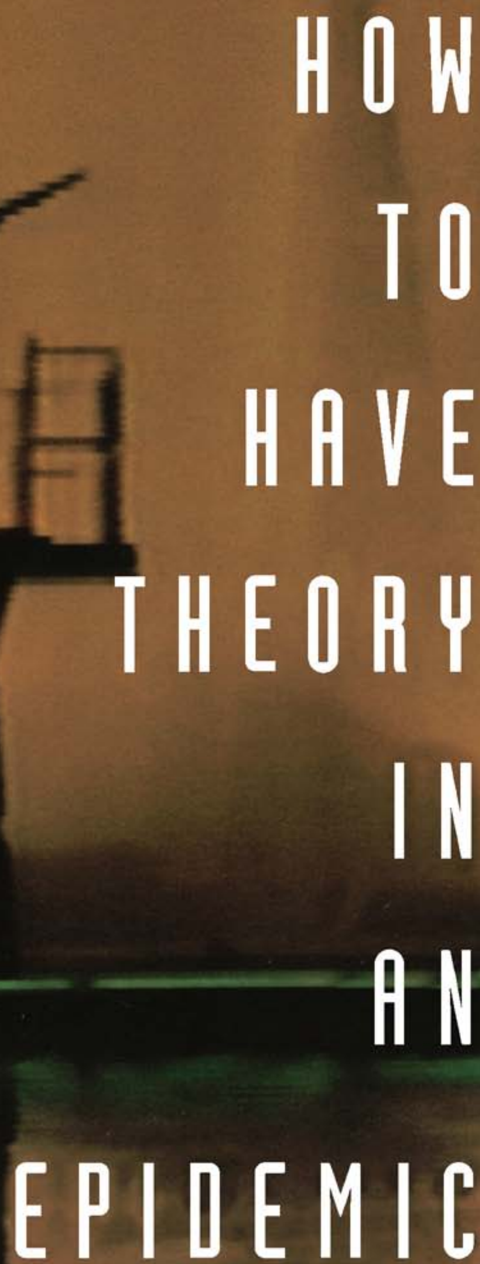
HOW TO HAVE THEORY IN AN EPIDEMIC

CULTURAL CHRONICLES OF AIDS



PAULA A. TREICHLER

How to Have Theory in an Epidemic

How to Have Theory in an Epidemic

Cultural Chronicles of AIDS

Paula A. Treichler

DUKE UNIVERSITY PRESS *Durham and London 1999*

2nd printing, 2004
© 1999 Duke University Press
All rights reserved
Printed in the United States of America on acid-free paper ∞
Typeset in Trump Mediaeval by Keystone Typesetting, Inc.
Library of Congress Cataloging-in-Publication Data appear
on the last printed page of this book.

For Cary,
the one and only—
my one and only

Contents

Acknowledgments ix

A Note on the Text xiii

Prologue 1

1 AIDS, Homophobia, and Biomedical Discourse: An Epidemic of Signification 11

2 The Burdens of History: Gender and Representation in AIDS Discourse, 1981–1988 42

3 AIDS and HIV Infection in the Third World: A First World Chronicle 99

4 Seduced and Terrorized: AIDS in the Media 127

5 AIDS, HIV, and the Cultural Construction of Reality 149

6 AIDS Narratives on Television: Whose Story? 176

7 AIDS, Africa, and Cultural Theory 205

8 Beyond *Cosmo*: AIDS, Identity, and Inscriptions of Gender 235

9 How to Have Theory in an Epidemic: The Evolution of AIDS, Treatment, and Activism 278

Epilogue 315

Notes 331

Bibliography 387

Index 453

Acknowledgments

Acknowledgment must first be made to those whom AIDS/HIV has infected or killed; like those who continue to fight the epidemic every day, their courage is amazing and their examples inspiring.

Research for this project has been supported in part by grants from the National Council of Teachers of English and the University of Illinois at Urbana-Champaign Graduate College Research Board. Throughout its evolution, this work has also been supported in countless ways, both intellectual and material, by the academic units at the University of Illinois to which I have the good fortune to belong: the College of Medicine at Urbana-Champaign, the Institute of Communications Research, the Women's Studies Program, and the Unit for Criticism and Interpretive Theory. I am grateful to other institutions for furnishing me, at crucial points in this project, with a room of my own: the Ragdale Foundation in Lake Forest, Illinois; the Society for the Humanities at Cornell University; and the Women's Studies Program at the University of California, Santa Barbara.

Within the vast network of people committed to ending the AIDS/HIV epidemic, the following people have especially helped and inspired me: Dennis Altman, Allan M. Brandt, Douglas Crimp, Lisa Duggan, Paul Farmer, Elizabeth Fee, Jan Zita Grover, Nan Hunter, Stephanie Kane, Katie King, Emily Martin, Richard Parker, Cindy Patton, Steve Rabin, Eve Kosofsky Sedgwick, and Simon Watney. Intellectual debts to many others are reflected in the citations throughout this book.

I am indebted to many friends and colleagues for information, materials, and guidance in interpreting the cultural domains that this project spans: Kwame Anthony Appiah, Awour Ayudo, Shari Benstock, Edward Brunner, Lisa Cartwright, Wendy Dallas, Peter Ekstrom, Terry England, Faith Evans, Henry Finder, Daniel M. Fox, Francine W. Frank, Colin Garrett, Barrie Grenell, Evelynn Hammonds, Donna Haraway, Brad Hudson, Lau-

rence H. Jacobs, Ibulaimu Kakoma, Stephen J. Kaufman, Alan Klusaček, Joan Lathrop, Allan Levy, Ana Lopez, Phil Mariani, Sally McConnell-Ginet, Richard Mohr, Timothy Murphy, Dorothy Nelkin, Rick Rambuss, Roddey Reid, Sheri Scott, Esther Sleator, Thomas Spech, Sarah Stein, John Stokes, Marita Sturken, John Tagg, Willard Visek, and Charles Whitney.

My profound thanks to the work of the Unit for Criticism and Interpretive Theory, a sustaining intellectual force for so many of us at Illinois since it was founded in 1977. A special debt is owed, collectively, to my colleagues in the Unit's Faculty Criticism Seminar, which has met regularly for more than twenty years. I especially thank Kal Alston, Amanda Anderson, Michael Bérubé, Edward Bruner, Cheryl Cole, Norman Denzin, Lisa Duggan, Peter Garrett, Larry Grossberg, Janet Lyon, Sonya Michel, Meaghan Morris, Carol Neely, Cary Nelson, Constance Penley, Andrew Ross, William Schroeder, Carole Stabile, Ellen Wartella, and Richard Wheeler.

To Howard Maclay, former director of the Institute of Communications Research, who makes being smart look easy, thanks for giving me a job and being an all-round champ. To Clifford Christians, the Institute's current director, thanks for leadership and generosity above and beyond the call of administrative duty. My gratitude also to Diane Tipps for expert help in many things, to the faculty of the Institute for being terrific colleagues, and to the Institute itself for the "rigorous intellectual pluralism," as our brochure puts it, that encourages interesting interdisciplinary work.

My colleagues in the Medical Humanities and Social Sciences Program, past and present, have contributed in innumerable ways to my knowledge, work, and spirits: Daniel K. Bloomfield, Clark Cunningham, Ann Barry Flood, Diane Gottheil, Evan Melhado, Leslie Reagan, and Harold M. Swartz. So have Suzanne Poirier and Barbara Sharf in the Medical Humanities Program, University of Illinois at Chicago.

To Daniel K. Bloomfield, founder, dean, and guiding light of the medical school—yes, there is a medical school at the University of Illinois in Urbana-Champaign—thanks for hiring me, having faith in me, and supporting my work.

Through its unusual collaborations with the Urbana campus over the last two decades, the medical school has contributed to the education of a stellar company of students, physicians, and physician-scholars for whom the biomedical sciences also encompass the humanities and the social sciences. They are part of a larger community of students and graduates of Illinois who are equally committed to progressive and interdisciplinary

work. All have enriched my teaching and research in countless ways, often through their own outstanding scholarship. Thank you to Charles Acland, Martin Allor, Anne Balsamo, Lance Becker, Chloe Bird, Ernestine Briggs, Rachel Coel, Stacie Colwell, Matthew Doolittle, Anne Eckman, John Erni, Jamie Feldman, Gregory Flentje, Karen Foli, Allen Fremont, Paul Hattis, Christine Horak, Niranjan Karnik, Cris Mayo, Matthew McAllister, Daniel McGee, Robert McRuer, M. Kerry O'Banion, Karin Rhodes, Denise Roth, Marie V. Ruiz, Elisabeth Santos, Erik Stewart, Mary Vavrus, Catherine Warren, and Michael Witkovsky.

The list of graduate students and M.D.-Ph.D. students who have labored as research assistants on this project over the years is embarrassingly long, but it is certainly distinguished. Many thanks to Anne Balsamo, Theresa Conefrey, Jill Conway, Anne Eckman, Karen Ford, Matthew Hurt, Kirsten Lentz, Theresa Mangum, Robert McRuer, Shawn Miklaucic, William Murdoch, Carrie Rentschler, Maria T. Rodriguez, Denise Roth, Jay Stemmle, and Catherine Warren.

My thanks also to University of Illinois librarians John Littlewood (Documents) and Yvette Scheven (Africana) and to Phyllis Self and Victoria Pifalo (Medical Sciences Library).

Thanks to Denice Wells at the medical school for assistance in many ways over many years, including help preparing manuscripts and managing files for many drafts. For preparation of the final manuscript, I am grateful to the outstanding work of the Document Management Center at the College of Medicine and in particular to Candy Sullivan and Dianne Wickes.

To Ken Wissoker, for being everything an editor should be, my immense gratitude and thanks. Thanks also to Richard Morrison and the rest of the staff at Duke University Press.

To my dear friends Carol Neely, Sally McConnell-Ginet, and Constance Penley, with whom there will never be time enough to talk often or long enough, my deep thanks for inspiration, love, and immense help over many years for thinking through intellectual and professional challenges too numerous to count.

Finally, I come to that point where one acknowledges one's loving partner for support, sacrifice, and the patience of a saint. With wholehearted love and admiration, I give profound thanks to Cary Nelson, my longtime companion and best of friends, for unwavering support through good times and bad, professional wisdom both conceptual and practical, and true love. The less said about patience the better.

A Note on the Text

How to Have Theory in an Epidemic chronicles cultural, intellectual, and political engagements with AIDS/HIV over nearly two decades. Many chapters were originally written and published to address problems, events, or issues at particular points in the epidemic's evolution. In revising them to form a coherent intellectual narrative, I have nevertheless tried to preserve a strong sense of the occasions and imperatives that first shaped their composition. Even when material is largely new, I have tried to invoke and be true to the contemporary context of the events and issues described. Chapter 2, for example, examines evolving conceptions of gender in AIDS discourse from 1981 to 1988; although written in the mid-1990s, the chapter's critique is based less on hindsight than on the struggles surrounding knowledge and action that were taking shape throughout that first decade of crisis.

The term *AIDS* in this book refers to the AIDS epidemic as a broad social and cultural crisis; the terms *HIV disease* and *AIDS and HIV infection* are used interchangeably to mean the broad clinical spectrum of HIV-related conditions from asymptomatic infection to the specific diseases presently used to define AIDS (I use *AIDS* to mean the inclusive medical spectrum only if this sense is clear in context). I also use *AIDS/HIV* rather than *HIV/AIDS* to preserve continuity with earlier alphabetical listings.

Prologue

By the end of the 1980s, the AIDS epidemic had been invested with an abundance of meanings and metaphors. Scientists, physicians, and public health authorities argued repeatedly that AIDS represented "an epidemic of infectious disease and nothing more." This uncompromisingly medical argument, developed over the course of the twentieth century as medicine and public health wrenched themselves free of moral understandings of disease, has had value and power for the AIDS epidemic that must not be minimized. Continually eluding such containment efforts, however, the AIDS epidemic has produced a parallel epidemic of meanings, definitions, and attributions. This semantic epidemic, which I have come to call an *epidemic of signification*, has not diminished in the 1990s; it is the major subject of this book. In this prologue, I briefly sketch my argument and map for the reader the ground that I revisit in individual chapters.

The AIDS epidemic is cultural and linguistic as well as biological and biomedical. To understand the epidemic's history, address its future, and learn its lessons, we must take this assertion seriously. Moreover, it is the careful examination of language and culture that enables us, as members of intersecting social constellations, to think carefully about ideas in the midst of a crisis: to use our intelligence and critical faculties to consider theoretical problems, develop policy, and articulate long-term social needs even as we acknowledge the urgency of the AIDS crisis and try to satisfy its relentless demand for immediate action. This book documents cultural and linguistic dimensions of the AIDS epidemic and examines the tension between theory and practice as it recurs in diverse arenas. More broadly, *How to Have Theory in an Epidemic* is about the cultural evolution of the AIDS epidemic. Its subtitle, *Cultural Chronicles of AIDS*, signals its focus on the ways we have come to understand the AIDS epidemic, its interaction with culture and language, the intellectual debates and

political initiatives that the epidemic has engendered, its function as a site for competing ideologies and sites of knowledge, and its possibilities for guiding us toward a more humane and enlightened future.

This enterprise focuses on a body of linguistic data and, through time, space, and multiple cultural venues, keeps this body in view. The evolution of the AIDS epidemic has coincided with a period of attention to language. Scientists commonly point out that AIDS arrived at the "right time"—that is, a time when basic scientific research in molecular biology, virology, and immunology could provide a foundation for an intensive research effort focused on AIDS. They point out that no other epidemic disease has been analyzed so quickly or had its cause so efficiently determined. At the same time, as the British critic and AIDS activist Simon Watney has often pointed out, investigation in the human sciences provides an equally crucial foundation for the understanding of AIDS. The apparatus of contemporary critical and cultural theory prepares us to analyze AIDS in relation to questions of language, representation, interpretation, narrative, ideology, social and intellectual difference, binary division, and contests for meaning. But the AIDS epidemic does not exist to demonstrate the value of contemporary theory. If anything, it puts theory stringently to the test, serving as a useful and often dramatic corrective for inadequate theoretical formulations. Of course, to my mind, *theory* is not the constellation of texts and thinkers demonized by William Bennett et al. Nor is it the creature disdained by other anti-intellectual traditions, including U.S. medicine, for whom *theory* is defined as that which is devoid of relevance for "practice" and real-life experience. At the end of the day, *theory* is another word for *intelligence*, that is, for a thoughtful and engaged dialectic between the brain, the body, and the world that the brain and the body inhabit.

My investigation of language in a medical and cultural crisis like AIDS is thus framed by a more profound question: What should be the role of theory in an epidemic? Of all the meanings and metaphors generated by the AIDS epidemic and identified throughout this book, AIDS as a war—a long, devastating, savage, costly, expensive, and continuing war—best helps us consider this question. When we try to account for the social and cultural impact, the economic toll, the multiplicity of understandings, and the unpredictable cultural upheavals and realignments that the AIDS crisis continues to generate, the major wars of our time offer a precedent as useful as plague, polio, and other more conventional comparisons. AIDS is a war whose participants have been in the trenches for years, surrounded daily by death and dying, yet only gradually has the rest of the population

come to know that there is a war at all. To quote Simon Watney again, "for those of us living and working in the various constituencies most devastated by HIV it seems . . . as if the rest of the population were tourists, casually wandering through at the very height of a blitz of which they are totally unaware" (1994, 47).

The war metaphor also captures the dichotomy between theory and practice that marks the AIDS epidemic as well as U.S. cultural life more generally. The very mention of *theory*, *cultural construction*, or *discourse* may be exasperating or distressing to those face to face with the epidemic's enormity and overwhelming practical demands. Nowhere has this pressure for action been more poignant than in questions about treatment, an arena of the epidemic wholly informed by the sense of time passing and time lost. Martin Delaney, the AIDS treatment activist who founded Project Inform in San Francisco, participated in a forum on treatment options for people with HIV and AIDS at Columbia University in 1988; in a panel on AZT, Delaney argued that, however flawed or incomplete, results to date suggested AZT's benefits and that, in any case, it was at present the best hope. When other panelists urged caution and encouraged audience members to be skeptical of AZT's success, Delaney lost his patience with what he perceived as a quest for abstract truth: "This isn't an argument about how many angels can dance on the head of a pin. People's lives hang in the balance of this decision" (quoted in Douglas 1989, 33).

Yet theory is about "people's lives." As Stuart Hall (1992) has said, our inability to end this epidemic humbles us as intellectuals; at the same time, the epidemic demands our attention:

> AIDS is one of the questions which urgently brings before us our marginality as critical intellectuals in making real effects in the world. And yet it has often been represented for us in contradictory ways. Against the urgency of people dying in the streets, what in God's name is the point of cultural studies? What is the point of the study of representations, if there is no response to the question of what you say to someone who wants to know if they should take a drug and if that means they'll die two days later or a few months earlier? At that point, I think anybody who is into cultural studies seriously as an intellectual practice, must feel, on their pulse, its ephemerality, its insubstantiality, how little it registers, how little we've been able to change anything or get anybody to do anything. (pp. 284–85)

At the same time, Hall writes, AIDS

> is indeed a more complex and displaced question than just people dying out there. The question of AIDS is an extremely important terrain of struggle and contestation. In addition to the people we know who are dying, or have died, or will, there are the many people dying who are never spoken of. How could we say that the question of AIDS is not also a question of who gets represented and who does not? AIDS is the site at which the advance of sexual politics is being rolled back. It's a site at which not only people will die, but desire and pleasure will also die if certain metaphors do not survive, or survive in the wrong way. Unless we operate in this tension, we don't know what cultural studies can do, can't, can never do; but also, what it has to do, what it alone has a privileged capacity to do. (p. 285)

This tension permeates the present book as it considers how the AIDS epidemic helps us understand the complex relation between language and reality, between meanings and definitions—and how those relations help us understand AIDS and develop interventions that are more culturally informed and socially responsible. Camus called the plague itself a kind of abstraction; "Still," he wrote, "when abstraction sets to killing you, you've got to get busy with it" ([1947] 1948, 81). But abstraction plays a central role in our ability to "get busy with it." To speak of AIDS as a linguistic construction that acquires meaning only in relation to networks of given signifying practices may seem politically and pragmatically dubious, like philosophizing in the middle of a war zone. But, as I argue throughout this book, making sense of AIDS compels us to address questions of signification and representation. When we deduce from the facts that AIDS is an infectious, sexually transmitted disease syndrome caused by a virus, what is it that we are making sense of? *Infection, sexually transmitted, disease,* and *virus* are also linguistic constructs that generate meaning and simultaneously facilitate and constrain our ability to think and talk about material phenomena. Language is not a substitute for reality; it is one of the most significant ways we know reality, experience it, and articulate it; indeed, language plays a powerful role in producing experience and in certifying that experience as "authentic."

This book, then, can be seen as a set of cultural chronicles that investigate these questions. In what follows, I sketch its basic structure and offer the reader a preliminary map of the themes, arguments, cultural domains, and evolving meanings that I revisit in individual chapters. But I want also, here, to say something about the nature of these chronicles. Written over the last decade, they can be read in several different ways. Their

organization is roughly chronological, each chapter representing a particular era or phase in the AIDS epidemic and, in turn, a particular constellation of issues that seemed to me to be critically important. But, for someone working, as I have been for as long as I can remember, at the intersection of language, culture, medicine, gender, and institutional authority, neither *era* nor *phase* is very useful. No issue in the AIDS epidemic is ever fully settled, and no discursive term is ever free of its history. Rather, I see this book as a series of case studies, each centered around some unique conjunction in time and space of those questions that concern me, and each uniquely manifested through some particular set of texts. These case studies, then, serve to document the epidemic, to read its texts with some attention to contemporary theory, and to explore what theory does or does not do in this epidemic. I will not get ahead of myself in this prologue by summarizing the "findings" of this exploration—what theory tells us about AIDS, that is, and what AIDS tells us about theory. Rather, I will sketch the book's plan and get on with it, at the same time inviting the interested reader to join me for the epilogue, where I do offer several propositions about what I believe this study teaches us.

Chapter 1, "AIDS, Homophobia, and Biomedical Discourse," introduces a central question: How do people make sense of a novel cultural phenomenon that is complicated, frightening, and unpredictable? A preliminary approach involves framing the new phenomenon within familiar narratives, at once investing it with meaning and suggesting the potential for its control. One investment strategy is to link the new phenomenon with existing issues, social arrangements, or institutional sites, a linking that has been characterized as the process of "articulation" (as the bones of a human body are articulated to one another). I demonstrate in more detail what I have suggested above: that the AIDS epidemic has been articulated to a remarkable diversity of issues, perspectives, and agendas and that these different linkages may have differential material and ideological consequences. This inventory of narratives and meanings serves to illuminate alternative understandings of the epidemic as well as contradictory meanings and changing scientific accounts. An important point is that a complex cultural phenomenon produces diversity and contradiction but also that in a variety of ways "dominant" meanings emerge—default meanings, that is, that can be expressed with little fear of being challenged.

The early years of the epidemic functioned in part to link its fate with that of homosexuality, thereby constructing one such dominant meaning.

The widespread construction of AIDS as "a gay disease," I demonstrate, invested both AIDS and homosexuality with meanings neither had alone and produced specific material consequences across a broad social and scientific spectrum. The initial attribution of viral transmission to "gay lifestyle issues," for example, produced a burst of research in scientific journals that starkly revealed prevailing scientific conceptions and mythologies about the sexual practices of gay men—and, indeed, about sexuality and sexual behavior more generally. In turn, efforts to counter these mythologies by the gay community and others, beginning early in the epidemic, altered the course of AIDS's inscription in science by initiating the dialogue between physicians and patients, scientists and activists, so characteristic of this epidemic. This commitment to intervention and counterinscription led, too, to the development of safe sex recommendations, the drafting and dissemination of the Denver principles for the ethical representation of people with AIDS, and the establishment of crucial institutions for caretaking, fund-raising, and service. This articulation of AIDS to other cultural and theoretical questions reveals also, I argue here, the impossibility of identifying and isolating an element like *homophobia* within a given body of discourse, for any such characteristic enters into a system of binary divisions. If one pair of terms is repressed, others take on their function—hence, when the division between *homosexual* and *heterosexual* is called into question, it comes to be reenacted elsewhere, for example, by the division between the *vulnerable rectum* and the *rugged vagina.*

Chapter 2, on the role of gender in the AIDS epidemic from 1981 to 1988, examines how the semantic baggage attached to AIDS has had special consequences for women. Throughout the 1980s, deeply entrenched cultural stereotypes about sex, class, gender, and sexuality confused perceptions of who could get HIV disease, how it could be contracted, and the practices through which "a person with AIDS" was inevitably, if never totally, gendered. I document resistance to acknowledging HIV infection in nonhomosexual bodies, especially women and infants, and identify numerous points at which "the burdens of history" shaped policy, media treatment, and the choice of narratives through which the epidemic was understood. Taking the CDC's epidemiological account of AIDS as the bedrock data source for information about the epidemic in the 1980s, I trace the narrative threads about gender through the discourse of the *Morbidity and Mortality Weekly Report* (*MMWR*). These close readings reveal the ambiguities and contradictions built into the official record and their suppression as this record was translated into myriad academic and

popular discourses in the public arena. I then look at how the *MMWR*'s account was interpreted, translated, modified, negotiated, denounced, or explained in selected other publications. Representations in leading biomedical journals, mainstream media discourse including women's magazines, and alternative and feminist publications suggest that the insights of the women's health movement and of feminist theory did little to illuminate AIDS for women.

Chapter 3, "AIDS and HIV Infection in the Third World," explores representations of "Third World AIDS" as they occur in typical "First World" publications. With few exceptions, and in contrast to a sampling of images and stories that originate within the countries in question, Western representations reinforce familiar stereotypes about the less-developed world. In these predictable roundups of the usual suspects, most obvious are the limited set of words and images through which people themselves are portrayed: wasted, naive, and passive "natives" lie on mud floors, under trees, on bare mattresses in stark hospital wards. While to a degree these portrayals mimic Western photographic conventions for depicting the dying, nothing is provided to offset the portrait of hopeless, apocalyptic devastation: beyond officials from the World Health Organization or the country's health ministry, professionals and other experts are rarely shown, and even rarer are appearances of experienced and informed nonprofessionals. Underlying this discourse is another fundamental conviction: while the AIDS/HIV epidemic in industrial and postindustrial societies is believed to be complex, intellectually and politically contested, and theoretically interesting, Third World epidemics are seen to be simple material disasters. Examples drawn from AIDS commentary in a number of nations are used to discuss systematic differences between external and internal reporting; special problems of media and other resources in developing countries; the intersection of the local, the national, and the global; the role of ethnographies; and the function, value, and theoretical significance of conspiracy theories. I further explore the notion of articulation, identifying the ways that the global AIDS epidemic plays into preexisting social and cultural divisions.

How are media representations of the AIDS epidemic constituted, and why? Chapter 4 examines media treatments of AIDS and HIV, particularly on television network news programs. I discuss differences between mainstream, targeted, and specialized media outlets and note the widespread failure of liberal and left (straight) media, including feminist media, to cover AIDS adequately. In contrast, much of the gay media—including broadly based publications like the *Advocate*, regional and local

newspapers, alternative and oppositional films, videos, and performance art—tells a different story and more often gets it right. AIDS coverage is sketched impressionistically through examples from newspapers and journals, independent videos, talk shows, news reports, documentaries, made-for-TV movies, and prime-time dramatic shows.

Chapter 5, "AIDS, HIV, and the Cultural Construction of Reality," forms the center of the book and the core of my argument, marking also a turning point in the intellectual construction of the AIDS epidemic. I try first to provide an intellectual and theoretical grounding for an analysis of science and medicine as "culturally constructed," drawing from work in sociology, history, and the philosophy of science as well as from anthropological writing on medicine and culture. I then examine shifting power relations, sites of knowledge, and regimes of credibility in terms of the right to define the reality of HIV and AIDS. The 1989 International Conference on AIDS in Montreal provides the specific context in which a series of contests for meaning are described and analyzed. While the vast majority of scientific papers at the 1989 conference further stabilized HIV as a reality in AIDS discourse, challenges to that reality also became more visible. ACT UP's debut at the conference introduced the media to the story it couldn't refuse. This chapter is the structural hinge from which the second half of the book unfolds, its last four chapters revisiting, in reverse order, the themes and preoccupations of the first four.

Chapter 6 takes up the media question again, this time to examine more extended AIDS narratives on television and to ask whose story they actually tell. Close readings of *An Early Frost* and *Our Sons* provide insights. On the one hand, a wholesome family movie like *An Early Frost* leaves out most of the problematic elements of sexual transmission; its blandness makes it hard to explain why this first AIDS drama about a gay man on prime-time television (1985) remained virtually the only one until *Our Sons* was broadcast in 1991. On the other hand, through its palatability, *An Early Frost* accomplished goals that other, more incisive and critical productions could not have. Its effectiveness as an educational vehicle requires us, I argue, to look closely at our common assumptions about identity and identification in narrative media and to recognize the value of the kinds of cultural work performed by different media genres and outlets. That said, I also argue, we can nevertheless hold some genres culpable for not doing the cultural work that they are uniquely suited to do. Network television could "do" condoms better than anyone and should be held responsible for colossal failure.

Chapter 7, "AIDS, Africa, and Cultural Theory," uses a *New York Times*

series on AIDS in Africa to ask how we know what it is we think we know about AIDS "elsewhere." Returning to the conference scene via several conferences, including the San Francisco International AIDS Conference in 1990, I raise more questions about the production and politics of knowledge. Moving beyond the chronicles and accounts produced by First World narrators, I examine commentary on the epidemic originating in less-developed countries and argue for the importance of juxtaposing different accounts and representations.

Chapter 8, "Beyond *Cosmo*: AIDS, Identity, and Inscriptions of Gender," continues the story of women and AIDS and asks why, nearly twenty years into the epidemic, gender is still a conceptual muddle. Taking as my starting point a January 1988 article in *Cosmopolitan* claiming that "normal heterosexual women can't get AIDS," I review and update the evidence from chapter 2 that gender has been downplayed, ignored, stereotyped, alibied, and misrepresented. At the heart of these renditions are ongoing confusions surrounding identity, many introduced in chapter 2. Despite multiple impediments, however, by the end of the 1980s women had initiated many projects through which they could become active participants rather than passive receivers in the fight against the epidemic. Taking as exemplary the formation of the Women and AIDS Caucus within the activist group ACT UP New York, I document the relevance of women's AIDS activism and advocacy to other women's issues, including reproduction, birth control, benefits, access to health care, sex education, and poverty, and argue that collective activism is needed in order seriously to challenge the pervasive conservative agenda for women championed by the political and religious Right. The success of progressive projects worldwide now depends, in part, on their respect for such basic feminist tenets as the right to self-definition and self-representation as well as the recognition that *women* is not a monolithic category even while it is inscribed as unitary in discourse. What the role in the United States will be of the actual, historical feminist movement in the struggles ahead remains a question.

The final chapter, "How to Have Theory in an Epidemic: The Evolution of AIDS, Treatment, and Activism," returns to the title theme, the struggle for an intelligent vision to live by in the face of crisis, contradiction, and the urgent need to make life-or-death decisions. Using questions surrounding the pathophysiology of AIDS and the hypothesized effects of HIV on the body, I examine the strategies used by AIDS communities to develop educational materials and treatment regimens. The use of the human body as an experimental laboratory has long been a feature of clinical

drug trials; in addition to the courage that such a decision demands, debates over AIDS drugs also address the terms of the debates themselves. They ask, for example, Am I eligible for experimental drugs? But they also ask, Who decides whether I am eligible? They ask, Is this drug safe and effective? But they also ask, What are the criteria that determine safety and efficacy? They ask, Should I take this drug? But they also ask, What theoretical vision of health and disease, of life and death, of science and medicine, guides me in deciding whether to take this drug? What, in the midst of this terrible epidemic disease—this "tidal wave of death" (Harrington 1997)—is acceptable as "good science"? What kind of "medicine" is required? As Steven Epstein has written, the engagement of AIDS activists with biomedical authorities is "no romantic tale of resistance that privileges the 'purity' of knowledge-seeking from below": "What makes the story . . . interesting and important are the ironies and tensions embedded in the process of forging novel scientific, political, and moral identities. This is a complicated history in which no party has had all the answers. All players have revised their claims and shifted their positions over time; all have had to wrestle with the unintended consequences of their actions" (1996, 4).

For readers who are comforted by closure, I use the epilogue to summarize the insights of this study about the operation of language in culture and the complicated circulation and status of meaning in a media-rich democracy. I try, in other words, to distill the linguistic lessons of the epidemic and the conclusions of my efforts to address the questions that I have identified in this prologue.

These "lessons" do not, of course, tell us how to determine the "truth" of the AIDS epidemic; yet, as continuing controversies surrounding AIDS and HIV make clear, they help us better understand how various kinds of knowledge are produced, the rules and universes of discourse through which truth is variously represented and understood, and the crucial role of theory in an epidemic. AIDS's lessons constitute a significant legacy and hold the key, I believe, to the kind of democracy and democratic technoculture that we will be able to build and inhabit in the years ahead.

1

AIDS, Homophobia, and Biomedical Discourse: 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, yet finally neither directly nor fully knowable. AIDS is no different in this respect from other linguistic constructions that, in the commonsense view of language, are thought to transmit preexisting ideas and represent real-world entities yet in fact do neither. The nature of the relation 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.

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, with its genuine potential for global devastation, the AIDS epidemic is simultaneously an epidemic of a transmissible lethal disease and an epidemic of meanings or signification. 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.[2] This epidemic of meanings is readily apparent in the chaotic assemblage of understandings of AIDS that by now exists. The mere enu-

Blood sucking is no bowl of cherries these days!

AIDS-wary vampires pull in their fangs!

Granny's shaking the family tree!

Test-tube mom pregnant with her own grandkids

Why you're blue on cloudy days

Noises can harm babies

Gay Monopoly game miffs dealers

Readily grafting the AIDS *epidemic onto their hardy narrative stock, the tabloids flooded the market with hybrid plague stories: of celebrities major and minor, innocent wives, predatory bisexuals, spread-of-aids sensations, cures and conspiracies, morality and mortality, and endless human oddities (*1.1: Weekly World News, *12 May 1987, 29).*

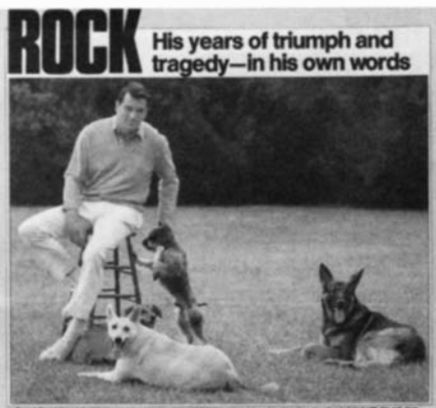
meration of some of the ways AIDS has been characterized suggests its enormous power to generate meanings:[3]

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.
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 United States 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 1960s.
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 miserable and expensive way to die.

Such diverse conceptualizations of AIDS are coupled with fragmentary interpretations of its specific elements. Confusion about transmission now causes approximately half the U.S. population to refuse to *give* blood. Many believe that 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 sitting near a friend of mine in an airport 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 that people do in attempting to understand—



Live or stuffed animals in photographs of persons with AIDS *distinguish the "innocent" from the "guilty" or at least normalize their "otherness," as, for example, in these photos of Ryan White and of Matthew Kozup with his mother (1.2: both in* Newsweek, *12 August 1985, 29). After Rock Hudson's death, many sympathetic stories showed him with his dogs (1.3:* Star, *15 October 1985): he had* AIDS, *ran the subtext, but he was still a good person. Courageously going public in an interview with* Macleans *magazine (1.4: 31 August 1986, 34) Canadian* PWA *Candice Mossop offered herself as "living proof" that women, too, were vulnerable to* AIDS; *despite her desire to counter stereotypes about the epidemic, the magazine depicted her in a Camille-like deathbed pose, the bed heaped with stuffed animals (Walmsley 1986; photo by Mary Ann Donohue). Given widespread perceptions of* AIDS *as "a gay disease," the mainstream media also took pains to establish that at least some of the epidemic's featured heroes had wives and kids: they may study* AIDS, *but they're heterosexual (1.5: Dr. Gerald R. Friedland at work and at home,* Newsweek *21 July 1986: 50, 48; story by Goldman and Beachy).*

however imperfectly—the complex, puzzling, and quite terrifying phenomenon of AIDS. No matter how much we desire, with Susan Sontag, to resist treating illness as metaphor, illness *is* metaphor, and this semantic work—this effort to "make sense of" AIDS—must 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."[4]

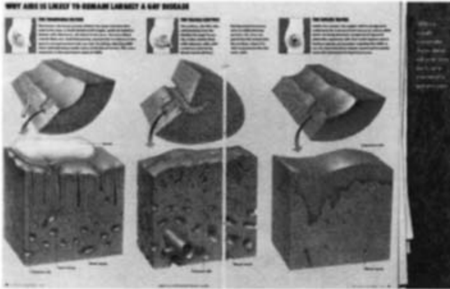
I am arguing, then, not that we must take both the social and the biological dimensions of AIDS into account, but rather that the social dimension is far more pervasive and central than we are accustomed to believing. Science is not the true material base generating our merely symbolic superstructure. Our social constructions of AIDS (in terms of global devastation, the threat to civil rights, the emblem of sex and death, the "gay plague," the postmodern condition, whatever) are based not on objective, scientifically determined "reality" but on what we are told about this reality: that is, on *prior* social constructions routinely produced within the discourses of biomedical science.[5] (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" [(1979) 1986, 281]), 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 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.[6]

The point is not merely that this particular scientist has not yet learned to "talk to the media" (see Fain 1985; and Check 1985) but that ambiguity and uncertainty are features of scientific inquiry to be socially and linguistically managed. Few scientists in the mid-1980s could produce more than common sense or contradiction—or both (as here: we can't be certain but the public should not worry). 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's imaginations give birth to many different conceptions; to label them *mis-conceptions* implies what? Wrongful birth? 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 born in the course of the AIDS crisis:

> AIDS could be *anything*, considering what homosexual men do to each other in gay baths (cited in Leibowitch 1985).
> Heroin addicts won't use clean needles because they would rather get AIDS than give up the ritual of sharing them (cited in Barrett 1985).
> Prostitutes do not routinely keep themselves clean and are therefore "reservoirs" of disease (cited in Langone 1985).
> AIDS is homosexual; it can be transmitted only by males to males.
> AIDS in Africa is heterosexual but unidirectional: it can be transmitted only from males to females (cited in Langone 1985).
> AIDS in Africa is heterosexual because anal intercourse is a common form of birth control there (cited in L. Altman 1985b).

Such assertions blur the line 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 semantic epidemics as well as biological ones are 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 let's-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



What cartoonist Steve Bell called "supply-side sexuality" preoccupied conservative members of the U.S. Congress, the Reagan-Bush administrations, and the 1984–85 Meese Commission for the Study of Pornography (1.6: "If . . . ," Guardian, *16 October 1984, 29). In the early years of the epidemic, even leading scientists equated "sex" with missionary-position orthodoxy: "How can AIDS be sexually transmitted?" they would ask. "It's a gay disease: how can a virus carry a disease from one man's body to another man's? Where would it get in?" Science writer John Langone explained it all but cautioned that nature never intended men to have sex with men and did not build their bodies for it. The "rugged vagina," in contrast, "is designed to withstand the trauma of intercourse as well as childbirth" (1.7: illus. by Lewis E. Calver,* Discover, *December 1985, 40–41). Plausible prose and decisive illustrations lent credibility to the story's influential but flawed argument that "AIDS is, and will continue to be, the fatal price paid for anal intercourse." Over the next decade, women would be continuously bombarded by contradictory messages about their biological vulnerability.*

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.* 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 (pp. 40–41).

"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" (p. 52). (This excerpt from the article also ran as the cover blurb.) It sounded plausible, and detailed illustrations demonstrated the article's conclusion.[7]

But, by December 1986, the big news—what the major U.S. newsmagazines were running cover stories on—was the grave danger that AIDS posed to heterosexuals.[8] No dramatic discoveries during the intervening year had changed the fundamental scientific conception of AIDS.[9] What had changed was not "the facts" but the way in which they were now used to construct the AIDS text and the meanings that we were now allowed—indeed, at last encouraged—to read from that text.[10] The AIDS story, in other words, is not merely the familiar story of heroic scientific discovery. And until we understand AIDS's dual life 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.

Sources outside biomedical science, however, have helped shape the discourse on AIDS. Almost from the beginning, through intense interest and informed political activism, members of the gay community 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 (see Bayer 1981). In the succeeding period, gay men and lesbians 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 (1982): "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."

Challenging biomedical authority—whose meanings are part of powerful and deeply entrenched social and historical codes—has required con-

siderable tenacity and courage from people dependent in the AIDS crisis on science and medicine for protection, care, and the possibility of cure. These contestations provide the model for a broader social analysis, one that moves away from AIDS as a "lifestyle" 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.

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

Whatever else it may be, AIDS is a story, or multiple stories, and read to a surprising extent from a text that does not exist: the body of the male homosexual. People so want—need—to read this text 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 each other. 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 ([1947] 1948) 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" (p. 37) with the bourgeois town of Oran, where the plague struck. How could a disease so extraordinary as *plague* happen in a place so ordinary and dull? Initially striking people perceived as alien and exotic by scientists, physicians, journalists, and much of the U.S. population, AIDS did not pose such a paradox. The "promiscuous" gay male body—early reports noted that AIDS "victims" reported having had as many as a thousand 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 (1986) notes, able to be read as "the story of a metaphor."[11]

Ironically, a major turning point in the U.S. 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."[12] In fact, this possibility had 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 vari-

eties is a major pathway of transmission" (p. 147). But only in late 1986 (and somewhat reluctantly at that) did the CDC (1986c) expand on its original "4-H list" of high-risk categories: *homosexuals, hemophiliacs, heroin addicts,* and *Haitians* and the sexual partners of people within these groups. The original list, developed during 1981 and 1982, has structured evidence collection in the intervening years and contributed to the view that the major risk factor in acquiring AIDS is being a particular kind of person rather than doing particular things.[13] Ann Giudici Fettner, AIDS reporter for the *New York Native,* pointed out in 1985 that "the CDC admits that at least ten 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" ("AIDS: What Is to Be Done?" 1985, 43). So the "gay" nature of AIDS was in part an artifact of the way data were collected and reported. Although, 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,* would ultimately turn out to be one of the four Hs.[14] This commitment to categories based on monolithic identity filters out information. Shaw (1986) 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." 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 ("the AIDS virus"), passive receptacles without the projectile capacity of a penis or a syringe—stolid, uninteresting barriers that impede the unrestrained passage of the virus from brother to brother.[15] Exceptions include prostitutes, whose discursive legacy—despite their long-standing professional knowledge and continued activism about AIDS—is to be seen as so contaminated that their bodies are virtual laboratory cultures for viral replication.[16] Other exceptions are African women, whose exotic bodies, sexual practices, or who knows what are seen to be so radically different from those of women in the United States that anything can happen in them.[17] 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 (Leibowitch 1985, 73). The fact that one of the more extensive and visually elegant analyses of AIDS appeared in the *National Geographic* (Jaret 1986) is perhaps further evidence of its life on an idealized "exotic" terrain.

After the first cases appeared in New York, Los Angeles, and Paris, the early hypotheses about AIDS were sociological, relating it directly to the supposed "gay male lifestyle." 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 (1985), 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 eight to twelve 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.* (p. 5)

This new perspective generated numerous possibilities. One was that sperm itself could destroy the immune system. "God's plan for man," after all, "was for Adam and Eve and not Adam and Steve."[18] 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. In the lay press, AIDS became known as the "toxic cock syndrome." 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 would this make them sexual lepers, but it also did not make sense: "How could a disease pick out gays? That had to be medical homophobia" (Black 1986, 40).[19] Important to note here is a profound ambivalence about the origins of illness. Does one prefer an illness that is caused by who one is and that can therefore perhaps be prevented, cured, or contained through "self-control"—or an illness that is caused by some external "disease" that 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 that 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 cases among monogamous homebodies are ignored) is that sex is a "cofactor": 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.[20] Gay men on the sexual "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:[21] examples from *Science* from June 1981 through December 1985 (collected in Kulstad 1986) include "homosexual and bisexual men who are extremely active sexually" (Marx 1983, in Kulstad 1986, 22), "admitted homosexuals" (Gelmann et al. 1983, in ibid., 40), "homosexual males with multiple partners" (Barré-Sinoussi et al. 1983, in ibid., 49), "homosexual men with multiple partners" (Essex et al. 1983, in ibid., 65), "highly sexually active homosexual men" (Richards et al. 1984, in ibid., 142), and "promiscuous" versus "nonpromiscuous" homosexual males (Gallo et al. 1984, in ibid., 160). Also documented (examples are again from the *Science* collection) are exotic travels or practices: "a Caucasian who had visited Haiti" (Gallo et al. 1983, in ibid., 47), "persons born in Haiti" (Jaffe et al. 1983, in ibid., 130), "a favorite vacation spot for U.S. homosexuals" (Marx 1983, in ibid., 73), rectal insemination (Richards et al. 1984, in ibid., 142–46), "bisexual men" (Jaffe et al. 1983, in ibid., 130), "increased frequency of use of nitrite inhalants" (Curran et al. 1985, in ibid., 611), and "receptive anal intercourse" (Curran et al., 1985, in ibid., 611).

Out of this dense discursive jungle came the "fragile anus" hypothesis (tested by Richards et al. [1984, in Kulstad 1986], who rectally inseminated laboratory rabbits) as well as the vision of "multiple partners." 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—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 heterosexuality's ideological superiority. In the service of this hypothesis, both homophobia and sexism are folded imperturbably into the language of the scientific text. As I noted above, women are characterized in the scholarly literature as "inefficient" transmitters of AIDS; Leibowitch refers to the "refractory impermeability of the vaginal mucous membrane" (1985, 36). In the *Journal of the American Medical Association* (Redfield et al. 1985) a study of German prostitutes who seemed to demonstrate female-to-male transmission of AIDS was interpreted by some as representing "quasi-homosexual" transmission with successive male clients infecting each other via deposits of contaminated semen (quoted in Langone 1985, 49).

But the conception and the conclusion are inaccurate. It is not monogamy or abstention per se that protects one from AIDS infection but practices that prevent the virus from entering one's bloodstream. Some evidence suggests that prostitutes are at greater risk not because they have multiple sex partners but because they are likely to use intravenous drugs; indeed, they may protect themselves better "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' " (Shaw and Paleo 1987, 144). At this point, COYOTE and other organizations of prostitutes had been addressing the issue of AIDS for several years.[22]

Donald Mager (1986) 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.

Beginning with How to Have Sex in an Epidemic, *gay communities pioneered "safe sex" initiatives in the 1980s. Departing from the long-standing anti-VD public health tradition, these campaigns demonized neither sex nor the contaminated Other, urging instead that safer sex practices be universally adopted by men who have sex with men (1.8: illus. by H. Cruze, panels from safe sex pamphlet, New York, 1984). The initial federal response to AIDS also broke historical precedent by farming out responsibility for public AIDS education to a private firm in Connecticut. Channing L. Bete's small "Scriptographic" booklets (1.9: Scriptographic* AIDS *booklet, 1984) were already recognized as a prolific fount of health education and public service messages. Whether the problem is AIDS, herpes, birth control, or proper food storage, generic Scriptographic citizens can be computer morphed as needed to represent the target audience (males, females, African Americans, grandmothers, whatever) and sent out into the world to help. Unlike the Public Health Service materials on AIDS/HIV eventually produced, the copyrighted Scriptographic booklets prohibited reproduction for wider distribution.*

Leibowitch (1985) 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" (p. 3).

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 (see, e.g., U.S. House 1984; Schwartz 1984; Office of Technology Assessment 1985; and Institute of Medicine and National Academy of Sciences 1986). Attempting to assess the degree to which prejudice, fear, or ignorance of homosexuality may have affected policy and research, Panem (1985, 24; 1988) 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." She quotes 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. Other instances of ignorance are reported by Patton (1985a, 1985b) and Black (1986). Physician and scientist Joseph Sonnabend (1985) 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." An Institute of Medicine/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 United States, noting that no comprehensive re-

search 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.

It has been argued that the perceived *gayness* of AIDS was ultimately a crucial political factor in obtaining funding. Dennis Altman (1986) observes that the principle of providing adequate funding for AIDS research was institutionalized within the federal appropriations process as a result of the 1984 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" (pp. 116–17).

But these social and political issues were becoming, for many, essentially irrelevant. The hypothesis that AIDS was caused by an infectious agent, favored by some scientists, 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. The real question became precisely what kind of viral agent this could be, and how the epidemic could now be re-read.

Rendezvous with 007

"Interpretations," write Bruno Latour and Steve Woolgar in *Laboratory Life* ([1979] 1986, 285), their analysis of the construction of facts in science, "do not so much *in*form as *per*form." And rarely 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* (Adair and Epstein 1986) 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."

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. It all became official in 1981, when five deaths in Los Angeles from *pneumocystis* pneumonia were described in the 5 June issue of the CDC's bulletin *Morbidity and Mortality Weekly Report*, with an editorial note explaining, "The occurrence of pneumocystis in these 5 previously healthy individuals without a clinically underlying immunodeficiency is unusual. The fact that these patients were all homosexuals suggests an association between some aspect of a homosexual lifestyle or disease acquired through sexual contact and *Pneumocystis* in this population" (CDC 1981a, 250).

Gottlieb et al.'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. 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 informally called GRID: Gay-Related Immunodeficiency. The published reports drew similar information from physicians in other cities (CDC 1981b), and, before too long, these rare diseases had been diagnosed in nongay people (e.g., hemophiliacs and people who had recently had blood transfusions). 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" [Black 1986, 60]).

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, the Centers for Disease Control, the National Cancer Institute, and the National

Institute of Allergy and Infectious Disease) 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. And, although some independent researchers, clinicians, and non-U.S. 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.[23] The National Cancer Institute (NCI), for example, developed a research strategy that focused on retroviruses, essentially to the exclusion of other lines of research (Panem 1985, 25), while other U.S. virology and immunology laboratories put forward their own favored possibilities. 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.[24] 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 lifestyle. 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, a lymphoadenopathy-associated virus. In 1984, Robert Gallo at the NCI identified what *he* called HTLV-III, human T-cell lymphotropic virus type III (the third type identified by his laboratory). In accordance with Koch's postulates, both viruses were isolated in the blood and semen of AIDS patients; no trace was found in the healthy control population.[25]

These powerful findings—disputed and fractious 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 ([1979] 1986, 105–50) divide the research that 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. So too with AIDS: before the isolation of the virus, there were considerably more universes of inquiry and open-ended speculation. Evidence for a virus as agent intensified scientific control over signification and enabled scien-

tists 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 consensus began to form 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 (the 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 always has borders peopled by other statements" (Foucault 1972, 97), and it is important for us to keep in mind the provisional and consensual nature of this U.S. 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 that 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-U.S. researchers (L. Altman 1985b, 8). 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 tribes in central Africa (Lee 1985). In the Caribbean, and even within the United States (see Rechy 1983), AIDS is widely believed to come from U.S. biological testing. The French first believed that AIDS was introduced by way of an "American pollutant," probably contaminated amyl nitrate (they also believed that AIDS came from Morocco). The Soviet Union, Israel, Africa, Haiti, and the U.S. armed forces

deny the existence of indigenous homosexuality and thus claim that AIDS must always have originated "elsewhere."[26]

By 1986, five years after the initial article in *Morbidity and Mortality Weekly Report*, the Human Retrovirus Subcommittee of 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 (e.g., *Science*, 9 May 1986, 697). Its task has been made crucial, the subcommittee notes, by the widespread interest in AIDS and the multiplicity of names now in use:

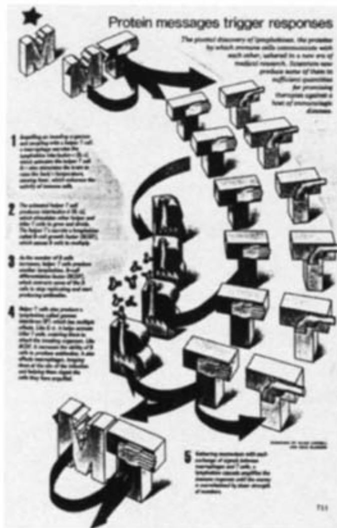
> *LAV*: lymphadenopathy-associated virus (1983—Montagnier, Pasteur);
> *HTLV-III*: human T-cell lymphotropic virus type III (1984—Gallo, NCI);
> *IDAV*: immunodeficiency-associated virus;
> *ARV*: AIDS-associated retrovirus (1984—Levy, University of California, San Francisco);
> *HTLV-III/LAV* and *LAV/HTLV-III*: 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

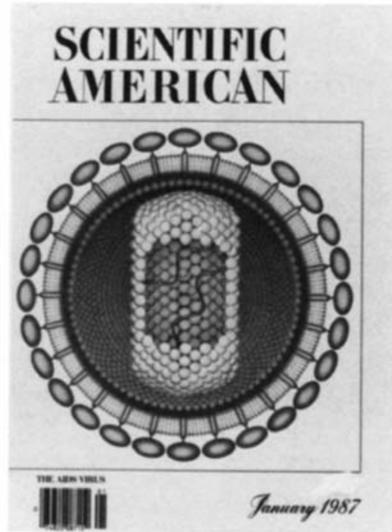
The subcommittee proposes *HIV*, Human Immunodeficiency Viruses. It reasons that this conforms to the nomenclature of other viruses, in which the first slot signals the host species (human), the second slot the major pathogenic property (immunodeficiency), and the last slot *V* for *virus*. (For some viruses, although 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 certify the health of the single-agent hypothesis. The subcommittee argues in favor of its proposed name that it does not incorporate the term *AIDS*, on the advice of many clinicians; that 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 that it distinguishes the human immunodeficiency 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' " (Marx 1986a, 699–700).

Why such struggles over naming and interpretation? Because 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. As Donna Haraway (1979, 1985, 1989a, 1996) observes, modern immunology moved into the realm of high science when it reworked the military combat metaphors of World War II (battle, struggle, territory, enemy, truce) into the language of postmodern warfare: communication command control (coding, transmission, messages), interceptions, spies, lies. Scientific descriptions for general readers, like this one from the *National Geographic* article on the AIDS virus (Jaret 1986), accentuate this shift from combat to code: "Many of these enemies [of the body or the 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" (p. 709).

No ground troops here, no combat, not even generals: what we see instead is the evolution of a conception of the AIDS virus as a topflight 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 (Jaret 1986, 723; see also Anderson and Yunis 1983 and, for discussion, Sturken 1997, 296), but "the virus is not an innocent passenger in the body of its victims" (Krim 1985a):





The military metaphors and images that pervade biomedical discourse are continuously upgraded and retooled. Illustrations for a National Geographic *story by Peter Jaret subtitled "The Wars Within" (1.10: "Protein messages trigger responses," illus. by Allen Carroll and Dale Glasgow,* National Geographic, *June 1986, p. 711) reflect a shift in the field of immunology, noted by Donna Haraway (1989a), from conventional military metaphors to the communication and coding trope of postwar molecular biology. As represented on the cover of* Scientific American *in January 1987, the AIDS virus" is a smart grenade (1.11), genetically coded to detonate within the very* DNA *of its cellular target and hijack its communication command center. Inside the journal, Robert C. Gallo told the story of the virus he called* HTLV-III *(whose image, published earlier in* Science *[4 May 1984], had turned out to be that of* LAV, *isolated in Luc Montagnier's laboratory*

> 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 system. Phagocytes and killer cells receive no call to arms. B-cells are not alerted to produce antibodies. The enemy can run free. (Jaret 1986, 723–24)

at the Pasteur Institute). Indeed, these competing names (as well as ARV *and others) had in 1986 led an international scientific commission to urge the adoption of an altogether new name: human immunodeficiency virus, or* HIV*. Wrote the commission chair Harold Varmus (1989, 4), "Since such names are in daily use by the working virologist, much ink and some blood have been spilled over them. The forces that influence decisions about them are as various as the forces that influence the naming of a baby, a book, a bridge, or a city. Scientific principles, political realities, convention, and justice must all be served" (1.12: still from video by Tom Kalin,* They Are Lost to Vision Altogether *[1988]). In April 1987, France and the United States announced the settlement of the dispute: henceforth, the two countries would share paternity for* HIV *and reapportion income from patents related to the virus formerly known as* HTLV-III/LAV *(1.13: French prime minister Jacques Chirac and U.S. president Ronald Reagan, photo by Jose R. Lopez,* New York Times, *7 April 1987). A second* Scientific American *article (October 1988) represented a detailed coauthored account by Gallo and Montagnier.*

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"; indeed, even now, "the envelope of the virus seems to be changing." 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 that we might even acknowledge our own historical moment more specifically by giving the AIDS virus a postmodern metaphor and identity: a terrorist's terrorist, an Abu Nidal of viruses.[27]

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 [1986], is an "epidemiologist's dream," a mystery disease that is fatal), 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 to basic scientists. But with the discovery that the agent associated with AIDS appeared to be a virus—indeed, a *novel retrovirus*—what 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, 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 (e.g., enabling researchers to map precise relations among diverse AIDS and AIDS-like clinical manifestations), but it also created opportunities for monetary rewards (e.g., revenue from patents on the testing kits). For these reasons, AIDS research became a highly competitive professional field.[28] 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. "The biomedical sciences is going brilliantly well" was how Dr. June Osborn summarized AIDS progress mid-decade (Eckholm 1986a, 19). "Indeed," wrote one science reporter, "had AIDS struck 20 years ago, we would have been utterly baffled by it" (Jaret 1986, 723). Ten years ago we had not even confirmed the *existence* of human retroviruses, noted *Scientific American*. Asked whether the NCI's strategy of focusing exclusively on retrovirus research was appropriate (considering that it might not have paid off), an official said that this would not have mattered: basic retroviral research was NCI's priority in any case (Panem 1985, 25). Because it *did* pay off, it could be said (as it could not have been said before 1984) that "AIDS may be a disease that has arrived at the right time" ("Science and the Citizen" 1987, 59). In the words of one biomedical scientist (quoted by Hunt 1986, 78), we face "an impending Armageddon of AIDS, and the salvation of the world through molecular genetics."[29]

Reconstructing the AIDS Text: Rewriting the Body

There is now broad consensus that AIDS—"plague of the millenium," "health disaster of pandemic proportions"—is the greatest public health problem of our era.[30] 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 momentum and context in which AIDS acquires meaning. It is extremely hard to resist the lure, familiarity, and ubiquity 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 legacies of difference and reinvigorates them:

self and not-self;
the one and the other;
homosexual and heterosexual;
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 Brooke-Rose (1986) demonstrates, one must pay close attention to the way in which these apparently fundamental and natural semantic oppositions are put to work: What is self, and what is not-self? Who wears the white and who the black hat? (Or in Brooke-Rose's discussion, perhaps, who wears the pants and who the skirt?) As Turner observes with regard