotypes in mind, let me turn next, then, to a personal story concerning my own quest here in Pittsburgh to locate a primary care physician whose professionalism inspired my trust and respect. That quest began with what, to me, was a disquieting experience around 1990. I had the experiences of having had a routine physical two years in a row without being touched by my primary care physician. That's right, she managed to conduct my entire physical for two consecutive years without touching me so much as once. In fairness, we had just come through an intense period of fear during the early years of the AIDS pandemic. During those early years, one fallible sign that correlated with AIDS was having Hepatitis B antibodies.

²¹ Suzanne L. Dibble, Stephanie A. Roberts, and Brenda Nussey, "Comparing Breast Cancer Risk Between Lesbians and Their Heterosexual Sisters," *Women's Health Issues* 14 (2004): 60-68. For early commentary on correlating factors, Elizabeth J. Rankow, "Breast and Cervical Cancer Among Lesbians," *Women's Health Issues* 5.3 (1995): 123-129. Researchers have found that lesbians are at a higher risk of cardiovascular disease than heterosexual women, which has been ascribed to weight differences. Stephanie A. Roberts, Suzanne L. Dibble, Brenda Nussey, and Karen Casey, "Cardiovascular Disease Risk in Lesbian Women," *Women's Health Issues* 13 (2003): 167-174. Yet I wonder whether living with higher levels of stress as a result of dealing with heterosexism and homophobia is an additional underlying factor

Because, after talking it over with my partner, I was among the men who had the early vaccination for Hepatitis B, back when the vaccination required three shots over a brief period, there were detectable antibodies in my system. But, by the time of my physicals which left me feeling like an untouchable, there were dependable tests for HIV and, as my primary care physician, she was certainly aware that I had tested negative for HIV, as indeed I always have over the decades since then. During my second physical, I mentioned to her that my uncle Melvin had recently had prostate cancer and had surgery for it at a younger than usual age. Because my uncle was only a few years older than me (we used to ride the same school bus together), I was worried. My doctor declared that I was not in the statistical age group that need to be tested for prostate cancer. She refused to check me, even though it is neither an expensive nor a time consuming test. It does, however, require touching a patient.

So I decided to look for another primary care physician. Over the decades since then, I have had two primary care physicians, both of whom I located by word of mouth among other gay men and lesbians. I chose my next primary care physician, a Black gay doctor whose office was located in an economically depressed part of the city, because he had been among the doctors who accepted AIDS patients back when we did not know exactly how HIV was transmitted. Though I was concerned about HIV, I wanted to give him my business as a sign of my appreciation for his courage, when it was needed by gay communities. When he ended his practice, I turned to my current primary care physician, whom I have had for more than a decade and a half now. To my knowledge, he is heterosexual and he does a superb job of maintaining my trust and confidence in him. My current doctor is definitely a keeper. He does not look merely at my vital statistics, but contemplates the environment within which I live and work, and he does so in a way that is unequivocally accepting and life affirming for me.

Yet, even though I have complete confidence in him, I should mention some general differences in the living circumstances for a gay man in a relationship or single in comparison with public heterosexuals' lives in terms of health benefits, standard coverages, and the like. You might be surprised to learn that, even at a world class research institution like the University of Pittsburgh, there are noticeable differences in how benefits packages impact employees. These next two personal stories are politically difficult to share with you. It concerns the ramifications of my employer's non-recognition of my partnership. It will be easy for you to misunderstand my next story. So I request careful reading.

Shortly after Keith and I had settled into our Pittsburgh home, we decided to use the University's recreational facilities. We went swimming. My married counterpart could bring a spouse plus all of the children for free. But, for me to bring Keith, or anyone at all, I had to pay one dollar — not a large sum. But it was symptomatic of an extensive system of economic discrimination through my employer's benefits package, including life and health insurance, free tuition, recreation and library privileges for spouse and kids. Through the benefits package alone, I estimated that the difference in compensation over a thirty-year career exceeded a quarter of a million dollars. This was in the 1980s. And this figure did not include differences in actual salaries between single and married employees, which was significant, too.

Perhaps it is so difficult to get by with the potential for two incomes that those of us with only one income needed to subsidize their relationship. I did so by working almost every summer to earn the approximate difference in the value of benefits packages for single and married employees. Note, additionally, that the health care coverage

at my home university does not seem to have gay men or lesbians particularly in mind. To my knowledge, disparities in the health coverage in benefits continues to abide, not only in terms of the overall value of the coverage, but also what specifically is covered by our benefits. For instance, some years ago now — I believe in 2006 — I was out of pocket for a routine vaccination that gay men should consider having as a matter of standard health care. My doctor informed me that my antibodies for Hepatitis B had declined to a point that I needed a booster immunization. Imagine my surprise when I had to pay for this relatively inexpensive vaccination, while relatively costly expenses are covered for public heterosexuals, whose standard benefits are already worth considerably more than single gay or lesbian counterparts.²²

Now it would be easy to misunderstand my point, because I do not begrudge others support for their committed relationships. We're all interdependent. We depend on each other all the time, albeit in different ways and to different degrees. Yet, there should be equal compensation for comparable labor without regard for marital or family status. I am of the opinion that, while recognition of same-sex civil marriage would move us toward a society that is more humane, inclusive, and compassionate, it is not sufficient to enact our commitment to equality. Recognition of same-sex civil marriage, or, for that matter, domestic partners, will not be enough to assure equality between those who marry or form such partnerships. Nor does it assure equality between married and single persons. We need to have difficult conversations concerning how to actualize equality. We could start by recognizing benefits packages as compensation for labor and treating the cost value of benefits as a labor issue rather than treating it primarily a way to subsidize or reward personal choices in our family lives.

VI. Caring for Others Dealing with Stress and the Aftermath of Bias Harms

Then, too, there is the matter of stress related factors in health care from dealing so regularly with overt and easily confirmed harassment and other forms of bigotry in the work place and society in general. Stress, unless I am mistaken, has a several health consequences to be considered as a consequence of dysfunctions that public heterosexuals oftentimes bring to their relationships with self respecting gay men and lesbians. Study after study since the mid-1980s have shown that about 90 percent of gay men and lesbians have firsthand experience as the target of harassment. About 20 percent of us have been physically assaulted to punish our being gay or lesbian. One explanation for these assaults is the so-called the “homosexual panic defense,” even though ordinarily a heterosexual has panicked in harmful ways. To be precise, it should be called “panicky heterosexual defense.” Perhaps the best of the studies on anti-gay and lesbian biases is the Kaiser Family Foundation’s study, *Inside-Out: A Report on the Experiences of Lesbians, Gays and Bisexuals in America and the Public’s Views on Issues and Policies Related to*

²² Bonvicini and Perlin have documented that “in the area of medical insurance, coverage is often unaffordable or unavailable to the gay and lesbian patient, compared with heterosexuals” (119), a factor which probably accounts in large part for why gay men and lesbians are less likely to seek out preventative health care than heterosexual counterparts (see 116)

Sexual Orientation, a copy of which you can conveniently download online if you want the hard statistics concerning violence, vandalism, harassment, discrimination, and overt hatred impacting gay men and lesbians (<http://www.kff.org>). If you compare the statistics with the figures in 1986 in the Anti-Gay Violence Hearings, you may detect some slight evidence of improvement in the situation confronting gay men and lesbians. But, in the big picture, there are still huge problems increasing the likelihood of stress related illnesses that can be physical and mental, everything from depression and trauma — both psychological and physical trauma — to ulcers, diverticulitis, and high blood pressure with increased risks of heart attacks. Think about the human costs of hostile living environments, not merely the incredible economic costs in medical expenses, or to mention workplace productivity.

Here again, it might be helpful to ask gay men and lesbians an open ended question, such as: what is your work life like for you? On one occasion, my doctor (the keeper) began talking with me about work while he was checking my heart rate and blood pressure. The heart rate sped up noticeably and my blood pressure went up — way up. Then, after a time, he changed the subject and, later, checked both figures again, which had returned to healthy, normal levels. He detected considerable work related stress by how he timed checking those rates in relationship to our conversation about work. I strongly suspect that this timing was deliberate on his part.

Over the decades, bias harms have exacted a huge human cost on health. So my last story concerns how harassment of gay men in the workplace and public life can interact with pre-existing health conditions with literally deadly consequences. My last story concerns a close friend, whom I will name Rob, who lived with HIV / AIDS for more than a quarter of a century. I want to share this story to underscore the sometimes deadly consequences of work place harassment, which, to judge from study after study from the mid-1980s through the millennium, has impacted about 90 percent of gay men and lesbians. On a hopeful note, too, I want to reflect with you on the matter of whether we sometimes can become family for each other without necessarily knowing it at the time.

Rob had lived with HIV for about 25 years at the time of his death, probably longer than that. To my knowledge, he was among the earliest gay men to have become infected with HIV in the early 1980s, when the disease was not yet known or even named, not yet called AIDS but rather GRID (Gay Related Infectious Disease). HIV had yet to be identified or named, too. That means that Rob was already infected, but he did not know it, when I first met him in 1984, while my partner and I were at an outdoor concert. Rob was one of those dependable friends who are there for you in difficult times. I like to think that I was there for him during his difficult times, too. Back in the mid 1990s, health care professionals were already referring to him as “a long term survivor,” an expression that enraged him, because his plan was to live a full, long life, as indeed, he managed to do in some measure. He died by suicide four years ago in winter 2009.

A crucial turning point in Rob’s life happened when an Assistant Principle at the public school, where Rob loved to teach, decided to make a campaign of anti-gay harassment targeting him that was so severe that it became a legal struggle, largely invisible to most people who knew Rob even well. Although Rob prevailed in the protracted legal contest, the stress and aggravation exacerbated his other health issues. He left his job disabled before medicare or medicaid would have become available to him, and he soon had a formal AIDS diagnosis with his T cell count dipping below 400 and then, almost miraculously, rising back above 400 before diving downward yet again. As his

health declined noticeably, impacting his mood, his disheveled appearance, even his ability to carry on a conversation without sudden bursts of anger and fury, he began to have unexpected falls, usually when he was alone.

Then came the not altogether unanticipated news that he was in intensive care at Presby, a local hospital where I went to visit him and was admitted two days after I had been informed initially that he might not survive. At intensive care, I was relieved to see Rob. During my initial hospital visit, the female nurse or doctor or intern — I'm not sure which — said to Rob in my presence for me to hear, "Neither of the two usual explanations for this account for it." She added, "The story is not adding up." What, I wondered, was she intimating by her reference to "the story"? What "story"?

I made a priority of going to visit Rob at the hospital at least once a week for the several ensuing weeks, relieved when he was moved from intensive care to another hospital room to receive more routine medical attention. There I met his parents for the first time at his bedside. After a bit of friendly conversation, his father asked me abruptly in his mother's presence, "They asked us if he might have attempted suicide. Is that possible?" Not knowing what to say, I responded, "I hope not. He has been depressed for a long time now." It was an honest reply, which is all that it had to commend it. I was stunned. Over the weeks that followed, Rob recovered remarkably, initially going into a nursing home before moving back to live with his elderly parents, who cared for him at their home. My impression from my conversations with Rob was that his insurance was proving to be a huge problem for him.

On one occasion, I was with Rob at a restaurant, when he collapsed and needed to be taken by ambulance to a hospital. At the hospital, Rob seemed to be faring well when I saw him in the emergency room. When I mentioned to the two people who were working with Rob that I was aware he was HIV positive, they informed me that his T cell count was in the low 50s. His vital signs seemed to be fine. So the doctor, a young woman, was planning to release him to go to his home. I was troubled. So, in the doctor's presence, I assured Rob that I would take him home, if he wished, but I really would prefer that he stay the night, because, after he got home, how would anyone know whether he collapsed again. The doctor, listening to our conversation, pieced together, as I hoped she would, that Rob was living alone and, under the circumstances, vulnerable. So she encouraged him to stay the night so that a few additional tests could be run. I wonder whether during those brief moments I became, for all practical purposes, Rob's family.

Rob's story does not have a happy ending, because about three weeks later Rob committed suicide. Rob's death appears to be representative of combinations of factors that lead gay men to suicide in that his life had lost its meaning in the aftermath of leaving his job, while he experienced protracted psychological pain and deepening hopelessness.²³ I remembered Rob saying that he did not want to be a burden to his family. His parents, he said, were now in their 80s and, in his view, should not have to care for him in their old age. His insurance would not cover extended care at a nursing home, he had confided. He had fought HIV for a quarter of a century and the medicines were no longer working for him. He had been collapsing from time to time, as I witnessed at the

²³ See Angela McNaught and John Spicer, "Theoretical Perspectives on Suicide in Gay Men with AIDS," *Social Science & Medicine* 51 (2000): 65-72

restaurant. There were virtually no T-cells left in his system. His death, he knew, was in sight. The only questions, in his view, were how long and protracted and costly and burdensome his death would be. His comments have proved to be difficult for me in that they have forced me to re-examine my views concerning euthanasia, my views concerning how profitable it can be for medical professionals to extend life without any realistic hope, while evoking what seem to me today like sometimes sanctimonious platitudes concerning “the sanctity of life,” and, yes, even to confront my own mortality.

Perhaps that is a large part of what my being judgmental was all about. In any event, at a time of crisis, I wonder whether for a brief time I became Rob’s family by ensuring that health care providers had information, not about his vital signs, but rather the circumstances of his living. One point that I have been repeating in this essay is that competent health care attends not merely to vital signs and measurements of bodily fluids and physiological conditions, but, more broadly, to the circumstances of living as they impact each person’s well being.

VII. Conclusion

In conclusion, I would like to mention some general circumstances of living that gay men and lesbians must deal with, whether we are arranged into families or not. Though I find giving any attention organized hate groups distasteful, I do want to share with you a couple of resources for your learning more about organized hatred, because oftentimes members of relatively safe groups imagine that gay men and lesbians have exaggerated worries for safety. One resource for learning about patterns of organized hatred in the United States is the Southern Poverty Law Center, whose “hate map” identifies the number of organizations in each state that actively work to support supremacy. Most of their work focuses on race and religion, as you can see from the list of organizations on their website (<http://splcenter.org/get-informed/hate-map>). So the statistics that they provide for each state are low and they underestimate the magnitude of the problem. Their 2013 figure of 36 groups in Pennsylvania is somewhat lower than a few years ago, yet may obfuscate that some organizations have multiple chapters. The White Knights of the Klu Klux Klan, for example, are an active chapter located over in Moon Township, a nearby township which is home for six organized hate groups. Franklin Park, just north of Pittsburgh, is home for two more hate organizations.

As disturbing as numbers on this hate map are, they omit other damaging organizations, such as the Concerned Women for America, who have had a longstanding role in promulgating supremacy toward gay men and lesbians (<http://www.cwfa.org/main.asp>). The Concerned Women for America have had a history of combating the National Education Association’s efforts to provide youths with positive gay and lesbian role models, despite common knowledge that gay and lesbian youths are at the highest risk of suicide of any group in the nation.²⁴

²⁴ Bonvicini and Perlin, 117. For germane health care perspectives on self harm and suicides, Richard T. Liu and Brian Mustanski, “Suicidal Ideation and Self-Harm in Lesbian, Gay, Bisexual, and Transgender Youth,” *American Journal of Preventive Medicine* 42.3 (2012): 221-228; Michael P. Marshal, Laura J. Dietz, Mark S. Friedman, Ron Stall, Helen A. Smith, James McGinley, Brian C. Thoma, Pamela J. Murray, Anthony R. D’Augelli, and David A. Brent, “Suicidality and Depression Disparities Between Sexual Minority and Heterosexual Youth: A Meta-

Apparently, the Concerned Women's self proclaimed efforts to "protect" children do not extend to gay and lesbian youths, who experience a complicated range of health concerns.²⁵ In February 2012, their website had articles denouncing advances in legal recognitions for domestic partnerships and same sex marriages. Their website hosts articles claiming that same sex marriages are unchristian and inferior to their marriages, while assuring members that they are neither hateful nor meanspirited. There is an active chapter of the Concerned Women here in Pittsburgh and other chapters scattered across the entire state. As a matter of First Amendment freedoms, they can continue to promulgate these views, however deliberately harmful to others.

You might be tempted to consider these as fringe examples of supremacy and bias groups rather than recognize the magnitude of how less obvious biases can harm competent and compassionate health care for people sometimes considered "expendable". So allow me one final, sustained example concerning the conduct of former President Ronald Reagan, who for six long years maintained a silence about HIV / AIDS, a silence that he maintained even after the modes of transmission were well identified and known. This is how former Surgeon General Everett Lee Koop described the situation before October 1986, when he released his Surgeon General's Report on AIDS without securing the usual clearances from upper administrators, because Koop feared that his report would be made less explicit. According to Koop, although he was the nation's Surgeon General, he was:

completely cut off from AIDS. I was told by the assistant secretary of health, my immediate boss, that I would not be assigned to cover AIDS [...] Even though the Centers for Disease Control commissioned the first AIDS task force as early as June 1981, I, as Surgeon General, was not allowed to speak about AIDS publicly until the second Reagan term. Whenever I spoke on health issues at a press conference or a network morning TV show, the government public affairs people told the media in advance that I would not answer questions on AIDS, and I was not to be asked any questions on the subject.²⁶

Analytic Review," *Journal of Adolescent Health* 49 (2011) 115-123; Jun Sung Hong, Dorothy L. Espelage, and Michael J. Kral, "Understanding Suicide Among Sexual Minority Youth in America: An Ecological Systems Analysis," *Journal of Adolescence* 34 (2011): 885-894; Mark S. Friedman, Gary F. Koeske, Anthony J. Silvestre, Wynne S. Korr, and Edward W. Sites, "The Impact of Gender-Role Nonconforming Behavior, Bullying, and Social Support on Suicidality Among Gay Male Youth," *Journal of Adolescent Health* 38 (2006): 621-623; Marla E. Eisenberg and Michael D. Resnick, "Suicidality Among Gay, Lesbian and Bisexual Youth: The Role of Protective Factors," *Journal of Adolescent Health* 39 (2006): 662-668; Linda L. Morrison and Jeff L'Heureux, "Suicide and Gay/Lesbian/Bisexual Youth: Implications For Clinicians," *Journal of Adolescence* 24 (2001): 39-49

²⁵ Jennifer L. Kreiss and Diana L. Patterson, "Psychosocial Issues in Primary Care of Lesbian, Gay, Bisexual, and Transgender Youth," *Journal of Pediatric Health Care* 11 (1997): 266-274

²⁶ Quoted in Tina L. Perez and George N. Dionisopoulos, "Presidential Silence, C. Everett Koop, and the *Surgeon General's Report on AIDS*," *Communication Studies* 46 (1995): 21

As communication scholars Tina L. Perez and George N. Dionisopoulos have documented, “Indices for the Public Papers of the Presidents of the United States lists no entries concerning AIDS for the years 1981 through 1984.²⁷” There are no generous interpretations for how President Reagan and his administration handled the active silencing of public discussion of AIDS, so poignantly detailed by the former Surgeon General. Reagan and his administration allowed political expediency, their own lust for power, and cowardice to take priority over the nation’s health and well being. Indeed, former President Reagan’s conduct implicates him, most of his administration, and countless media personal who complied with instructions that there be no public questions — all of these people acting together deprived U.S. citizens with timely, dependable, and necessary information concerning health maintenance during a pandemic that claimed more American lives than all the major wars of that century taken together. Had the former Surgeon General not released his Report on AIDS in October 1986 without securing the usual approvals, because he was concerned that the report would be watered down, Reagan’s disgraceful Presidential silence would have cost more human lives of our fellow American citizens. Perhaps, you may think, that is now history.

But what can we learn from it, and how can we improve health care today? Since the millennium, a wealth of useful resources and books have been published on health care for gay men and lesbians. For example, at the University of Pittsburgh in 2001, Anthony J. Silvestre prepared a binder, *Lesbian, Gay, Bi-sexual and Transgender Health Issues: Selections from the American Journal of Public Health*. In 2003, Allan Peterkin and Cathy Risdon authored *Caring for Lesbian and Gay People: A Clinical Guide*, which begins “The health of a nation, physically and emotionally, can only be as good as the health of its most vulnerable and stigmatized citizens” (ix). In 2006, Michel D. Shackle edited *The Handbook of Lesbian, Gay and Transgender Public Health: A Practitioners Guide to Service*. In 2008 Harvey J. Makadon and others produced the *Fenway Guide to Lesbian, Gay, Bisexual, and Transgender Health*. There is also an extensive website resource under the name Fenway. In 2011, The Institute of Medicine produced *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. The lack of resources is no longer a plausible excuse for inadequate health care for the families of gay men and lesbians. So I challenge you to become a part of the solution to the problem of health disparities.

I have mentioned several other resources for you to learn actively from to improve health care for gay men, lesbians, and our modern families. Among these are national organizations, such as Parents, Families, and Friends of Lesbians and Gays. Furthermore, Persad, the Pittsburgh AIDS Task Force, and the Shepard Wellness Center are three additional resources for referrals in Pittsburgh. Health care professionals in other regions of the country should make time to locate comparable organizations for making referrals. In general, I have emphasized focusing on behaviors more than labels for groups. I have suggesting asking open ended questions to learn about the behaviors and living environment of your patients. You should inquire about their circumstances at work, for instance. Above all, I have underscored the importance of becoming dependable care givers for gay men and lesbians, by becoming

²⁷ Perez and George N. Dionisopoulos, 21

more aware of your language choices and how stereotypes can get in the way of providing competent health care. I mentioned *The Celluloid Closet* as one convenient video resource for your learning to identify and deal with harmful stereotypes and damaging narratives that can impede recognizing the humanity of gay men and lesbians. In my opinion, if you are going to become competent health care professionals, you will need to make time to identify those moments when you have the potential to be judgmental and work deliberately to make conscientious healthcare more salient in your work than any discomforts with human differences. Above all, you might need to examine what it means to you to become family, if only momentarily, if or when a patient's medical circumstances call for it.

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