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Interviewee:	Philip Berger
Interviewers:	Alexis Shotwell; Gary Kinsman
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Persons Present: Philip Berger (PB)
Alexis Shotwell (AS)
Gary Kinsman (GK)

[START OF TRANSCRIPT]

AS: I start off by saying at the beginning that we're in Toronto, it's February 19th, 2018, and we're talking to Philip Berger about Toronto. Thanks so much for making the time for us.

PB: You're very welcome.

GK: So, the first question we start off with everyone is, thinking back, when was the first time you heard about AIDS? And what did you hear?

PB: So, fortuitously, I was working at a community health center with a colleague of mine, who I just had brunch with an hour ago, named Doctor Michael Rachlis, who happened to subscribe to the CDC *Morbidity/Mortality Weekly Report* [from the Centres for Disease Control]. This was very unusual for a family doctor, or primary healthcare practitioner, to do. So he'd get them every week. I work at South Riverdale Community Health Center where he worked, and already had a large number of gay men and a few injection drug users. I'm straight but I was known as a "gay-positive" physician, that's the term they used back then. Maybe still now, I don't know. Anyway, we get this report, June 5th, 1981. I know this sounds fantastic, but it's absolutely true, that's where I first read about AIDS. It was the first CDC report of five homosexual men, I think in San Francisco, developed this life-threatening pneumonia, PCP pneumonia. So we're on the look-out from the very beginning, actually. Then, at around the same time, we'd heard stories from our patients with lovers or partners in these major American urban centers – Miami, LA, San Francisco, New York – who were talking about some mysterious illness that was going around the gay community. So those are my first contacts. The CDC report, the original one, which I still have down in the basement. And patients bringing back stories to us as doctors.

GK: So, obviously this must have had some impact on your medical—

PB: Well it did, but I didn't know what I was looking for, to be quite frank. I mean, we had no idea what it was. Although by August of 1981, when another CDC report came out about transfusion recipients I believe, within a few months it was pretty close … Those of us who had read whatever little literature there was were pretty confident it must be a blood-born infection of some kind, even though it wasn't really established until, when, 1984? Spring of 1984?

GK: 1983-1984.

PB: 1983-1984. With Robert Gallo and Luc Montagnier. So we were on the look-out, and I remember actually, I had a patient… he's a police officer – it was very rare to have a gay police officer in those days – who came in with a skin lesion. I sort of thought – this is around 1981 or so – I know the year because I moved into my own community practice in fall of 1982, so this would have been before that.

GK: You're still at South Riverdale.

PB: Still at the health center. And I didn't know what this was. I sent him to a very sympathetic dermatologist, this guy named Doctor Colin Ramsay. He was a professor, and head of the faculty of medicine, dermatology department back then. I said, "Could this be Kaposi sarcoma" and he wrote back and said "I have no idea what Kaposi sarcoma looks like", in AIDS especially. He had no clue. He said, "You know as much as I do." The reason I remember that moment is because that held true for a number of years. I realized we, and there's about a dozen of us initially, primary care practitioners, knew no less than the specialists who were also seeing the same illnesses in patients. So we couldn't go to them. We knew as much as they knew. And he was a very modest man, and he was a very kind man, because I had, there were terrible dermatological conditions – this is a few years later when we were fully into the epidemic – that people would get. I remember I had a patient who was just basically covered from nose to toes in this red, raw rash and he admitted the guy into hospital and he was so kind, he was very self-effacing. There were numbers of doctors you never heard about, no-one knows about, who were like that.

AS: Yes.

PB: I remember I wrote an article for the *Canadian Medical Association Journal* on one of the AIDS conferences, and referenced how kind he was as an academic professor, straight man, everything else like that, but he was, and he was so embarrassed when I mentioned his name. So that was my first encounter, and the first indication that no-one knew what was going on.

AS: Normally, would it be that in general practice you would be able to go to a specialist and say—

PB: Of course! But you couldn't do that with these cases. Absolutely not.

AS: What was that like, as a doctor?

PB: Well, it was pretty scary. We're, I mean, as the years went on… let me back up a bit. So 1984 was the first time I saw someone have AIDS-defined illness, like AIDS Kaposi sarcoma. Prior to that, we saw men with persistent generalized lymphadenopathy or PGL or PLS, persistent lymphadenopathy syndrome, or GRID – Gay-Related Immune Deficiency. There were all these acronyms that are gone to the winds of history now… So I saw them in 1981, 1982, in fact I had, I remember I had a patient who did die of AIDS about ten years ago and I went back into his chart and had documented meticulously what was obviously, in 1982, what was obviously an acute HIV infection, but it hadn't been labeled as such, it wasn't labeled until 1984 or 1985, it wasn't described what acute HIV was. He had this classic acute HIV condition and he got there, and went away, and I had no idea what it was, actually. So I knew I was seeing people who'd been infected right from the beginning, and the reason I checked is that I wanted to make sure I wasn't embellishing, because I've done these interviews before, when I answered your question about when I first became engaged with it. But… not having specialists was, in a sense, was the least of our problems. The biggest problem was being shell-shocked, honestly, at young men who were being stuck with an onslaught of ferocious infections and tumors that killed them within months. And there was nothing you could do about it. It was agonizing. Especially, it must have been worse for gay physicians because they were losing their friends and partners, in fact many of the physicians I knew who were quite closeted gay men came out, finally, because of the AIDS epidemic. So the shell-shock, the… inability to prevent any of this from happening, the inability to treat it, watching people waste away… and all you could do, I mean I know this is going to sound hokey, all you can do was just be kind and available, in the end. And use narcotics and barbiturates to help people sleep and get rid of pain.

AS: Yes. Quite a different kind of…

PB: There was nobody you could ask, and that's the truth of it. There was no specialist to go to. We relied on the specialists if people needed to be admitted to hospital because we didn't have admitting privileges, so that's when they would kick in. But there's some neat stories. There's a guy named… who's still around, who started, a guy named Gabor Kandel, a gastroenterologist. Who, in the 1980s, when we couldn't, CAT scans were relatively new, we couldn't get them, I'd have someone come in a suspected brain infection. It was not his area. He'd organize a CAT scan. In fact he even drove a patient home once from his office. There was another two surgeons there, young general surgeons at the time, John Bohnen, who's now on sabbatical from being the vice dean in the faculty of medicine at U of T, and a guy named Bob Mustard Jr, who retired, were the first general surgeons in the city, the odds were, to operate unconditionally on people with HIV/AIDS. In the early-mid 1980s when people were not treating people. And I remember one day, in about 1987, I was at the Wellesley Hospital and I bumped into Bob Mustard Jr, and he was ranting furiously. I said, "What's the problem?" He says, "The residents, they don't want to operate on people with HIV! They don't read the literature, there's no risk at all, I'm furious!" He was mad at his own trainees for being so reactionary and backwards. But they were, you know, Wellesley used to have twenty-five patients at any one time, there at the hospital. And there'd be trays of food left at the doors. I saw it. With drugs and my patients at the hospital, they wouldn't go in. It was pretty bad.

GK: So maybe just to step—

PB: I'm stepping all over the place.

GK: No, no, no, no, this is great, this is great. Just to maybe step back for a moment, because we also, we usually ask everyone, in some way, shape, or form, if they brought with them, into dealing with AIDS, other types of political or, in this case, medical experiences.

PB: Well, you know, there's a book called *AIDS Doctors* that came out around twenty, twenty-five years ago. It's a very good book. I did a review for them. I'm sorry to be boasting so much, but I'm not just telling you because I know about it, I did a review for the *Canadian Medical Association Journal.* Demographically, there were four groups that AIDS doctors in the States fell into. Can you guess what they are? What's an obvious one?

AS: Well, I would say gay doctors.

PB: Okay. Gay doctors. One. Two: Leftist doctors.

GK: Yes. Okay.

PB: Three: Jewish doctors, which I am. I'm a Jewish leftist.

GK: Jewish-leftist. You've got two of the categories.

PB: Four: People who are religious Christians, actually, felt – like the Catholics did – they have a duty to take care of people and, in fact, one of the leading editorials written on AIDS in 1987 was by a leading Catholic bioethicist named Edmund Pellegrino. You can go look it up. There were two articles. One by him, and one by somebody else, where Pellegrino argued that, well the title of the second editorial, following Pellegrino's, was "The Newest Epidemic: Patients Without Doctors."

GK: Right.

PB: It was describing a time when people were dumping – and we saw that in Toronto – people were dumping patients out of their practices, refusing to treat them. But Pellegrino wrote this beautiful – now this Catholic bioethicist – saying that patients who were sick had a moral claim on the expertise, and doctors did not have an ethical right to refuse to see them. That was in 1987. I just happened to read it again, because I was talking to journalism Fellows at Massey College, and they wanted, a free, a rambling, off-the-record conversation. And they said "What reading can I do?" I said, "Read this."

AS: Yes.

PB: Thirty-one years later, it's still relevant.

AS: It's still relevant. I mean, it's becoming more relevant again, in the U.S.

PB: Yes, for sure.

AS: So you were already a lefty—

PB: So I was, had been quite involved in… refugee health care, immigration… medical reform. We had a group of pro-Medicare, group of doctors that was established in 1979, we'd taken on the entire medical association. People still won't talk to me, to this day, because they lost that fight. And I had that political experience, you know, that's all I had. I guess from about 1976 or 1977, I became fully engaged with fights for refugees in Canada.

AS: How did you come to all of that? Like, was that something that emerged out of your medical practice, or did it…

PB: So. It's not from any deep religious or philosophical conviction. I'm not going to bluff you at all. I didn't have an epiphany or see the sun shine through the clouds or anything. I stumbled into it. I had been active in medical school. Really. Back in, I was age nineteen, I was in medical school, University of Manitoba in Winnipeg and got quickly involved, politically, with student politics and fighting for a pass/fail system, and then there was a hospital workers' strike when I was in fourth year medical school. I convinced the students to support the hospital workers and denounced my teachers for scabbing, and had to run for my life. They tried to kick me out of medical school, actually, in fourth year medical school.

AS: For that.

PB: In fact, I was failing a twelve-week internal medicine rotation, which would have prevented me from doing internship, and I still have the evaluation that says, "Performs satisfactorily but has little respect for the medical profession." I agree with the latter, but the former should trump the latter. I appealed successfully. So I had some experience coming to Toronto. And then in, I didn't know what I was doing with my life, and I can't go into all those details, but I ended up working at Hassle-Free Clinic in the spring of 1977, which is the first time I hit the streets of the gay community as a straight man. When Anita Bryant came to town.

GK: Okay.

PB: She's an awful person. Despicable.

AS: Can you say a little bit about how you got involved with Hassle-Free?

PB: I went to work there. I was trying to figure my life out. I was twenty-six, having a bit of an existential crisis is too strong a word. I kind of took some time off, I went to law school for four months and decided that wasn't good enough. Then I got accepted for a second year of residency. But I had about four or five months off so, and Hassle-Free needed doctors through, actually through Michael Rachlis, same guy. Actually, I just went for lunch with another woman who used to work there during that time, named Katherine Gaultier, who's a doctor in Ottawa. But before she went to medical school, she worked as a – do you know who she is?

GK: I think I know.

PB: She worked as a counselor – at Hassle-Free. She was the one that actually taught me, even though I'd graduated from medical school and done my internships, she taught me how to do a proper speculum exam. A speculum exam with women, without hurting them, and being respectful of them. She had not even been to medical school, she wasn't even a nurse, and she taught me. I just had brunch with her this morning, and Michael. Forty-one years ago I was there. So I hit the streets against Anita Bryant, and tried to be supportive and follow the lead of the gay leadership of the time. They had weird groups back then. There was a group called "Heterosexuals for Homosexuals." Remember that group? It was after the bath-house raid days.

GK: Right.

PB: I forget the name of the group. Then a friend of mine had asked me to see a Chilean refugee, after they'd been tortured, this woman. So I did, and I wrote a medical report for him. Just out of courtesy. They decided to use the medical report as evidence in the refuge determination hearing that she's been tortured, and that led to a bunch of us doing it, and the establishment of the Canadian Center for Victims of Torture, which still exists today. Amnesty International, Canadian Medical Group, which still exists today. So that was pretty accidental.

AS: Yes.

PB: In fact, that same guy, that's a lawyer friend of mine who I've known since I was eighteen, was one of the lawyers for the South African dance troupe who defected… Do you remember that?

GK: I sort of do …

PB: I'm not looking at you [Alexis] because you're not old enough to know… the South African dance troupe came here and defected in about 1977, 1978. Some of them stayed in the house I was living in. This friend of mine was a refugee lawyer, and I still have this image of him on CBC National TV News, like, accompanying South African dancers. He became a judge, eventually. But he started it all off by asking me to examine this Chilean refugee. So I'd had experience— and then I joined the refugee fight that we occupied [Immigration Minister] Ron Atkey's office and disrupted political meetings, a bunch of us. That was in my twenties. So I had some experience before AIDS hit, which I think helped when the HIV Primary Care Physicians Group was established in 1987. I had some experience, politically.

AS: In those years between 1981, when you start hearing about these different conditions that you're seeing connections between, and 1987 where the Primary Care Physicians Group gets established — How would you talk to each other? It sounds like there were groups, there were doctors, that you would talk to each other about "Oh, here's the CDC", how does that—

PB: So there wasn't much talking in Toronto, but there was kind of a funky, hipster-type infectious disease specialist from the States named Mary Fanning, at Toronto General, who I liked a lot. I'm not sure what the view of her was from her colleagues, but… She was smart enough to realize that there was this group – at that time alone there was about a dozen or so primary care downtown doctors – she knew them through referrals to get people admitted. We kind of knew the names of the ID [Infectious Disease] specialists, you heard them, and she was the one that said "You've got to form a group." So I held the first meeting with her, and a few others, and we established a group, which then we took over and she exited.

So it was very smart of her, because she saw, also, the potential for facilitating research into HIV/AIDS if you had a group of primary care doctors who had hundreds of patients. I had about two hundred and fifty people for a numbers of years, and that was not unusual. I remember some of them had up to four or five hundred patients with HIV. Two hundred and fifty patients with HIV/AIDS, in those years. I had a regular private care practice, which took up half my time. Like, I measured it. I had another twelve hundred patients without HIV. But it was, like, weekends – I can describe it to the letter – weekends, evenings, death certificates, the whole business. So Mary Fanning was actually the impetus for organizing it. Our first job once the family doctors were organized here, the primary care doctors – was how to keep up on the medical part. Well, there wasn't a whole lot of literature. I actually used to clip articles from journals. Can you imagine that? Xerox them and have them mailed out to these dozen or so downtown doctors, and eventually I convinced the Toronto Department of Public Health to do this. I'd give them the references and they'd do the mechanical work of clipping, copying, and mailing out once a month to our group, so they could keep up. I'm not sure how long that lasted. Maybe… until the early 1990s sometime?

AS: Wow.

PB: And then, I knew it would lead to – I mean, these are pretty straight, in the linear sense of the word, like conservative, doctors some of them. They'd never been engaged politically in their life. Even though some did come out, because of the AIDS epidemic. I had to go sort of slowly, in my own mind, but eventually – they didn't need much pushing, because when they saw their mostly straight physician colleagues kicking people out of their practices, or refusing to see them, they became enraged. And the discrimination by the state, and the fight against anonymous HIV testing… I mean, they started contributing to all these battles. Shortly after the group was established, in fact.

We would do press conferences with AIDS ACTION NOW!. You may remember those days. You know, when one of our reps would be, you know for drug costs, our group also announced publically we were going to give out free needles to anybody who wanted them, clean needles, before there was a single needle exchange program in the country established. A deputy police chief, I heard him on radio saying "We'll arrest any doctor for distributing drug paraphernalia, if they give out the needles." They never came near us, of course. So the group naturally evolved into becoming politically engaged as well as educating themselves. We used to have guest speakers come in to talk about various medical subjects. We did it in the waiting room of my office at 597 Parliament Street, actually. We also kept track of doctors who were dumping patients, and dentists. One of our doctors… I forget his name now, it's terrible. He became a pathologist eventually. But we'd keep names of physicians and dentists – we didn't act on it – who were behaving unethically.

GK: So, do you remember the names of some of the other doctors?

PB: Oh, yes. There's a straight doctor around the corner, Alex Klein. Remember that name?

GK: Yes.

PB: Wayne Boone. I don't even know what happened to Wayne.

GK: Yes, I know Wayne Boone.

PB: Is he still living, Wayne Boone?

GK: I'm not sure. Wayne was from the East coast, wasn't he?

PB: Yes. He was an East coaster. There was Dennis Conway. He's still around. He's from the early, I actually trained with him many years ago. John Goodhew, a relatively recent addition, he's quite a bit younger than the rest, and he wasn't there in those early years, but he's been around. There was… Michael Hulton, who moved to California.

GK: Right. He's in San Francisco.

PB: San Francisco. I haven't seen him for years. I actually fixed him up with a cousin of mine, but it never worked out. Who died of AIDS, ironically. Twenty-three years ago, twenty-four years ago.

Rick Green was a doctor, I think I mentioned, moved to London, died of AIDS. I remember he came to a few meetings. You know, I could go back, I have paper files somewhere. I kept them all, actually. The minutes of the meetings and everything like that. There would be lists of names. My memory's failing me.

GK: No problem.

AS: And if you want to have any of that preserved, or digitized, and put up, we can—

PB: I should, I have to go through… No, I don't view them as my personal property. I don't have a proprietary claim over them. I just don't know which box it's in.

AS: I know. But if it ever, periodically people, like, mail us a box of stuff and say "Figure out what's useful in this," and we go through it.

PB: I would rather do that. What's the point of keeping it and dumping it? My kids aren't going to keep it, that's for sure. Adult kids.

AS: It's amazing that this came together.

PB: Yes, I do have it somewhere. So those are, trying to think who else was… I just can't. I mean, there were the specialists, too. Anita Rachlis, who just retired recently, who was solid from the beginning. Anne Phillips, who went to work for a drug company eventually. Sharon Walmsley, Irv Salit, who's the head of, I still think is the head of the HIV Clinic at Toronto General. Doug McFadden—

GK: I remember that name.

PB: —This fabulous respirologist -pulmonologist from Toronto Western, who actually was kind of a wild cowboy of AIDS at the time, because he would get into these… alternate therapies. There was a drug called Peptide T that he's tried to push very hard. And he pushed the limits more than anybody did, actually, in those years. I'm not sure what happened to him. I haven't been in touch with him for decades.

AS: Because there were lots of ideas about what might help, right?

PB: There was Doxycycline for syphilis treatment, I forget the name of the man from the States… he came here, I went to hear him talk once. It was Doxycycline, the view that it would suppress syphilis and somehow help people. In fact, Doxycycline is still funded, to this day, under the Ontario Drug Benefit Plan, for HIV only. They won't pay for it for any other condition. Which is an historical anomaly. It's only because we pushed hard for it—

AS: At that moment—

PB: At that moment. That was pre-AZT days, I think, or just around it. There's nothing else to offer, so… the government kind of capitulated. We pushed them for that. Fluconazole, also, only for HIV. Acyclovir, only for HIV. There's a view of Acyclovir, and it probably does help, a little, Acyclovir, but not in a big way. All got covered for these historical reasons that there's nothing else available, and the government agreed to fund it under the Ontario Drug Benefit plan, under a program called Facilitated Access. Facilitated Access was a social program that allowed these non-antiretroviral drugs to be paid for. So there's Doxycycline, there's the Kenyan wafer biscuits, I'm not sure if you've heard about that. Do you remember the Kenyan wafer biscuits?

GK: I don't remember that one.

PB: There's Amplogen.

GK: I remember hearing that.

PB: And… what else? I remember Peptide T. I mean, they're all… of no benefit. But… I wouldn't say that to people. They had nothing else and I lied.

AS: And so how would it -- earlier you said you'd also need to get specialists being able to do research in order to tell… what would happen. How would you suggest, "Oh, maybe this is something useful"?

PB: Okay. So. That's very interesting. So there was a useful drug. One useful drug, early on, called Aerosolized Pentamidine, not only for treating PCP but, more importantly, preventing it. And… my view always was, and it's not a radical view, was that for drugs that are not yet approved, I understand why the state may not feel an obligation to pay for the drugs. But at least the individual person who's sick with a fatal illness should have the right to decide what risks they want to take and not take, what they think will benefit and not benefit, without the state intruding. But the state, at that time, wouldn't let that happen. Don't forget, PCP was killing a third or more of the people with AIDS. It was deathly. Actually, I think two thirds of all AIDS-defined conditions were PCP, if I remember correctly. Now was the time that you had an AIDS-defined illness, very early on in the mid-1980s, that the average median life expectancy was around six months. It eventually got, pre-ARV (anti-retrovirals), extended to about two years, eventually. But the beginning was six months from the time you had AIDS to the time that one died. So to prevent PCP would be really important, and there was a placebo-controlled trial going that Mary Fanning actually ran, despite the fact that she was a progressive. There was a demonstration – I'm sure you can find this in AIDS ACTION NOW! archives – held at Toronto General Hospital.

GK: Yes.

PB: You have all that stuff? Where they protested against it. And eventually, she—

GK: That was the first public demonstration that AIDS ACTION NOW! organized.

PB: It was. Yes, because I was at the first meeting at Jarvis Collegiate, actually, with AIDS ACTION NOW!. Tim McCaskell planted a question with me. I remember that. I forget what the question was but, in the audience. But, so that was quite successful, because they capitulated and then they actually had some ethicist from McMaster named Doctor Johnson, I think, he's supposed to be the independent external advisor, but he fell to the side. I remember I was on the radio attacking him for this report. But the hospital eventually capitulated and that's how the Aerosol Pentamidine Clinic actually got established in Toronto, after that demonstration. The government funded the establishment of an Aerosol Pentamidine Clinic, at Sherbourne and Bloor, six hundred Sherbourne Street. Charles Chan – who's now a vice president of medicine at University Health Network – was a young respirologist, who came here as a refugee as a kid and lived in a rooming house on Jarvis Street and then got into medical school and became a leading physician in the country. I mean there's a lot of interesting stories here. He was a really good guy. Really terrific young—

AS: So he ran the clinic?

PB: He ran it with me, but I didn't have time. He ran it. I mean, he was a very interesting man, Charles Chan, because besides his history of growing up poor and being very successful, he never forgot his roots. Anyhow, I had no interest in researching. Remind me to tell you a research story in a minute. But… he would publish these papers in leading medical journals, like this journal called *CHEST*, on Aerosol Pentamidine, because all his clients were going there. And he insisted on putting my name in these articles, even though I never did anything, I didn't even, "don't even send me a draft", I didn't do one single thing. But he felt, if I hadn't lobbied, politically, for the funding, that pressure, there would never have been a clinic, he would never have had his studies, and he insisted on putting my name in. Usually it's the exact opposite. Academics are all fighting each other, competing, so…[laughing] I always felt that was kind of an indication of how ethical a person he was. I mean, it didn't matter to me at all, I couldn't have cared less, really. But it was proper of him to do that.

AS: So let me back up a little bit. So Mary Fanning was actually running the placebo controlled trial?

PB: I believe she was part of it, at least, I can't remember.

AS: Or involved in it?

GK: Yes, that's my sense too.

PB: That she was running it? Or—

GK: Some of the doctors actually were quite pissed with us around that. I know you weren't. But some of the—

PB: No, of course. I felt I probably shouldn't show up.

AS: And so that trial, so…

PB: It was a very important moment, that was.

AS: Yes. So they were replicating a French study? Was that right?

PB: I can't remember.

AS: Okay.

PB: They'd known enough. Enough was known – my own memories – enough was known that we should let the people have this now. There's nothing else we can do for them.

AS: Right.

PB: But that quickly became a little bit obsolete because in 1988, I think it was the Margaret Fischl study that was first published on the benefit of Septra – Sulfamethoxazole-Trimethoprim – that was equally effective in preventing PCPs. There was an alternative. Except a lot were allergic to Septra, or Bactrim in another name. Septra's a trade name, Bactrim's a trade name. Sulfamethoxazole-trimethoprim is a generic name. It did the same thing as Aerosol Pentamidine and it was also used as a treatment for PCP. So there were other alternatives.

AS: Because Pentamidine was just prophylactic, if you'd already had PCP, and you were not wanting to get it again?

PB: Correct.

AS: But Septra or Bactrim could be a treatment. .

PB: Treatment and prophylactic.

GK: And you're also talking about Pentamidine in an aerosolized form.

AS: Right. Not injection.

PB: Yes.

GK: Because it's quite toxic.

PB: It is toxic. But it would be used intravenously also to treat people who were dying from PCP. Like, Bill Lewis – a leading microbiologist who I knew from Winnipeg, actually – he died of AIDS, when, in the late 1980s probably? [Bill Lewis dies in 1987]

GK: Bill was Michael Lynch's partner and wrote some of the early material in *The Body Politic,* too.

AS: So how did you get the clinic set up?

PB: I forget the details, but the government gave them money to rent an office, basically, and hire a staff person or two, and pay for the machines and the drug. And Charles Chan, was involved in the logistics of it, and so… I think I went there once, and I was actually in name a medical director. It was, oh god, I was embarrassed. I shouldn't have, but they wanted my name with it. So I said "Go ahead, take it."

AS: Yes, use it.

PB: Then doctors would refer their patients to it. Some of the family doctors – I forgot about this until just now – had already got Aerosol Pentamidine machines in their own offices, and were administering it illegally – not that anybody cared – before this clinic was opened. Denis Conway, I think was one of them, actually.

GK: Michael Hulton had some sort of license, that allowed him to get drugs.

PB: He was an anesthetist.

GK: Yeah. So we would, AIDS ACTION NOW! would actually get people to go to Buffalo, pick up the drug, and retrieve what Michael Hulton would have signed for, and then we would bring it back here, and we actually, this was before the official clinic, there's sort of an underground clinic.

PB: You're absolutely right. No, there was a Buffalo Shuffle, as they used to call it. And the Parliament Hill demonstration where Michael Lynch was in the, using one of these machines, you know the famous image of them taking these treatments —

GK: Yes. There's pictures of it.

PB: Was that the same time they burned…

GK: A couple of weeks apart.

PB: A couple of weeks apart. That was a dramatic moment.

GK: Were you in Ottawa at the time?

PB: No, I wasn't there.

GK: I wasn't either. I was there for the burning of the Jake Epp effigy.

PB: Were you there?

GK: Oh, yes.

PB: That was a dramatic moment, by the way.

AS: Yes. Do you want to talk about it?

PB: Well, no, because, I mean I knew about it. There was this sort of complacent, apathetic, probably homophobic federal government at the political, elected level. It opened their eyes very quickly when Jake Epp got burned in effigy. I think it's the only time it's ever happened. In the AIDS movement. It's considered dramatic, but that really caught their attention, I can tell you. Really, I mean there's all sorts of movement after that, on the drug access front, on the CATIE – what was the predecessor of CATIE called?

GK: TIE – Treatment Information Exchange.

PB: Yes, I think that arose out of the Jake Epp effigy burning as well. So things started loosening up, finally. I think that's when the National AIDS Advisory Committee had been established. I can't quite remember the chronology, but it was…

GK: The commitment to the National AIDS Strategy comes shortly thereafter, too.

PB: So it loosened things up tremendously, this one action. It got their attention. Finally.

GK: The rumour we heard in AIDS ACTION NOW! was that Brian Mulroney called Jake Epp into his office and said "Why are people so angry that they're burning an effigy of you in the streets of Toronto?" I mean, whether that's true or not, it's sort of mythological.

PB: Oh, it's a good story. [laughter] And then, in November 1988, can we jump ahead to that? Because I don't want to forget that story.

GK: Sure.

PB: There was a first National Canadian AIDS Conference of Researchers. And I happened to be invited to it. There may have been about 200 people in this hotel in London, Ontario.

GK: Yes. That's right, it was in London.

PB: And none of the AIDS service groups or activist groups were invited.

AS: It was just doctors?

PB: Just doctors and researchers.

AS: Researchers.

PB: And I'm not a researcher, but I got invited anyways. A number of us who were clinicians got invited. But, of course, Wayne Boone was there, then. And, I remember most distinctly, they rented rooms in the same hotel that the conference was happening. And protested outside the hotel, protested inside the hotel. There's a man who died many years ago, had Kaposi's all over his face, remember that?

GK: Is that Ross?

PB: There's a photo of him at these demonstrations in London, in 1988.

GK: I was at the demonstrations, it was my first time in London.

PB: Well, there's a funny side-story I could tell you about that. But I remember, you see, he was one of these people who didn't care, he had it, he came out anyway.

GK: It might be somebody else, but I'm trying to think who…

PB: There's a picture of him at the front of the demonstration. It's a long time ago. I still have a vague memory. Anyway. So I had a bit of and, I've told this story hundreds of times but I didn't tell this personal part, which is, I'm boasting, but it's true. The Chair of the conference was a, not a bad guy, named John Ruedy, who's Dean of the Faculty of Medicine, at the University of British Columbia. He chaired the conference. I went up to him and said, "You know, why don't you invite some of these men in? What do you have to lose? It's a two-day conference. They're not going to disrupt the meeting. You know, we're making decisions on their behalf. They should be making decision on their own, not us. You have nothing to lose." And he said, "You know? You got a point." I said, "Just go and meet them. Just go talk to them." And he did go out and talk to them, and invited about a half a dozen of them in to join in the rest of this first ever AIDS Research Conference in Canada. One of the people who came in – this is a side-story, this –was Chuck Grochmal. Chuck was not effusive in the use of words. He got right to the point, which I liked about him, and he wrote in the same style. Just direct, business-like, not a bunch of extravagant language. There was a moment in the conference where he got up. He literally got up, you know this is true, but who knows if I'm embellishing, I'm not sure if I am or if I'm getting it right, but: I have a distinct memory of him getting up in this room, round tables of about twenty people, ten persons, to a table, 200 people, looking around the room, and he goes like this [rhythmic banging on the table]: He says "WE can stop any clinical trial we want to in Canada, at any time, if you don't include us in your decision-making process." And the room went… dead silent. You know, I detest platitudes, but it was like you could hear a pin drop in the room.

That, to me, that was one of the most critical moments in AIDS history in Canada, because the researchers were – many of them who are still at it and are good people – realized that the relationship they had as doctors and clinicians and researchers with the so-called patients had changed forever, and the power inequality had evaporated, and they knew they were going to have to conduct themselves differently. It was after that that people with HIV/AIDS were appointed to AIDS Advisory Committees, Chair of AIDS Advisory Committees, Chair of hospital advisory committees on AIDS, clinical trials network ethics committees, scientific review committees. U of T still has an HIV/AIDS-specific ethics review committee. Which, probably, is not necessary anymore, but it's from those days.

So the reason I remember it so carefully is that Chuck said "Do you want to go for a drink afterwards." I said "Sure, I'll go for a drink after, but I have to call my wife first", and his jaw dropped.

All: laughter

PB: He was "Your wife?? You're married??" I said "I'm sorry, Chuck. Sorry, there's no cure for heterosexuality. What can I do?" [laughter] I really liked him a lot. He died in 1993, at Casey House.

GK: Yes. Other people have told us similar accounts of that story, so I think it's pretty accurate.

PB: I really have a clear memory of it. It was a dramatic moment in AIDS history. Maybe that's putting too lofty a term on it.

AS: What changes when you have people who are directly affected by an illness making those decisions?

PB: Well, I mean, the traditional answer to what changes, is it's a total rejection of medical paternalism. Which is obviously a good thing, generally. But I think what changes is… that it's the people who are enduring the illness, moment-to-moment, through the night, the next morning when they wake up, who know best, really, what's going to be in their interests. Especially in policy decisions, like access to experimental medication. But also in assessing what the risks or benefits may be of drugs that are undergoing research. They can say, "Look, you can't test this. We're never going to use it, anyway. Here's why we're never going to use it." Well, they know that better than the researchers or scientists do. And… also what changes is that there's a decent study, that's a reliable and a good one. It gives to the researchers a credibility, to have the imprimatur, the stamp of approval, of leaders in the AIDS movement, or AIDS activism, or among patient groups. Of any kind. In fact, now it's standard. HIV/AIDS set the standard for what's expected of researchers for people with any chronic illness. So there're all sorts of advisory committees, I mean the breast cancer activists model themselves after the AIDS activists. But they began it all in Canada. And Chuck Grochmal was singly responsible for this change in the power relationships between doctors and patients. As far as I'm concerned.

AS: Yes. Amazing.

GK: So… There's a number of lines of conversation…

PB: Yes, I'm sorry I'm taking it all—

GK: No, no. This is great! I was just wondering if there are other experiences you remember of having difficulties getting your patients access to drugs and treatments beyond Aerosolized Pentamidine.

PB: Well, yes. Well, there was the first, there was you know, AZT, DDC or ddI [didonosine] DDI – which came next, DDI came?

GK: I think DDI was first.

PB: No, AZT was first.

GK: For sure.

PB: And then ddI. Well, we had protests for ddI. Against the drug company. There was a Holocaust survivor, a Jewish woman, I think she's a Holocaust survivor. Eva something…

GK: Eva Halpert.

AS: Her son—

PB: Her son died of AIDS, but…

GK: Ivan.

PB: Ivan. She was desperate to get the treatment, so we all joined her outside, I forget the name of the drug company, Brystol-Myers?

GK: Well, it was at the corner of Queen and Bay…

PB: Yes.

GK: Because I was, we were, we also did an attempted occupation of their office. We ended up doing a blockade. That was where Patrick and I and others were arrested.

AS: Eva. Her son was in the hospital and he was allergic to AZT?

PB: He was sick and dying of AIDS. I don't know if he was in or out of hospital, but she… was going to fight for her son. I don't know, it's unusual. The Jewish community was pretty conservative, especially to do with homosexuality, but she didn't give a damn about any of it. She loved her son unconditionally. That was good enough for her. And he was dying. And she knew this drug was there, and she couldn't get the drug.

AS: Why couldn't she get it?

PB: Because they wouldn't release it! It was experimental. It was before it was approved.

GK: So, I think with ddI, you actually had the government saying that it could be released, but the pharmaceutical corporations—

PB: Wouldn't do it.

AS: Wouldn't release it.

GK: So that's why we were actually targeting the pharmaceutical corporations.

AS: And do you remember how…?

PB: They had to, it was both the government had to approve it, but the company didn't have to release it. Just because the government said it's okay. I met Eva, I knew the whole story.

AS: How did you come to meet her?

PB: Because my name was around. What year was that, do you remember? It must have been 1987, 1988? 1989? I can't remember... I really can't remember.

GK: It was 1989.

PB: Because at that time, our group of doctors was established and my name was out there as a spokesperson for the group.

GK: So 1988 is when AIDS ACTION NOW! Now really started, 1988 is when the action around Aerosolized Pentamidine is and the burning of the effigy. So it's 1989, after the Montreal AIDS conference.

PB: Yes. In Montreal.

AS: And so there were protests at the pharmaceutical company to say "Release this drug."

GK: So we did the attempted occupation first, and then Eva actually did this individual thing, like she was out there every day—

PB: For weeks.

GK: Right? And it was eventually these things together that produced the change.

PB: They capitulated.

GK: ddI wasn't always that helpful to people, unfortunately.

AS: Did the physicians group, would you have made statements about it, or…?

PB: Well, I'm sure we did. We were part of all those actions. And there were other things going on at the same time, don't forget. So there was a doctor named Don McCauley – I forgot about him… Who has since died, I'm pretty sure. So Don McCauley was the senior gay physician that, he was about ten, fifteen years older than the rest of us, and out, which was very unusual. He had a very difficult time, the profession was riddled with homophobia. Boy, things change. The current Dean of Medicine is openly gay, can you imagine that? I mean, it was unimaginable. Really, it's fantastic. I know I sound like an old man saying this, but you know, in my days as a student, you could never dream of anything like that. It was impossible. So Don worked with Alex Klein, who lives around the corner from here. And that was a time when the Public Health Department, if they knew names, would demand that you hand over the names of people who tested HIV. HIV antibody tests became officially available in Ontario on November first, 1985. A few of us were sending blood tubes to Ottawa, where they could do it in the early parts of 1985, end of 1984, when the first tests became available. But they became widely available on November first, 1985. Toronto Public Health, and Public Health in general, was insisting on names. There was a terrible Ottawa medical officer of health, I forget his name… I can't remember his name—

AS: We know his name, Ian Gemill.

PB:. He was terrible on these issues. He could have been a twin to Schabas.

AS: He was doing all these, are they called schedule Twenty-Fives?

PB: Section Twenty-Twos.

AS: Section Twenty-Twos.

PB: Under the Ontario Health Protection Promotion Act. So, we were all looking at ways to sabotage him. So I had a system where I'd put a number on the test tube. Give the patient the number, and I never had the number. So if, when I got a positive result, like I had no clue who it was. I said "The deal is you have to come back in. You don't come in, you don't get the result." Which is not how you are supposed to practice medicine. Usually, when you get a result, you have a duty as a doctor to chase the patient down. But I made, I would document all this, so that when they came in and said, "What number is so-and-so?" I'd say, "I have no idea. I don't keep records of the numbers. I give the patients." It drove them a bit crazy. So I never reported.

AS: That's amazing.

PB: But Don McCauley had a patient who was identified, they knew he did the test, and they went public, it was in the newspapers, you can probably google it still. They were insisting he provide a name. He refused to do it. They said, "We'll arrest you." He said, "Come arrest me." Like, he openly defied them. And they backed off.

Then Hassle Free Clinic, what year did they start doing anonymous HIV testing? I can't remember. God, I should know this. I mean, some were written down.

GK: Yes. They did.

PB: So I met Schabas, who was a Chief Medical Officer of health, for lunch to discuss anonymous testing. I remember him saying, "As long as I'm Chief Medical Officer of Health, there'll never be anonymous HIV testing in Ontario." He actually did, to his credit, he invited me to speak at this conference of medical officers of health, and I gave the review of the literature. There were hardly any articles, but there was enough to show that the people most at risk were the very ones who were not coming in for HIV testing because the reporting requirements had been pretty well established. It didn't convince them. Until finally, I think, Elinor Caplan overruled them? Is that what happened? The Minister of Health…?

GK: We're talking specifically about anonymous testing.

PB: Specifically anonymous testing. Then he did the oral sex, you know, report everybody routine. And we went after him. That's the last time I think I actually spoke at an AIDS protest. Down by the 519 was—

AS: Can you say more about the oral sex stuff? Or that protest?

PB: Well, he viewed it as enough to report you, if you were having oral sex with a— They had condoms, you probably don't remember them, maybe you do, called stubbies? Do you remember stubbies? Most gay men have never heard of them. It's making me nuts now. They were little mini condoms you would put over the tip of penis, not the whole shaft.

AS: "Stubbies"

PB: So you could have "quasi" oral sex, you know. (laughing) I don't think they were widely taken up, actually.

GK: They were not.

PB: They were not popular. I don't know, I don't blame them at all. But he was going to classify it as a virulent disease and reporting oral sex unsafe… it was, like, nuts.

AS: Do you have a sense of why that was, I mean I don't need to understand Schabas…

PB: Well, Schabas was an interesting guy. He's an inflexible guy. But he's a radical in his own way. So just, parenthetically, during the Walkerton inquiry, he testified. And he told a story that's one of the most dramatic moments, which you'd agree with, at the Walkerton inquiry. Which was that he was at a meeting with Mike Harris, and he tried to tell Mike Harris, the water supply's at risk. Mike Harris basically said, "I don't want to hear about it" and turned around and walked away, and Schabas, in inquiry testimony, says "When Mike Harris turned his back on me, I knew he was turning his back on public health in Ontario." It was like a critical political moment. So… he can be good in an area, but in this area he was terrible. I just don't think he liked being pushed around by laypeople, to tell you the truth. And he viewed AIDS ACTION NOW! and other AIDS activists as "uninformed medically", laypeople, and he was the expert because he was a Public Health doctor. Doctors like me, he couldn't quite figure it out. But they eventually lost— And, actually the Toronto City, the City of Toronto Public Health doctors were not that unsympathetic to us, to tell you the truth. I mean, he was their boss, provincially, but… There was a guy, I forget his name, Sandy McPherson-I think. He was at City of Toronto Public Health… He had really curly hair, I remember. He was not a bad MoH [Medical Officer of Health].

AS: Now, and if people got tested anonymously, either later because it was, you could officially do it, or because people had these practices of … actually, as you were doing. Doing anonymous testing. What would happen when someone… when treatments were available, right?

PB: We wouldn't report. There was an arrangement – it was more than tacit – that provided the public health authorities, at least in the City of Toronto, don't forget it was done differently in different regions. So Ottawa was terrible, in particular. That guy would chase down every test. We just assured them we did the counseling and contact-tracing. We'd done it. That's all they cared about. So they wouldn't ask for the names. And they still don't.

AS: And so then you could start doing treatment for people.

PB: Yes. Because people couldn't get treatment without declaring, without a record of an HIV test somewhere.

AS: But I think in Ottawa, like when I was there, people told us that he would just, if you were getting treated for syphilis, right, he would trace you down and slap a Section Twenty-Two—

PB: Yes, I know. If you had another STD.

AS: Yes. That's really vile.

PB: Eugh.

There were some terrible things that went on. I remember I used to see some of the prisoners who were heroin users and… I remember this one guy came in, he was a really rough guy, straight guy -- from needles he got it. Actually, there's another guy named Kyle Downey, I should tell you about him in a minutes – but this guy… he's not, I'm not going to say his name, I still remember but it's not public. But they brought him in, like, in a moon suit. And I'm not kidding. Like… and they were dressed in moon suits, these guys. Three of them walked in like aliens.

AS: From the prison?

PB: From the Don Jail. In the late 1980s. When it was known already how HIV was transmitted. I took the guy's hat off, and I remember I had to pat him, I had to see, I said "I'm married. I have two kids, young kids at home, I'm rubbing his head, and I can't get HIV. Don't be ridiculous." I took him into our little lounge at the backroom medical office, I was so enraged that they'd, but they didn't care. They treated him terribly. There was a guy named Kyle Downey. Do you remember Kyle

GK: Yes.

PB: So he was a patient of mine. He said so publically, I'm not breaching privacy. He actually took the Don Jail and the Ministry of Correctional Services to the Human Rights Tribunal. Or to court. I forget which. Suing them for the way he was – he was a coke user, wild guy – for the way he was treated in jail.

AS: And how was he treated in jail?

PB: Pills. Food trays. Isolation. Everything. They found in his favour, and called the way they were treating him "cruel and unusual punishment" – or treatment. They used the words "cruel and unusual" in relation to him.

AS: Amazing.

GK: If my memory's right, Michael Smith and other people from AIDS ACTION NOW! organized a fair amount of support for him. We had pickets outside the Don Jail.

PB: There was another demonstration—

GK: And that's also what led to the formation of PASAN [Prisoners HIV/AIDS Support Action Network].

PB: That's right. This one guy.

AS: That's amazing.

PB: It's going to sound, I mean I don't like to think of politicians as being individuals, but often it is an individual that triggers an entire movement, like Chuck Grochmal did with research, Anne Marie DiCenso did with the prisons. There's another couple, I had these two patients, both heroin users, heterosexual couple. The woman came from out east somewhere. This is about 1991. There was a hundred and fifty people in Ontario on methadone for opioid addiction at the time. I was phoned by the then-Clark Institute, "Would I prescribe—" I'd never prescribed methadone in my life. I knew who was giving out clean needles, by then. This time I said I'd do it, and I read about it. But I didn't know what the hell I was doing. What I was doing was dangerous, because there was no-one to instruct us. And you had to get a federal government exemption, directly from the federal Department of Health at the time to prescribe methadone. Anyway, the word got out very quickly that myself, my partner Abe Hirsz who's still practicing at age seventy, were giving out methadone. So, this woman walks, and her partner walks in. She wanted methadone. And I started them on it. But then the number of people phoning our office wanting methadone – because that community also speaks, even though it's an atomized community, the drug-dependent. So what we did was, first myself and Mary Grondin, a nurse who was actually seconded from Public Health to do HIV testing and counseling and stuff in my office, we organized a press conference at Queen's Park. I think in early February in 1992. It was the first time that three so-called "junkies" went public with their names and faces to speak at a press conference. At Queen's Park.

AS: Amazing.

PB: I remember, the press gallery was jammed. I know it's not dramatic now, but then it pretty well was. Never had any of them seen "Real Live Heroin Addicts" at a press conference at Queen's Park demanding the gold-standard of therapy, which it was by then, methadone. Methadone's been shown since 1965, in peer-reviewed literature, to be beneficial preventing withdrawal and long-term avoidance, once you put them on it, for the rest of their lives. But it was completely ignored here because people couldn't, politicians couldn't get their heads around using one addictive drug that didn't have all the—

AS: All these affects.

PB: For another addictive drug. So… we had this press conference. I remember it well because my hair was quite long at the time. I had to say to the media, I said "Well, I'm a doctor, they're the 'addicts'."

All: (laughing)

PB: Which was true. They all broke out laughing, too. I remember one guy, this real tough guy who pushed a lot weights in jail, been in and out of jail his whole life. He's one of the speakers, and was quoted in the papers afterwards, and he was really macho. He drives and parks his car in an MPP's parking spot, by the side of Queen's Park, goes into the Queen's Park hallway lounge, lights a cigarette up in the middle of Queen's Park, like, no-one would go near him. Stubbed it out on the floor. I said "Tony, what are you—?" "Augh…" He was really articulate, very smart, this guy, I remember. He was the one who said he thought the only solution to methadone prescribing was to have family doctors generally do it. Because now you have these methadone clinics for profit, and that's a whole other problem. But he was right. Had it been started as a routine medical practice, it would have been a lot better, people could have seen their own family doctors. Anyway. It was a very big, successful press conference. There was wide-spread coverage in the radio, tv, and the newspapers. And, in fact, the Globe and Mail on February 10th, I think, 1992, actually wrote a leading editorial saying "Why We Need More Methadone." So you couldn't do better than that.

Well. The provincial government at the time, an allegedly social democratic government, the NDP, wouldn't budge. They described me and methadone treatment as controversial. And other people had different views about methadone. And blah-blah-blah. And wouldn't do anything. This couple, this woman from the east, she was the type of person – I don't know how to describe it – who just kind of grabs your heart. I don't know, but you can't help but like her. So her boyfriend, her husband, was an artist. He drew, do you know the story? He drew a little eight and eleven poster with a picture of a needle on it and a bar across it. It said "Heroin addicted? Methadone is the best treatment. If you want methadone, phone Michael Decter, Deputy Minister of Health" and a deep – I call it a "deep stethoscope" – a deep throat in the ministry gave us his private office phone number. On a tear-off at the bottom. The couple, all I did is I gave them my staple gun, Xerox machine use, and paper to copy these notices. They plastered this poster from one end of Toronto to the other end, where they knew drug users were hanging out and using. Bars and places like that. On a Saturday morning in February, because the first sort of activist protest didn't work. The press conference. Despite that you can't do better than a *Globe and Mail* editorial. That was Saturday morning. About Saturday at one o'clock, there's a message from Michael Decter on my voice mail at my Parliament Street office. "I need to meet with you urgently!" I got a bit cocky, "Well, you know…" and it was part of the truth was I couldn't do it Monday morning because I had a whole clinic of patients booked, and I never canceled patients. For anybody. I said "I can't meet you Monday morning." . I couldn't cancel patients ahead of time. So we met Tuesday. He had to assign someone, like, full time, according to him, for the next six straight weeks, to do nothing but take these phone calls that were coming in. And he came into my office, like, do you know who Michael Decter is? Michael Decter was the NDP Deputy Minister of Health. He's a big, important person now in health care. He wrote a few books. He came in like this to my office, like, stiff and defensive. I brought this woman in, and her husband, and the public health nurse, and by the time that one hour meeting was over, he'd slunk down in his chair, like this, he says "I promise you, I will authorize more methadone supply." And about a month or two later, the Ministry issued a press release, they're going to fund Parkdale Community Health Center for over four hundred thousand dollars to increase numbers of methadone availability. Then it spread from there.

AS: Did it.

PB: Part of no group. No-one knows anything about them, and I can't disclose their names because I don't have their consent. In my opinion they were responsible for cracking open the entire system of methadone availability. At that time they did it, there was about four hundred people in the whole province on methadone. By the time the final protest happened. Now there's well over forty thousand. Even though there's a better drug now than methadone. If it wasn't for them. They saved lives. And no-one knows who they are.

AS: Amazing.

GK: Right.

PB: They're both dead of AIDS. She died in 1994. He died in '95.

GK: Can you tell us about the struggle to get the Emergency Drug Release Program to release AIDS/HIV treatments?

PB: My direct involvement? What I knew about it was when Michael Hulton was filmed on CBC National TV, phoning up the Emergency Drug Release Program? Do you know about this?

AS: I want to hear that story.

PB: Well, I wasn't involved directly, and I forget why I wasn't. I think it was called the Emergency Drug Release Program. The EDRP. And they were very strict and they would not approve release of medications, and they're giving all sorts of different stories of why, they were inconsistent to the media. So finally the CBC National TV News taped, I think it was Michael Hulton, I'm pretty sure. Do you remember this?

GK: I have a vague memory.

PB: Vague. I'm trying to rely on Gary, here, and he's not being helpful! (laughing)

GK: It's vague. I think someone else has told about this.

PB: Well, I still can see the TV screen, and Michael on a phone having this conversation and being given a completely different line, like almost opposite to what the same person would say later on to the journalists. And it totally exposed the inconsistency and really mistruths – and I don't use that word lightly – of the EDRP. And, I think within a day or two, the whole thing just—

AS: Changed.

PB: —Was smashed, and they started authorizing everything.

AS: Yes. I think Glen Brown told us about that. Because, you know, it's so interesting, like this program that existed that just wasn't being used.

PB: Well, they wouldn't let it be used. You got Glen Brown before he died, then, eh? Before he was sick, too?

AS: Yes. We talked to him twice, so we have this very long, really wonderful interview with him.

PB: I was quite close with him. Shocking. Really.

AS: Yes. Really, really unfortunate.

GK: Yes. If he was sick at the time we were talking to him, I wasn't really aware of it.

PB: But he looked okay, did he?

AS: Yes. A little…

GK: A little bit reddish in the face? But when I'd run into him recently, that's how he looked.

PB: Yes… How long ago did he die, now? I forget.

AS: Was it a year ago? [It was in January 2017]

AS: I was away when he died.

GK: I know I wasn't able to go to his memorial service.

PB: Yes, I wasn't either.

GK: I did go to Bob Gardner's, but not his.

PB: I remember Bob Gardner—

AS: I would like to hear about how you… related to, or interacted with, people who were sort of explicitly activists.

PB: Well, I mean, I was often the main connection between the doctors. But not the only one. There were people like Hulton who did his own thing, and Wayne Boone was quite involved.

GK: Wayne was at some of the founding meetings of AIDS ACTION NOW!.

PB: Yes.

PB: I mean, there was a little bit of gay-straight tension at the time. I hope not from me, but I think there was a time when I just started, there was a distrust of why would a straight doctor be involved… I didn't go telling them my history of being in the streets in '77 or the last time I kicked a police car was n 1981. I was a licensed doctor with four years and everything, and I kicked a police car, like "fuck you, fifty-two", after the bath house raids. I had more come-ons that demonstration than I have my entire— I was so sorry I wasn't gay. I'll just back up a little. There's a doctor, an openly gay psychiatrist in Vancouver, named Doctor Wesley Friesen. He graduated from medical school with me in Winnipeg in 1974. He was a year ahead, actually, and he dropped out when he came out, had a bit of a crisis, but then came back into medical school in my class, and was accepted really unconditionally. There were a lot of lefty, progressive, dope-smoking hippy types in my medical class. I went to Toronto and came back to Winnipeg in 1975 and worked for a year at a hospital, as did he. I knew nothing about homosexuality. I mean, quite frankly. I hope I didn't have a prejudice. Maybe I did, and didn't even realize it. I don't remember. But I knew he was gay, and he did me probably one of the best favours I've had in my life, which was he let me ask him any question I wanted about male homosexuality, without fear of inadvertently offending him by asking a stupid question. He said, "Nothing will bother me." And he demystified this so-called "homosexual lifestyle" – what a stupid term – But I didn't realize at the time. I just didn't. He was, I mean, telling me about his own history of personal persecution. He came from a Mennonite family, they wanted to marry him off. Then, when he went through medical school, and he actually went on radio in Winnipeg in 1974, as an openly gay man, and he came to our medical school graduation party, in May of 1974, with his then male partner. Which is quite a daring act to do, especially in Winnipeg, not the most friendly place to gays, believe me, at that time especially. So I learned a lot. And it really had a profound effect on me. He has no memory of this conversation at all. "What, what?" It's really interesting how one person remembers something – you must know this as a sociologist, but – and, for me, it stays with me, as fresh as can be, for him it was just…

AS: One of many.

PB: And then, when Anita Bryant came into town, that was it. Like, once he'd done this consciousness raising, I… was as enraged as other people were when she came into town with her hate campaign. So I had had this history, but still… I think there was a bit of distrust that I wasn't part of the gay community, right? That's normal. I understand it. So some things they did on their own, which I wasn't involved in. One of them being that EDRP protest. Wayne Boone… was involved, not totally disconnected, but separately from me. Actually, behind any activism that went on when there were press conferences about drug-release, anonymous HIV testing, anything like that.

I knew Tim McCaskell quite well from the anti-apartheid days, and he was involved in, they used to call it "third-world solidarity work." Imagine these old terms. You know about these terms?

AS: Yes.

PB: You must have read about a lot of this.

AS: I read about a lot of it, and then also, I grew up in a… a Buddhist community that had a leader who was HIV-positive and died of AIDS.

PB: Oh, really…

AS: I started thinking about HIV and AIDS when I was, twelve?

PB: Oh my goodness, that's a long time.

AS: And, yes. I've had some kind of—

PB: Connection. They should do a documentary on you. You're a lot more interesting!

AS: No! I absolutely would not be a lot more interesting. No, but, then you read about the things that are all these movements.

PB: Yes.

AS: Yes. So, did people join the physicians group?

PB: Yes. It grew bigger. I think the most it ever was, was maybe thirty, thirty-five. There weren't a whole lot of doctors in the city, and they were… I met a doctor, a woman doctor, who used to live in the Church-Wellesley area, who was totally paranoid and would not see people with HIV, and she actually moved out of her apartment, because she didn't want to touch the elevator buttons in the apartment building. This is the late 1980s!

AS: This is a doctor.

PB: A doctor. You know what I said to myself? "Don't start up with her. There's no point. Don't waste your energy." Go, go move to North York somewhere. Fine. Goodbye.

AS: That kind of irrationality.

PB: I, there's another guy I met who… A gay man died of AIDS, it was terrible, he was really—he used to live in a place painted in black, and… after he was diagnosed. His doctor, this GP he'd seen for decades, found out he had HIV – this was mid-1980s – he… the patient had an ear infection, and the doctor wouldn't look in his ear. And wouldn't touch him. So he left the practice. You know, to see how hurt this guy was, the total rejection by a doctor he trusted for decades, who suddenly wouldn't want to touch him. There was a lot of that going on, I'm telling you. Whether it was swimming pools and restaurants and… I had a patient. I met his sister, his straight sister, who wouldn't let him eat at the dinner table with his nieces and nephews who he was very close to. I said… It didn't help. People want to believe it, some people you could convince, but… the fear and terror was so irrational and tremendous.

AS: Yes. So hurtful.

PB: Yes! It was total rejection. I had another person who died in 1987, I remember why. It was just before AZT was offered, so he was desperate to get AZT, but we couldn't get it yet. And he had AIDS. He wanted, he was always saying he always wanted to go to … I'm not going to say the country, because I don't want to say anything that'll expose him, but: a far away country. And he said "Should I go?" and I said, "Well, you know, it really depends on your personal view of life and death and living. You know, that… if you want the total protection of western medicine, and the safety, and you can't risk not having it, then you probably shouldn't go. But if you want to live your life fully, do something, do your dream trip, then go. What's the worst that's going to happen? You'll come back dead. I mean, that's the worst that's going to happen. When you know you're dying anyway." I wasn't that blunt, but I was pretty direct. He decided to go. And he came back alive. It was the best thing for him. And it was… I was so happy for him. His parents were divorced. And his dad, when he came out gay, had severed all contact with him. You must have heard these stories at the time. And all he wanted to do was to see his dad, once, before he died. I know what he wanted. He didn't say it. His dad had to say three words, "I love you." I mean, he didn't say it to me, the patient, but I knew that's all he wanted was just… "Accept me for who I am" and "I love you." He put the word out through his mother – they were divorced – that he wanted to see his dad. His dad refused to see him. On his death bed, basically. He died ten days later. Imagine his dad. I have kids. I just can't imagine anyone doing that—

AS: would make you do that…

PB: Yes. So… And then, a number of years later, I saw an obituary for the dad in the paper. You know, it said "predeceased by blah-blah-blah" it was all normal. It was a total lie. Fake. Everything. You know? So there was that type of stuff that went on. It was horrible. I remember I had a trans patient, she then called herself transsexual. He was a biological "he", a real-life "she", but her parents buried her as a man. And her trans friends were so enraged, because it denied who she was! So that went on all the time.

GK: Is this a trans person who died of AIDS-related disorders?

PB: Yes. Hadn't medically transitioned, but lived her life as a woman. She should have been buried as a woman. And her friends felt completely excluded from affirming who she was.

AS: Yes.

PB: But there were some other, wonderful parents you know, I met during those terrible days, who were totally, unconditionally, not only accepting, but fighting for their kids lives with them, who had trans kids or gay kids. So, I mean, there was a mix. We saw the worst and we saw the best. Such a platitude. But you did see the worst and best.

AS: And the, sometimes it, somehow it does sometimes feel… that people did not have to be that way. Right? They could have loved their kids.

PB: They should have loved their kids. You know, I have a friend. Do 'you know who Mendelson Joe is? He's this quirky artist who lives in Emsdale, Ontario. He's a part of Canada's biggest rock-and-roll band, in the late 1960s, called McKenna Mendelson Mainline. He did that painting of my daughter, when she was a young kid.

AS: That's a great painting!

PB: She was really skinny, and her pants keep falling… But anyway, he— in relation to how people treat each other, I mean he's hard to get along with because he's very rigid and, in a positive way, but he's very… intolerant of frivolity and people who… compromise their principles. And his slogan is that "Humans are the lowest form of mammal intelligence, judging by the way they treat each other." I think that would hold for what happened during the worst part of the AIDS epidemic.

AS: Yes.

PB: To tell you the truth.

GK: I wanted to just go back—

PB: I know! To, to, direct me.

GK: No, no! This is all great! Just go back to the primary care physicians group for a moment, because we, we talked to people who've told us some things about it, but no-one who was actually directly involved in it? So, just a little bit more about its history, how it might have been organized?

PB: Well, just to review, briefly. So, Mary Fanning organized this first meeting of about a dozen GPs, I think it was at the Toronto General, with the purpose of establishing a primary care physicians group in Toronto, I think her interest was having research support, with all the patients we had, she knew we had the majority of patients. We saw the potential for doing much more. The first one was educating ourselves, which I mentioned to you already. Do you want me to go through that again, or no?

AS: Yes, that would be good.

PB: To go through it again?

AS: Yes.

PB: So… "Educate ourselves" meant that I used to clip medical articles, the very few that there were. I did all, okay. Copied them, sent them out, mailed them. And then Public Health took it over. But it did quickly evolve, really within a year or so, into the politics of HIV/AIDS. That would mean supporting AIDS ACTION NOW!. And they did want doctors around to support their requests for access to experimental treatments. Taking on the Public Health Department when they wanted names of people. Supporting anonymous HIV testing. It did help to have the stature of doctors engaged that way. And, as I mentioned before the last time, I already did a protest as a doctor. I've been to many since then. Also with Schabas and the virulent virus and oral sex and quarantining people.

AS: And so the physicians group would have made an official statement on that kind of thing—

PB: Yes! Or a spokesperson for us. And, don't forget, we used to meet monthly. Roughly monthly. We would have guest speakers to give medical updates and then discuss political issues that were relevant at that time. After ARVs became available, it kind of dwindled and then eventually stopped meeting, I'd say fifteen years ago. I was Chair from 1987 to the end of 1993. It might have gone on 'til… '98, '99 maybe. Just kind of… the urgency was not felt. I'm not saying it's not urgent, but it just wasn't—

AS: It changed.

PB: It changed dramatically. There were drugs, people were actually not dying like they were before. Well, that's borne out by the epidemiology. The death rates plummeted with anti-retrovirals.

AS: So, in those years when you were Chair, was there space to talk together as physicians about what it was like …

PB: That's an interesting question. Well… You know, there were… There were really these T-group sessions. I went to one. There's a psychiatrist named Steven Woo – do you remember that name? Steven Woo was a psychiatrist at Mount Sinai Hospital, who himself died of AIDS. He was open about it. And, I'm typical of hetero, macho guy emotion. I won't express anything. Not that I didn't feel anything, because I saw some terrible things. My wife could tell you. So, Steven said "Just come to one of these sessions. Just one of these 'talk about how you feel' sessions." So I said, "Okay, I'll go to one." And, you know, I saw the benefit, but I knew it wasn't for me. They were hand-holding at the end. I'm not being contemptuous of it. I just cringe. It makes me acutely uncomfortable. I can't hug people goodbye after dinner parties. I'm out the front door before I have to give them a hug, even today, to be quite honest. I realize it's a definite flaw, but it's just who I am. But I went, and I'm glad I went, because I saw its function, its benefit—

AS: For the—

PB: For the people who attended. And so there were groups like that, but I was never part of it after that. But there was one doctor, Alex Klein, who lives on Simpson Avenue, right down from the church, actually, a straight doctor. That wasn't why I talked with him. It may have been because he was Jewish and his parents were Holocaust survivors, we had a lot in common, his kids went to the same school as my kids did. We used to go on long, long walks. Regularly, together. And then we wouldn't say, "Oh, I'm suffering." We'd… talk in detail about patients and their suffering and what we had to do, and someone who was hassling us at a hospital, or… every aspect of it, we would talk about. But it was clear it was therapeutic. We both kind of admitted it. He was sort of that same way as I was. Not that into the… T-group type "I'm okay, you're okay." But, I mean, there was no question that it helped a lot.

AS: It is important to have a person that you can talk about that stuff with.

PB: And plus he was seeing all the same things I was seeing. He was. We would talk a lot about the suffering, the sicknesses, and the wasting, the onslaught of these life-threatening, just conditions that were just unbelievable. People would have, four, five AIDS-defined life-threatening conditions at the same time. And we're both, by the way, doing house-calls practically every weekend.

AS: Really?

PB: We had death certificates in our homes, in our brief-cases. Yes. I had, I'm not – without exaggeration, it was a ten-year period. All my patients, I gave them my home phone number, so as long as I'm in the city, they can get ahold of me. Same with him. If I wasn't in town, they'd have to use the call-throughs, but I didn't want them to have to see some strange person that didn't know—

AS: About them, know them.

PB: About them, or their conditions, and I used to take my kids on house-calls with me, when they were young, because I didn't want to… I'd literally be gone a whole Saturday, from one end of the city to the other.

AS: Not see your kids.

PB: Not see them. So they'd come with me sometimes. I remember one time, so my wife was working out of town. It was a Tuesday afternoon or something. I get a call. So, my one kid's in school at daycare, which ends. Another kid had an art class lesson at the art gallery, I think. They were seven and nine years old. I remember the exact age. My son was seven, my daughter was nine. I get this call from a nurse. "You have to come do a house-call on this man. He's getting a bit agitated and edgy and there's something wrong." I said, "Well, look, I have a whole clinic. It's eleven in the morning. I don't know how I'm going to get there today." One o'clock, I get a second call. Third time, three o'clock, I get a call from like the home care head supervisor. "He's totally agitated, he's becoming violent. We can't leave anybody there with him." I said, "Okay." And I never thought to ask one of my friends around the corner to—

AS: Take the kids.

PB: —Drop my kid off there. I said, "What am I going to do?" So I take one kid, race off to the art gallery, drop her off. Go get my son. Say, "You're coming to a house-call." We get to this apartment, and it's like strewn with furniture, toppled over. Plates on the ground, and the telephone cord pulled out, and the bookshelf pulled over. It was a guy who was, like, totally psychotic. With his boxer shorts stained with urine, he was incontinent. Frothing and wild and… and I realized this. And the nurse had left. She was too freaked out to stay around the house. And I had my son with me. It was one of these classic incongruous situations: Is it your work or your life, you know what I mean? So I put my son in one corner, as far away from this guy as I could. I realized that if he starts going after my kid, I'm going to have to tackle him. I mean… Imagine a doctor thinking that about their medical patient. And I phoned 911 and, luckily, they came. He died… handcuffed, apparently, two weeks later of this rare AIDS condition called Progressive Multifocal Leukoencephalopathy, of PML, which makes you lose your soul. You're unrecognizable. Actually, that heroin user who died of AIDS, without methadone, she died of that same condition. You become unrecognizable to people and totally psychotic. And that's what happened to him.

AS: That's a kind of dementia?

PB: It's a Jakob-Creutzfeldt virus type of infection that, it punches holes, at random, in your brain, essentially, is what it does. Pathologically. It's really rare. But I saw about half a dozen people who had it. We had so many patients. That was pretty tough. And I actually ended up presenting his story at the HIV rounds at Toronto General, and the title was "Your Family or Your Work", you know. Because it was a whole metaphor for this conflict that all of us had between your personal life and your work life, and where do you spend your time. My son refused to go on a house-call ever again. My son was seven years old.

AS: Too traumatic.

PB: Too terrified to go. But there was another time here, actually. I had another heroin user couple, both. Actually, the woman was my patient, and… I remember that she came from a very upper class, highly educated family. Both heroin users. She was getting sicker and sicker. She became paralyzed from the cytomegalovirus, spinal cord infection. As did this other heroin user who died. I remember she had this terrible vulvar infection called Molluscum Contagiosum, which is a viral infection. She had, like, lesions, huge, on her labia, and there was nothing you could do. It's because of immunosuppression. Anyway. She wanted me to help her kill herself. I said I couldn't do it. I said, "But I promise you, I'll do whatever it takes to control the pain" – she had, like, terrible pain all down her legs – "I'll give you whatever it takes. And we'll start with this…" Her use escalated in her last few months of life, which was no problem. She was actually on an unapproved Dilaudid – you know the drug Dilaudid? – So, at that time, it was unapproved for under the skin at high concentrations doses, but I was able to get it. She was at home, really, in her last days of life, and it was working. Then I get a call, in the late morning, mid-morning, from her boyfriend who was taking care of her, who says her pain is suddenly totally out of control. I could hear her screaming. Excruciatingly, in the background. I said "Double dose." "I have." "Double it again." Give it every two hours, every four. He did everything. Nothing was working. So I phoned the head of the Palliative Care Services at Mount Sinai, a man who's, a doctor himself who actually died of pancreatic cancer a few years ago, named Doctor Larry Librach.. Considered one of the patriarchs – sorry to use the term – of palliative care. They were mostly men. In Canada. And he said, well the only thing you can do is put her in a phenobarbital coma.

AS: Oh, wow.

PB: Which is what they do for people who have totally uncontrollable pain. They anesthetize them until they die, basically. I said, "Well, better do that, because there's nothing I'm doing, you know, her dose—

AS: She's just in incredible pain.

PB: So the regular nurse comes, when this is all happening, and discovers that the other nurse had just came in the first time had, by accident, calibrated the machine to give 1% of the dose she was normally on. One one-hundredth. In her last 24 hours of her life. So I felt like I'd totally failed her. Because I'd said "I promise you I do what I can to control your pain." No-one discovered this error until the regular nurse came in. They upped her dose again. She was fine. She didn't need the phenobarbital coma. I went and declared her dead that night. I remember I came in, and she was lying on her side with her hair, like, wavy long hair. I remember like, to the side, like this. She looked beautiful. And… I don't like the word "at peace", but she actually looked relieved. My wife said I came home, and I was grey when I came home. It was, that was really tough. I was furious. I got home and I wrote the head of Home Care Toronto a letter, and I got pretty dramatic in my language and I ended on, I remember how I ended this letter, I described the whole thing that happened. I said it should never have happened. You have to double-check the stuff, you know. But in the end, I said that she died with a pain that burned her to her soul. It was a bit extravagant, I admit, but I just didn't know how else, I wanted to communicate "You really fucked up on this one and hurt someone in the last twenty-four hours of their life, and I broke a promise to her because of your errors." They changed the whole system after that.

AS: That's amazing.

PB: She told me she did. I don't know what they did, they implemented double-checks.

AS: Because it is kind of a thing that you might check, like are we actually administering the dose that we're supposed to be? Right?

PB: Of course! Absolutely! I should have thought of it myself! But it never occurred to me. I'm not there, first of all, physically, and even if I went there and saw the machine, I'd have wondered. But I wasn't there, I couldn't get there in time. I had to move really quickly, phenobarbital because she was in such pain. She lived a good forty minute drive from where I worked, and I didn't want to waste time driving there, and then seeing it. I just wanted to get it going on the telephone, which I did. But that was one of the worst, worst, things I ever saw. Except when I went to Africa, because I was in Africa for eight months there.

AS: Really?

PB: At a front-line AIDS clinic in a country called Lesotho.

AS: When was that?

PB: That was December 2004 'til the summer of 2005, actually.

AS: How did that happen?

PB: Well, it was through the Ontario Hospital Association. Stephen Lewis said, "You have to do something." Long story, they decided to send a team of Canadian health care professionals to team up with first publically funded AIDS clinic in Lesotho, which is in the north-western part of Lesotho, in a rural area. And the administrator was: Russell Armstrong.

GK: Oh, really!

PB: Yes.

GK: He's in Europe somewhere.

PB: Yes. He's, isn't he in Africa still?

GK: I don't know. The last I heard—

PB: So, Russell Armstrong. It was a bit of a weird thing—

GK: He was part of the group that got arrested at the ddI protest.

PB: And in Montreal. He falsified the entry, what-do-you-call-them?

GK: Oh really? Russell was doing that?

PB: The ID cards.

AS: Really?

PB: Of the young, gay activists, AIDS activists, in 1989. He falsified all these name tags that you needed to get into the conference. He let McCaskell and all these people into the AIDS Conference.

AS: He was the one who did that!

PB: And then he became a vice president of one of the Ottawa hospitals, and he went on this mission with his partner-at-the-time, Bob Birnbaum, who was a well-known GP in Ottawa who'd been to Lesotho as a younger man.

GK: Okay.

PB: So we all went. It was really tough. There were people dying in the waiting rooms. You'd go to the pediatric ward, the next day three of the kids would have died. I saw women, I'm not exaggerating, women who weighed twenty-eight kilos, thirty kilos. And, you know, no treatments, running out of drugs, dehydration— it was awful. That's a whole different scene.

AS: The distribution of suffering.

PB: Well they had way more than their share in that kind. Between one in three and one in four adults is HIV infected. And marriage is one of the biggest risk factors for HIV infection among women. You can see, because men… I shouldn't be judgmental but… I got to detest some of these guys. I mean, they'd have a girlfriend every thirty miles, thirty kilometers, and they didn't have safe sex. You'd got there at Christmas, Boxing Day, for clinic and you'd see a two-year-old was raped. I just remember, I saw a fifteen-year-old girl was raped by her uncle. It was often relatives that did it. I can't get over it, I can't understand it, but I just couldn't understand how you could do this to a kid. I remember this girl came in… and she didn't speak English. Many of them didn't speak English. And I just said to her, through translator, "You're good. He's bad. You're right. He's wrong." That's all I said. All I could think of. Actually. Was at the core of it all. She just sort of took her pills and ran out, I remember. But… that was the toughest.

AS: We spoke with a doctor in Nova Scotia, and one of the things that he talked about was working with the Infectious Disease because, in Nova Scotia, the primary care physician couldn't actually administer some of the drugs, or prescribe them, because they had to go through Infectious Diseases and—

PB: We didn't. Have to.

AS: Yes. You didn't have to.

PB: No. We had access to all the drugs from the beginning. Other than if they needed to be in the hospital, which is a whole different situation.

AS: Right. Then it would be, you'd have to have admitted them with a specialist.

PB: The ID Unit. Yes.

AS: But one of the things that he said, that I thought was so interesting, was that he said it was awkward working with Infectious Diseases, because they're used to being, the kind of doctor that they were is a doctor that comes in, figures out the problem, solves the problem. And so, for them, HIV and AIDS was completely separate from the kind of the medicine that they had planned to practice. And so that really interested me, and I wondered about, when you became a family physician, I have this conception that family physicians are like… have a long relationship with patients over years and years and years. And… I mean, but it sounds like your practice, as a doctor, kind of was like co-emergent with HIV and AIDS. Can you just talk about that?

PB: Probably unbeknownst to me as well, there was… There was about, as I mentioned, about a dozen primary care docs in the downtown area who had large gay practices, and some injection drug users, and I happened to be one of them. We had, a lot of the guys we saw, had STDs and, you know, it wasn't a big deal. You treat them. They were at bath houses. Each of us had a few patients, probably in the late '70s, early 1980s… The earliest one I can substantiate is 1982, as I mentioned. But each of us had these patients who'd come in with these weird illnesses. Fever. Sore throat. Rash. Swollen lymph nodes. Mild laboratory abnormalities. All of which would resolve after two or three months and be back to normal.

AS: Yes.

PB: But we were never trained in medical school to gaze beyond the individual patient sitting in the office, and try to question "Is there some external condition going on, that's common to these six people I've seen in the last four months, that could explain this." If we had done that, we might have discerned the epidemic was happening. Because it was exploding before our very eyes, and we never recognized it.

I often wonder, well we weren't even trained to recognize the biological condition, how could we be trained to recognize economic and human rights and social justice and legal and socio-economic determinative conditions which make people sick and prevent them from getting healthy again. We couldn't even recognize the biological condition that was doing it. So those, for those doctors, and they were all young, don't forget. I was, like… what maybe thirty-one, thirty years old in 1981. We did kind of grow up with the epidemic, even though we didn't realize it. Well, in the beginning. But very quickly, we did realize it. We weren't trained to deal with four, five, six deaths a month, which was happening to each of us. Or, even to go on house-calls. Or to declare someone dead at three in the morning. And there were no long-term relationships—

AS: Because there wasn't long-term.

PB: Because of how many deaths there were. It was very difficult, you know, bearing witness to the suffering, so we'd see, we saw individuals, there were some men I've seen now survive, decades later, where their entire social group's been completely wiped out. Doesn't exist. No collective memory. No collective discussions. No collective future. No reminiscing about the parties or travels of the past. Zero. They don't exist anymore. And they're solo. I mean, that's… In Canada!

AS: Yes. …

PB: I'm thinking of a few in particular who're, like, I can see them in my mind, who are still living. Who… lost all their friends. I mean literally all their friends. Their close friends. Their close social circle. How's that for an existential vacancy? Pretty bad.

AS: Yes. And then everyone around them just goes along as though, you know, "disco." Right?

PB: Well that's why it's important you're doing this, you know, because I've found the younger gay men I talk to, I know many younger gay doctors, I shouldn't say all of them, I don't mean to generalize, but I remember one in particular says, "I just view that generation as old and sick", that's what he told me. He wasn't even being contemptuous—

AS: He wasn't trying to be mean.

PB: He just didn't want to know about it, you know? I'm glad Tim wrote his book [*Queer Progress*], because there's much of a record of people's lives… I'm not sure it's been widely, has it been widely read, do you think? The younger gay generation, in my opinion, should be reading it, honestly. Because… You know, where I work at Saint Mike's, where I used to then have my clinical practice. There are a lot of openly gay doctors, and it's totally normal and natural, which it should be. But I keep thinking, "You just can't imagine what this was like, would have been like for you, thirty years ago. You have no idea what it was like." But I would never say it to them, because it's very patronizing to talk like that. But it really strikes me. I'm thrilled that they can be who they are and come to our Christmas parties with their partners, like no-one bats an eyelash anymore.

GK: Yes. I think there's an awful lot of forgetting, active forgetting, that goes on. Both because it's painful, but also because it's not really recorded, it's not very accessible and not very present. So that's part of what we're trying to do.

PB: Oh, good.

GK: We can only do a little bit, but we're trying to.

PB: No, no! I think it's important!

AS: But it, you know, ordinary people don't have any idea of what was won for us in those years. Right? That there's, in terms of many of the things that you're talking about, like in terms of patient-representation on these panels, So there's all these things that actually are just part of the, the everyday life of people living in Ontario, and Canada, that actually is a result of all this work that people did.

PB: Yes. AIDS activism, people with HIV started all sorts of, I mean the ripple effect is still going on. And you're right. People have no clue about it.

AS: Yes. So that's something that I think about, like, you know, what can we do?

PB: Yes, absolutely.

GK: So, I have two HIV physicians group questions.

PB: Yes.

GK: They're probably pretty short.

PB: No, I don't mind.

GK: One is… We're actually talking, I can tell you this because she's quite fine about the interview. We're talking to Maggie Atkinson next.

PB: Oh, yes. She was a patient rep of the group, actually. Yes.

GK: That's right. So I was wondering if that was a standard part of how these—

PB: It became standard. We didn't do it initially, I know that. It became evident pretty quickly that we should.

GK: Okay.

PB: And she was terrific, actually. Because she, you know, I'll just be quite frank. Some of the people with HIV were very justifiably angry and irate, but it made relationships difficult. You probably know about this. But not with her.

GK: Right. Okay. But, so that wasn't there, initially, but it evolved.

PB: Yes. As a matter of principle. I mean it was a matter of that's what should happen. I mean, she knew we had our own mandate, and she was quite helpful to the group also, in the advice she gave. And I think it gave more legitimacy, even though some of the doctors in the room, themselves, were HIV infected, don't forget. And some of our members have died of HIV/AIDS.

GK: And my other question, I know you weren't involved in research, but was there any overlap between the primary care HIV physicians group and the attempt to set up a community research initiative.

PB: There was. There was community— I just didn't have the patience for research. There's a Yiddish word called "Shpilkes." You know what Shpilkes?

AS: No.

PB: It means sitting on pins and needles. I can't sit still. I couldn't sit for long enough to do anything, to do all these papers and analyses. It's a great word. Yiddish is great, I don't know it very well, but some words that the way it sounds describes the actual feeling. But there was a community research initiative. People like Hulton and Denis Conway and others were doing community-based research, I think with some alternative therapies as well, they were involved in different studies. I think it floundered eventually, they just didn't have the infrastructure to continue it for long periods of time. You're right. That was definitely part of the history. I don't think our group did it officially. But members of the group were engaged in it. Like Peptide-T was McFadden, for example.

GK: Right. Okay.

AS: Yes.

GK: Yes. Well those were my primary care physician questions.

AS: Do you want to say anything else about Michael Hulton?

PB: Other than my failed fix-up [laughter] with my cousin?

AS: [laughter]. Yes.

PB: Well, you know, Michael was pretty gutsy. Because he was an anesthetist, don't forget. Working, like, in the bowels of these straight-laced main corridors of hospitals. But was there when it counted, you know. I mean, he was very high-profile for a brief period of time in this EDRP smash-up. I mean that was a major contribution, to tell you the truth. Just that one interview broke open the entire system.

AS: Yes. That was quite brave.

PB: Yes! To go public? Are you kidding? First of all, basically he's identifying himself as a gay physician. Then he's identifying himself as an AIDS physician. And one thing I've not talked about, you know, it was documented in the American literature, that doctors who identified as AIDS physicians were losing non-AIDS patients.

GK: Right.

PB: And the financial incentives were not there to do HIV, I can tell you.

AS: Right. The time commitment.

PB: The time commitment. So we had a wonderful secretary. Our first secretary was from Windsor, Ontario. She actually started this fund, in our private office, for poor people. Like, winter coats and stuff like that. This was expanded into Saint Michael's, where I eventually went. And… she, so she used to work at our office and another office in Mississauga that had a healthy practice. She said that our incomes were two thirds of the other doctors, and we were twice as busy as they were. You couldn't, I mean, we still did very well. I'm not complaining about my income. But it was, for sure, way less than average fee-for-service doctors at the time. I had a few patients who left my practice. I didn't care. But... in the States it had been documented that doctors who were identified as AIDS doctors, publically, were losing patients. I'm not sure that happened to me or not, that wouldn't have stopped me or anybody else, I can tell you.

AS: But those doctors also… I mean, doctors that didn't have AIDS patients wouldn't have been giving out their home number, going to house-calls, you know … that wouldn't have been part of their practice, almost certainly.

PB: Probably not.

AS: It's a different…

PB: You had to be available. I mean, it's all you could do — I mean, we realized very quickly, there was no pill to give people in the early-mid 1980s, until ARVs came along. And, even then, they weren't that effective, initially. It really wasn't until 1996, that there's substantial, dramatic improvements in people's health. Which you probably heard about from other people.

AS: But will you say some things about that? Like how that changed things?

PB: Well, I went to the Vancouver International AIDS Conference in 1996, and I went and did a house-call on this man who had frontal-lobe dementia from HIV. So, totally uninhibited. Really highly-educated, articulate, deeply analytic person when he had his intellect. And he was dying. I thought I'd never see him again. So I went to say goodbye to him, basically.

AS: Before going to the conference.

PB: Before going to the conference. It was just around the same time he got started on ARVs. I came back, three weeks later, he was back in the bars. Dancing. Doing drugs. Partying. Totally like a transformed person. He's still – well, he was still alive when I left my practice, six months ago. Yes, I'm sure he's still alive. And, like, very healthy. His T-cells are, like, higher than the average person without HIV. They're normal results, basically. So that was… amazing to see. And then, the first time I saw Kaposi's sarcoma regress and disappear. That was unimaginable to me. You know, men with Kaposi's sarcoma were marked men. Literally and metaphorically. Doomed. And some of them died terrible deaths, bleeding into their lungs, huge swelling of legs, it was awful.

AS: Because the lesions would also be in their lungs.

PB: They'd go inside. They'd be inside. They could be in your eyelids, your guts, your lungs, your throat. My cousin died of AIDS, had it all over the place. And… so. I thought it was the worst. It was so visible. I had a patient who was sort of one of these pretty-boy poster children for the gay community. He'd be in different ads. And he really was a pretty man. Who got Kaposi's, who got a very aggressive form of Kaposi's sarcoma, and it really spread quickly on his face, neck, chest. And he'd come into my office and he'd sit there with his shirt-collar down to the middle of his chest. Open about it all. And finally, I remember, I said to him, you know, I said, "Do you mind me asking, it's pretty amazing you are out like that" and he said, "What am I going to do? Either I can live my life in a closet, or I'm going to live normally, who I am. And I've chosen the latter." Which I really respect. I remember him also because he used to come in every couple of weeks, and I would listen to his lungs with my stethoscope. I know it's going to sound hokey, but I said, "What am I doing this for? It's a totally useless physical examination maneuver" and this is the only mushy part, but I tell you it's true, because I've thought about it, so. I realized, as I held the stethoscope on his back, I was also touching the Kaposi. You couldn't help but do it. So, had I stopped doing that, it would have been like, I would have stopped touching his lesions, it would have been a complete, he might have interpreted it as a total rejection about who he was. So I just did it. Even though it was useless, medically. It might have been useful, I don't know, existentially. Religiously. I don't know.

AS: On a human level.

PB: A human level, yes. A human level. So that's why, the only reason I kept doing it. He died very, very quickly though. Shortly after that.

AS: That question of touch really feels… Like some people have talked about that, you know, that… what it meant to touch people, right?

PB: Yes, because you were rejecting them. Otherwise you were totally rejecting them. It's such a basic, human way of communicating and connecting. I'm thinking… boy, you resurrected all sorts of memories. I mean, I saw another guy, who came in just to hug me, because he died twenty-four hours later. I mean, I knew he was in trouble, because he was very healthy physically but had very low T4 cells. This is pre-anti-retrovirals. I get a call from a friend of his, saying… a girlfriend of his, a woman friend of his, saying that "He's stumbling and off-balance, and I'm going to be bringing him in." By the time he came into my office, he could hardly walk, he was like… reeling from side to side. He had this terrible condition called Cryptococcal Meningitis, which is… fatal. It's a killer. He just gave me a big hug, left my office, went to the hospital, and died a day later. I still can see his face in my mind, still. You know? Those were tough.

AS: Yes.

PB: They were really tough. They were all so young, too. Gosh.

AS: Yes. Right?

PB: Well, Michael Lynch said "My waves of dying friends", that famous poem of his. I put that up front at any AIDS archives. That poem.

AS: Yes.

PB: I had him and, who was it… I mediated a dispute between… was it Michael? No. It was… the other professor. Who is he? Oh! Leading AIDS activist—

GK: Oh! George Smith. Yes, there was a point where George leaves AIDS ACTION NOW! to focus entirely on CAITIE, and I think it is CATIE by then.

PB: What was it called before—

GK: It was still TIE. Treatment Information Exchange.

PB: But now it is CATIE.

GK: Well, no, it might have been tensions over Treatment Information Exchange becoming more independent from AIDS ACTION NOW!—

AS: —and turning into CATIE—

GK: This must have all been incredibly draining in terms of time and energy. Also the amount of time you must have had to spend learning about new things all the time.

PB: Well…

GK: If you want to talk about it. You don't have to.

PB: No. I don't mind. I never thought about, I didn't, maybe it's just total denial mechanism. I never contemplated how I deal with emotion. I just knew I had to. When I went to Africa, it was the same thing, though. I saw people who went to Africa, in Lesotho, implode within weeks of getting there, and became useless to ailing people.

AS: Useless to the work. They couldn't do it—

PB: Yes, they couldn't do it. Drinking. Drugs. Breaking down crying. I understand the agony, but… This is going to sound harsh, but that's your problem. You don't help anybody when you're breaking down weeping and sobbing in a hospital ward. Sorry. Like, take it somewhere else. I know it sounds cruel, and I don't mean to be… It didn't help. People had to leave. I saw this is the Peace Corp volunteers, the same thing happened, because they couldn't deal with it. I think, if I was trying to be honest about how I dealt with emotions, it was mainly by existential numbing. I mean, I wouldn't think about it. Is that terrible to say? I mean, not that I didn't feel the pain of people, the suffering of people, the death and the loss and the devastation of communities, and the social groups that I spoke about, but I just realized that I can't think about this because I'll just become paralyzed otherwise. So. I forget the nature, of the question?

GK: Just about time and energy.

PB: So the time and energy. I can't stop moving at the best of times. I'm very efficient in my work. I don't mean to boast, but I am. I also accepted that I had to put the time in. Like, there's no point in fighting the time. If you're going to spend a Saturday morning, and it would go from, you know, mid-morning to late afternoon, or middle of the night, you can't rush when someone's dying. You just can't do it. So you just accept, "I'm into this." Or you can't rush sitting with the family after someone dies, so you – at least when I do it – I just said, "This is my duty. I'm not going to get anxious about it. I'm here for an hour and a half at two in the morning." That's what has to be done. I mean that's honestly what my view of it was. There's no point in fighting it. I was younger then, Gary, don't forget. Like, I was in my thirties and forties and I did have energy. You see how the bodies of these young kids, they're— we had a neighbour here who's was sort of connected to that whole group including Tim McCaskell, Gerald Hannon, and also Robert Trow, who died of AIDS. My neighbor was this handsome man, he had like a Romanesque features, and the most pleasant guy. I remember I took my daughter on a house-call to see him in one of the houses they owned in the west end somewhere, and… that's another story I forgot to tell about, but anyway. I went with my daughter and – my daughter loves cats, she still does – and my daughter was playing with the cats, and this guy was right at the end of his life, his face was totally deformed by uncontrolled infection, he lost half his nose, he was in terrible shape. But he started engaging with my daughter. About the cat. I said: This is really amazing. This guy can sort of get out of himself – where, normally, you'd be totally inner-focused on your own dying, death and suffering – get out of himself and relate to a kid. Those are really special moments to watch. Not many people could do it. He could do it. He could transcend his own misery to sort of be empathetic to another person, a little kid. There was another time, I had two other patients, both heroin users, who lived in the basement of this Parkdale apartment. I did a house-call on them on a Saturday afternoon. Three o'clock in the afternoon. I get there, there's four heroin users, just waking up. I look outside, all there are used needles and Ensure cans outside the entrance to the apartment. I walk in, I look in the fridge – which I often do for house-calls, see that people have proper nutrition. With their permission. Just Coca cola bottles. And two of the, three of the four people are my patients, but one, miraculously, did not have HIV. The other two did. One was a woman who'd been sexually abused as a young girl, by relatives, of course. Then she went into the sex trade to support her drug use and got HIV infected, and she was really wasting away. She was this big woman, and quite full in her body. But she was like, just, skeletal when I went there. She yelled, she says "Come with me!" I said "Okay." She goes to the bathroom, and she takes off her clothes. She says "Look at me. Look at my body!" Which was totally inappropriate for a doctor to go into a bathroom with a patient in their home, and the woman takes her clothes off. But it had nothing to do with that. She just wanted me to witness her wasting. What was happening to her. She was tough, because she went to a major hospital in Toronto's out-patient department, and they wouldn't touch her. She got mad, she said to the nurses, "You got a worse disease than I have. There's no cure for your disease." She told me this story. I wasn't there to watch it.

AS: Yes.

PB: A lot of stories, eh?

AS: Yes.

GK: So I've got two last questions. But is there anything else you want to tell?

AS: I feel like I could just listen to you talk about this for ever.

PB: No, no… Everybody has these stories.

AS: This is a thing that I think about, right? The number of people who hold these stories and we can't listen to all of them, right?

PB: No.

AS: So and then there's also, the experience of them.

PB: These are the stories that stand out most, and I forgot about some of them until now, but I must have remembered them. I mean, what we talked about in the last half-hour was five or ten years ago, and it comes back later.

GK: Right.

AS: Yes.

PB: It's the ones I don't remember that are probably more tragic, because they're sort of lost to memory and history, you know?

AS: Yes.

GK: So, one of the last questions we ask people is, as we've been talking here, are there any other things that have come up that you wanted to talk about? Because one of the things that happens when you reconnect with memories or think about things is there might be things you want to talk about that don't fit into the question we asked.

PB: No, of course. I can't think of any off hand, honestly. I really can't.

GK: And then the last question we ask everyone is can you think of other people we should talk to? And, I think in this context, it would be particularly people who were involved in the doctor side of things.

PB: Well there's Denis Conway. I think he was—

GK: Yes.

PB: Yes, he's still practicing. I think if you want to get a few younger-aged doctors that have been around, veterans already, like fifty-ish, there's John Goodhew.

GK: The name rings a bell.

PB: Yes. He took over as Chair of the HIV Primary Care Physicians Group with a guy named Gary Rubin. Gary Rubin is quite interesting. Gary must be in his mid-fifties. They all worked together.

Gary Rubin was a radiologist, a radiology resident, in the Maritimes at the time AIDS first hit. And he has some interesting stories from there, actually. And he left radiology has done general practice ever since. These are the Toronto doctors. Ken Logue? Do you know that name?

GK: Yes.

PB: Cheryl Wagner. I think it's important to get some women. But there are two key women doctors. Cheryl Wagner and Donna Keystone, who retired a number of years ago.

GK: It was Donna Keystone?

PB: Donna Keystone. And Cheryl Wagner. She had a lot of women patients.

GK: Yes, I remember Cheryl Wagner's name.

PB: Two very, very progressive, they were neat doctors. I've got to admit they were definitely not part of the mainstream kind of people.

AS: Yes. I need to do another project that's about talking to doctors.

PB: But you know why I was starting off with them – which is not to do with only HIV/AIDS, but what I think has changed, medically, in the last forty years is the emergence of doctor-advocacy groups that could have never happened before. There's an anti-poverty, food security, housing, refugee-health is a classic example. HIV/AIDS. Even religious-type groups. I mean it never, forty years ago it didn't exist. Pro-medicare groups. Pro-environmental groups. Anti-nuclear groups. All of these sort-of activist doctor groups and individuals that were never around, in Canada it's, maybe it's in other countries as well, but I don't think as much as in Canada, quite honestly, or as diverse. In my opinion.

AS: Interesting.

PB: I may be uninformed about what goes on in the States and in Europe, and this refugee health-care fight that I was deeply involved in. There was nothing like it ever before in Canada. And it was successful, too.

GK: Yes.

PB: It had every element of activism one can, and it was not even in. Now I gave this talk on it, and these younger activist doctors that I know, they're very academic and scholarly in their presentation and activism. "Well, here's what the National Association of Doctors for Human Rights in the United States says. Step one, two, three, four, step six." I remember I gave a talk to these young doctors. I said "Well. We started at step four." [laughter] Because there was no planning, you know? For the refugee health-care fight. But it had every element, like street protests, going after cabinet ministers, research papers, op-eds in journals, supportive mainstream medical associations, involving the academy, I mean everything, all together. Court challenges.

AS: Yes. And how to actually transform something. I mean, and it comes back to something you said about: What does it mean to be trained as a doctor in such a way that you're just looking at the individual person and not at the social relations that make health or illness—

PB: Yes. We're not trained. Well, we are more-so, now.

AS: But now. Yes. So that, I think, is really fascinating, right? Like how would you train someone to be able to talk about the social conditions that produce health or illness?

PB: It's hard.

AS: Yes.

PB: Yes. It is being taught though. At U of T, which has been really good, actually. It's been, they're actually evaluated, with a grade, on advocacy projects.

AS: Interesting.

PB: Yes.

AS: Yes. I have a friend who's been working on some of that. On what's the pedagogy of how you do that. But then there is this other part that—

PB: There's nothing like taking the students with you. I remember during the federal election, we went to Chris Alexander's – Minister of Citizenship – we went to his constituency office in Oshawa somewhere. And it was seven, and he'd shut, I think the office had been shut for hours, and so we taped all our placards onto the windows of his constituency office. Then the students got freaked out that they'd committed a crime, so I had to phone Clayton Ruby, and Clayton says, "Well, actually, it is illegal, but it'd be viewed as something called de minimus? Do you know what that means? It means it's so negligible that no-one would ever prosecute it. So you can reassure the students it's okay." (laughing) So I had to reassure the students. "Don't worry, don't worry." But, you know they see their faculty in action, doing this, which they view as – I don't view it as edgy at all, but they view it as really edgy, push-to-the-limits stuff. That's a pretty good way of teaching students. Pedagolog, how do you pronounce the word?

AS: Pedagogical.

PB: Pedagogical – I can't even pronounce it – approach. And, yes, I give lectures on it, too. I used to, before I retired. But when they see you in action.

AS: It's the experience.

PB: It's the experience. That's what stays. This generation, four or five years worth of generation of students, who participated in refugee health-care cuts, will never, ever be afraid, I think, again – as long as we're still a democracy – to confront the state in its power, when it's abusing its power. That was the most important lesson they got out of this whole thing, I think. And the same thing happened, somewhat, with HIV/AIDS. But it wasn't students. It was doctors who'd already graduated who were confronting the state all the time. Regularly, there were different issues. But it, people were literally fighting for their lives back then, don't forget. They had to, to discharge their duty as doctors.

AS: Yes. And in the refugee health-access work, that's like, you have to see who's fighting for their lives, right? Who's being—

PB: Yes. Of course. And, but the difference between the refugee health-care fight and the AIDS fight was: In HIV/AIDS, our role was really to follow the lead of the people with HIV and support them, and do what they wanted us to do. By using our stature. With the refugee health-care fight, they couldn't, refugees couldn't speak out because they're totally terrified of saying anything that would put them at risk of not being accepted into the country. So they, the media was always saying "We want to talk to the refugees, we want to talk to the refugees." We couldn't find anybody. We wouldn't ask anybody. There are one or two that came out, for very specific reasons. So, that was an example of where we had to be paternalistic. There was no other way of raising the issue. On behalf of a population who could not raise it on their own behalf. So I have to distinguish here. I'm giving you the elements of both that distinguish between the two political approaches. But it really was a basic distinction, but with good reason.

GK: Yes.

PB: We had a demonstration, the occupation of Joe Oliver's office. I don't know if you know about that. But we occupied the Minister of Finance's – who's the highest ranking Cabinet Minister in Toronto – we occupied his constituency office on May 11th, 2012. Ninety doctors in white coats. And we said doctors only. Well, there's a purpose for it. The whole idea is you don't get doctors doing this. That's going to grab their attention. It's a tactic.
We banned anybody who wasn't a doctor. But intentionally. Then, after that, it was opened up.

GK: No, that was really good organizing.

PB: But there was an elitist element, I guess, but those are the contradictions you find yourself in when you're involved in politics.

AS: Right. And if you're going to get things done, you have to live with the contradictions right?

PB: Yes, of course. Alright. That's it's.

AS: Good. Thank you so much.

GK: I think we're done. So thank you very much for this. This was very, very helpful.

PB: Oh, you're welcome. I took this out of my CV. I was on a board of directors with Maggie's Safe Sex Project for Prostitutes, 1986 to 1989. I was a founding member.

AS: Really? That's amazing! Do you want to just say something about that?

PB: Well, I took my kids to the Christmas party. Or opening party.

AS: For Maggie's.

PB: And the sex workers loved my kids. They were playing with them, they were running all over.

AS: Of course.

PB: The kids had no idea what was going on. But anyway. No, that was very, Jim Callwood and I were on the founding board of directors of Maggie's Safe Sex Project.

AS: How did you get connected to it?

PB: Somebody asked me to join the board, and I said "Of course." I had a number of sex workers, I always have, in my practice. Some of them are in their seventies now. They have really interesting stories.

AS: Was Maggie's involved at all with HIV/AIDS?

PB: They must have been. But so we're founded in 1986. So the AIDS epidemic was starting to, like Danny Cockerline was involved with Maggie's.

GK: Yes.

AS: Yes. He was one of the co-founders, right?

PB: Yes. I remember he was a young…

GK: And Chris Bearchell was around it.

PB: Who was?

GK: Chris Bearchell?

PB: Was she around at Maggie's also?

GK: Yes. So it's probably a little bit later on.

PB: They're all dead. It was terrible. I remember, I still remember, Chris Bearchell saying "No more shit!" You remember?

GK: At the first demonstration against the bath raids in 1981?

PB: She was the one who constructed the slogan, you know. I had a sticky in my filing cabinet with that on there.

AS: What was the slogan?

PB: It said, "No more shit!"

GK: That was the main slogan at the first demonstration.

PB: Bathhouse raids. Yes.

GK: "No more shit." Yes. I think it was, I don't think she quite understood, I think, that it would be taken up by the crowd in the way that it was.

PB: Oh, they grabbed it immediately. They went wild.

GK: It was great.

PB: That demo, you know Tim McCaskell was a marshal for that first bathhouse raids demonstration. I'd gone to pick my brother up at the airport. I have a younger brother who's sixty-two, like, total hippy still. I said, "Come on, we're going to a demonstration." So we went to the bathhouse demonstration. I was in the back of the crowd. Tim was circling all over the place. And, do you remember when these queer-bashers broke the picket fence and took these pieces of wood from the fence?

GK: That's not from the first demonstration.

PB: Is that the second one? No, it was in February, Gary. Maybe not the first one.

GK: Okay, maybe it was. But there's two demonstrations in February.

PB: Well, it was one of them. Maybe not the first one. But it was one of them, for sure.

GK: The first one is the one that ends up going up to Queen's Park at the end.

PB: Where's the one that ended up at 52 Division?

GK: The first one goes to 52 Division.

PB: Okay, so whatever that one was.

GK: I think it's the first one you're talking about. And there were queer-bashers around. I remember that. I was marshalling, too.

PB: Okay. So, but I wasn't an official marshal at that point. You were. Because I went up. That's when I said "Fuck you, fifty-two", kicked the police car, and then we all walked up from Dundas street.

GK: Oh, you were the one doing that. Okay! Now we know.

All: (laughing)

PB: That was me. I could have lost my medical license, like right off the bat. But you just get so enraged, you don't think about it.

GK: You should be getting an award!

PB: No. So, anyways. So these queer-bashers came at the back of the crowd.

GK: That's right.

PB: And Tim saw them.

AS: They had pieces of the fence?

PB: Of the fence. Threatening the crowd. What idiots they were. It was a time when a lot of gay men were into body-building. There's a lot of really tough guys in that crowd. And they were furious. And so Tim says "You're a marshal!" he says to me. He says to my brother, "You're a marshal, too!" So he puts these bands on us. And at the back of the crowd, I just started saying "I pray the crowd bursts through." Which, of course, the crowd did. These queer-bashers are total cowards. They ran for their lives, like rabbits. And this crowd was surging, chasing them down the street. They ran for their lives. This crowd chasing these total bully cowards – they are, of course, at their core. So was that the first one?

GK: I think it must have been. Because, if it was in February?

PB: Yes, it was in February.

GK: And there were queer-bashers around. I remember that.

PB: I mean, what idiots. You know there's three thousand angry men – mostly, and some women – and you're going to threaten the crowd? Good luck!

AS: That's a beautiful image.

PB: And, actually, my picture's in *The Body Politic*. I still, they had a picture of me, and you can see, like, holding… Well, you'll see a picture of the bathhouse raids, and I'm definitely in the photo.

AS: Nice.

PB: Holding hands with my brother and somebody else, I don't know who, before they burst through.

GK: That was a pretty… pretty neat demo.

PB: But those, there are no demonstrations anymore. You go to Gay Pride day, it's like a bank event. That's how I view it… What's happened?

GK: Well, we could talk about that.

PB: Okay.

GK: Because I would love to talk about that. But I mean, there's moments of recovery of that. I was one of the allies with BLM, with Black Lives Matter Toronto, doing the protest at Pride in 2016.

AS: And that's happening in Ottawa, too.

AS: Okay, I don't believe that you're not going to say anything interesting after I turn this off, but I'm turning it off.

PB: No, I won't.