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AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification*

PAULA A. TREICHLER

An Epidemic of Signification

In multiple, fragmentary, and often contradictory ways we struggle to achieve some sort of understanding of AIDS, a reality that is frightening, widely publicized, and yet finally neither directly nor fully knowable. AIDS is no different in this respect from other linguistic constructions, which, in the common-sense view of language, are thought to transmit preexisting ideas and represent real-world entities and yet, in fact, do neither. For the nature of the relationship between language and reality is highly problematic; and *AIDS* is not merely an invented label, provided to us by science and scientific naming practices, for a clear-cut disease entity caused by a virus. Rather, the very nature of AIDS is constructed through language and in particular through the discourses of medicine and science; this construction is “true” or “real” only in certain specific ways—for example, insofar as it successfully guides research or facilitates clinical control over the illness.¹ The name *AIDS* in part *constructs* the disease and helps make it intelligible. We cannot therefore look “through” language to determine what AIDS “really” is. Rather we must explore the site where such determinations *really* occur and intervene at the point where meaning is created: in language.

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1. Discussing the validity of their interpretation of everyday life in a science laboratory, Bruno Latour and Steve Woolgar claim, similarly, that the “value and status of any text (construction, fact, claim, story, this account) depend on more than its supposedly ‘inherent’ qualities. . . . The degree of accuracy (or fiction) of an account depends on what is subsequently made of the story, not on the story itself” (*Laboratory Life: The Construction of Scientific Facts*, Cambridge, England, Cambridge University Press, 1985, p. 284).

Of course, AIDS is a real disease syndrome, damaging and killing real human beings. Because of this, it is tempting—perhaps in some instances imperative—to view science and medicine as providing a discourse about AIDS closer to its “reality” than what we can provide ourselves. Yet the AIDS epidemic—with its genuine potential for global devastation—is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings or signification.² Both epidemics are equally crucial for us to understand, for, try as we may to treat AIDS as “an infectious disease” and nothing more, meanings continue to multiply wildly and at an extraordinary rate.³ This epidemic of meanings is readily apparent in the chaotic assemblage of understandings of AIDS that by now exists. The mere enumeration of some of the ways AIDS has been characterized suggests its enormous power to generate meanings:

1. An irreversible, untreatable, and invariably fatal infectious disease that threatens to wipe out the whole world.
2. A creation of the media, which has sensationalized a minor health problem for its own profit and pleasure.
3. A creation of the state to legitimize widespread invasion of people’s lives and sexual practices.
4. A creation of biomedical scientists and the Centers for Disease Control to generate funding for their activities.
5. A gay plague, probably emanating from San Francisco.
6. The crucible in which the field of immunology will be tested.
7. The most extraordinary medical chronicle of our times.
8. A condemnation to celibacy or death.
9. An Andromeda strain with the transmission efficiency of the common cold.
10. An imperialist plot to destroy the Third World.
11. A fascist plot to destroy homosexuals.

2. I use the term *epidemic* to refer to the exponential compounding of meanings as opposed to the simpler spread of a term through a population.

3. The term *signification*, derived from the linguistic work of Ferdinand de Saussure, calls attention to the way in which language (or any other “signifying system”) organizes rather than labels experience (or the world). Linking signifiers (phonetic segments or, more loosely, words) and signifieds (concepts, meanings) in ways that come to seem “natural” to us, language creates the illusion of “transparency,” as though we could look through it to “facts” and “realities” that are unproblematic. Many scientists and physicians, even those sensitive to the complexities of AIDS, believe that “the facts” (or “science” or “reason”) will resolve contradiction and supplant speculation; they express impatience with social interpretations, which they perceive as superfluous or incorrect. (See, for example, Richard Restak, “AIDS Virus Has No Civil Rights,” *Chicago Sun-Times*, September 15, 1985, pp. 1, 57–58.) Even Jacques Leibowitch writes that, with the discovery of the virus, AIDS loses its “metaphysical resonances” and becomes “now no more than one infectious disease among many” (*A Strange Virus of Unknown Origin*, trans. Richard Howard, intro. by Robert C. Gallo, New York, Ballantine, 1985, p. xiv). The position of this essay is that signification processes are not the handmaidens of “the facts”; rather, “the facts” themselves arise out of the signifying practices of biomedical discourse.

12. A CIA plot to destroy subversives.
13. A capitalist plot to create new markets for pharmaceutical products.
14. A Soviet plot to destroy capitalists.
15. The result of experiments on the immunological system of men not likely to reproduce.
16. The result of genetic mutations caused by "mixed marriages."
17. The result of moral decay and a major force destroying the Boy Scouts.
18. A plague stored in King Tut's tomb and unleashed when the Tut exhibit toured the US in 1976.
19. The perfect emblem of twentieth-century decadence, of fin-de-siècle decadence, of postmodern decadence.
20. A disease that turns fruits into vegetables.
21. A disease introduced by aliens to weaken us before the takeover.
22. Nature's way of cleaning house.
23. America's *Ideal Death Sentence*.
24. An infectious agent that has suppressed our immunity from guilt.
25. A spiritual force that is creatively disrupting civilization.
26. A sign that the end of the world is at hand.
27. God's punishment of our weaknesses.
28. God's test of our strengths.
29. The price paid for the sixties.
30. The price paid for anal intercourse.
31. The price paid for genetic inferiority and male aggression.
32. An absolutely unique disease for which there is no precedent.
33. Just another venereal disease.
34. The most urgent and complex public health problem facing the world today.
35. A golden opportunity for science and medicine.
36. Science fiction.
37. Stranger than science fiction.
38. A terrible and expensive way to die.⁴

4. These conceptualizations of AIDS come chiefly from printed sources (journals, news stories, letters to the editor, tracts) published since 1981. Many are common and discussed in the course of this essay; the more idiosyncratic readings of AIDS (e.g., as a force destroying the Boy Scouts) are cited to suggest the dramatic symbol-inducing power of this illness as well as our continuing lack of social consensus about its meaning. Sources for the more idiosyncratic views are as follows: (2) Senator Jesse Helms; (6) Gallo's introduction to Leibowitch, *A Strange Virus*, pp. xvi–xvii; (8) gay rights activist on Channel 5 television broadcast, Cincinnati, October 18, 1985 (compare the French joke that the acronym for AIDS, SIDA in French, stands for Syndrome Imaginaire pour Décourager les Amoureux [*Newsweek*, November 24, 1986, p. 47]); (9) one science writer's characterization of the popular view (John Langone, "AIDS: The Latest Scientific Facts," *Discover*, December 1985, pp. 27–52); (10) GRIA (Haitian Revolutionary Internationalist Group), "AIDS: Syndrome of an Imperialist Era," undated flyer distributed in New York City, Fall 1982 (and see Marcia Pally, "AIDS and the Politics of Despair: Lighting Our Own Funeral Pyre," *The Advocate*, no. 436, December 24,

Such diverse conceptualizations of AIDS are coupled with fragmentary interpretations of its specific elements. Confusion about transmission now causes approximately half the US population to refuse to *give* blood. Many believe you can “catch” AIDS through casual contact, such as sitting beside an infected person on a bus. Many believe that lesbians—a population relatively free of sexually transmitted diseases in general—are as likely to be infected as gay men. Other stereotypes about homosexuals generate startling deductions about the illness: “I thought AIDS was a gay disease,” said a man interviewed by *USA Today* in October 1985, “but if Rock Hudson’s dead it can kill anyone.”

We cannot effectively analyze AIDS or develop intelligent social policy if we dismiss such conceptions as irrational myths and homophobic fantasies that deliberately ignore the “real scientific facts.” Rather they are part of the necessary work people do in attempting to understand—however imperfectly—the complex, puzzling, and quite terrifying phenomenon of AIDS. No matter how much we may desire, with Susan Sontag, to resist treating illness as metaphor, illness is metaphor, and this semantic work—this effort to “make sense of” AIDS—has to be done. Further, this work is as necessary and often as difficult and imperfect for physicians and scientists as it is for “the rest of us.”⁵

1985, p. 8); (12) Gary Lee, “AIDS in Moscow: It Comes from the CIA, or Maybe Africa,” *Washington Post National Weekly Edition*, December 30, 1985, p. 16; (13) Langone, in *Discover*, citing a story in a Kenyan newspaper; (14) *National Inquirer* story cited in Brian Becher, “AIDS and the Media: A Case Study of How the Press Influences Public Opinion,” unpublished research paper, College of Medicine, University of Illinois at Urbana-Champaign, 1983; (15) John Rechy, “An Exchange on AIDS,” Letter to the Editor, with reply by Jonathan Lieberman, *New York Review of Books*, October 13, 1983, pp. 43–45; (16) Soviet view cited in Jonathan Lieberman, “The Reality of AIDS,” *New York Review of Books*, January 16, 1986, p. 45; (17) Jonathan Gathorne-Hardy, Letter to the Editor, *New York Times Book Review*, June 29, 1986, p. 35; (18) cited in William Check, “Public Education on AIDS: Not Only the Media’s Responsibility,” *Hastings Center Report*, Special Supplement, vol. 15, no. 4 (August 1985), p. 28; (19) Toby Johnson, “AIDS and Moral Issues,” *The Advocate*, no. 379, October 27, 1983, pp. 24–26: “Perhaps AIDS is just the first of a whole new class of diseases resulting from the tremendous changes human technology has wrought in the earth’s ecology”; (20) example of AIDS “humor” cited in David Black, *The Plague Years: A Chronicle of AIDS, The Epidemic of Our Times*, New York, Simon & Schuster, 1986; (23) acronym cited in Lindsay Van Gelder and Pam Brandt, “AIDS on Campus,” *Rolling Stone*, no. 483, 1986, p. 89; (24) Richard Goldstein, “Heartsick: Fear and Loving in the Gay Community,” *Village Voice*, June 28, 1983; (25) Black, *The Plague Years*, citing one view of plagues; (31) cited in Pally, “AIDS and the Politics of Despair”; (37) Robert C. Gallo, “The AIDS Virus,” *Scientific American*, January 1987, pp. 47–56.

5. Sontag, in *Illness as Metaphor*, New York, Farrar, Strauss & Giroux, 1978, argues that the confusion of illness with metaphor damages people who are ill, and certainly with AIDS there is ample evidence for this argument. Laurence R. Tancredi and Nora D. Volkow, for example, in “AIDS: Its Symbolism and Ethical Implications,” *Medical Heritage*, vol. 2, no. 1 (January–February 1986), pp. 12–18, arguing that “the metaphor essentially creates the framework for the individual’s experience of the disease,” cite studies indicating that many people with AIDS experience a variety of psychological difficulties as a result of its symbolic (as opposed to its prognostic) message. But metaphor cannot simply be mandated away. Goldstein, in “Heartsick,” writes: “Since we are so vulnerable to the erotic potential of metaphor, how can we hope to be less susceptible when illness intersects with sex and death?” Sontag argues that once the cause and cure of a disease are known it

I am arguing, then, not that we must take both the social and the biological dimensions of AIDS into account, but rather that the social dimension is far more pervasive and central than we are accustomed to believing. Science is not the true material base generating our merely symbolic superstructure. Our social constructions of AIDS (in terms of global devastation, threat to civil rights, emblem of sex and death, the “gay plague,” the postmodern condition, whatever) are based not upon objective, scientifically determined “reality” but upon what we are told about this reality: that is, upon *prior* social constructions routinely produced within the discourses of biomedical science.⁶ (AIDS as infectious disease is one such construction.) There is a continuum, then, not a dichotomy, between popular and biomedical discourses (and, as Latour and Woolgar put it, “a continuum between controversies in daily life and those occurring in the laboratory”),⁷ and these play out in language. Consider, for example, the ambiguities embedded within this statement by an AIDS “expert” (an immunologist) on a television documentary in October 1985 designed to *dispel* misconceptions about AIDS:

The biggest misconception that we have encountered and that most cities throughout the United States have seen is that many people feel that casual contact—being in the same room with an AIDS victim—will transmit the virus and may infect them. This has not been substantiated by any evidence whatsoever. . . . [This misconception lingers because] this is an extremely emotional issue. I think that when there are such strong emotions associated with a medical problem such as this it’s very difficult for facts to sink in. I think also there’s the problem that we cannot give any 100 percent assurances one way or the other about these factors. There may always be some exception to

ceases to be the kind of mystery that generates metaphors. Her view that biomedical discourse has a special claim on the representation of “reality” implies as well that the entities it identifies and describes are themselves free from social construction (metaphor). But as Stephen Durham and Susan Williams insist, in “AIDS Hysteria: A Marxist Analysis,” presented at the Pacific Northwest Marxist Scholars Conference, University of Washington, Seattle, April 11–13, 1986 (Freedom Socialist Publications, 5018 Rainier Ave. South, Seattle, WA 98118), despite the origins of the AIDS crisis in the domain of microbiology, the “greatest obstacles to establishing a cure for AIDS and a rational, humane approach to its ravages do not flow from the organic qualities of the [virus].”

6. Allan M. Brandt, in *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, New York, Oxford University Press, 1987 (expanded version of 1985 edition), p. 199, summarizes the ways in which AIDS thus far recapitulates the social history of other sexually transmitted diseases: the pervasive fear of contagion, concerns about casual transmission, stigmatization of victims, conflict between the protection of public health and the protection of civil liberties, increasing public control over definition and management, and the search for a “magic bullet.” Despite the supposed sexual revolution, Brandt writes, we continue through these social constructions “to define the sexually transmitted diseases as uniquely sinful.” This definition is inaccurate but pervasive, and as long as disease is equated with sin “there can be no magic bullet” (p. 202).

7. Latour and Woolgar, *Laboratory Life*, p. 281.

the rule. Anything we may say, someone could come up with an exception. But as far as most of the medical–scientific community is concerned, this is a virus that is actually very *difficult* to transmit and therefore the general public should really not worry about casual contact— not even using the same silverware and dishes would probably be a problem.⁸

Would you buy a scientific fact from this man? Can we expect to understand AIDS transmission when this is part of what we have to work with? The point is not merely that this particular scientist has not yet learned to “talk to the media,” but that ambiguity and uncertainty are features of scientific inquiry that must be socially and linguistically managed.⁹ What is at issue here is a fatal infectious disease that is simply not fully understood; questions remain about the nature of the disease, its etiology, its transmission, and what individuals can do about it. It does not seem unreasonable that in the face of these uncertainties people give birth to many different conceptions; to label them “*misconceptions*” implies what? Wrongful birth? That only “facts” can give birth to proper conceptions and only science can give birth to facts? In that case, we may wish to avert our eyes from some of the “scientific” conceptions that have been born in the course of the AIDS crisis:

AIDS could be *anything*, considering what homosexual men do to each other in gay baths.

Heroin addicts won’t use clean needles because they would rather get AIDS than give up the ritual of sharing them.

Prostitutes do not routinely keep themselves clean and are therefore “reservoirs” of disease.

8. Allan Sollinger, PhD, Department of Immunology, University of Cincinnati Medical Center, speaking as an expert guest on a television documentary, Cincinnati, October 1985. By this time a number of leading authorities on AIDS had come to believe that scientists had to begin communicating to the public with greater clarity and certainty. The Centers for Disease Control issued a “definitive statement” in October 1985 that AIDS *cannot* be spread by casual contact. Mathilde Krim, PhD, director of the American Foundation for AIDS Research, discussed transmission with emphatic clarity on the *MacNeil-Lehrer Newshour*, September 4, 1985: “AIDS is contagious strictly through the transmission of a virus which passes from one person to another during sexual intercourse or with contaminated blood. It is not contagious *at all* through casual interaction with people, in normal social conditions such as living in a household with a patient or meeting patients on the bus or in the working place or in school.” Interestingly, as Deborah Jones Merritt’s comprehensive review makes clear, constitutional precedents for addressing public health problems give broad latitude to the state; strong scientific “evidence” is essentially not required as a basis for interventions (“Communicable Disease and Constitutional Law: Controlling AIDS,” *New York University Law Review*, no. 61 [November 1986], pp. 739–799).

9. Nathan Fain and Check discuss turning points in AIDS-related communications as scientists gained skill in reducing ambiguity. See Nathan Fain, “AIDS: An Antidote to Fear,” *Village Voice*, October 1, 1985, p. 35, and Check, “Public Education on AIDS.”

AIDS is homosexual; it can only be transmitted by males to males.

AIDS in Africa is heterosexual but uni-directional; it can only be transmitted from males to females.

AIDS in Africa is heterosexual because anal intercourse is a common form of birth control.¹⁰

The point here is that no clear line can be drawn between the facticity of scientific and nonscientific (mis)conceptions. Ambiguity, homophobia, stereotyping, confusion, doublethink, them-versus-us, blame-the-victim, wishful thinking: none of these popular forms of semantic legerdemain about AIDS is absent from biomedical communication. But scientific and medical discourses have traditions through which the semantic epidemic as well as the biological one is controlled, and these may disguise contradiction and irrationality. In writing about AIDS, these traditions typically include characterizing ambiguity and contradiction as “nonscientific” (a no-nonsense, lets-get-the-facts-on-the-table-and-clear-up-this-muddle approach), invoking faith in scientific inquiry, taking for granted the reality of quantitative and/or biomedical data, deducing social and behavioral reality from quantitative and/or biomedical data, setting forth fantasies and speculations as though they were logical deductions, using technical euphemisms for sensitive sexual or political realities, and revising both past and future to conform to present thinking.

Many of these traditions are illustrated in an article by John Langone in the December 1985 general science journal *Discover*.¹¹ In this lengthy review of research to date, entitled “AIDS: The Latest Scientific Facts,” Langone suggests that the virus enters the bloodstream by way of the “vulnerable anus” and the “fragile urethra”; in contrast, the “rugged vagina” (built to be abused by such blunt instruments as penises and small babies) provides too tough a barrier for the AIDS virus to penetrate.¹² “Contrary to what you’ve heard,” Langone concludes—and his conclusion echoes a fair amount of medical and scientific writing at the time—“AIDS isn’t a threat to the vast majority of heterosexuals. . . . It is now—and is likely to remain—largely the fatal price one can pay for anal intercourse.”¹³ (This excerpt from the article also ran as the cover

10. These conceptions and others are widespread. For specific citations and discussion, see, for example, Leibowitch, *A Strange Virus*; Langone, “AIDS: The Latest Scientific Facts”; Wayne Barrett, “Straight Shooters: AIDS Targets Another Lifestyle,” *Village Voice*, October 26, 1985, pp. 14–18; Lawrence K. Altman, “Linking AIDS to Africa Provokes Bitter Debate,” *New York Times*, November 21, 1985, pp. 1, 8.

11. Langone, “AIDS: The Latest Scientific Facts.”

12. *Ibid.*, pp. 40–41.

13. *Ibid.*, p. 52.

WHY AIDS IS LIKELY TO REMAIN LARGELY A GAY DISEASE



THE VULNERABLE RECTUM

The rectum, the lower portion (left) of the large intestine that ends in the anus, is lined (below) with fragile, easily invaded columnar cells. Moreover, the closer to the anus, the more blood vessels there are. Anal intercourse, second only to oral sex in frequency among homosexuals, can tear the lining, allowing AIDS virus-infected semen ready entry to the blood stream. This sexual practice is the commonest cause of AIDS.



THE FRAGILE URETHRA

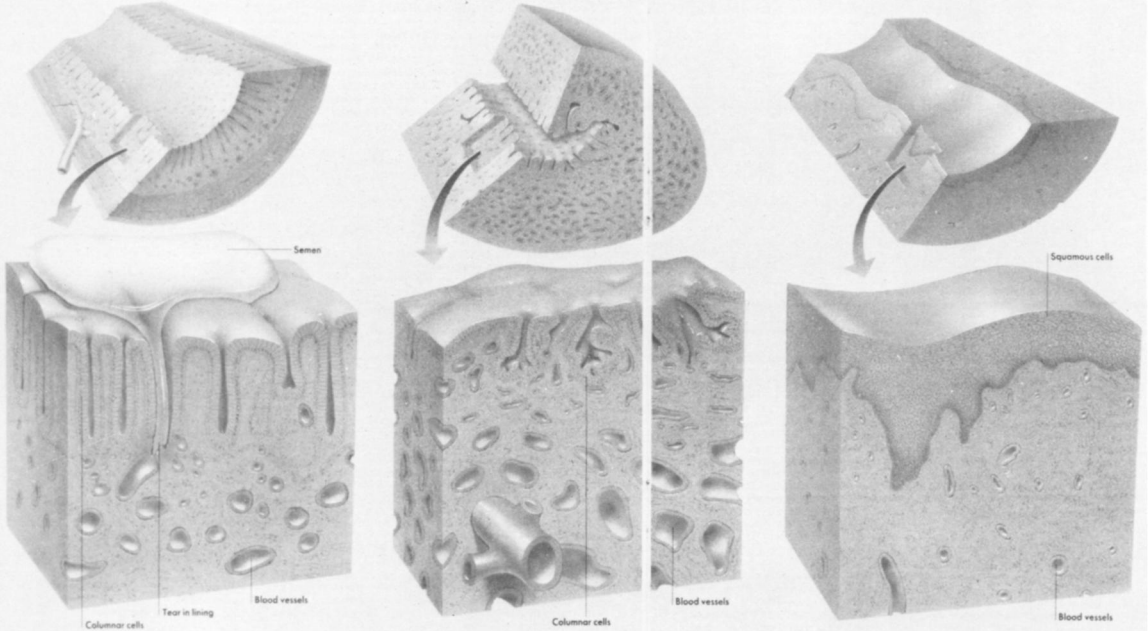
The urethra, the thin tube (left) leading from the bladder through the penis, is also mostly lined with columnar cells, with numerous underlying blood vessels (below).

During anal intercourse with an AIDS-infected partner, the virus can pass from the rectum into the urethra, where it is able to penetrate the delicate walls.



THE RUGGED VAGINA

Unlike the rectum, the vagina (left) is designed to withstand the trauma of intercourse as well as childbirth. Its lining (below) is composed of layers of plate-like squamous cells that resist rupture and infectious agents, presumably including the AIDS virus. Its tissue has fewer blood vessels and is usually naturally lubricated during intercourse.



*Vulnerable Rectum / Fragile Urethra / Rugged Vagina.
Medical illustrations by Lewis E. Calver for Discover,
December 1985.*

blurb.) It sounded plausible; and detailed illustrations demonstrated the article's conclusion.¹⁴

But by December 1986 the big news—what the major US news magazines were running cover stories on—was the grave danger of AIDS to heterosexuals.¹⁵ No dramatic discoveries during the intervening year had changed the fundamental scientific conception of AIDS.¹⁶ What had changed was not “the facts” but the way in which they were now used to construct the AIDS text and the meanings we were now allowed—indeed, at last encouraged—to read from that text.¹⁷ The AIDS story, in other words, is not merely the familiar story of

14. Visual representations of AIDS are not the subject of this essay, yet it is worth noting that they have been a source of continuing controversy. In Watney and Gupta's textual and visual “dossier” on the rhetoric of AIDS, one writer calls the magnified electron micrograph of the HTLV-III virus “the spectre of the decade” (Simon Watney and Sunil Gupta, “The Rhetoric of AIDS: A Dossier Compiled by Simon Watney, with Photographs by Sunil Gupta,” *Screen*, vol. 27, no. 1 [January–February 1986], pp. 72–85). The cover of *Time*, August 12, 1985, also treats a photograph of the virus as proof of its reality; “magnified 135,000 times,” the virus is pictured “destroying T-cell”—cf. Roberta McGrath's analysis of the cultural and political role of photography in naturalizing the biomedical model (“Medical Police,” *Ten*, no. 8 [1984], p. 14). Some members of the San Francisco gay community complained early that public health warnings used euphemistic language (“avoid exchange of bodily fluids”) and through innocuous pictures subverted the message that AIDS was a deadly and physically ravaging disease (Frances FitzGerald, *Cities on a Hill*, New York, Simon & Schuster/Touchstone, 1987, p. 93. First published as “A Reporter at Large: The Castro-II,” *The New Yorker*, July 28, 1986). On other aspects of media coverage of AIDS, see Becher, “AIDS and the Media”; Black, *The Plaque Years*; Check, “Public Education on AIDS”; Barbara O'Dair, “Anatomy of a Media Epidemic,” *Alternative Media*, vol. 14, no. 3 (Fall 1983), pp. 10–13; Harry Schwartz, “AIDS in the Media,” in *Science in the Streets: A Report to the Twentieth Century Task Force on the Communication of Scientific Risk*, New York, Priority Press, 1984. Controversies over graphics were not limited to popular journals: a photo published in *Science* purporting to be an isolated strain of Gallo's “AIDS virus” figured in the international dispute over its discovery (Robert C. Gallo, *et al.*, “HTLV-III Legend Correction,” Letter to the Editor, *Science*, no. 232 [April 18, 1986], p. 307; Colin Norman, “A New Twist in AIDS Patent Fight,” News and Comment, *Science*, no. 232 [April 18, 1986], pp. 308–309).

15. See, for example, *Newsweek*, November 3, 1986, pp. 66–67, and November 24, 1986, pp. 30–47; Erik Eckholm, “Broad Alert on AIDS: Social Battle Is Shifting,” *New York Times*, June 17, 1986, pp. 19–20; Kathleen McAuliffe, *et al.* “AIDS: At the Dawn of Fear,” *US News and World Report*, January 12, 1987, pp. 60–69; Mortimer B. Zuckerman, “AIDS: A Crisis Ignored,” Editorial, *US News and World Report*, January 12, 1987, p. 76; Katie Leishman, “Heterosexuals and AIDS: The Second Stage of the Epidemic,” *The Atlantic*, February 1987, pp. 39–58; “Science and the Citizen,” *Scientific American*, January 1987, pp. 58–59.

16. The 2nd International Conference on AIDS, held in Paris in June 1986, revealed no major scientific breakthroughs (Deborah M. Barnes, “AIDS Research in New Phase,” *Science*, no. 233 [July 18, 1986], p. 282); rather, answers to several crucial questions were clarified or strengthened. Check notes that, as health and science reporting on AIDS has evolved, “articles about the spread of AIDS to the so-called general public do not have to be pegged to any specific new data” (“Public Education on AIDS,” p. 31).

17. The Paris conference was one of several fact-pooling and consensus-building events in 1986 that influenced new readings of existing evidence. Also influential were the *US Surgeon General's Report on Acquired Immune Deficiency Syndrome*, Washington, D.C., Public Health Service, 1986, which advocated intensified sex education in the schools; an investigation by the National Institute of Medicine and the National Academy of Sciences (David Baltimore and Sheldon M. Wolff, *Confronting AIDS: Directions for Public Health, Health Care, and Research*, Washington, D.C., National Academy Press, 1986), which emphasized the dangers of heterosexual transmission; and a World Health

heroic scientific discovery. And until we understand AIDS as both a material and a linguistic reality—a duality inherent in all linguistic entities but extraordinarily exaggerated and potentially deadly in the case of AIDS—we cannot begin to read the story of this illness accurately or formulate intelligent interventions.

Intelligent interventions from outside biomedical science have helped shape the discourse on AIDS. Almost from the beginning, members of the gay community, through intense interest and informed political activism, have repeatedly contested the terminology, meanings, and interpretations produced by scientific inquiry. Such contestations had occurred a decade earlier in the struggle over whether homosexuality was to be officially classified as an illness by the American Psychiatric Association.¹⁸ Gay men and lesbians in the succeeding period had achieved considerable success in political organizing. AIDS, then, first struck members of a relatively seasoned and politically sophisticated community. The importance of not relinquishing authority to medicine was articulated early in the AIDS crisis by Michael Lynch:

Another crisis exists with the medical one. It has gone largely unexamined, even by the gay press. Like helpless mice we have peremptorily, almost inexplicably, relinquished the one power we so long fought for in constructing our modern gay community: the power to determine our own identity. And to whom have we relinquished it? The very authority we wrested it from in a struggle that occupied us for more than a hundred years: the medical profession.¹⁹

To challenge biomedical authority—whose meanings are part of powerful and deeply entrenched social and historical codes—has required considerable tenacity and courage from people dependent in the AIDS crisis upon science and medicine for protection, care, and the possibility of cure. These contestations provide the model for a broader social analysis, which moves away from AIDS as a “life-style” issue and examines its significance for this country, at this time, with the cultural and material resources available to us. This, in turn, requires us to acknowledge and examine the multiple ways in which our social constructions guide our visions of material reality.

Organization conference that concluded that AIDS must now be considered a pandemic of catastrophic proportions. (An epidemic disease is prevalent within a specific community, geographical area, or population at a particular time, usually originating elsewhere; a pandemic disease is present over the whole of a country, a continent, or the world.) See also “AIDS: Public Health and Civil Liberties,” *Hastings Center Report*, Special Supplement, vol. 16, no. 6 (December 1986); “AIDS: Science, Ethics, Policy,” *Forum, Issues in Science and Technology*, vol. 2, no. 2 (Winter 1986), pp. 39–73.

18. See Ronald Bayer, *Homosexuality and American Psychiatry: The Politics of Diagnosis*, New York, Basic Books, 1981.

19. Michael Lynch, “Living with Kaposi’s,” *Body Politic*, no. 88 (November 1982).

REAGAN: POLITICAL TROUBLES AHEAD

U.S. News & WORLD REPORT

JANUARY 12, 1987 \$1.95

AIDS

What You Need to Know
What You Should Do

Year	AIDS Deaths (Estimated)
1983	1,320
1985	~5,000
1987	~15,000
1989	~35,000
1991	54,000*

AIDS DEATHS PER YEAR IN THE U.S.

* Americans killed in Vietnam: 58,135

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*AIDS and Homophobia:
Constructing the Text of the Gay Male Body*

Whatever else it may be, AIDS is a story, or multiple stories, read to a surprising extent from a text that does not exist: the body of the male homosexual. It is a text people so want — need — to read that they have gone so far as to write it themselves. AIDS is a nexus where multiple meanings, stories, and discourses intersect and overlap, reinforce, and subvert one another. Yet clearly this mysterious male homosexual text has figured centrally in generating what I call here an epidemic of signification. Of course “the virus,” with mysteries of its own, has been a crucial influence. But we may recall Camus’s novel: “The word ‘plague’ . . . conjured up in the doctor’s mind not only what science chose to put into it, but a whole series of fantastic possibilities utterly out of keeping” with the bourgeois town of Oran, where the plague struck.²⁰ How could a disease so extraordinary as *plague* happen in a place so ordinary and dull? AIDS, initially striking people perceived as alien and exotic by scientists, physicians, journalists, and much of the US population, did not pose such a paradox. The “promiscuous” gay male body — early reports noted that AIDS “victims” reported having had as many as 1,000 sexual partners — made clear that even if AIDS turned out to be a sexually transmitted disease it would not be a commonplace one. The connections between sex, death, and homosexuality made the AIDS story inevitably, as David Black notes, able to be read as “the story of a metaphor.”²¹

20. Albert Camus, *The Plague*, trans. Stuart Gilbert, New York, Modern Library, 1948 (first published Paris, Gallimard, 1947).

21. “I realized . . . that any account of AIDS was not just a medical story and not just a story about the gay community, but also a story about the straight community’s reaction to the disease. More than that: it’s a story about how the straight community has used and is using AIDS as a mask for its feelings about gayness. It is a story about the ramifications of a metaphor” (Black, *The Plague Years*, p. 30). AIDS is typically characterized as a “story,” but whose? For AIDS as a story of scientific progress, see Gallo, “The AIDS Virus”; Arnold Relman, “Introduction,” *Hastings Center Report*, Special Supplement, vol. 15, no. 4 (August 1985), p. 1; Eve K. Nichols, *Mobilizing Against AIDS: The Unfinished Story of a Virus* (Conference of the Institute of Medicine/National Academy of Sciences), Cambridge, Massachusetts, Harvard University Press, 1986; Jonathan Lieberman, “Anatomy of an Epidemic,” *New York Review of Books*, August 18, 1983, pp. 17–22. But for Lynch (“Living with Kaposi’s”), Goldstein (“Heartsick”), FitzGerald (*Cities on a Hill*), Larry Kramer (“1,112 and Counting,” *New York Native*, March 1983, pp. 14–27), D. W. McLeod and Alan V. Miller (“Medical, Social, and Political Aspects of the AIDS Case: A Bibliography,” *Canadian Gay Archives*, no. 10), Thom Gunn (*Lament*, Champaign, Illinois, Doe Press, 1985), Steve Ault (“AIDS: The Facts of Life,” *Guardian*, March 26, 1986, pp. 1, 8), Dennis Altman (*AIDS in the Mind of America*, New York, Doubleday, 1986), the San Francisco *A.I.D.S. Show—Artists Involved with Death and Survival* (documentary video produced by Peter Adair and Rob Epstein, directed by Leland Moss; based on theater production at Theatre Rhinoceros, San Francisco; aired on PBS, November 1986), and others, AIDS is the story of crisis and heroism in the gay community. In the tabloids, AIDS has become the story of Rock Hudson (ROCK IS DEAD, ran the headlines in the [London] *Sun* on October 3, 1985, THE HUNK WHO LIVED A LIE), Liberace, and other individuals. A documentary film about the Fabian Bridges case, a young man with AIDS in Houston, is called *Fabian’s Story* (see J. Ostrow, “AIDS Documentary Addresses Agonizing Issues,” *Denver Post*, March 24, 1986). For Geoff Mains (*Urban Aboriginals: A Celebration of Leathersexuality*, San Francisco, Gay Sunshine Press, 1985), AIDS inter-

Ironically, a major turning point in US consciousness came when Rock Hudson acknowledged that he was being treated for AIDS. Through an extraordinary conflation of texts, the Rock Hudson case dramatized the possibility that the disease could spread to the “general population.”²² In fact this possibility had

rupts the adventure story of leather sex, a “unique and valuable cultural excursion” (p. 178). And in Thom Gunn’s poem, *Lament*, AIDS is a story of change and the death of friends. The stories we tell help us determine what our own place in the story is to be. FitzGerald writes that the “new mythology” about AIDS in the San Francisco gay community—that many gay men are changing their lives for the better—was “an antidote to the notion that AIDS was a punishment—a notion that . . . lay so deep as to be unavailable to reason. And it helped people act against the threat of AIDS” (*Cities on a Hill*, p. 116). But for Richard Mohr (“Of Deathbeds and Quarantines: AIDS Funding, Gay Life and State Coercion,” *Raritan*, vol. 6, no. 1 [Summer 1986], pp. 38–62), this new mythology—in which the loving relationship replaces anonymous sex—is a dangerous one: “The relation typically is asked to bear more than is reasonable. The burden on the simple dyad is further weighed down by the myth, both romantic and religious, that one finds one’s completion in a single other. White knights and messiahs never come in clusters” (p. 56). For discussion of AIDS as a public drama, see “AIDS: Public Health and Civil Liberties”; Ronald Bayer, “AIDS: The Public Context of an Epidemic,” *Millbank Quarterly*, no. 64, Supplement 1, pp. 168–182; and McLeod and Miller, “Medical, Social, and Political Aspects.”

22. Articulate voices had taken issue with the CDC position from the beginning, warning against the public health consequences of treating AIDS as a “gay disease” and separating “those at risk” from the so-called “general population.” See, for example, comments by Gary MacDonald, executive director of an AIDS action organization in Washington: “I think the moment may have arrived to desexualize the disease. AIDS is *not* a ‘gay disease,’ despite its epidemiology. . . . AIDS is not transmitted because of who you *are*, but because of what you *do*. . . . By concentrating on gay and bisexual men, people are able to ignore the fact that this disease has been present in what has charmingly come to be called ‘the general population’ *from the beginning*. It was not spread from one of the other groups. It was *there* (“AIDS: What Is to Be Done?” Forum, *Harper’s Magazine*, October 1985, p. 43).

One can extrapolate from Ruth Bleier’s observation that questions shape answers (*Science and Gender*, London, Pergamon, 1986, p. 4), and suggest that the question “Why are all people with AIDS sexually active homosexual males?” might more appropriately have been “*Are* all people with AIDS sexually active homosexual males?” It is widely believed (not without evidence) that federal funding for AIDS research was long in coming because its chief victims were gay or otherwise socially undesirable. Black describes a researcher who made jokes about *fagocytes* (phagocytes), cells designed “to kill off fags” (*The Plague Years*, pp. 81–82). Secretary of Health and Human Services Margaret Heckler was only one of many officials who expressed concern not about existing people with AIDS but about the potential spread of AIDS to “the community at large” (with the result that Heckler was called “the Secretary of Health and Heterosexual Services” by some gay activists; see “AIDS: What Is to Be Done?” p. 51).

There is evidence that the “gay disease” myth interferes with diagnosis and treatment. Many believe that AIDS may be underdetected and underreported in part because people outside the “classic” high-risk groups are often not asked the right questions (physicians typically take longer to diagnose AIDS in women, for example). Health professionals and AIDS counselors sometimes avoid the word *gay* because for many people this implies an identity or life-style; even *bisexual* may mean a life-style. Although “homosexually active” is officially defined as including even a single same-sex sexual contact over the past five years, many who have had such contact do not identify themselves as “homosexual” and therefore as being at risk for AIDS. Nancy Shaw (“California Models for Women’s AIDS Education and Services,” report, San Francisco AIDS Foundation [333 Valencia St., 4th Floor, San Francisco, CA 94103], and “Women and AIDS: Theory and Politics,” presented at the annual meeting of the National Women’s Studies Association, University of Illinois, Urbana, June 1986) suggests that for women as well the homosexual/heterosexual dichotomy confuses diagnosis and treatment as well as the perception of risk. Pally (“AIDS and the Politics of Despair”),

been evident for some time to anyone who wished to find it: as Jean Marx summarized the evidence in *Science* in 1984, "Sexual intercourse both of the heterosexual and homosexual varieties is a major pathway of transmission."²³ But only in late 1986 (and somewhat reluctantly at that) did the Centers for Disease Control expand upon their early "4-H list" of high-risk categories: HOMOSEXUALS, HEMOPHILIACS, HEROIN ADDICTS, and HAITIANS, and the sexual partners of people within these groups.²⁴ The original list, developed during 1981 and 1982, has structured evidence collection in the intervening years and contributed to a view that the major risk factor in acquiring AIDS is being a particular kind of person rather than doing particular things.²⁵ Ann Giudici Fettner pointed out in 1985 that "the CDC admits that at least 10 percent of AIDS sufferers are gay and use IV drugs. Yet they are automatically counted in the homosexual and bisexual men category, regardless of what might be known—or not known—about how they became infected."²⁶ So the "gay" nature of AIDS was in part an artifact of the way in which data was collected and reported. Though almost from the beginning scientific papers have cited AIDS cases that appeared to fall outside the high-risk groups, it has been generally hypothesized that these cases, assigned to the categories of UNKNOWN, UNCLASSIFIED, or OTHER,

Marea Murray ("Too Little AIDS Coverage," Letter to the Editors, *Sojourner*, July 1985, p. 3), and Cindy Patton ("Feminists Have Avoided the Issue of AIDS," *Sojourner*, October 1985, pp. 19–20) all argue that AIDS is a "women's issue" and should receive more attention in feminist publications (and see COYOTE, Background Paper, 1985 COYOTE Convention Summary, May 30–June 2, 1985, San Francisco; Ellen Switzer, "AIDS: What Women Can Do," *Vogue*, January 1986, pp. 222–223, 264–265; Jane Sprague Zones, "AIDS: What Women Need to Know," *The [National Women's Health] Network News*, vol. 11, no. 6 [November–December 1986], pp. 1, 3). The persistence and consequences of the perception that AIDS is a disease of gay men and IV drug users are documented in a number of recent publications, notably Leishman, "Heterosexuals and AIDS." CDC interviews with members of two heterosexual singles clubs in Minneapolis documented that as of late 1986 this already infected population had made virtually no modifications in their sexual practices ("Positive HTLV-III/LAV Antibody Results for Sexually Active Female Members of Social/Sexual Clubs—Minnesota," *Morbidity and Mortality Weekly Report*, no. 35 [1986], pp. 697–699). Ralph J. DiClemente, Jim Zorn, and Lydia Temoshok ("Adolescents and AIDS: A Survey of Knowledge, Attitudes, and Beliefs about AIDS in San Francisco," *American Journal of Public Health*, vol. 76, no. 12 [1986], pp. 1443–1445) found that many adolescents in San Francisco, a city where public health information about AIDS has been extensive, were not well informed about the seriousness of the disease, its causes, or preventive measures.

23. Jean L. Marx, "Strong New Candidate for AIDS Agent," *Research News, Science*, May 4, 1984, p. 147.

24. Centers for Disease Control, "Update: Acquired Immunodeficiency Syndrome—United States," *Morbidity and Mortality Weekly Report*, no. 35 (1986), pp. 757–760, 765–766.

25. Jeff Minson, "The Assertion of Homosexuality," *m/j*, nos. 5–6 (1981), pp. 19–39, and Jeffrey Weeks, *Sexuality and Its Discontents: Meanings, Myths, and Modern Sexualities*, London, Routledge & Kegan Paul, 1985, analyze the evolution of homosexuality as a coherent identity. Bayer, *Homosexuality and American Psychiatry*, and Ronald Bayer and Robert L. Spitzer, "Edited Correspondence on the Status of Homosexuality in DSM-III," *Journal of the History of the Behavioral Sciences*, no. 18 (1982), pp. 32–52, document the intense and acrimonious "contests for meaning" during the American Psychiatric Association's 1970s debates over the official classification of homosexuality.

26. Fettner, in "AIDS: What Is to Be Done?" p. 43.

would ultimately turn out to be one of the four H's.²⁷ This commitment to categories based on stereotyped identity filters out information. Nancy Shaw argues that when women are asked in CDC protocols "Are you heterosexual?" "this loses the diversity of behaviors that may have a bearing on infection."²⁸ Even now, with established evidence that transmission can be heterosexual (which begins with the letter *H* after all), scientific discourse continues to construct women as "inefficient" and "incompetent" transmitters of HIV, passive receptacles without the projectile capacity of a penis or syringe—stolid, uninteresting barriers that impede the unrestrained passage of the virus from brother to brother.²⁹ Exceptions include prostitutes, whose discursive legacy—despite their longstanding professional knowledge and continued activism about AIDS—is to be seen as so contaminated that their bodies are virtual laboratory cultures for viral replication.³⁰ Other exceptions are African women, whose exotic bodies,

27. See Nichols, *Mobilizing Against AIDS*, and Associated Press, "571 AIDS Cases Tied to Heterosexual Causes," *Champaign-Urbana News-Gazette*, December 12, 1986, p. A-7, on the reclassification in 1986 of the CDC's 571 previously "unexplained cases"; formerly classified as "none of the above" (i.e., outside the known high-risk categories), some of these cases were reclassified as heterosexually transmitted.

28. Shaw, "Women and AIDS."

29. Even after consensus in 1984 that AIDS was caused by a virus, there continued to be conflicting views on transmission and different explanations for the epidemiological finding that AIDS and HIV infection in the US were appearing predominantly in gay males. One view holds that this is essentially an artifact ("simple mathematics") created because the virus (for whatever reason) infected gay men first and gay men tend to have sex with each other. The second is that biomedical/physiological factors make gay men and/or the "passive receiver" more infectable. A third view is that the virus can be transmitted to anyone but that certain cofactors facilitate the development of infection and/or clinical symptoms. For more information, see Leibowitch, *A Strange Virus*, pp. 72–73, Leishman, "Heterosexuals and AIDS," and Mathilde Krim, "AIDS: The Challenge to Science and Medicine," in *AIDS: The Emerging Ethical Dilemmas: A Hastings Center Report*, Special Supplement, vol. 15, no. 4 (August 1985), p. 4. Many scientists suggest that, whatever sex the partners may be, infection, as Fain ("AIDS: An Antidote to Fear") put it, "requires a jolt injected into the bloodstream, likely several jolts over time, such as would occur with infected needles or semen. In both cases, needle and penis are the instruments of contagion." Women, having no penises, are therefore "inefficient" transmitters. For more detailed discussion, see my essay on women and AIDS, forthcoming in *AIDS: The Burdens of History*, ed. Elizabeth Fee and Daniel M. Fox, Berkeley, University of California Press.

Evidence of heterosexual transmission was at first explained away. When R. R. Redfield, *et al.* ("Heterosexually Acquired HTLV-III/LAV Disease [AIDS-Related Complex and AIDS]: Epidemiological Evidence for Female-to-Male Transmission," *Journal of the American Medical Association*, no. 254 [1985], pp. 2094–2096; "Female-to-Male Transmission of HTLV-III," *Journal of the American Medical Association*, no. 255 [1986], pp. 1705–1706) identified infection in US servicemen who claimed sexual contact only with female prostitutes, some hypothesized "quasi-homosexual contact" or called the data into question on the grounds that servicemen would be likely to withhold information about homosexuality or drug use (some evidence for this is offered by John J. Potterat, *et al.*, "Lying to Military Physicians about Risk Factors for HIV Infections," Letter to *Journal of the American Medical Association*, vol. 257, no. 13 [April 3, 1987], p. 1727). For discussion of the relation of transmission to funding, see Barnes, "AIDS Research in New Phase," p. 283, and "AIDS Funding Boost Requested," *Daily Illini*, September 27, 1985, p. 7.

30. Brandt, *No Magic Bullet*, and Judith Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State*, New York, Cambridge University Press, 1983, review the longstanding equation of

sexual practices, or who knows what are seen to be so radically different from those of women in the US that anything can happen in them.³¹ The term *exotic*, sometimes used to describe a virus that appears to have originated “elsewhere” (but “elsewhere,” like “other” is not a fixed category), is an important theme running through AIDS literature.³² The fact that one of the more extensive and visually elegant analyses of AIDS appeared recently in *National Geographic* is perhaps further evidence of its life on an idealized “exotic” terrain.³³

The early hypotheses about AIDS, when the first cases appeared in New York, Los Angeles, and Paris, were sociological, relating it directly to the supposed “gay male life-style.” In February 1982, for example, it was thought that a particular supply of amyl nitrate (poppers) might be contaminated. “The poppers fable,” writes Jacques Leibowitch, becomes

a Grimm fairy tale when the first cases of AIDS-without-poppers are discovered among homosexuals absolutely repelled by the smell of the product and among heterosexuals unfamiliar with even the words *amyl nitrate* or *poppers*. But, as will be habitual in the history of AIDS, rumors last longer than either common sense or the facts would warrant. The odor of AIDS-poppers will hover in the air a long time—long enough for dozens of mice in the Atlanta epidemiology labs to be kept in restricted cages on an obligatory sniffed diet of poppers 8 to 12 hours a day for several months, until, nauseated but still healthy, without a trace of AIDS, the wretched rodents were released—provisionally—upon the announcement of a new hypothesis: *promiscuity*.³⁴

This new perspective generated numerous possibilities. One was that sperm

prostitutes with disease, and the conceptual separation of infected prostitutes (and other voluntarily sexually active women) from “innocent victims” (see also COYOTE, “Background Paper”; Shaw, “Women and AIDS”; Colin Douglas, *The Intern’s Tale*, New York, Grove, 1975, repr. 1982; Erik Eckholm, “Prostitutes’ Impact on Spread of AIDS Debated,” *New York Times*, November 5, 1985, pp. 15, 18; and Nancy Shaw and Lyn Paleo, “Women and AIDS,” in *What to Do about AIDS*, ed. Leon McKusick, Berkeley, University of California Press, 1986, pp. 142–154).

31. Discussions of AIDS and heterosexual transmission in Africa include Lieberman, “The Reality of AIDS”; Treichler, forthcoming in *AIDS: The Burdens of History*; Cindy Patton, *Sex and Germs: The Politics of AIDS*, Boston, South End Press, 1985; June E. Osborn, “The AIDS Epidemic: An Overview of the Science,” *Issues in Science and Technology*, vol. 2, no. 2 (Winter 1986), pp. 40–55; Jean L. Marx, “New Relatives of AIDS Virus Found,” *Research News, Science*, no. 232 (April 11, 1986), p. 157; Fran P. Hosken, “Why AIDS Pattern Is Different in Africa,” Letter to the *New York Times*, December 15, 1986; Douglas A. Feldman, “Role of African Mutilations in AIDS Discounted,” Letter to the *New York Times*, January 7, 1987; Lawrence K. Altman, “Heterosexuals and AIDS: New Data Examined,” *New York Times*, January 22, 1985, pp. 19–20; and “New Human Retroviruses: One Causes AIDS . . . and the Other Does Not,” *Nature*, no. 320 (April 3, 1986), p. 385.

32. Leibowitch, *A Strange Virus*, p. 73.

33. Peter Jaret, “Our Immune System: The Wars Within,” *National Geographic*, June 1986, pp. 702–735.

34. Leibowitch, *A Strange Virus*, p. 5.

itself could destroy the immune system. “God’s plan for man,” after all, “was for Adam and Eve and not Adam and Steve.”³⁵ Women, the “natural” receptacles for male sperm, have evolved over the millennia so that their bodies can deal with these foreign invaders; men, not thus blessed by nature, become vulnerable to the “killer sperm” of other men. AIDS in the lay press became known as the “toxic cock syndrome.”³⁶ While scientists and physicians tended initially to define AIDS as a gay sociological problem, gay men, for other reasons, also tended to reject the possibility that AIDS was a new contagious disease. Not only could this make them sexual lepers, it didn’t make sense: “How could a disease pick out just gays? That had to be medical homophobia.”³⁷ Important to note here is a profound ambivalence about the origins of illness. Does one prefer an illness caused by who one is and therefore perhaps preventable, curable, or containable through “self-control” — or an illness caused by some external “disease” which has a respectable medical name and can be addressed strictly as a medical problem, beyond individual control? The townspeople of Oran in *The Plague* experience relief when the plague bacillus is identified: the odd happenings — the dying rats, the mysterious human illnesses — are caused by something that has originated elsewhere, something external, something “objective,” something medicine can name, even if not cure. The tension between self and not-self becomes important as we try to understand the particular role of viruses and origin stories in AIDS.

But this anticipates the next chapter in the AIDS story. Another favored possibility in the early 1980s (still not universally discarded, for it is plausible so long as the cases of AIDS among monogamous homebodies are ignored) was the notion of “cofactors”: no *single* infectious agent causes the disease; rather, someone who is sexually active with multiple partners is exposed to a kind of bacterial/viral tidal wave that can crush the immune system.³⁸ Gay men on the sexual

35. Congressman William Dannemeyer, October 1985, during a debate on a homosexual rights bill (quoted in Langone, “AIDS: The Latest Scientific Facts,” p. 29).

36. Black, *The Plague Years*, p. 29.

37. *Ibid.*, p. 40. In the gay community, the first reaction to AIDS was disbelief. FitzGerald quotes a gay physician in San Francisco: “A disease that killed only gay white men? It seemed unbelievable. I used to teach epidemiology, and I had never heard of a disease that selective. I thought, They are making this up. It can’t be true. Or if there is such a disease it must be the work of some government agency — the F.B.I. or the C.I.A. — trying to kill us all” (*Cities on a Hill*, p. 98). In the San Francisco *A.I.D.S. Show*, one man is said to have learned of his diagnosis and at once wired the CIA: “I HAVE AIDS. DO YOU HAVE AN ANTIDOTE?”

38. See Lieberman, “The Reality of AIDS,” p. 43, for an example of the view that, although the virus is the “sine qua non” for AIDS, the syndrome actually develops “chiefly in those whose immune systems are already weak or defective.” For broader discussion of public health issues in relation to scientific uncertainties and questions of civil liberties, see Ronald Bayer, “AIDS and the Gay Community: Between the Specter and the Promise of Medicine,” *Social Research*, vol. 52, no. 3 (Autumn 1985), pp. 581–606; Mervyn F. Silverman and Deborah B. Silverman, “AIDS and the Threat to Public Health,” *Hastings Center Report*, Special Supplement, vol. 15, no. 4 (August 1985), pp. 19–22; and Gene W. Matthews and Verla S. Neslund, “The Initial Impact of AIDS on Public Health Law in

“fast-track” would be particularly susceptible because of the prevalence of specific practices that would maximize exposure to pathogenic microbes. What were considered potentially relevant data came to be routinely included in scientific papers and presentations, with the result that the terminology of these reports was increasingly scrutinized by gay activists.³⁹ Examples from *Science* from June 1981 through December 1985 include “homosexual and bisexual men who are extremely active sexually,” “admitted homosexuals,” “homosexual males with multiple partners,” “homosexual men with multiple partners,” “highly sexually active homosexual men,” and “promiscuous” versus “nonpromiscuous” homosexual males.⁴⁰ Also documented (examples are also from the *Science* collection) are exotic travels or practices: “a Caucasian who had visited Haiti,” “persons born in Haiti,” “a favorite vacation spot for US homosexuals,” rectal insemination, “bisexual men,” “increased frequency of use of nitrite inhalants,” and “receptive anal intercourse.”⁴¹

Out of this dense discursive jungle came the “fragile anus” hypothesis (tested by Richards and his colleagues, who rectally inseminated laboratory rabbits) as well as the vision of “multiple partners.”⁴² Even after sociological explanations for AIDS gave way to biomedical ones involving a transmissible virus, these various images of AIDS as a “gay disease” proved too alluring to abandon. It is easy to see both the scientific and the popular appeal of the “fragile anus” hypothesis: scientifically, it confines the public health dimensions of AIDS to an infected population in the millions—merely mind-boggling, that is—

the United States—1986,” *Journal of the American Medical Association*, vol. 257, no. 3 (January 16, 1987), pp. 344–352.

39. L. Altman, “Heterosexuals and AIDS,” and Black, *The Plague Years*, discuss changes in specific terminology as a result of gays’ objections; “sexually promiscuous” generally shifted, for example, to “sexually active” or “contact with multiple sex partners.” A new classification system for AIDS and AIDS/HIV-related symptoms (adopted at the 2nd International AIDS Conference in Paris, June 1986) is based on the diverse clinical manifestations of the syndrome and its documented natural history; it avoids presumptive terminology like “pre-AIDS.” J. Z. Grover’s useful review of Nichols’s *Mobilizing Against AIDS* (“The ‘Scientific’ Regime of Truth,” *In These Times*, December 10–16, 1986, pp. 18–19) points out a number of problematic terms and assumptions that occur repeatedly in this book and other scientific writing on AIDS: (1) the term *AIDS victim* presupposes helplessness (the term *person with AIDS* or PWA was created to avoid this), prevention and cure are linked with a conservative agenda of “individual responsibility,” sex with multiple partners and/or strangers is equated with “promiscuity,” and “safe” sexual practices are conflated with the cultural practice of monogamy; (2) it differentiates “caregivers” from “victims,” scientific/medical expertise from other kinds of knowledge, and “those at risk” from “the rest of us”; and (3) it notes but fails to challenge existing inequities in the health-care system. Julie Dobrow, “The Symbolism of AIDS: Perspectives on the Use of Language in the Popular Press,” presented at the International Communication Association annual meeting, Chicago, May 1986, notes the dramatic and commercial appeal of common “cultural images” in popular press scenarios of AIDS.

40. Terms are quoted from the collection *AIDS: Papers from Science 1982–1985*, ed. Ruth Kulstad, Washington, D.C., American Association for the Advancement of Science, 1986, pp. 22, 40, 49, 65, 142, and 160, respectively.

41. *Ibid.*, pp. 47, 130, 73, 142–146, 130, 611, 611, respectively.

42. *Ibid.*, pp. 142–146.

enabling us to stop short of the impossible, the unthinkable billions that widespread heterosexual transmission might infect. Another appeal of thinking of AIDS as a “gay disease” is that it protects not only the sexual practices of heterosexuality but also its ideological superiority. In the service of this hypothesis, both homophobia and sexism are folded imperturbably into the language of the scientific text. Women, as I noted above, are characterized in the scholarly literature as “inefficient” transmitters of AIDS; Leibowitch refers to the “refractory impermeability of the vaginal mucous membrane.”⁴³ A study of German prostitutes that appeared to demonstrate female-to-male transmission of AIDS, reported in the *Journal of the American Medical Association*, was interpreted by one reader as actually representing “quasi-homosexual” transmission: Man A, infected with HIV, has vaginal intercourse with Prostitute; she, “[performing] no more than perfunctory external cleansing between customers,” then has intercourse with Man B; Man B is infected with the virus via the semen of Man A.⁴⁴ The prostitute’s vagina thus functions merely as a reservoir, a passive holding tank for semen that becomes infectious only when another penis is dipped into it—like a swamp where mosquitoes come to breed.

But the conception and the conclusion are inaccurate. It is not monogamy or abstinence per se that protects one from AIDS infection but practices and protections that prevent the virus from entering one’s bloodstream. Evidence suggests that prostitutes are at greater risk not because they have multiple sex partners, but because some of them use intravenous drugs; at this point “they may be better protected than the typical woman who is just going to a bar or a woman who thinks of herself as not sexually active but who ‘just happens to have this relationship.’ They may be more aware than women who are involved in serial monogamy or those whose self-image is ‘I’m not at risk so I’m not going to learn more about it.’”⁴⁵ Indeed, COYOTE and other organizations of prostitutes have addressed the issue of AIDS rather aggressively for several years.⁴⁶

43. Leibowitch, *A Strange Virus*, p. 36.

44. Data on female-to-male transmission presented at the 1985 International Conference on AIDS in Atlanta are summarized by Marsha F. Goldsmith, “More Heterosexual Spread of HTLV-III Virus Seen,” *Journal of the American Medical Association*, no. 253 (1985), pp. 3377–3379. The hypothesis that such data reflect “quasi-homosexual contact” is suggested by Harold Sanford Kant, “The Transmission of HTLV-III,” Letter to the Editor, *Journal of the American Medical Association*, no. 254 (1985), p. 1901.

45. Shaw and Paley, “Women and AIDS,” p. 144.

46. Kant’s hypothesis in *JAMA* is quoted by Langone, “AIDS: The Latest Scientific Facts,” p. 49, to support his own “vulnerable anus” hypothesis: “It is not unlikely that these prostitutes had multiple partners during a very short time, and performed no more than perfunctory external cleansing between customers.” Langone does not note that the source is a Letter to the Editor. Meanwhile, reports from prostitutes in many countries, summarized in the June 1986 *World Wide Whores’ News* (published by the International Committee for Prostitutes’ Rights), indicate familiarity with AIDS as well as concern with obtaining better protection from infection and better health care. See also COYOTE, “Background Paper.”

Donald Mager discusses the proliferation among heterosexuals of visions about homosexuality and their status as fantasy:

Institutions of privilege and power disenfranchise lesbians and gay men because of stereotypic negative categorizations of them—stereotypes which engage a societal fantasy of the illicit, the subversive, and the taboo, particularly due to assumptions of radical sex role parodies and inversions. This fantasy in turn becomes both the object of fear and of obsessed fascination, while its status as fantasy is never acknowledged; instead, the reality it pretends to signify becomes the justification of suppression both of the fantasy itself and of those actual persons who would seem to embody it. Homophobia as a critique of societal sexual fantasy, in turn, enforces its primary location as a gay discourse, separate and outside the site of the fantasy which is normative male heterosexuality.⁴⁷

Leibowitch comments as follows on AIDS, fantasy, and “the reality it pretends to signify”:

When they come to write the history of AIDS, socio-ethnologists will have to decide whether the “practitioners” of homosexuality or its heterosexual “onlookers” have been the more spectacular in their extravagance. The homosexual “life style” is so blatantly on display to the general public, so closely scrutinized, that it is likely we never will have been informed with such technicophantasmal complacency as to how “other people” live their lives.⁴⁸

It was widely believed in the gay community that the connection of AIDS to homosexuality delayed and problematized virtually every aspect of the country’s response to the crisis. That the response *was* delayed and problematic is the conclusion of various investigators.⁴⁹ Attempting to assess the degree to which prejudice, fear, or ignorance of homosexuality may have affected public policy and research efforts, Panem concluded that homosexuality per se would not have deterred scientists from selecting interesting and rewarding research projects. But “the argument of ignorance appears to have more credibility.”⁵⁰ She quotes

47. Donald Mager, “The Discourse about Homophobia, Male and Female Contexts,” presented at the annual meeting of the Modern Language Association, New York, December 1986.

48. Leibowitch, *A Strange Virus*, p. 3.

49. See, for example, Schwartz, “AIDS in the Media”; Baltimore and Wolff, *Confronting AIDS: “AIDS Hearing.”* Committee on Energy and Commerce, Subcommittee on Health and the Environment, US House of Representatives, September 17, 1984 (Serial No. 98–105, Washington, D.C., US Government Printing Office); and Office of Technology Assessment, *Review of the Public Health Service’s Response to AIDS: A Technical Memorandum*, OTA-TM-H-24, Congress of the US, Washington, D.C., US Government Printing Office, February 1985.

50. Sandra Panem, “AIDS: Public Policy and Biomedical Research,” *Hastings Center Report*, Special Supplement, vol. 15, no. 4 (August 1985), p. 24.

James Curran's 1984 judgment that policy, funding, and communication were all delayed because only people in New York and California had any real sense of crisis or comprehension of the gay male community. "Scientists avoid issues that relate to sex," he said, "and there is not much understanding of homosexuality." This was an understatement: according to Curran, many eminent scientists during this period rejected the possibility that AIDS was an infectious disease because they had no idea how a man could transmit an infectious agent to another man.⁵¹ Other instances of ignorance are reported by Patton and Black.⁵² Physician and scientist Joseph Sonnabend attributes this ignorance to the sequestered ivory towers that many AIDS investigators (particularly those who do straight laboratory research as opposed to clinical work) inhabit and argues instead that AIDS needs to be studied in its cultural totality. Gay male sexual practices should not be dismissed out of hand because they seem "unnatural" to the straight (in both senses) scientist: "the rectum is a sexual organ, and it deserves the respect that a penis gets and a vagina gets. Anal intercourse is a central sexual activity, and it should be supported, it should be celebrated."⁵³ A National Academy of Sciences panel studying the AIDS crisis in 1986 cited an urgent need for accurate and *current* information about sex and sexual practices in the US, noting that no comprehensive research had been carried out since Kinsey's studies in the 1940s; they recommended, as well, social science research on a range of social behaviors relevant to the transmission and control of AIDS.⁵⁴

It has been argued that the perceived *gayness* of AIDS was ultimately a crucial political factor in obtaining funding. Dennis Altman observes that the principle of providing adequate funding for AIDS research was institutionalized within the federal appropriations process as a result of the 1983 Congressional hearings chaired by Representatives Henry Waxman and Theodore Weiss, members of Congress representing large and visible gay communities.

Here one sees the effect of the mobilization and organization of gays . . . ; it is salutary to imagine the tardiness of the response had IV users and Haitians been the only victims of AIDS, had Republicans controlled the House of Representatives as well as the Senate (and hence chaired the relevant oversight and appropriations committees) or, indeed, had AIDS struck ten years earlier, before the existence of an organized gay movement, openly gay professionals who could testify before the relevant committees and openly gay congressional staff.⁵⁵

51. *Ibid.*

52. Patton, *Sex and Germs*; Patton, "Feminists Have Avoided the Issue of AIDS"; Black, *The Plague Years*.

53. Joseph Sonnabend, "Looking at AIDS in Totality: A Conversation," *New York Native*, 129 (October 7–13, 1985).

54. Baltimore and Wolff, *Confronting AIDS*.

55. D. Altman, *AIDS in the Mind of America*, pp. 116–117.

But these social and political issues were felt by many to be essentially irrelevant. From the beginning, the hypothesis that AIDS was caused by an infectious agent was favored within the US scientific community. The hypothesis was strengthened when the syndrome began to be identified in a diversity of populations and found to cause apparently identical damage to the underlying immune system. By May 1984 a viral etiology for AIDS had been generally accepted, and the real question became precisely what kind of viral agent this could be.

Rendezvous with 007

“Interpretations,” write Bruno Latour and Steve Woolgar in *Laboratory Life*, their analysis of the construction of facts in science, “do not so much *inform* as *perform*.”⁵⁶ And nowhere do we see interpretation shaped toward performance so clearly as in the issues and controversies surrounding the identification and naming of “the AIDS virus.”

As early as 1979, gay men in New York and California were coming down with and dying from illnesses unusual in young healthy people. One of the actors who helped create the San Francisco *A.I.D.S. Show* recalled that early period:

I had a friend who died way way back in New York in 1981. He was one of the first to go. We didn't know what AIDS was, there was no name for it. We didn't know it was contagious—we had no idea it was sexually transmitted—we didn't know it was anything. We just thought that he—alone—was ill. He was 26 years old and just had one thing after another wrong with him. . . . He was still coming to work—'cause he didn't *know* he had a terminal disease.⁵⁷

The oddness of these nameless isolated events gave way to an even more terrifying period in which gay men on both coasts gradually began to realize that too many friends and acquaintances were dying. As the numbers mounted, the deaths became “cases” of what was informally called in New York hospitals WOGS: the Wrath of God Syndrome.⁵⁸ It all became official in 1981, when five deaths in Los Angeles from *Pneumocystis pneumonia* were described in the June 5 issue of the CDC's bulletin *Morbidity and Mortality Weekly Report* with an editorial note explaining that

the occurrence of pneumocystosis in these 5 previously healthy individuals without a clinically apparent underlying immunodeficiency is unusual. The fact that these patients were all homosexuals suggests an association between some aspect of a homosexual lifestyle or disease

56. Latour and Woolgar, *Laboratory Life*.

57. From *The A.I.D.S. Show*.

58. See Sontag, *Illness as Metaphor*.

acquired through sexual contact and *Pneumocystis pneumonia* in this population.⁵⁹

Gottlieb's 1981 paper in the *New England Journal of Medicine* described the deaths of young, previously healthy gay men from another rare but rarely fatal disease.⁶⁰ The deaths were attributed to a breakdown of the immune system that left the body utterly unable to defend itself against infections not normally fatal. The syndrome was provisionally called GRID: gay-related immunodeficiency. These published reports drew similar information from physicians in other cities, and before too long these rare diseases had been diagnosed in nongay people (for example, hemophiliacs and people who had recently had blood transfusions).⁶¹ Epidemiological follow-up interviews over the next several months confirmed that the problem — whatever it was — was growing at epidemic rates, and a CDC task force was accordingly established to coordinate data collection, communication, and research. The name *AIDS* was selected at a 1982 conference in Washington (*GRID* was no longer applicable now that nongays were also getting sick): acquired immune deficiency syndrome (“reasonably descriptive,” said Curran, “without being pejorative”).⁶²

Over the next two years, epidemiological and clinical evidence increasingly pointed toward the role of some infectious agent in AIDS. Researchers divided over this, with some searching for a single agent, others positing a “multifactorial cause.” Most scientists affiliated with federal scientific agencies (primarily the National Institutes of Health and Centers for Disease Control) have tended toward the single-agent theory (as though “cofactors” were a kind of deuces-wild element that vulgarized serious investigation), and this view has tended to dominate scientific reporting. Although some independent researchers, clinicians, and non-US scientists protested the increasingly rigid party line of what has been called “the AIDS Mafia,” multifactorial and environmental theories were subordinated to the quest for the single agent.⁶³ The National Cancer Institute (NCI),

59. Centers for Disease Control, “*Pneumocystis Pneumonia—Los Angeles*,” *Morbidity and Mortality Weekly Report*, vol. 30, no. 21 (June 5, 1981), pp. 250–252.

60. M. S. Gottlieb, R. Schroff, H. M. Schanker, et al., “*Pneumocystis Carinii Pneumonia and Mucosal Candidiasis in Previously Healthy Homosexual Men*,” *New England Journal of Medicine*, 305 (1981), pp. 1425–1431.

61. See Centers for Disease Control, “*Kaposi's Sarcoma and Pneumocystis Pneumonia among Homosexual Men—New York City and California*,” *Morbidity and Mortality Weekly Report*, vol. 30, no. 25 (July 3, 1981), pp. 305–308, and Keewhan Choi, “*Assembling the AIDS Puzzle: Epidemiology*,” in *AIDS: Facts and Issues*, ed. Victor Gong and Norman Rudnick, New Brunswick, New Jersey, Rutgers University Press, 1986.

62. Quoted in Black, *The Plague Years*.

63. Some scientists outside the federal health care network charge that the US government — “the AIDS Mafia” — dictates a party line on AIDS. Joseph Sonnabend, MD, former scientific director of the AIDS Medical Foundation, began the *Journal of AIDS Research* to print scientific articles he believed were being suppressed because they argued for a multifactorial cause rather than a single virus. See Black, *The Plague Years*, pp. 112–118, for discussion.

for example, developed a research strategy that focused on retroviruses, essentially to the exclusion of other lines of research, while other US virology and immunology laboratories put forward their own favored possibilities.⁶⁴ By 1983 the “leading candidate” for the AIDS virus seemed to be a member of the human T-cell leukemia family of viruses (HTLV), so called because they typically infect a particular kind of cell, the T-helper cells. But these were *retroviruses*, and there was doubt that a retrovirus could cause immunosuppression in humans.⁶⁵ Yet by this time it was widely agreed that AIDS was, indeed, a “new” disease—neither a statistical fluke nor a feature of the gay life-style. This generated excitement in the medical and scientific community not only because truly new diseases are rare, but also because its *cause* might be new as well. In 1983 Luc Montagnier at the Pasteur Institute in Paris identified what he called LAV, lymphadenopathy-associated virus.⁶⁶ In 1984 Robert Gallo, at NCI, identified what *he* called HTLV-III, human T-cell lymphotropic virus type III (the third type identified by his laboratory).⁶⁷ In accordance with Koch’s postulates, both

64. Panem, “AIDS: Public Policy and Biomedical Research,” p. 25.

65. The scientific account of retroviruses goes something like this: A virus (from Latin *virus*, “poison”) cannot reproduce outside living cells: it enters into another organism’s “host” cell and uses that cell’s biochemical machinery to replicate itself. These replicant virus particles then infect other cells; this process is repeated until the infection is either brought under control by the host’s immune system or the infection overwhelms and kills or debilitates the host, making it susceptible to other infections (as HIV does). Alternatively, virus and host may reach a state of equilibrium in which both coexist for years. The virus’s initial entry into the host cell may cause symptoms of viral infections. Certain viruses can remain inactive, or latent, inside the host cell for long periods without causing problems; they can remain integrated with the cell’s DNA (genetic material) until triggered to replicate (typically when the organism is compromised by old age, immunosuppressive drug therapy, or infection by another virus or bacteria); at this point the DNA is transcribed to RNA, which in turn becomes protein.

A retrovirus replicates “backward,” transferring genetic information from viral RNA into DNA, the opposite of previously known viral actions. The retrovirus carries RNA (instead of DNA) as its genetic material along with a unique enzyme, reverse transcriptase (from which the name *retro* comes); this uses the RNA as a template to generate (transcribe) a DNA copy. This viral DNA inserts itself among the cell’s own chromosomes; thus positioned to function as a “new gene” for the infected host, it can immediately start producing viral RNAs (new viruses) or remain latent until activated. In the case of HIV the latency period can be as long as fourteen years (as of this writing) followed by a very sudden explosion of replication activity that may directly kill the host’s cell—chiefly the T4-lymphocyte, a white blood cell that regulates the body’s immune response. The rapid depletion of T4-cells, characteristic of AIDS, leaves the human host vulnerable to many infections that a normal immune system would repel. The HTLV isolated by Gallo in 1980 was the first identified retrovirus associated with human disease (see Osborn, “The AIDS Epidemic,” p. 47).

66. F. Barre-Sinoussi, J. C. Chernann, F. Rey, *et al.*, “Isolation of a T-Lymphotropic Retrovirus from a Patient at Risk for Acquired Immune Deficiency Syndrome,” *Science*, no. 220 (1983), pp. 868–871; L. Montagnier, J. C. Chernann, F. Barre-Sinoussi, *et al.*, “A New Human T-Lymphotropic Retrovirus: Characterization and Possible Role in Lymphadenopathy and Acquired Immune Deficiency Syndromes,” in *Human T-Cell Leukemia / Lymphoma Virus*, ed. R. C. Gallo, M.E. Essex, and L. Gross, Cold Spring Harbor, New York, Cold Spring Harbor Laboratory, 1984, pp. 363–379.

67. Gallo and his colleagues published four papers on the isolation of HTLV-III in *Science*, no. 224 (1984), pp. 497–508.

viruses were isolated in the blood and semen of AIDS patients; no trace was found in the healthy control population.⁶⁸

These powerful findings—disputed and contentious though they were to be—narrowed almost at once the basic biomedical science agenda with regard to AIDS. In the construction of scientific facts, the existence of a name plays a crucial role in providing a coherent and unified signifier—a shorthand way of signifying what may be a complex, inchoate, or little-understood concept. Latour and Woolgar divide the research they studied into the long and uncertain phase that led up to the identification, synthesis, and naming of TRF (H) (the thyrotropin-releasing factor [hormone], a substance involved in neuroendocrine hormone regulation) and the subsequent narrower and more routine phase in which the concept's status as “a fact” was taken for granted (the dispute over naming is relevant to the tussle over the names LAV and HTLV).⁶⁹ So too with AIDS: before the isolation of the virus, there were considerably more universes of inquiry and open-ended speculations. Evidence for a virus as agent intensified scientific control over signification and enabled scientists to rule out less relevant hypotheses and lines of research. Of course, the existence of *two* names—LAV and HTLV-III—complicated the signification process: did two signifiers entail two distinct signifieds? Despite the wrangling over this point between the involved parties, a clearer consensus nevertheless emerged that basic research should now relate directly to the hypothesis that a single virus was “the culprit” responsible for AIDS. Important issues included (1) etiology, (2) the identification of the virus's genetic structure and precise shape, (3) clinical and other information about transmission, (4) information about the clinical expression of the disease (discovery that the virus infected brain cells encouraged its renaming, since the names LAV and HTLV both presupposed an attack on lymph cells), (5) the scope and natural history of the disease, (6) differences among “risk groups,” and (7) epidemiological information including the long-term picture (circumstantial evidence but important nevertheless).

To most scientists this process of narrowing inquiry and relinquishing peripheral lines of thought is simply the way science is done, the procedural *sine qua non* for establishing anything that can be called a “fact.” But “a statement

68. Koch's postulates, developed by bacteriologist Robert Koch, would require that, in order to establish a specific virus as the “cause” of the AIDS syndrome, the virus would have to be present in all cases of the disease; antibody to the virus must be shown to develop in constant temporal relation to the development of AIDS; and transmission of the same virus to a previously uninfected animal or human must be demonstrated with subsequent development of the disease and reisolation of the infective agent. With AIDS, a lethal disease, this last requirement cannot be tested on humans, but a demonstration that the virus could be used to produce an effective vaccine would more or less fulfill this requirement. See Marx, “Strong New Candidate for AIDS Agent,” p. 151, and P. M. Feorino, *et al.*, “Lymphadenopathy Associated Virus Infection of a Blood Donor-Recipient Pair with Acquired Immunodeficiency Syndrome,” in Kulstad, ed., *AIDS: Papers from Science*, p. 216.

69. Latour and Woolgar, *Laboratory Life*, pp. 105–150, esp. pp. 108–112.

always has borders peopled by other statements,"⁷⁰ and it is important for us to keep in mind the provisional and consensual nature of this US AIDS research agenda, each area of which exists within a heavily populated social, cultural, and ideological territory. Consider the hypothesis that AIDS originated in Africa, for example (a view supported by the research of Gallo's colleague Myron Essex, whose African viruses are genetically similar to the virus Gallo's lab identified). Not surprisingly, some "geographic buck-passing" took place among the African countries themselves (Rwanda and Zambia say AIDS originated in Zaire, Uganda says it came from Tanzania, and so on). Beneath such public maneuvering, however, many Africans privately believe AIDS may have originated somewhere else. And, despite Gallo's assertion that he cannot "conceive of AIDS coming from elsewhere into Africa," the view is by no means universal, especially among non-US researchers.⁷¹ Further, Americans refuse to acknowledge the possibility that exports of American blood products may have spread the disease to people elsewhere. In the Soviet Union, AIDS is considered a "foreign problem," attributable to the CIA or to tribes in Central Africa.⁷² In the Caribbean, and even within the US, AIDS is widely believed to come from US biological testing.⁷³ The French first believed AIDS was introduced by way of an "American pollutant," probably contaminated amyl nitrate (they also believed AIDS came from Morocco).⁷⁴ The Soviet Union, Israel, Africa, Haiti, and the US Armed Forces deny the existence of indigenous homosexuality and thus claim that AIDS must always have originated "elsewhere."⁷⁵

By 1986, five years after the initial article in the *Morbidity and Mortality Weekly Report*, a Human Retrovirus Subcommittee empowered by the International Committee on the Taxonomy of Viruses was at work "to propose an appropriate name for the retrovirus isolates recently implicated as the causative agents of the acquired immune deficiency syndrome (AIDS)" — to consider, that is, what "the AIDS virus" should officially be named. After more than a year of deliberation, the nomenclature subcommittee published its recommendations in the form of a letter to scientific journals.⁷⁶ Their task has been made crucial, they note, by the widespread interest in AIDS and the multiplicity of names now in use:

70. Michel Foucault, *The Archaeology of Knowledge*, trans. A. M. Sheridan Smith, New York, Pantheon, 1972, p. 97.

71. African data are reviewed in L. Altman, "Linking AIDS to Africa," p. 8.

72. Lee, "AIDS in Moscow."

73. See Rechy, "An Exchange on AIDS."

74. Leibowitch documents French views in *A Strange Virus*.

75. For a fuller analysis of the theory and politics of these origin and alibi stories, see Patton, *Sex and Germs*; Weeks, *Sexuality and Its Discontents*; D. Altman, *AIDS in the Mind of America*; Ann Guidici Fettnr and William Check, *The Truth About AIDS: Evolution of an Epidemic*, New York, Holt, Rinehart & Winston, 1985; and Leibowitch, *A Strange Virus*.

76. The letter appeared in *Science*, no. 232, (May 9, 1986), p. 697.

LAV:	lymphadenopathy-associated virus (1983 — Montagnier, Pasteur)
HTLV-III:	human T-cell lymphotropic virus type III (1984 — Gallo, NCI)
IDAV:	immunodeficiency-associated virus
ARV:	AIDS-associated retrovirus (1984 — Levy, UCSF)
HTLV-III/LAV and LAV/HTLV-III:	compound names used to keep peace (the CDC's use was perhaps a reprimand to the NCI for its perceived uncooperativeness in sharing data)
AIDS virus:	popular press

The subcommittee proposes HIV, “human immunodeficiency viruses.” They reason that this conforms to the nomenclature of other viruses in which the first slot signals the host species (human), the second slot the major pathogenic property (immunodeficiency), and the last slot *V* for virus. (For some viruses, though not HIV, individual strains are distinguished by the initials of the thus “immortalized” patient from whom they originally came and in whose “daughter cells” they are perpetuated.) The multiple names of “the AIDS virus” point toward a succession of identities and offer a fragmented sense indeed of what this virus, or family of viruses, “really” is. The new name, in contrast, promises to unify the political fragmentations of the scientific establishment and to certify the health of the single-virus hypothesis. The subcommittee argues in favor of its proposed name that it does not incorporate the term AIDS, on the advice of many clinicians; it is distinct from all existing names and “has been chosen without regard to priority of discovery” (not insignificantly, Montagnier and Levy signed the subcommittee letter but Gallo and Essex did not); and it distinguishes the HI viruses from those with distinctly different biological properties, for example, the HTLV line (HTLV-I and HTLV-II), which this subcommittee calls “human t-cell leukemia viruses,” perhaps to chastise Gallo for changing the *L* in the nomenclature of the HTLVs from *leukemia* to *lymphotropic* so that HTLV-III (the AIDS virus) would appear to fit generically into the same series (and bear the stamp of his lab). In the same issue of *Science*, the editors chose to discuss this letter in their “News and Comment” column: “Disputes over viral nomenclature do not ordinarily command much attention beyond the individuals immediately involved in the fray”; but the current dissension, part of the continuing controversy over who should get credit for discovering the virus, “could provide 6 months of scripts for the television series ‘Dallas.’”⁷⁷

Why such struggles over naming and interpretation? Because, as the *Science*

77. Jean L. Marx, “AIDS Virus Has New Name — Perhaps,” News and Comment, *Science*, no. 232 (May 9, 1986), pp. 699–700.



The dispute over nomenclature of “the AIDS virus,” called LAV by Luc Montagnier and HTLV-III by Robert Gallo, led to the international adoption in May 1986 of a new name—HIV; in April 1987, Prime Minister Chirac and President Reagan met to announce an agreement for shared paternity of the virus. (Photo: José R. Lopez.)

editors point out, there are high stakes where this performance is concerned—not only patent rights to the lucrative test kits for the “AIDS virus” (Gallo fears that loss of the HTLV-III designation will weaken his claims) but the future and honor of immunology. Modern immunology, as Donna Haraway observes, moved into the realm of high science when it reworked the military combat metaphors of World War II (battles, struggle, territory, enemy, truces) into the language of postmodern warfare: communication command control—coding, transmission, messages—interceptions, spies, lies.⁷⁸ Scientific descriptions for general readers, like this one from the *National Geographic* article on the immune system, accentuate this shift from combat to code:

Many of these enemies [of the body, or self] have evolved devious methods to escape detection. The viruses that cause influenza and the common cold, for example, constantly mutate, changing their fingerprints. The AIDS virus, most insidious of all, employs a range of strategies, including hiding out in healthy cells. What makes it fatal is its ability to invade and kill helper T cells, thereby short-circuiting the entire immune response.⁷⁹

No ground troops here, no combat, not even generals: we see here the evolution of a conception of the “AIDS virus” as a top-flight secret agent—a James Bond of secret agents, armed with “a range of strategies” and licensed to kill. “Like Greeks hidden inside the Trojan horse,” 007 enters the body concealed inside a helper T-cell from an infected host;⁸⁰ but “the virus is not an innocent passenger in the body of its victims”:⁸¹

In the invaded victim, helper T’s immediately detect the foreign T cell. But as the two T’s meet, the virus slips through the cell membrane into the defending cell. Before the defending T cell can mobilize the troops, the virus disables it. . . . Once inside an inactive T cell, the virus may lie dormant for months, even years. Then, perhaps when another, unrelated infection triggers the invaded T cells to divide, the AIDS virus also begins to multiply. One by one, its clones emerge to infect nearby T cells. Slowly but inexorably the body loses the very sentinels that should be alerting the rest of the immune

78. Donna J. Haraway, “The Biological Enterprise: Sex, Mind, and Profit from Human Engineering to Sociobiology,” *Radical History Review*, no. 20 (Spring–Summer 1979), pp. 206–237, and “A Manifesto for Cyborgs: Science, Technology, and Socialist Feminism in the 1980s,” *Socialist Review*, no. 80 (March–April 1985), pp. 65–108.

79. Jaret, “Our Immune System,” p. 709.

80. *Ibid.*, p. 723; and see D. J. Anderson and E. J. Yunis, “‘Trojan Horse’ Leukocytes in AIDS,” *New England Journal of Medicine*, no. 309 (1983), pp. 984–985.

81. Krim, “AIDS: The Challenge to Science and Medicine.”

system. Phagocytes and killer cells receive no call to arms. B cells are not alerted to produce antibodies. The enemy can run free.⁸²

But on no mundane battlefield. The January 1987 *Scientific American* column "Science and the Citizen" warns of the mutability—the "protean nature of the AIDS virus"—that will make very difficult the development of a vaccine, as well as the perfect screening of blood. "It is also possible," the column concludes, "that a more virulent strain could emerge"; even now "the envelope of the virus seems to be changing."⁸³ Clearly, 007 is a spy's spy, capable of any deception: evading the "fluid patrol officers" is child's play. Indeed, it is so shifting and uncertain we might even acknowledge our own historical moment more specifically by giving the AIDS virus a postmodern identity: a terrorist's terrorist, an Abu Nidal of viruses.⁸⁴

So long as AIDS was seen as a battle for the body of the gay male—a battle linked to "sociological" factors at that—the biomedical establishment was not tremendously interested in it. The first professionals involved tended to be clinicians in the large urban hospitals where men with AIDS first turned up, epidemiologists (AIDS, writes Black, is an "epidemiologist's dream"; a mystery disease that is fatal),⁸⁵ and scientists and clinicians who were gay themselves. Although from the beginning some saw the theoretical implications of AIDS, the possibility that AIDS was "merely" some unanticipated side-effect of gay male sexual practices (about which, as I've noted above, there was considerable ignorance) limited its appeal for basic scientists. But with the discovery that the agent associated with AIDS appeared to be a virus—indeed, a *novel retrovirus*—what

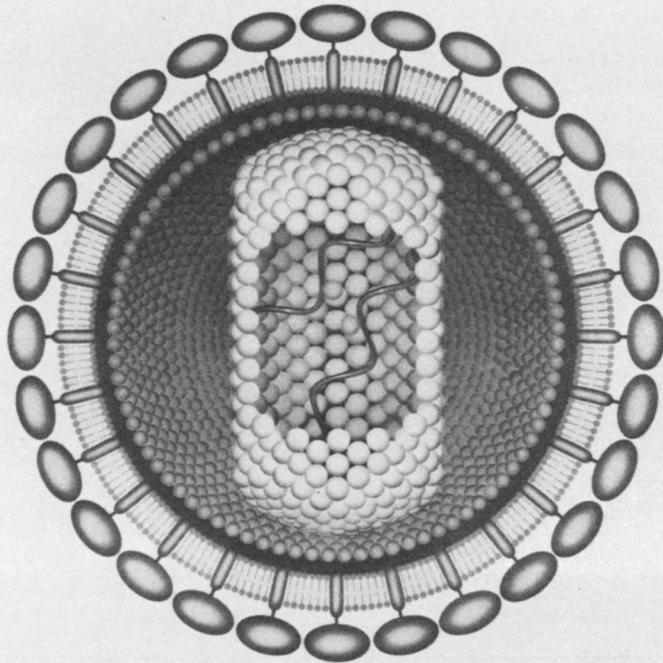
82. Jaret, "Our Immune System," pp. 723–724.

83. "Science and the Citizen," pp. 58–59.

84. Leibowitch, in *A Strange Virus*, describes the scientific effort to identify the AIDS virus as a "medico-biological Interpol" on the trail of an international "criminal" charged with "breaking and entering" (pp. 41–42), and asks "Who is HTLV?" (p. 48). Mervyn B. Silverman, describing the mechanism of AIDS transmission at the Congressional AIDS hearing in 1983, testified in comparable language that "many believe that the virus does not act alone" ("AIDS Hearing," p. 125). In an article on a related finding in immunological research, Jos Van ("Cell Researchers Aim to Flush Out Body's Terrorists," *Chicago Tribune*, October 5, 1986) refers to cells called "free radicals," which serve as the body's "terrorists." A *Consumer Reports* article entitled "AIDS: Deadly but Hard to Catch" inadvertently invokes the structural ambiguity of "catching" the virus (who is the catcher, who is the catchee?). The policing metaphor (and the connection between *policy* and *police* has not gone unnoticed) carries over to efforts to control the spread of the virus. Lieberman ("The Reality of AIDS," p. 47) reports that some gay clubs have created "fluid patrol officers" who try to ensure that no "unsafe sex" takes place. Mohr argues that such attempts to promote "safe" sexual behavior, like recommendations for celibacy, seem "remote from reality and quite oblivious to the cursedness of sex and culture." Further, Mohr argues, "though in midcrisis it is politically injudicious to say so, safe-sex is poor sex" ("Of Deathbeds and Quarantines," p. 52); as an epigram for his essay he quotes a former gay "reprobate," now reformed: "Who wants to suck a dick with a rubber on it?" (See also Richard Goldstein, "The New Sobriety," *Village Voice*, December 30, 1986, pp. 23–28.)

85. Black, *The Plague Years*.

SCIENTIFIC AMERICAN



THE AIDS VIRUS



January 1987

Virus as grenade. In the cover article for Scientific American by Robert Gallo, AIDS is inevitably a story of his own "discovery" of what he called "the HTLV-III virus." The stylized graphic encourages us to see the virus as a perfect inorganic military mechanism, primed for detonation.

had seemed predominantly a public health phenomenon (clinical and service-oriented) suddenly could be rewritten in terms of high theory and high science. The performance moved from off-off Broadway to the heart of the theater district and the price of the tickets went way up. Among other things, identifying the viral agent made possible the development of a “definitive test” for its presence; not only did this open new scientific avenues (for example, in enabling researchers to map precise relationships among diverse AIDS and AIDS-like clinical manifestations), it also created opportunities for monetary rewards (for example, in revenue from patents on the testing kits). For these reasons, AIDS research became a highly competitive professional field.⁸⁶ Less-established assistant professors who had been working on the AIDS problem out of commitment suddenly found senior scientists peering at their data, while in the public arena the triumphs of pure basic science research were proclaimed. “Biomedical science is going brilliantly well,” was how Dr. June Osborn summarized AIDS progress in mid-1986.⁸⁷ “Indeed,” writes one science reporter, “had AIDS struck 20 years ago, we would have been utterly baffled by it.”⁸⁸ Ten years ago we had not even confirmed the *existence* of human retroviruses, notes *Scientific American*. Asked whether NCI’s strategy of focusing exclusively on retrovirus research was appropriate (considering that it might not have paid off), an official said this wouldn’t have mattered: basic retroviral research was NCI’s priority in any case.⁸⁹ Because it *did* pay off, it can now be said (as it could not have been said before 1984) that “AIDS may be a disease that has arrived at the right time.”⁹⁰ In the words of one biomedical scientist, we face “an impending Armageddon of AIDS, and the salvation of the world through molecular genetics.”⁹¹

86. For discussion and analysis of the growing competition in AIDS research as the funding increased, see D. Altman, *AIDS in the Mind of America*; Black, *The Plague Years*; Patton, *Sex and Germs*; Panem, “AIDS: Public Policy and Biomedical Research”; Schwartz, “AIDS in the Media”; Office of Technology Assessment, *Review; Hastings Center Report*, Special Supplements. For an account of the case of French physician Willy Rozenbaum, see Paul Raeburn, “Doctor Faces Politics of AIDS Research,” *Champaign-Urbana News-Gazette*, January 25, 1986, p. A-8.

87. Cited in Eckholm, “Broad Alert on AIDS,” p. 19.

88. Jaret, “Our Immune System,” p. 23.

89. Panem, “AIDS: Public Policy and Biomedical Research,” p. 25.

90. “Science and the Citizen,” p. 59.

91. Quoted in Morton Hunt, “Teaming Up against AIDS,” *New York Times Magazine*, March 2, 1986, p. 78. Despite whatever criticisms biomedical scientists may have had about AIDS research, an ideology of heroism, progress, and faith in ultimate scientific conquest pervades discussions. Examples include Choi, “Assembling the AIDS Puzzle”; Relman, “Introduction”; Gallo, “The AIDS Virus”; Donald S. Frederickson, “Where Do We Go from Here?” in *The AIDS Epidemic*, ed. Kevin M. Cahill, New York, St. Martin’s Press, 1983, pp. 151–161; Donald P. Francis, “The Search for the Cause,” in *The AIDS Epidemic*; American Medical Association Council on Scientific Affairs, “The Acquired Immunodeficiency Syndrome: Commentary,” *Journal of the American Medical Association*, vol. 252, no. 15 (October 19, 1984), pp. 2037–2043; Sheldon H. Landesman, Harold M. Ginzburg, and Stanley H. Weiss, “The AIDS Epidemic,” *New England Journal of Medicine*, vol. 312, no. 8 (February 21, 1985), pp. 521–525; and Merle A. Sande, “Transmission of AIDS: The Case against Casual Contagion,” *New England Journal of Medicine*, vol. 314, no. 6 (February 6, 1986), pp. 380–382. Sonnabend (“Looking at AIDS in Totality”) criticizes the assumptions of heroic science,

Reconstructing the AIDS Text: Rewriting the Body

There is now broad consensus that AIDS—“plague of the millennium,” “health disaster of pandemic proportions”—is the greatest public health problem of our era.⁹² The epidemic of signification that surrounds AIDS is neither simple nor under control. AIDS exists at a point where many entrenched narratives intersect, each with its own problematic and context in which AIDS acquires meaning. It is extremely difficult to resist the lure, familiarity, and ubiquitousness of these discourses. The AIDS virus enters the cell and integrates with its genetic code, establishing a disinformation campaign at the highest level and ensuring that replication and dissemination will be systemic. We inherit a series of discursive dichotomies; the discourse of AIDS attaches itself to these other systems of difference and plays itself out there:

self and not-self

the one and the other

homosexual and heterosexual

while Leibowitch (*A Strange Virus*) is distinctive in his irony and political self-consciousness about the nature of the scientific enterprise.

92. As of December 1986, ten million people were estimated to carry the virus worldwide; at least a quarter of these people are expected to develop AIDS within the next five years and many more to develop illnesses ranging from mildly disabling to lethal. By the end of 1986, almost 30,000 people in the US had been diagnosed with AIDS, and half of them had already died. The number of diagnosed cases is expected to reach 270,000 by the end of 1991, with a cumulative death toll of 179,000. There will be a heavy financial toll. With repeated hospitalizations, a person with AIDS may have medical costs of up to \$500,000. The cases of AIDS diagnosed in 1986 alone will eventually cost the nation \$2.25 billion in health care costs and \$7 billion in lost lifetime earnings. Its expenses are seventy-five times what we are currently spending on it. (Costs vary greatly from city to city: the CDC estimated in 1986 that each case would average \$147,000; the US Army estimated that a case could cost as much as \$500,000 to treat; but in San Francisco, use of nonphysician caretakers, home care, and nursing home services can bring the cost of a comparable case down to \$42,000. See “AIDS Hearing”; Patton, *Sex and Germs*; D. Altman, *AIDS in the Mind of America*; David L. Wheeler, “More Research Is Urged in Fight against AIDS,” *Chronicle of Higher Education*, November 5, 1986, pp. 7, 10; and David Tuller, “Trying to Avoid an Insurance Debacle,” *New York Times*, February 22, 1987, sec. 3, pp. 1, 8, for discussion of the politics of AIDS funding. The National Academy of Sciences Report [Baltimore and Wolff, *Confronting AIDS*] judges recent federal allocations to be “greatly improved” but still “woefully inadequate” and calls for spending \$2 billion per year by 1990 for education and the development of drugs and vaccines.) See American Medical Association Council on Scientific Affairs, “Commentary,” Centers for Disease Control, “Update”; Edward S. Johnson and Jeffrey Vieira, “Cause of AIDS: Etiology,” in *AIDS: Facts and Issues*, ed. Victor Gong and Norman Rudnick, New Brunswick, New Jersey, Rutgers University Press, 1986, pp. 25–33; Redfield *et al.*, “Heterosexually Acquired HTLV-III/LAV,” and “Female-to-Male Transmission”; Katie Leishman, “Two Million Americans and Still Counting,” review of Black, *The Plague Years*, and Nichols, *Mobilizing Against AIDS*, *New York Times Book Review*, July 27, 1986, p. 12; Gong and Rudnick, eds., *AIDS: Facts and Issues*; and Warren Winkelstein, Jr., *et al.*, “Sexual Practices and Risk of Infection by the Human Immunodeficiency Virus: The San Francisco Men’s Health Study,” *Journal of the American Medical Association*, vol. 257, no. 3 (January 16, 1987), pp. 321–325, for predictions based on current distribution of HIV antibodies.

homosexual and “the general population”
 active and passive, guilty and innocent, perpetrator and victim
 vice and virtue, us and them, anus and vagina
 sins of the parent and innocence of the child
 love and death, sex and death, sex and money, death and money
 science and not-science, knowledge and ignorance
 doctor and patient, expert and patient, doctor and expert
 addiction and abstention, contamination and cleanliness
 contagion and containment, life and death
 injection and reception, instrument and receptacle
 normal and abnormal, natural and alien
 prostitute and paragon, whore and wife
 safe sex and bad sex, safe sex and good sex
 First World and Third World, free world and iron curtain
 capitalists and communists
 certainty and uncertainty
 virus and victim, guest and host

As Christine Brooke-Rose demonstrates, one must pay close attention to the way in which these apparently fundamental and natural semantic oppositions are put to work.⁹³ What is self and what is not-self? Who wears the white and who the black hat? (Or, in her discussion, perhaps, who wears the pants and who the skirt?) As Bryan Turner observes with regard to sexually transmitted diseases in general, the diseased are seen not as “victims” but as “agents” of biological disaster. If Koch’s postulates must be fulfilled to identify a given microbe with a given disease, perhaps it would be helpful, in rewriting the AIDS text, to take “Turner’s postulates” into account: (1) disease is a language; (2) the body is a representation; and (3) medicine is a political practice.⁹⁴

93. Christine Brooke-Rose, “Woman as a Semiotic Object,” in *The Female Body in Western Culture: Contemporary Perspectives*, ed. Susan Rubin Suleiman, Cambridge, Massachusetts, Harvard University Press, 1986, pp. 305–316. See also Teresa de Lauretis, *Alice Doesn’t: Feminism, Semiotics, Cinema*, Bloomington, Indiana University Press, 1984.

94. Bryan A. Turner, *The Body and Society*, New York, Basil Blackwell, 1984, pp. 221, 209.

There is little doubt that for some people the AIDS crisis lends force to their fear and hatred of gays; AIDS appears, for example, to be a significant factor in the increasing violence against them, and other homophobic acts in the US.⁹⁵ But to talk of “homophobia” as though it were a simple and rather easily recognized phenomenon is impossible. When we review the various conceptions of the gay male body produced within scientific research by the signifier *AIDS*, we find a discourse rich in signification as to what AIDS “means.” At first, some scientists doubted that AIDS could be an infectious disease because they could not imagine what gay men could do to each other to transmit infection. But intimate knowledge generated quite different conceptions:

AIDS is caused by multiple and violent gay sexual encounters: exposure to countless infections and pathogenic agents overwhelms the immune system.

AIDS is caused by killer sperm, shooting from one man’s penis to the anus of another.

Gay men are as sexually driven as alcoholics or drug addicts.

AIDS cannot infect females because the virus can’t penetrate the tough mucous membranes of the vagina.

Women cannot transmit AIDS because their bodies do not have the strong projectile capacity of a penis or syringe.

Prostitutes can transmit the virus because their contaminated bodies harbor massive quantities of killer microbes.

Repeated hints that the male body is sexually potent and adventurous suggest that homophobia in biomedical discourse might play out as a literal “fear of the same.” The text constructed around the gay male body—the epidemic of signification so evident in the conceptions cited above and elsewhere in this essay—is driven in part by the need for constant flight from sites of potential identity and thus the successive construction of new oppositions that will barricade self from not-self. The homophobic meanings associated with AIDS continue to be layered into existing discourse: analysis demonstrates ways in which the AIDS virus is linguistically identified with those it strikes: the penis is “fragile,” the urethra is “fragile,” the virus is “fragile”; the African woman’s body is “exotic,” the virus is “exotic.” The virus “penetrates” its victims; a carrier of

95. William R. Greer, “Violence against Homosexuals Rising, Groups Say in Seeking Protections,” *New York Times*, November 23, 1986, p. 15.

death, it wears an “innocent” disguise. AIDS is “caused” by homosexuals; AIDS is “caused” by a virus. Homosexuality exists on a border between male and female, the virus between life and nonlife. This cross-cannibalization of language is unsurprising. What greater relief than to find a final refuge from the specter of gay sexuality where the language that has obsessively accumulated around the body can attach to its substitute: the virus. This is a signifier that can be embraced forever.

The question is how to disrupt and renegotiate the powerful cultural narratives surrounding AIDS. Homophobia is inscribed within other discourses at a high level, and it is at a high level that they must be interrupted and challenged. Why? The following scenario for Armageddon (believed by some, desired by many) makes clear why: AIDS will remain confined to the original high-risk groups (primarily gay males and IV drug users) because of their specific practices (like anal intercourse and sharing needles). At the Paris International AIDS Conference in June 1986, the ultimate spread of the disease was posed in terms of “containment” and “saturation.” “Only” gay males and drug addicts will get infected—the virus will use them up and then have nowhere to go—the “general population” (who are also in epidemiological parlance a “virgin” population) will remain untouched. Even if this view is correct (which seems doubtful, given growing evidence of transmission through plain old everyday heterosexual intercourse), and the virus stops spreading once it has “saturated” the high-risk population, we would still be talking about a significant number of US citizens: 2.5 million gay men, 7 million additional men who have at some time in the last ten years engaged in homosexual activity, 750,000 habitual IV drug users, 750,000 occasional drug users, 10,000 hemophiliacs already infected, the sex partners of these people and the children of infected women—in other words, a total of more than 10 million people (the figures are from the June 1986 Paris conference). And “saturation” is currently considered a *best-case* scenario by the public health authorities.

The fact is that any separation of not-self (“AIDS victims”) from self (the “general population”) is no longer possible. The US Surgeon General and National Academy reports make clear that “that security blanket has now been stripped away.”⁹⁶ Yet the familiar signifying practices that exercise control over meaning continue. The *Scientific American* column goes on to note fears that the one-to-one African ratio of females with AIDS to males may foreshadow US statistics: “Experts point out, however, that such factors as the prevalence of other venereal diseases that cause genital sores, the use of unsterilized needles in clinics, and the lack of blood-screening tests may explain the different epidemiology of AIDS in Africa.”⁹⁷ Thus the African data are reinterpreted to reinstate

96. “Science and the Citizen,” p. 58.

97. *Ibid.*, p. 59.

the “us”/“them” dichotomy and project a rosier scenario for “us” (well, maybe it improves on comic Richard Belzer’s narrative: “A monkey bites some guy on the ass in Africa and *he* balls some guy in Haiti and now we’re all gonna fuckin’ die. THANKS A LOT!”).⁹⁸

Meanwhile on the home front monogamy is coming back into its own, along with abstinence, the safest sex of all. The virus in itself—by whatever name—has come to represent the moment of truth for the sexual revolution: as though God has once again sent his only beloved son to save us from our high-risk behavior. Who would have thought He would take the form of a virus: a viral Terminator ready to die for our sins.⁹⁹

The contestations pioneered by the gay community over the past decade offer models for resistance. As old-fashioned morality increasingly infects the twentieth-century scenario, whether masquerading as “preventive health” or spiritual transformation, a new sampler can be stitched to hang on the bedroom wall: BETTER WED THAN DEAD. “It’s just like the fifties,” complains a gay man in San Francisco. “People are getting married again for all the wrong reasons.”¹⁰⁰ One disruption of this narrative occurs in the San Francisco *A.I.D.S. Show*: “I like sex; I like to get drunk and smoke grass and use poppers and sleep with strangers:

98. Though Lieberson insists that a “heterosexual pandemic [comparable to Africa’s] has not occurred in the United States” and criticizes those who suggest it is going to (“The Reality of AIDS,” p. 44), current data based on tests for antibodies to HIV among 1986 army recruits (nongay, non-drug-using, so far as researchers could determine) argue for increasing heterosexual transmission (Redfield, *et al.*, “Female to Male Transmission”). For discussion and analysis, see L. Altman, “Heterosexuals and AIDS”; D. Altman, *AIDS in the Mind of America*; Marx, “New Relatives of AIDS Virus Found”; Osborn, “The AIDS Epidemic”; Patton, *Sex and Germs*; Hosken, “Why AIDS Pattern Is Different in Africa”; Feldman, “Role of African Mutilations in AIDS Discounted”; and Robert Pear, “Ten-Fold Increase in AIDS Death Toll Is Expected by ’91,” *New York Times*, June 13, 1986, pp. A-1, A-17. See also Potterat, *et al.*, “Lying to Military Physicians.” It has been suggested that malnutrition plays an important role in the rapid spread of AIDS in Africa (worldwide, malnutrition is the most common cause of acquired immune deficiency).

99. We must even, perhaps, identify with the virus, an extraordinarily successful structure that has been comfortably making the acquaintance of living organisms for many more millions of years than we have. A virus that enters the human bloodstream and circulates through the body may ultimately negotiate with the host some mutually livable equilibrium. The relationship may be a close one: it is difficult to separate the effects of the virus from those of the body’s defenses; and any poison intended for the guest may kill the host as well. Any given species, including human beings, may sometimes prove to be an inhospitable, even unnatural host. To speak teleologically for a moment, it is obvious that to kill the host is not in the microorganism’s best interests; this sometimes happens, however, when a virus adapted to a nonhuman host shifts, through some untoward turn of events, to the human body. For the human immunodeficiency virus, believed to be a relative newcomer on earth (the presence of antibodies in stored blood now goes back to 1959 samples collected in Africa, to 1973 in US blood) and to have first inhabited African monkeys, we might have turned out to be inhospitable. But though from our perspective the virus is indeed virulent, killing quickly, in fact the long latency between infection and the appearance of clinical damage provides plenty of time—often years—for the virus to replicate and infect a new host. For the time being we are sufficiently hospitable for this virus to live off us relatively “successfully”; if mutation occurs, our relationship to the AIDS virus could evolve into something relatively benign or mutually disastrous.

100. FitzGerald, *Cities on a Hill*, p. 115.

Call me old-fashioned, but that's what I like!" A gay pastor in San Francisco tells Frances FitzGerald that the moral transformation being forced upon the gay community reminds him of the days before Stonewall: "If I had to go back to living in the closet, I'd have to think very clearly about whether or not I'd rather be dead."¹⁰¹ For Michel Foucault, the "tragedy" of AIDS was not intrinsically its lethal character, but rather that a group that has risked so much—gays—are looking to standard authorities—doctors, the church—for guidance in a time of crisis. "How can I be scared of AIDS when I could die in a car?" Foucault asked a year or so before he died. "If sex with a boy gives me pleasure. . . ." And he added: "Don't cry for me if I die."¹⁰²

For AIDS, where meanings are overwhelming in their sheer volume and often explicitly linked to extreme political agendas, we do not know whose meanings will become "the official story." We need an epidemiology of signification—a comprehensive mapping and analysis of these multiple meanings—to form the basis for an official definition that will in turn constitute the policies, regulations, rules, and practices that will govern our behavior for some time to come. As we have seen, these may rest upon "facts," which in turn may rest upon the deeply entrenched cultural narratives I have been describing. For this reason, what AIDS signifies must be democratically determined: we cannot afford to let scientists or any other group of "experts" dismiss our meanings as "misconceptions" and our alternative views as noise that interferes with the pure processes of scientific inquiry. Rather, we need to insist that many voices contribute to the construction of official definitions—and specifically certain voices that need urgently to be heard. Although the signification process for AIDS is by now very broad—just about everyone, seemingly, has offered "readings" of what AIDS means—one excluded group continues to be users of illegal intravenous drugs. Caught between the "first wave" (gay men) and the "second wave" (heterosexuals), drug users at high risk for AIDS remain silent and invisible. One public health official recently challenged the rush to educate heterosexuals about their risk when what is needed (and has been from the beginning) is "a massive effort directed at intravenous-drug abusers and their sex partners. This means treatment for a disease—chemical dependence on drugs. We have to prevent and treat one disease, drug addiction, to prevent another, AIDS."¹⁰³

101. *Ibid.*, p. 104.

102. Philip Horvitz, "Don't Cry for Me, Academia," Interview with Michel Foucault, *Jimmy and Lucy's House of K* (Berkeley), no. 2 (August 1985), pp. 78–80. This interview, conducted in Berkeley (and scrutinized, it's said, like the Watergate transcripts, to find out what did he know and when did he know it), concludes as Foucault enters the BART station: "Good luck," he tells Horvitz. "And don't be scared!"

103. See also Barrett, "Straight Shooters"; Stephen C. Joseph, "Intravenous-Drug Abuse Is the Front Line in the War on AIDS," Letter to the Editor, *New York Times*, December 22, 1986, p. 18. Though Check writes that "it sometimes appears that the only risk group that hasn't raised a ruckus

If AIDS's dual life as both a material and linguistic entity is important, the emphasis on *dual* is critical. Symbolic and social reconceptualizations of AIDS are necessary but not sufficient to address the massive social questions AIDS raises. The recognition that AIDS is heterosexually as well as homosexually transmitted certainly represents progress, but it does not interrupt fantasy. It is fantasy, for example, to believe that "safer sex" will protect us from AIDS; it may save us from becoming infected with the virus—New York City has instituted Singles Night at the Blood Bank, where people can meet and share their seropositivity status before they even exchange names.¹⁰⁴ But AIDS is to be a fundamental force of twentieth-century life, and no barrier in the world can make us "safe" from its complex material realities. Malnutrition, poverty, and hunger are unacceptable, in our own country and in the rest of the world; the need for universal health care is urgent. Ultimately, we cannot distinguish self from not-self: for "plague is life," and each of us has the plague within us; "no one, no one on earth is free from it."¹⁰⁵

The discursive structures I have discussed in this essay are familiar to those of us in "the human sciences." We have learned that there is a disjunction between historical subjects and constructed scientific objects. There is still debate about whether, or to what extent, scientific discourse can be privileged—and relied upon to transcend contradiction. My own view is unequivocal: it cannot be privileged in this way. Of course, where AIDS is concerned, science can usefully perform its interpretive part: we can learn to live—indeed, *must* learn to live—as though there are such things as viruses. The virus—a constructed scientific object—is also a historical subject, a "human immunodeficiency virus," a real source of illness and death that can be passed from one person to another under certain conditions that we can apparently—individually and collectively—influence. The trick is to learn to live with this disjunction, but the lesson is imperative. Dr. Rieux, the physician-narrator of Camus's novel, acknowledges that by dealing medically with the plague he is allowing himself the luxury of "living in a world of abstractions." But not indefinitely; for "when abstraction sets to killing you, you've got to get busy with it."

But getting busy with it may require us to relinquish some luxuries of our own: the luxury of accepting without reflection the "findings" science seems

is the IV drug users, who are not organized" ("Public Education on AIDS," p. 28), a few commentators are beginning to draw attention to this critical problem: Barrett, "Straight Shooters"; Joseph, "Intravenous Drug Abuse"; Shaw and Paleo, "Women and AIDS"; Peg Byron, "Women with AIDS: Untold Stories," *Village Voice*, September 24, 1985, pp. 16–19; and Francis X. Clines, "Via Addicts' Needles, AIDS Spreads in Edinburgh," *New York Times*, January 4, 1987, p. 8. In the last year, the Gay Men's Health Crisis in New York, aware that many drug users may avoid information centers as well as medical authorities, has taken responsibility for going to "shooting galleries," clinics, and drug treatment centers to provide AIDS education and training to these people so that they can in turn work with other drug users.

104. "A 'Social Card' to Reassure Sex Partners," *San Francisco Chronicle*, October 17, 1985, p. 30.

105. Camus, *The Plague*, p. 229.

effortlessly able to provide us, the luxury of avoiding vigilance, the luxury of hoping it will all go away. Rather, we need to use what science gives us in ways that are selective, self-conscious, and pragmatic (“as though” they were true). We need to understand that AIDS is and will remain a provisional and deeply problematic signifier. Above all, we need to resist, at all costs, the luxury of listening to the thousands of language tapes playing in our heads, laden with prior discourse, that tell us with compelling certainty and dizzying contradiction what AIDS “really” means.