Medical Policy without Scientific Evidence:

The Promiscuity Paradigm and AIDS

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Abstract

The inability to cure or even explain the aetiology and transmission of a disease potentially threatens the high status of medicine in U.S. society. Without any technological fix available, medical practitioners tend to blame disease victims' personalities, lifestyles, and/or "non-compliance" to physicians' recommendations of traditional morality. The original identification of a syndrome of opportunistic infections, suggesting impaired immune functioning among gay men during the early 1980s, fit into the dominant medical view of sexually transmitted diseases, and all but foreclosed other kinds of research. The removal of a "recent Haitian immigrant" risk group for acquired immune deficiency syndrome provides a clear case study of how non-scientific influence on public health classification. The need to legitimate medical power and expertise created great pressure to "do something" once segments of the public conceived the threat of

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an epidemic of AIDS in the mid-1980s. The something done did not need to be medically efficacious, but the symbolic politics of public health require rationalizations in terms of “scientific” evidence. Traditional moralism better explains the public health policy initiatives taken and not taken regarding the incurable disease AIDS than does existing scientific evidence. Actions taken against gay bathhouses and heterosexual prostitutes, attempts to prescribe routine HIV-antibody testing, and recurrent political obstacles to “promoting immorality” by making prophylactics more available are reviewed.

The great successes in finding cures or means to eradicate infectious diseases in industrialized societies from the era of Koch and Pasteur to that of antibiotics enormously increased the prestige of medicine within industrialized societies, and increased expectations of technological “fixes” (“magic bullets”) far beyond the important advances which had been made (McKinnell and McKinley 1977). The high status and concomitant rewards of medical professions rest on expectations of cures. This produces a strain between recognizing the limitations of scientific medical competence (Stelling and Bucher 1973; Fox and Swazy 1978; Bosk 1979), and wanting prestige and rewards to be maintained, or (preferably) enhanced. Such strain—which is probably a universal attribute of the healer role—leads to claiming more understanding of illness and what to do about it than scientific knowledge and therapeutic art can support.

Credibility crises are generally avoided only because the hopes of clients\(^1\) complement practitioners’ pretensions. When the miracle workers can do nothing at all, anxiety—profession-wide and individual—mounts. Frustrations of health practitioners are compounded by clients’ perception of the inability to work more miracles. The pressures and temptation to blame the patient or some other scapegoat increase when a failure becomes common knowledge throughout a society. “We don’t know” is a difficult answer for healers (of any sort) to give to the question “What should we do?” (see Kleinman 1980).

There is a push from within medical organizations and professions to increase the domain of medicine in order to achieve still higher status for medicine. There is also a pull from policymakers, as well as from patients, to apply medical knowledge. This pull does not wait for a knowledge base to develop. Individuals terrified with what is going wrong with their bodies want immediate reassurance that someone knows what to do, and is undertaking to do it. Public health bureaucrats also want to be able to say that everything possible is being done to protect the public and cure the sick.

The legitimacy of the high status and ever-increasing share of resources accorded scientific medicine in the USA is best supported by visible efficacy in dealing with dramatic physiological crises. If such efficacy is not demonstrable, the reputation and influence of scientific medicine are endangered.\(^2\) Any such occasion triggers something of a vested interest in attacking those who manifest inconveniently incurable or chronic diseases not amenable to displays of capital-intensive medical virtuosity. If no high-tech cure or management of the disease is available, resort to explanations in terms of patient “non-compliance,” lifestyle, or personality is likely (see Sontag 1978; Brandt 1985). Blaming the victim is more likely than reconsideration
of the basic conceptual and clinical organizations of disease and of medicine.

Moreover, as social control increasingly operates under a medical guise in industrialized societies (Zola 1972; Kitsuse and Spector 1973; Bullough 1974; Conrad and Schneider 1980; Foucault 1980), categories from the discourse of scientific medicine become the basis for public policy. Expert opinion on how to safeguard public health is sometimes pressed, sometimes sought, but rarely is it presented as heuristic and hypothetical rather than as established fact (Murray 1980a; Goodfield 1982)—not even when it interferes considerably with the lifeways and life chances of various populations. In their own view, as well as in that of many others, doctors know best. Saving lives is what doctors (and other health professionals) seek to do—without asking questions about the quality of life after salvation, and usually with expectations of not having this absolute value questioned. They are accustomed to violating the bodily integrity of their patients with little question or challenge to the legitimacy, rationality or effectiveness of what they do.

Clinical experience of overriding personal autonomy tends to be generalized from doctoring to individuals to doctoring to communities. At both levels of practice, there are many doctors who do not distinguish between trying their clinical guesses and applying a widely accepted scientific consensus. In their view, no one should question them, so long as their intentions are therapeutic. At both the level of treating individuals and that of intervening in the name of "the public," medical professionals take any second-guessing of their prescriptions as non-compliance, irrational resistance, or mental illness. It is genuinely difficult for those dedicated to medicine to conceive that health may not be everyone's highest value. Hence, medical professionals are generally insensitive to quality of life and individual liberties issues. As Mohr (1987a: 46) noted, "Doctors tend to hold their unrefined view that health policy is merely a matter of strategy because they tend to see health itself as a trumping good, second to none in importance."

In analyzing the challenge to the psychiatric medicalization of traditional Western condemnation of male homosexuality, Conrad and Schneider (1980: 211) predicted, "If a behavior is demedicalized but not vindicated (absolved of immorality), it becomes more vulnerable to moral attack." Besides showing the competition among would-be agents of social control, Conrad and Schneider suggested the possibility of remedicalization following demedicalization. Soon after their book was published, a new cycle began with the discovery of a new medical basis for proscribing male homosexual behavior. Just as with the psychiatric proscription, medical claims far outstripped the scientific evidence which was plastered onto traditional Judaeo-Christian intolerance of male homosexuality. Also repeating the history of the psychiatric colonial expeditions into male homosexuality, there have been struggles over territory between different medical specialties and organizations (most visibly between the National Cancer Institute and the Centers for Disease Control within the federal Department of Health Services), and the new medical model of why male homosexuality is unhealthy does not include any cure (cf. Conrad and Schneider 1980: 207).

We shall show how the original identification of a syndrome of opportunistic infections in gay men living in the most institutionally elaborated gay
communities (Murray 1979, 1988a) made it a "gay plague" and therefore sexually transmitted, and how such identification constrained conceptualization and research subsequent to the initial "explanation" of "gay promiscuity." The "discovery" of cases in populations with less access to medical facilities (viz., heterosexual Haitians, central Africans, and American intravenous drug users) was not merely delayed, but was muted for several years by attempts to fit such cases into the promiscuous male homosexuality etiology. We shall also suggest that public health intervention has been inhibited by moralistic pressures so that tactics of high cost to individual liberties and little likely benefit to preventing cases of AIDS have been adopted, while those which would be challenged by moralistic Christians as "condoning immorality" have been avoided despite their greater likely benefit and lower cost (see Crimp 1988:259–65).

Paradigms

As new medical terms become known in a society, they find their way into existing semantic networks. While new explanatory models may be introduced, changes in medical rationality seldom follow quickly. —Good (1977: 54)

Not just medical practitioners (see Roth 1957; Lipton and Hershaft 1985), but medical researchers apparently accept "scientific" claims without any empirical evidence, if they fit with prejudices (whether these are theoretical and/or religious). Indeed, in borrowing the term "paradigm" from linguistics, Kuhn (1962, 1977) argued that not just the "folk," but also scientists think along lines constrained by the terms of particular theories, sometimes failing to see what does not fit into the terms or within the theory, sometimes seeing what doesn't exist (archetypally, phlogiston). Conceptions shape perceptions, even if they do not entirely determine them. In particular, paradigms channel inquiries along established routes. Before scientists draw a new map, they are likely to proceed along well-mapped and travelled roads which have led to payoffs in the past.

Within the dominant paradigm of western "scientific" medicine, chronic illness is barely recognized, let alone understood (Strauss et al. 1985). Chronic illness leading to the death of men in their twenties and thirties is hard to accept (for clinicians as well as for theorists and researchers; see Lessor and Jurich 1985). The clinical entity conceived in the early 1980s within Western scientific medicine as Acquired Immune Deficiency Syndrome was forced into the theoretical procrustean bed of an acute, discrete sexually transmitted disease rather than being conceived as a a chronic illness (triggered by introduction of a virus into the bloodstream).

Labeling a syndrome

In the first reports in 1981, there was no single label for a mysterious outbreak of Kaposi's sarcoma and pneumocystis pneumonia among previously healthy gay men (Centers for Disease Control 1981a,b). By the end of 1981, "gay compromise syndrome" (GCS) seemed to be emerging as a consensus in medical reporting, and GRID (gay-related immunodeficiency) in the gay press. As Albert (1984: 12) observed, "The major source for early
information on AIDS was the CDC [Centers for Disease Control] in Atlanta. CDC reports tended to emphasize who got sick rather than the nature of the disease itself. The first mass media attention in the summer of 1982 presaged the media onslaught of the first months of 1983 by focusing on "hotbeds of homosexual promiscuity," "living playgrounds for infectious agents" (Newsweek 9/6/82; see Albert's Table One; Murray and Payne 1985). The leader of the CDC task force, James Curran, was quoted (in Astor 1983: 56) as recognizing a predisposition, which we would extend to CDC epidemiologists: "You get heterosexual doctors examining gays, and they jump on the first possible hypothesis, that it must be due to the sexual behavior of gays."

It was almost a year into CDC reports in the Morbidity and Mortality Weekly Reports (MMWR), in June 1982, that it was mentioned that almost twenty percent of the first 355 U.S. cases were heterosexual male and female intravenous drug users (and another three years before official notice of homosexual IV drug users was taken; see below). By the end of the year, AIDS in heterosexual hemophiliacs was also recognized, and in the 4 March 1983 report transfusion of blood was acknowledged as a vector for the same unexpected infections.

During this same period, a label crystallized. In the 24 September 1982 MMWR "AIDS" replaced the previous "Kaposi Sarcoma and Opportunistic Infections in Previously Healthy Persons." The new label was already current in Science (though not in medical journals) a month earlier. Although no longer containing "gay" as a preface, as in GCS and GRID, AIDS was already indelibly stamped as a "gay disease," a "gay plague" as some sensationalized it. Because early cases were urban gay men, the syndrome from the beginning was presumed to be a "sexually transmitted disease," an already trendy classification in the zeitgeist of "sexual counter-revolution."

Once a disease is classified as being transmitted sexually, the disease and its spread arouse strong negative emotional reactions of a kind not aroused by waterborne or airborne diseases or those carried by insects. The emotional reactions are often as marked in doctors and scientists as they are in other people, and like any powerful emotion, they are liable to impair clear thought. The recent classification of many diseases as venereal has been accepted very uncritically... Because of the emotional overtones, once doctors are convinced that a disease is transmitted through sexual contact, many assume that any patient with the disease must have acquired it by promiscuous sexual activity. Those afflicted are assumed to be guilty till they can prove their innocence. This medical attitude is not only arrogant, but potentially dangerous, because other means of transmission will inevitably be overlooked (Seale 1985: 38; on the original construction of a sexual-transmission paradigm to replace astrological and metallurgical explanations of syphilis see Fleck 1979[1935]).

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The initial epidemiological discourse focused on sexual promiscuity. The word “promiscuity” itself was not used in CDC publications, but the number of (self-reported) sexual partners over varying durations of time was the datum most frequently gathered and analyzed in epidemiological work, and the CDC’s semantic asceticism in eschewing the heavily-loaded and imprecise term “promiscuity” was not practiced by others.

Urban public health officials and CDC epidemiologists were familiar with endemic gonorrhea and hepatitis and with epidemic amebiasis among sexually active urban gay men. For those diseases there were identified etiological agents. Their ultimate causes were not sexual practices, although the proximate cause of transmission of the agents was often sexual practices.

The simultaneous occurrence of relatively high rates of diverse ailments, many of them induced by parasites, had given rise to a clinical concept, “gay bowel syndrome” (GBS) in the late 1970s. Parasites thought to be the province of tropical medicine became a new focus of healthcare for gay men. Young American men were not supposed to turn up with such parasites, just as they were not expected to present Kaposi’s sarcoma (KS) or pneumocystis carinii pneumonia (PCP). Although KS and PCP were not directly added to the inventory of GBS, this model of a syndrome of exotic (for middle-class Americans) diseases was an analog.

Work developing a vaccine for hepatitis-B also familiarized some medical scientists with the anal sexual practices and high number of sexual partners of the gay men whose bodies were culturing antibodies to be used in the vaccine — the in vitro factories as well as test site for manufacturing it.

A predisposition existed to equate an outbreak of unexpected diseases among gay men with anal transmission; and hepatitis-B remains, even now, as the favorite analog of the epidemiology of AIDS-risk, despite differences in contagiousness between the two. So satisfied with anal intercourse as an explanation for AIDS were American health officials that a 1984 New York State Department of Health AIDS information pamphlet attributed heterosexual African cases to it without any evidence of actual sexual practices in central Africa (Lieberson 1986: 44). Similarly, CDC researchers attempted to persuade those with AIDS in Belle Glade, Florida (where the per capita rate of cases is the highest in the United States) that they must be homosexual or intravenous drug-users (Fettnner 1986; Norman 1986).

Most of the epidemiological data gathered from Africa (or even from North American gay communities) have not been published (as of late 1988), except for self-reported number of partners and sexual practices. Despite the relative difficulty of female-to-male transmission of the virus supposed to trigger AIDS, the equal sex ratio of African AIDS cases has not been conceived as an anomaly to sexual transmission. Instead, various hypotheses about anal sex (and genital ulcers) in Africa have been advanced without being evidence of prevalence. For instance, female circumcision (which occurs in areas to the north of the central African societies beset with AIDS) was supposed to lead to substituting anal for vaginal sex, though this still does not explain male cases. Unacknowledged bisexuality has been presumed despite invariant denial by Africans (and Haitians) with AIDS (Murray and Payne 1988; Murray 1988b).
The need for a virus

The "organized skepticism" of science expected by some (Merton 1968: 614–615) seems to have been overpowered by the need of at least an explanation for AIDS, pending any effective remedies, a cure, or a vaccine. An explanation in terms of stigmatized behavior (anal sexuality, heroin injection) among stigmatized populations (gay men, black heroin users, and Haitians) was comforting to many white heterosexuals, including medical researchers, and also federal bureaucrats attempting to minimize the need for federal health initiatives and to further privatize health care in the USA. In particular, in 1984 the Reagan administration's Department of Health and Human Services was under mounting pressure to show that it was doing something and making progress in controlling what was nominally its first health priority—without seeking additional funding.9

Statistically, if not morally, receiving blood transfusions is abnormal. Unlike homosexual behavior, it is a recent innovation, it does not occur "in nature," and it is viewed, at least by Christian Scientists, as "unnatural," indeed "contrary to nature." After the link between the opportunistic infections associated with AIDS and earlier transfusions was reluctantly made in 1983, "deviant lifestyle" lost some of its comforting explanatory power for those not particularly perturbed to have gay men and IVDUs dying. The syndrome was "acquired" just as unknowingly as it was among gay men, and everyone knows that surgery is dangerous, yet no one (to my knowledge) mobilized the rhetoric of "trying to fool Mother Nature and reaping the penalty." Although members of the president's generation and political leanings, such as Paul Cann, who were infected with HIV could focus on finding the "deviant" who had infected them by donating blood that no one at the time knew was "contaminated," recognition of transfusion cases greatly increased the pressure to find a microbe — and a means of neutralizing any danger to "the general public."

The American "discovery" of a putative aetiological agent, labeled HTLV-III, within the National Cancer Institute was announced in a press conference by HHS Secretary Margaret Heckler, who at that time predicted development of a vaccine within six months. So eager was that National Institute of Cancer laboratory headed by Robert Gallo to assimilate a virus already linked to AIDS by Institut Pasteur researchers (Barre-Sinoussi et al. 1983) to the series of retroviruses that Gallo had been studying, that they retained their HTLV acronym, which had stood for Human T-cell Leukemia Virus in HTLV-I and HTLV-II, to Human T-Lymphotropic Virus in HTLV-III (see Connors and Kingman 1988 on the involved political history of credit for discovering what is now labeled the Human Immunodeficiency Virus). Similarly, so eager to claim progress, a causal model, and a potential marker with which to protect the nation's blood supply were HHS administrators and scientists, that this putative causal agent was not assessed using Koch's postulates, the usual standards for evaluating causal models for diseases:

To establish a microorganism as the cause of a disease (a) it must be found in all cases of the disease; (b) it must be isolated from the host and grown in pure culture; (c) it must reproduce the original disease when introduced into a susceptible host; and (d) it must be found present in the
experimental host so infected (Duesberg 1987; see Koch 1890; Duesberg 1988).

In particular, the third postulate of sufficiency has not been met, since many persons with evidence of exposure to the virus do not show suppressed immune systems. The first postulate of necessity remains dubious with about ten percent of the AIDS cases written off as “measurement error” by NCI scientists. The existing correlations between AIDS and HIV do not prove causation, for “correlations without evidence for biochemical activity are not sufficient to prove ‘etiologic’... It is necessary to demonstrate some HIV-specific biochemical activity at the onset of AIDS to prove that HIV causes AIDS” (Duesberg 1988:516). Although there are viruses which become pathogenic after evidence of immunity appears (including hepatits viruses, and herpes zoster virus), they are “very active when they cause fatal, degenerative diseases,” as HIV is not (Ibid.). Moreover, Duesberg (1987, 1988) called attention to the logical impossibility of the Gallo model of a virus which is supposed to kill the few cells it infects yet survives in cells for eight or more years before the onset of AIDS.

Once the challenge to the basic HTLV/HIV causal model was finally made in the spring of 1987 (Duesberg 1987:1211–15), the Centers for Disease Control suggested that cases falling outside its postulated risk groups and testing negative for the presence of HIV antibodies not be reported as AIDS cases, even if the cause of death was one of the opportunistic diseases in the official CDC definition. Such a tactic preserves the model of risk and causation from empirical counter-evidence. Given the stake the federal government has in the profits of marketing HIV tests, such paradigm maintenance strikingly departs from the norm of disinterestedness (Merton 1968:612–14), as well as that of organized skepticism. At the level of clinical practice, gay patients without the opportunistic infections of the CDC definition were being reported as AIDS cases, and non-gay patients with the infections were not being reported all along (McCombie 1986).

If the stigmatizing diagnosis of AIDS is applied disproportionately (or only) to those belonging to already stigmatized groups and withheld from other persons, the patterning of cases becomes distorted. The schema of categorizing “risk groups” becomes tautological, confirmed by recognizing cases from “risk groups” and refusing to recognize other cases.

Risk factors

The identification of AIDS as a “gay disease” was continuously reinforced by the CDC’s classification system. Rather than report all cases with each characteristic, AIDS reports in MMWR suppressed interaction effects, e.g., a gay IV drug user was categorized as a gay case, a Haitian IV drug user as an IV drug user, etc. Such tidy classification precluded independent judgment of the relative weight of risk factors and of their prevalence in the population at risk. As early as late 1982 a CDC report found that 58 percent of AIDS cases classified as “gay” rather than as “drug user” used five or more different street drugs; 68 percent had used amphetamines with a median of 120 times (Lauritzen 1985:7; Krieger and Caceres 1985: 53). Although these data seemed far more exceptional to observers of urban gay subcultures than the number of lifetime sexual partners reported, the
presumption of sexual transmission has guided data collection and reporting. Although a gay/bisexual IV drug user category was eventually added to the hierarchy, most behavioral data gathered by epidemiologists dealing with anything other than sexual behavior and needle use have gone unpublished.

Published analyses been strikingly univariate in an age when sophisticated multivariate analysis is the norm in social, biological, and medical science, and when multifactorial disease models are supposedly paradigmatic within the profession of epidemiology (Oppenheimer 1988:269). As Lauritsen (1985:7) concluded, CDC hierarchical presentation of risk factors along with confining “drug use” to intravenous injection “de-emphasizes and under-represents every patient characteristic except homosexuality. One cannot help but suspect a theological mindset behind this statistical misrepresentation of reality: that which is most ‘sinful’ is presumed to be most dangerous.” As Conrad and Schneider (1980) noted of the dialectic of medicalization, the scientific veneer over traditional Judeo-Christian condemnation of homosexuality is very thin.

That risk factor classification is subject to extra-scientific consideration is perhaps even better demonstrated by the 1983 removal of “Haitian immigrant” from the CDC’s hierarchical list of risk groups in 1983. That there was direct political pressure is indisputable. The minister of health for Haiti, Dr. Ary Bordes, ordered re-evaluation of results (reported in Medical World News 9/26/83), already having announced what results should be found via The New Republic (8/1/83). The Haitian ambassador to the United States decried linking AIDS and Haiti in a letter to Newsweek and to the New England Journal of Medicine in September 1983, although the CDC had moved Haitian AIDS cases in the U.S. from a separate risk group into the category “other” a month earlier (8/9/83 MMWR), following New York City Health Department’s removal 28 July (Altman 1983). In June of 1983 the Groupe Haitien d’Etude du Sarcome de Kaposi et des Infections Opportunistes (GHESKIO) complained that Vieira et al. (1983) had proposed the transmission of AIDS from Haiti to the United States “without any scientific basis” and countered with a hypothesis that AIDS was introduced to Haiti by vacationing U.S. homosexuals (Boony et al. 1983: 1419). This complaint was the prototype of defenses of Haiti’s “national honor” (and tourism revenue). The Haitian government’s interest in explaining away Haitian cases with homosexuality dovetailed with the U.S. government paradigm’s inability to explain heterosexual cases in Haiti or among Haitian-Americans.

Later in 1983, a more direct attempt to maintain AIDS as a “homosexual disease” rather than a “Haitian disease” was made under the title “Only Homosexual Haitians, Not All Haitians.” Altema and Bright (1983: 878) were either uninformed about or oblivious to the fact that the CDC AIDS risk factor classification methodology would not include anyone who could be labeled “homosexual” in any other risk category. They claimed, “Over the past several years there have been many gay clubs in Haiti, usually frequented by young, poor Haitian male prostitutes and vacationing gays,” although they did not present any evidence linking AIDS cases in either Haiti or the United States to such clubs, or, for that matter, to homosexual behavior. Instead, they concluded, “The controversy hinges on most men
denying homosexual behavior. The truth of the matter is that normally a Haitian homosexual disclaims his tendency to a heterosexual.”

The truth is that in most cultures—including even in the half of the states of the United States where, like Haiti, there are no laws against sodomy—most people who have been involved in homosexual behavior and even most of those with a gay identity frequently disclaim the “tendency” to many people, including doctors (Ross 1984). Such denial is not unique to Haiti by any means, any more than is the existence of prostitution or of gay clubs. Although for a former (quasi-)colony, Haiti has received relatively little attention from American social scientists, those who studied rural Haiti were able to elicit information about attitudes towards local homosexuals (Herskovits 1937a,b; Simpson 1942). The reported attitude of bemused denigration and the lack of any attempts to extirpate homosexual behavior do not differ from those reported throughout Latin America (Carrier 1975, 1976; Murray 1980b, 1987). If anything, less prominent machismo in Haiti connects with greater toleration of homosexuals—especially in such indigenous niches as rara bands (Davis 1986) and voudou(n) nations (Bourgignon 1976)—than is imaginable in any Spanish-speaking Latin American societies. Bahia, which was similarly populated from the West Coast of Africa, is the closest cultural analog, and there, cross-gender possession and homosexuality are prominent parts of Sango cults (Landes 1940; Fry 1987). The particularly notable taboo on homosexuality is not reported in pre-AIDS ethnographic literature about Haiti. Instead, in the folk religion, which was cultivated by the Duvalier regime (see Davis 1986; Fettner 1986), explicit gender non-conformity was notable. There is not any evidence in earlier literature on Haiti of a taboo on mentioning homosexuality.

Certainly, any serious assertion that it is particularly difficult to elicit information about homosexuality from Haitians must be comparative, but no one has compared elicitation in Haiti to elicitation in the Dominican Republic, Bahia, or any other point for comparison. In the United States itself, “except for three cases of AIDS in admittedly homosexual Haitians, none of the other cases reported have admitted to homosexual activity despite intensive questioning in both French and Creole by both American physicians and by Haitians” (Landesman 1983: 33). Taking all the 1983 reports of AIDS linked to Haiti in Lancet and the U.S. and Canadian medical literature, there were 53 female cases and 69 male cases. Twenty of the latter were linked to homosexuality / bisexuality. In addition, Landesman (1983) reported three of seventy cases of Haitian immigrants to the U.S. identified as homosexual. By the end of 1983, 23 of 266 (8.6 percent) AIDS cases born in Haiti had been linked to homosexual activity.14

The popularity of Haiti as a vacation spot for gay Americans suggested in GHESKIO communiques was unaccompanied by even anecdotal evidence. Examination of official U.S./Caribbean air travel statistics for the years preceding the recognition of AIDS shows that while travel to Haiti was increasing, both the absolute magnitude of travel and the rate of increase were greater for other Caribbean countries than for Haiti. Insofar as gay travel can be estimated from gay guidebooks,15 Haiti was once of the least-favored destinations in the Caribbean for gay travelers during the 1970s and the less-favored half of the island of Hispaniola (Murray 1988). Epidemiological data published through late 1988 does not include data on
Haitian travel of American AIDS cases ("gay" or other). At the Haitian end of the hypothesized transmission vector, Dr. Jean-Michel Guerin of GHESKIO told d’Adesky (1986: 16) that "all his patients—without exception—had denied having sex with tourists." He flatly stated, "AIDS in Haiti is not a homosexual disease" (Ibid.). Warren Johnson, a Cornell epidemiologist working with GHESKIO, was quoted by Norman (1986: 415) as saying that only eleven percent of AIDS cases in Haiti could be linked to homosexual sex, blood transfusions, or intravenous drug abuse. It should be noted that these statements were made after the fall of the Duvalier dynasty in 1986.

From special methods to special logic

Although the director of the Centers for Infectious Diseases, Walter Dowdle, justified dropping the Haitian risk factor on the basis it was "the only risk group identified because of who they were rather than what they did" (American Medical News, 19 April 1985, p. 11), it is in fact the risk factor most difficult to understand by behaviors thought to transmit the AIDS virus. The non-Haitian risk factors are all kinds of people: drug users/abusers/addicts, homosexuals, bisexuals, hemophiliacs, even recipients of blood transfusions. All these classifications can be resolved into behavior proposed to be means of transmission: sharing needles, passive anal intercourse without condoms, injecting clotting factor or blood containing the virus. The sharing of needles, which differentiates U.S. from Canadian case patterns, may also be a risk factor for Haitians (and Africans, as well). Especially after the introduction of tests for exposure to HIV, there was no logical/scientific reason to continue to speak of "risk groups," especially since as early as the 4 March 1983 MMWR, there was CDC cognizance that "each group contains many persons who probably have little risk of acquiring AIDS."

The logic of Dowdle’s "what they do"/"who they are" dichotomy of AIDS risk groups could easily be extended to the "homosexual/bisexual" (who they are) risk category, making the risk male-male anal intercourse (what they do). Instead, the facile CDC equation of homosexual behavior and "homosexuals" ignores the large literature about the problematic link between homosexual behavior and identity. Fischl and Dickinson (1984: 331) claim, "Haitian men who are the passive partner or homosexual prostitutes generally will not consider themselves homosexual." The same could be—and frequently has been—said about North American hustlers and about many other active partners in homosexual relations outside contemporary gay communities, as well. Not every man in the United States or in Haiti whose behavioral repertoire includes passive anal intercourse without condoms classifies himself or is classified in his social circle within the risk category "homosexual and bisexual men," whereas many men who consider themselves gay do not engage in that behavior, and some others who consider themselves gay do not engage in any homosexual behavior (Reiss 1961; Bell and Weinberg 1978; Weinberg 1978; Humphreys 1975; Murray 1987a).
Doing Something

Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. Men born to freedom are naturally alert to repel invasion of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding. —Justice Louis Brandeis in Olmstead vs. U.S.

The role of symbolic politics in the identification of an aetiological agent of AIDS and assignment of risk factors was considerable. AIDS was fit into the paradigm of consequences of "promiscuity," with drug use as well as stigmatized sexual behavior included within "promiscuity." This mindset led directly into paternalistic and punitive policy initiatives. The "application" of AIDS science to public health has been driven by the symbolic politics of conventional "morality" even more obviously than were the "scientific" classifications of the disease, its aetiology, and "risk groups." Blaming victims is a leitmotif of public discussion of AIDS, derived directly from the view that "promiscuity" is an invariant, defining characteristic of gay men. In media coverage and the cosmologies of many gay men exposed to the virus in the late 1970s or early 1980s before AIDS appeared are viewed by many as less "innocent victims" than those who received blood transfusions during the same time, before anyone knew there was a risk of a yet-to-be-identified disease.

Protecting the nation's blood supply—and thereby removing exclusively heterosexual white males other than those who received blood transfusions between the mid-1970s and March 1985 from all but the remotest risk of AIDS—was quickly accomplished. In March 1985 the Food and Drug Administration licensed the ELISA test to detect HIV antibodies (with an explicit statement that the test was to screen blood and was not a diagnostic test to predict acquisition of immunodeficiency). Tactics based on making behaviors found immoral by some safer, on the other hand, have been obstructed or blocked by moralists. They have been more intent on avoiding any appearance of state "condoning of immorality" than with concern about saving lives (or liberties) of those they regard as "immoral." Promoting safer sex is too controversial for U.S. public health departments. Politicized religious pressure presses pre- and extra-marital chastity as the only legitimate goal. At least annually, the U.S. Senate bans funding for any educational material that represents safe homosexual sex. In American public health during the 1980s, empiricism, realism, common sense, and rational weighing of costs and either benefits or dangers must oppose a flood of moralistic doublespeak, transparently specious rationalizations, and feverish anxiety about sex and disease.

In the following section the lack of scientific/statistical basis for some public health "applications" of knowledge/misinformation about AIDS will be outlined. Special attention will be devoted to an early action by what is generally conceived to be the most enlightened and liberal American city health department (see Altman 1986). If the ideology of the sexual counter-revolution can force the kind of symbolic politics that upholds "traditional morality" however slight the likelihood is that they effect AIDS transmis-
sion in San Francisco, it can drive health policy anywhere in the United States. Personal privacy is more cherished in California than in many other states, as evidenced both in initiative balloting and in state constitutional decisions. Yet, freedom of assembly was overridden without any demonstration of countervailing medical necessity in a city with a widely known history of tolerance for diversity—a diversity which includes four gay political clubs. The case is further deserving of special attention because of the dangers of well-meaning interference with liberty warned against by Justice Brandeis in the epigram to this section and because a best-selling historical novel (Shilts 1987) by one participant is taken, even by sociologists, as factual reportage.17

Closing gay baths

Until 1984, resisting pressure from San Francisco Mayor Dianne Feinstein (whose distaste for gay male "promiscuity" was a matter of public record prior to the identification of AIDS, and who is viewed by local civil libertarians as extraordinarily insensitive to civil liberties issues in general) and from others, Dr. Mervyn Silverman, director of public health, had refused to close down bathhouses and private sex clubs in the county, maintaining that it was behavior rather than its locale which mattered in risking AIDS. The formula for the alternative was "Out of the tubs, into the shrubs." Bayer (1989:32–33) quotes 1983 letters from Silverman asserting, "Because the facilities of most bathhouses do not present a public health hazard I feel it would be inappropriate and in fact illegal for me to close down all bathhouses and other such places that are used for anonymous and multiple sex contacts" (10 May 1983) and "I do not share your impression that the subculture who use bathhouses would not immediately switch to other locations where we would have less access to post warnings and provide some education" (12 September 1983). Public health warnings and guidelines were distributed in the baths, whereas no education campaign was feasible in locales of "public sex" such as the parks. Silverman also stressed that those engaging in homosexual sex in the baths, tearooms, and parks were not necessarily gay-identified (see Humphreys 1975; Bell and Weinberg 1978; Murray 1984), and, therefore, could not be reached with information via the gay press.

Silverman could have rationalized continuing not to interfere with the (federally recognized) right of assembly and the (state-recognized) right of privacy for adult consensual sex by citing the indicators of behavioral change, viz., the drop in rectal gonorrhea from 1,700 cases in the second quarter of 1982 to 400 cases in the second quarter of 1984 (see Figure One),18 and a still unreleased CDC study of bathgoing which failed to establish bathgoing as an AIDS risk factor.19

However, two gay San Franciscans took it upon themselves to force closure of the baths. Randy Shilts, a San Francisco Chronicle writer, who viewed constitutional rights of privacy and freedom of assembly as "let[ting] gay businessmen murder gay people" (quoted by Hippler 1989:130), was the most peripatetic. His first tactic was to supply a California Magazine attack on the San Francisco Department of Public Health for minimizing the threat of AIDS to the wider community (this venture is not mentioned in Shilts 1987). At the height of general paranoia about blood banks and the
safety of living in the same city as gay men, this was in itself a signal contribution to enhancing homophobia. At the same time it was a means of waging a new offensive in the interminable internecine struggle between San Francisco's two largest gay Democratic clubs (politics far too complex to explicate here, although the Department of Public Health's gay and lesbian liaison, Pat Norman, associated with the Alice B. Toklas Gay Democratic Club, was preparing to run for the Board of Supervisors, where Harry Britt, a former president of the Harvey Milk Gay Democratic Club, was running for re-election to one of six at-large slots).

Shilts' second offensive (Chronicle, 2 Feb. 1984) was to seize on a miniscule fluctuation in the trend of decreasing incidence of rectal gonorrhea as evidence that San Francisco gay men were resuming unsafe sexual practices. The rates of rectal gonorrhea are taken to be indicators of the amount of receptive anal intercourse with strangers. Since the latter is the major means of transmitting AIDS among gay men, the rates are taken as indicators of future AIDS rates (the time lag being due to the hypothesized incubation period of the posited virus, 11.8 years in the current best estimate of Lemp et al. 1990:1499). If this indicator is accepted, obviously its trend is important, so that prediction must depend not on differences from one quarter to another but a trend line. However, Shilts sensationalized a small fluctuation, ignored the trend, and, when the rate dropped the following quarter more than it had increased in the quarter he chose to publicize, he did not bother to report it at all. Indeed, Shilts (1987:415–416) again reported the fluctuation as if it were a change in the trend line.

The other offensive by a San Francisco gay man in 1984, the real “triggering event” (see Galliher and Cross 1983), was undertaken by Larry Littlejohn, a gay deputy sheriff later shown to be engaged in competition with bathhouses—he was dismissed in 1987 after being charged with pandering for young male prostitutes. Littlejohn did not attempt to organize a gay response, such as picketing the establishments. After meeting with Shilts and Leonard Matlovich (Hippler 1989:122), Littlejohn's first resort was to seek state intervention. He began seeking signatures for a city initiative closing the baths in the spring of 1984, arguing, “We must not fool ourselves. There are no educational programs that will effectively change high risk for AIDS sex habits of bathhouse patrons to safe sex” (California Voice, 5 April 1984, p. 2). Matlovich explained,

Some people argued that they were a place to educate. But I thought it was a far better strategy to close the places down first and then to educate, because people wouldn't have paid attention otherwise. Furthermore, I thought it was very foolish for our community to start drawing battlelines at the bathhouses (quoted by Hippler 1989:123).

Under pressure from Mayor Dianne Feinstein (Chronicle 28 March 1984, p. 20), and supported by some leaders of the Harvey Milk Gay Democratic Club and eager both to close the baths and to avert a plebiscite on the baths by San Francisco voters, Silverman assembled a group of gay medical and political leaders to discuss closing the baths as a menace to public health. Reportedly the orchestrated gay demand to close the baths to protect gay bathgoers from themselves was more dissonant than expected. The Bay
Area Physicians for Human Rights, a group of doctors concerned with gay health concerns and recognized for special expertise about diseases affecting gay men, refused to endorse any governmental action to close bathhouses. The National Gay Task Force stated its opposition in traditional civil liberties terms:

NGTF feels most strongly that personal behavior should not be regulated by the state, which historically has been an instrument of our oppression. Furthermore, state closure of such establishments would be largely symbolic, a largely symbolic gesture that would provide a false sense of security that the AIDS epidemic had somehow been contained (NGTF Update, 28 March 1984).

The consensus of gay community leaders for bath closure, which the Milk Club leaders assured Silverman existed, was far from evident at a 29 March meeting. The next day, at the news conference scheduled for announcing closure of the baths, Dr. Silverman merely announced that no decision had been reached pending determination of the legality of various courses under consideration. Although there can be no doubt that Mayor Feinstein continued to press for bath closure, gay doctors and their organizations did not support state intervention. For instance, the president of the American Association of Physicians for Human Rights wrote Silverman,

The closing of businesses to protect people from themselves cannot be accepted... There should be no understanding. AAPHR strongly discourages sexual contact with multiple anonymous partners. But we cannot and will not support any effort to enforce that viewpoint (2 April 1984 letter quoted by Bayer 1989:37).

From New York City, where the preponderance of AIDS cases were, both the Commissioner of Health and the director of New York City’s Office of Gay and Lesbian Health stated that they would not act to close private clubs, the latter stressing that “there is no science to support the closing of the bathhouses” (quoted in the April 1984 Coming Up!, p. 9).

Bayer (1989:38) asserts that “action against the baths was inevitable” in San Francisco. In his retrospective accounts of his pacing of bathhouse closure (to Fitzgerald, to Bayer, and in Silverman [1986]), Dr. Silverman has contended that in addition to waiting for opinions about the legality of various actions he could take (including quarantine), he was waiting for gay leaders, or at least gay physicians with experience of the ravages of AIDS, to orchestrate closure of private clubs in which anonymous sexual interaction with multiple partners continued, or at least to mobilize support for action by the Department of Public Health. The scientific literature available to him was the same as that available to directors of public health in other jurisdictions. If there was any evidence that the locale of multiple sexual encounters could be differentiated as a risk factor for AIDS, it would surely have been available in the other epicenters of the disease. If scientific evidence (new or not so new) suggested a course of action, let alone demonstrated the need for this particular one, it would be very remarkable
that public officials elsewhere, particularly in places without vociferous and organized gay rights organizations, did not draw the conclusions Silverman did.

Bayer (1989:38-9) reports that there was a long meeting of health officials on 3 April at which the tactic of regulating rather than closing private sex clubs was agreed upon. Such a meeting was not reported at the time, and would almost certainly violate California laws requiring meetings at which public policy are determined to be open to the public. Whatever the truth and source reporting a meeting on the third, it is certain that on the ninth of April Silverman held another press conference and announced a ban on sex between individuals in “public facilities.” Behind him were twenty-four of those with whom he had discussed what to do. Within a few days eleven of this group publicly rejected the policy (Bay Area Reporter 19 April 1984, p. 8).

Banning sex rather than closing the baths outright was a compromise sufficient for Littlejohn to halt collecting signatures for his initiative petitions. All sex, not just the kinds of sex the official policy and educational literature of the Department of Public Health had urged curbing until then, was proscribed in the baths and other kinds of private membership clubs licensed by the city and county of San Francisco. Mayor Feinstein was not satisfied that this action was sufficient. Although the Department of Public Health was supposed to enforce the edict, and also to monitor threats to the public health, some weeks after the promulgation of the bath sex ban, the mayor sent policemen (presumably in towels) to report on what was going on in the baths post-sex-ban. She refused to release the report even to the Board of Supervisors, but there is no doubt that the report indicated that sex continued to occur in the baths and clubs. No arrests for violating the sex ban were made, nor were any licenses to operate clubs or baths revoked, so there has not been a court test of whether Dr. Silverman had the legal authority to override the state’s consensual sex-in-private law. Toronto police got around the problem of how to accuse men in locked cubicles in Toronto baths of having sexual relations in public: tearing down the doors. San Francisco public health regulation aimed to accomplish the same end without such clumsy force: Silverman’s draft revision of Section 263 of the San Francisco Police Code (under which the baths are licensed) banned doors on cubicles.

Surveillance by private investigators reported continued (primarily oral or manual) sex in various places. On the morning of 9 October 1984, Dr. Silverman decreed that the operation of three bookstores, two theaters, and nine private clubs,

contributed to the spread of the virus that causes AIDS; accordingly, the Director of Public Health has determined that the continued operation of the above designated businesses constitutes a hazard and menace to the public health; then by virtue of the power yielded in him by the law of the State of California, the Charter of the City and County of San Francisco, the Director of Public Health for the City and County of San Francisco hereby orders the
above designated businesses to close no later than 12:00 noon (notice posted on doors of closed businesses).

His press statement elaborated:

The places I have ordered closed today have continued in the face of this epidemic to provide an environment that encourages and facilitates multiple unsafe sexual contacts, which are an important contributory factor in the spread of this deadly disease. When activities are proven to be dangerous to the public and continue to take place in commercial settings, the Health Department has the duty to intercede and halt the operation of such establishment.²⁴

Because the order was delivered by armed policemen and alluded to power vested by state law, the order was initially perceived to be a quarantine. However, the power invoked was that of “abating a public nuisance” (i.e., local rather than state grant of authority to the county Director of Public Health). Once this was learned, six of the businesses reopened to challenge the authority of public nuisance regulation (Bay Area Reporter, 11 October 1984). Within a week, San Francisco Superior Court Judge William Mullins signed a temporary restraining order that reclosed the clubs (but left theaters and bookstores open out of First Amendment considerations), pending a 30 October hearing on the city’s petition to close them indefinitely. In the request for a temporary restraining order Silverman again equated commercial with public, contending that “altering sexual activity is a matter of individual privacy; when that sexual activity takes place in a commercial setting, this government has the prerogative and duty to intercede,” and emphasizing that his professional judgement as a public health officer was that it was necessary to “bring to an end commercial enterprises that involve exploitation for profit of an individual’s willingness to engage in potentially lethal forms of recreation” (People of the State of California v. Ima Jean Owen et al. memorandum from Mervyn Silverman). As Bayer (1989:48) noted, “Perhaps most remarkable in the city’s [actually county’s] well-prepared case was the failure to obtain a clear declaration of support from any nationally known epidemiologist involved in the study of AIDS and the patterns of sexual behavior among gay men.”

The response for the defendants cited the lack of scientific evidence that bathgoing was a risk factor for AIDS, challenged the unsafeness of the sex reported by private investigators, and rejected Silverman’s equation of “commercial” and “public,” arguing, “There is simply no legal basis to distinguish the right to engage in consensual sexual activity in defendants’ premises from the right to engage in consensual sexual activity in hotels or private home, no difference between someone who rents a cubicle in a bathhouse and someone who makes a mortgage payment on his house.” They contended that the burden of proof that closure “will be sufficiently effective to justify the obviously serious intrusion on property rights, privacy rights, and associational rights” should rest on the county health department. They were also able to do what San Francisco officials had not been able to do, present briefs from experts outside the county government.
(specifically, public health officials from Los Angeles and New York) to
argue that the proposed closures could not be expected to have any
reasonable likelihood of affecting the rate of AIDS cases.

Judicial review in late November by Superior Court Judge Roy Wonder
rejected the county’s case for closure. On 28 November, Wonder ruled that
the clubs could reopen, but ordered them to remove private rooms, to hire
monitors (one for every twenty patrons) to survey the premises every ten
minutes to ensure that no unsafe sex acts were occurring, and to expel
patrons observed to be engaging in “unsafe sex practices.” To the amaze-
ment of almost everyone, the delineation of “unsafe sex” was initially
assigned to the San Francisco AIDS Foundation rather than to the County
Department of Public Health (to which the definitional power was later
reassigned along with other “technical” clarifications 21 December 1984).

The weekend after the bath closure in San Francisco, an Oakland bath-
house owner reported that his business increased 142 percent, repeating the
pattern from 1950s crackdowns on San Francisco gay bars, when patrons
also relocated their cruising across the bay (Bérubé 1984: 18). The decision
was not appealed, and over the course of the intervening years owners have
closed all the San Francisco bathhouses open in 1984. Commercial venues
for safe sex (mutual masturbation) operate in the county, and facilities with
private rooms for unregulated sex continue to operate in nearby counties.

Other jurisdictions

In late 1985 in New York City, where most of the diagnosed U.S. AIDS
cases were, parallel moves to close several gay bathhouses on the basis of
private investigator reports of unsafe sex (mostly fellatio) occurred. As in
San Francisco, the reversal of policy about bathhouse closure can be directly
related to pressure from above, viz. New York Governor Mario Cuomo,
who like Mayor Feinstein had a track record of insensitivity to gay civil
rights and what civil libertarians label “statism” in regulating conduct. Also
as in San Francisco, the New York City health department was bypassed
and surveillance of activity in clubs was conducted by investigators from
another department. Also, as in San Francisco, they observed and reported
practically no anal sex. In New York City the most visible and gay-owned
establishments (the Mineshaft and New St. Mark’s) were targeted; less
visible, allegedly Mafia-owned establishments remain open.

The major difference (other than a lag in timing) between the New York
and San Francisco actions is that the New York judge (Richard Wallach) did
not devise a policy of his own for regulating sex clubs. In City of New York
v. St. Marks Baths the judge deferred to the health department and did not
evaluate the evidence about sex clubs as a risk factor. In May 1986 in upstate
New York in Commissioner of Health of the County of Erie v. Morgan Inc., et
al closure was rejected because the county did not sustain the burden of proof
of dangerous behavior occurring. Los Angeles County Department of
Public Health sex club orders were overturned in the summer of 1986, again
because the county failed to establish any likelihood that its regulations
would reduce the spread of AIDS. Also during the summer of 1986, the San
José Water Garden, the largest and plusher gay bathhouse in northern
California, was given special recognition for its contribution to AIDS
education by the Santa Clara Department of Public Health.
Just as public officials elsewhere did not rally to Dr. Silverman’s side in 1984, Dianne Feinstein, who was chair of the U. S. Conference of Mayors, failed to enlist support from her peers for a resolution urging closure of sex clubs (Bayer 1989:69). In August of 1988 the state assembly and senate passed the Bradley Act to assist San Diego County efforts to shut down bathhouses there under the guise of nuisance abatement. However, as of mid-1990, gay bathhouses in Berkeley and San José continue to operate, and some unknown number of gay San Franciscans go to them. California county public health directors’ quarantine power has yet to be used in regards to AIDS.

The “scientific evidence”

There was (and is) no evidence showing bathgoing to constitute a risk factor for AIDS. As mentioned in the chronology above, 1984 CDC data still unpublished in 1989 found bathgoing to have no statistically significant effects. The more or less simultaneous report of an ongoing monitoring of changed sexual behavior among San Francisco gay men, which was funded by the Department of Public Health, appears to have been influenced by the policy of closing bathhouses more than it could have contributed to the policy. At least, its authors showed more interest in contrasting bathgoers with other gay men in the report than in their data collection: McKusick et al. (1984) compared only two self-reported behaviors for bathgoers and bargoers. To the surprise of many (and no doubt the consternation of some moral entrepreneurs), they found that those in their bathgoer sample were no more likely to have received anal intercourse with new or secondary partners five or more times during the previous month than their bar-going sample. Furthermore, 56 percent of the bath sample in contrast to 50 percent of the bar sample reported none.25

Considering that only two of the reports of behavior contrasted the bath subsample to the other subsamples, both the abstract and the conclusions of McKusick et al.’s 1984 report (abridged and published in 1985) gave inordinate attention to bathgoers, whom they characterized as more rigid and more compulsive than other gay men, although the evidence for these psychological characterizations is nowhere in the report. Similarly, the following indictment seems to have been pulled from the air or from officials’ prejudices rather than from any data reported in the study (or in other literature on the baths, such as Lee 1978; Styles 1979; Weinberg and Williams 1975):

It is apparent that the identities of men in the bathhouses are more attached to sexual behavior than men in other groups and that these men as a group are the most rigid and inflexible in their sexual response patterns. There may also exist in certain members of the bathhouse group a type of fatalism that is not subject to the influence of information, since they may already believe that they have come in contact with the hypothetical transmission agents (McKusick et al. 1984:29).
If it was apparent, it is on the basis of evidence other than that presented in their reports. In neither study did McKusick et al. (1983, 1984) attempt to determine whether bathgoers have more sex or are more “addicted” to sex than any other human group (see Levine and Troiden 1988), nor did they use any psychological scales for rigidity. Unless they asked their respondents why they did not stop more high-risk behaviors, belief by a regular bathgoer that he has already come in contact with the mysterious AIDS agent, and so has either survived exposure or is incubating it, can be considered a success of the dissemination of the scientific consensus, in this case the posited long incubation period and low contagiousness of the searched-for virus.26

Moreover, their assertion, “The efforts of the Public Health Department have been ineffective in influencing sexual activity at the bathhouses” (McKusick et al. 1984:2) was misleading. According to their own data, more of those in the bath sample than those in the bar or couple sample listed “public information brochures or posters” as a source of information about AIDS (p. 13). They also showed that “knowledge of the disease process and the risk reduction guidelines closely parallels opinion of experts and is well disseminated across subgroups” (1984:13). That is, for transmitting information, the public education efforts of the gay press (the main source of information for most sampled gay men), public health authorities, and others were successful prior to Silverman’s attempts to regulate or close gay clubs.

Sixty-five percent of the bar and bath samples, 88 percent of the coupled sample, and 85 percent of the volunteer sample indicated they had already made the changes in their lives needed to adapt to AIDS (for most this was something, because 84 percent reported AIDS had had an impact upon the behavior), so the informational diffusion could be viewed as quite widespread, presuming the McKusick et al. studies were valid. Whether the behavioral changes were sufficient was, of course, subject to interpretation. Longitudinal data from a random sample of single men in the nineteen San Francisco census tracts with the most AIDS cases in 1984 show HIV seropositivity to have been very high by the beginning of 1984 (48.6 percent), and to have increased only slightly since then (to 49.3 percent; Winkelstein et al. 1987a, 1988). Hessol et al. (1987), analyzing blood stored from gay volunteers attending San Francisco’s STD Clinic in the mid-1970s and participating in a hepatitis-B study, found most of the seroconversion occurred between 1979 (when five percent were already infected) and the beginning of 1984 (by which time more than fifty percent had seroconverted).27

In Los Angeles County where bathhouses have remained open, Richwald et al. (1988) interviewed 807 men who could speak English leaving bathhouses in 1986. Fifty percent reported that information about AIDS received in bathhouses played a major role in their understanding of AIDS prevention; another 37 percent reported it played a minor role. Ninety-seven percent were familiar with bathhouse information on AIDS prevention. Despite this information, five percent reported receptive anal intercourse without a condom. The ten percent involved in anal intercourse without a condom28 were significantly more likely than those who did not practice this highest risk sexual activity to be aged less than thirty, to be Hispanic, never to have attended college, to be earning less than $20,000 per year, and
to have had five or more male sexual partners in the past month. Unfortunately, no data were obtained from monolingual Spanish-speaking men, who constituted five percent of the sampled population. If one can extrapolate from Los Angeles in 1986 to San Francisco in 1984, it would seem that those who were not heeding the message of condom use were the segments of the population most difficult to reach outside the bathhouses. It would also seem that the small minority of bathgoers who continue to receive unprotected anal intercourse with multiple partners from a population which is more than half HIV-antibody positive are already infected, so that closing the baths would not afford them any protection. Whether it would protect their sexual partners (including women for seven percent of those reporting anal intercourse without a condom) or would distribute unsafe sex more widely is not easy to predict or to measure.

Three years after closing the bathhouses and sex clubs, Silverman (1986:34; also see his similar secondary elaborations to Bayer and Fitzgerald) still could not point to any evidence establishing bathgoing as a risk factor. Like any good politician, he could, however, provide folksy non sequiturs to make his policy sound plausible: (1) allowing bathhouses to continue to operate was like providing crop subsidies to tobacco growers at the same time public health education funds are spent to stop smoking, (2) “some people would feel that their civil liberties would be violated if we told them they could not have sex in a restaurant or a church” and (3) what gay leader would want to create the institution of the bathhouse if it didn’t exist? Obviously, the first is not unthinkable, since it describes policies of the federal government. The second is a peculiar comparison, since banning sex in restaurants and churches would not interfere with the purposes people assemble in those settings. The third non sequitur, the hypothetical question Silverman posed to gay opponents is counter-factual, so the answer is irrelevant to public policy. One could as easily ask, “If there wasn’t a bill of rights in the Constitution of the United States, would there be an impetus to amend the Constitution to add it in the 1980s or 90s?” Whatever the original purpose of social institutions, with the passage of time additional meanings attach to them. Gay bathhouses symbolized uncontrolled male promiscuity to some, a haven from violence and homophobia to others (see Weinberg and Williams 1975; Lee 1978; Styles 1979; Bérubé 1984), and the rights to privacy and freedom of assembly to others.

The symbolic politics of Silverman’s shifting or evolving policy (and Judge Wonder’s modifications of it) attempted to balance competing demands of persons with markedly differing definitions of the situation. Verifiable medical facts were not necessarily of interest to those pressing any of these foci. If there had been compelling medical evidence, the director of public health had and has sweeping quarantine powers (Novick 1985). American courts have shown great reluctance to question official claims of “medical necessity” or “military necessary” (Murray 1987); this is perfectly exemplified by the judge’s refusal to question the cogency of the health department case in City of New York v. St. Marks Baths.

As was mentioned above, the failure of neighboring counties to follow Silverman’s precedent is prima facia evidence that the decision stemmed from local political considerations rather than overwhelming scientific evidence. Yet another indication of the essentially political motivation of the decision is the frequency with which Dr. Silverman referred to a public
opinion poll published in the April 8 1984 San Francisco Chronicle, in which most respondents favored forcing the baths to close. As Brian Jones (1984: 6) commented, “When a doctor makes a decision because the voters favor it, that doctor is a politician” (see Perlstadt and Holmes 1987).

It is impossible to believe the bath closure was motivated by new scientific evidence rather than by political pressure. There was no new clinical or epidemiological evidence to justify a change of policy, especially since doing so would have undercut the credibility of the thrust of the education campaign and its most visible proponent until then, Dr. Silverman himself. Even six years later, no link between bath-going and AIDS has been established, and the CDC has not listed bath-going as a risk factor. As for the slight increase of rectal gonorrhea in one quarter sensationalized by Shilts, no serious epidemiologist, statistician, nor experienced public health figure would have staked his or her credibility on so slight an increase indicating a trend back to earlier levels. The Public Health Department’s own reports (McKusick et al. 1983, 1984; Werdeger et al. 1987) reported both information about medical opinion and changed behavior, including a 90 percent reduction in the number of gay San Francisco men “practicing receptive anal intercourse with nonsteady partners” between 1978 and 1985. The results could be interpreted as suggesting that more education was not going to lead to more change, although no one has publicly interpreted them that way.

No one knows whether the changes were “enough.” Seroconversion had markedly slowed before the bath closure, and no changes in seroconversion trendlines nor in rates of rectal gonorrhea in San Francisco date from April or October 1984. San Francisco County epidemiologists whom I have asked where the effect of bath closure in these data might be have not claimed any.

The Promiscuity Model Extended to Heterosexuality

If an intervention does not produce results, and yet is supported by officials and the public, one must look to secondary reasons to explain that support. The issue thus becomes not the desire to protect the public from hazard. . . Rather, these activities indicate a transformation from protection to punishment. —Brandt (1988: 165)

Just as AIDS has been used to rationalize traditional attempts to prevent homosexual behavior and close public institutions, it has been seized upon in the latest recurrence in a cyclical attempt to blame prostitutes for medical and/or moral problems of their clients (see Bullough 1976; Pivar 1973; Brandt 1985). The “nature” of prostitutes is to be promiscuous in serving a market, and transmission of sexually transmitted diseases is traditionally blamed on this “nature” rather than on that of their clients. The clients are generally viewed by the law and social opinion as tempted into sin. They are not viewed as being “by nature” promiscuous. Clients of prostitutes may infect their wives, but not the prostitutes — in this often-unconscious cosmology prostitutes are intrinsically diseased, and can never be “innocent victims” of infection by their customers. Given the apparent difficulty of female-male transmission of HIV, or whatever else may cause AIDS, focusing on prostitutes seems to be another instance of blaming the victims.
and thereby transforming “risk” in the sense of vulnerability to “risk” in the sense of threatening. Prostitutes have been regarded as being risks, not being at risk, although there is no “scientific evidence” implicating handling of money or having sex for money as vectors of AIDS transmission.

Genuinely professional prostitutes tend to protect themselves by using condoms and/or by substituting oral for vaginal intercourse. But it has not been established that even prostitutes who have AIDS or who harbor HIV constitute much of any danger to partners without lesions or cuts on their genitals, even through unprotected vaginal intercourse. Moreover, a CDC(1987) study found prostitutes at no higher risk of developing AIDS than are other sexually active women. Similarly, prostitutes’ HIV infection rates were comparable to the rates among all heterosexual women in the cities sampled (Bartos et al. 1985; Brenky-Fadeaux and Fribourg-Blanc 1985).

Nevada has already tested all of the prostitutes in legal brothels. Over 4,500 tests were conducted on 500 women and not one was seropositive. Needless to say, this did not make the front page of the New York Times (Katy Taylor, Deputy Director of the New York City Commission on Civil Rights in Crimp 1988: 135).

The focus on promiscuity as the essence of prostitution led to overlooking or underplaying intravenous drug use among prostitutes. In San Francisco none of 146 prostitutes who did not use IV drugs tested seropositive (Cohen et al. 1987). Eight of ten seropositive Florida prostitutes were IV drug users (CDC 1985).

Among Africa prostitutes, whose existence has frequently been regarded as the explanation of heterosexual AIDS transmission (Chumack et al. 1984; Van de Perre et al. 1985), intravenous drug abuse is little known. Kreiss et al. (1986) reported that none of their sample of 90 prostitutes used “recreational” drugs, but that all had a history of intramuscular injections. The combination of popularity of injections for any and all medical problems in Africa and the reuse of often-unsterilized needles needs to be considered before explaining HIV infection among Africa prostitutes as sexually transmitted, especially since reuse of needles in STD clinics would seem to be an especially good way to move a virus from bloodstream to bloodstream of the sexually active—far more efficacious a route than from vaginas to penises.

Similar commitment to the paradigm of sexual transmission is evident in a report dealing with the Caribbean island of Hispaniola: Koenig et al. (1987) reported that “only one of 115 female Dominican prostitutes showed evidence of exposure to HIV. She is an IV drug user...” and ignored the latter factor to reaffirm promiscuity as the danger: “Many of the young people who live near the poverty line accept prostitution as a means of support. Efforts must be made to control this major method of transmission.” It would seem that the decision about this “major” danger preceded the data collection and was unchanged either by negative findings (1/115) or by the presence of an alternative source of risk (the needle use of the one).

Interventions that look like “control” or “elimination” of prostitution are politically popular. For public health officials pressed to “do something, anything” about AIDS, prostitutes are inviting targets. In a worldview in
which AIDS is caused by promiscuity, actions against prostitutes are easily rationalized. Considerations of statistical analysis, or empirical questions about the actual sexual practices of prostitutes, or due process for stigmatized populations are not as salient to the general public as the wish for demonstrations that the public health is being protected from those who are believed to be willfully endangering it. As generations of politicians both inside and outside public health have known, “crackdowns” on prostitution (and other forms of sexual “immorality”) are popular, and are useful for distracting media and/or publics from criticism of officials’ other shortcomings. Similarly, both legislation against and publicity about prostitutes who have tested positive in HIV antibody tests and continue to ply their trade fail to distinguish performing safe sex acts from unsafe ones:

Since sex is not defined in these new laws creating harsher sentences, those who engage in activities such as manual stimulation and fantasy-oriented sex can also be charged with felonies. This scapegoating legislation sets a precedent for criminalizing erotic experience for anyone who is HIV-positive, even if the practices are 100 percent safe (Leigh 1988:181).

Legislation making it illegal for HIV-positive customers to have unprotected vaginal or anal intercourse with prostitutes somehow never follows. Prostitutes are morally contaminated in a way customers of prostitutes (a category which includes more than a few legislators) never are in American demonology. Husbands, sons, and fathers would be pure if it weren’t for the corrupting influence of prostitutes, homosexuals, and drug suppliers in this long-running fantasy and American purity crusades are always aimed at the supply rather than at the demand for illicit pleasures (see Pivar 1973). Those who buy drugs or the services of prostitutes are viewed as weak, while those who sell drugs or sex accumulate all the evil to be apportioned.34

**Moralistic Obstacles to Prevention Strategies**

Traditional moralistic politicians seek to ensure that what they see as “sin” is punished on earth. Not just prostitutes and homosexuals, but anyone who ventures from the “path of righteousness” is “asking for trouble” and “deserves whatever they get.” To take any public health actions to make it safer to engage in pre- or extra-marital sex or in drug use is opposed as “condoning immorality” and interfering with the “natural punishments” (unwanted pregnancy, sexually transmitted diseases, drug overdoses, hepatitis, AIDS, degradation and, preferably, grisly death) which should deter all right-thinking and -acting people in this “one nation under God.”

**Condoms**

For instance, seeming to condone “sexual immorality” (of which birth control is a significant part in the view of many Americans) is dangerous to careers in the intensely politicized domains of law enforcement and public health. Campaigns to promote greater condom usage by prostitutes (or
anyone else) are not politically feasible in the United States. Instead, condoms are routinely confiscated as "physical evidence" when prostitutes are arrested, and no accommodation to the reality of the demand for the service of "the oldest profession" can pass unnoticed by Christian moral entrepreneurs.

Attempts to extirpate any information about condoms—along with censoring any specific acknowledgement of sex outside marriage—from publicly financed AIDS education have been widely reported in mass media. Educational material has been recurrently censored by those who find any depiction of sexuality offensive and likely to encourage sex. Within the Reagan administration, Secretary of Education Williams piously counseled chastity, while the surgeon general pressed for information on condoms, surmising that Americans—in particular, young Americans—are not going to remain chaste until a cure for AIDS is found. The secretary of communications for the U.S. Catholic Conference of Bishops objected to condom advertisements specifically because "such ads might promote 'safe sex,'" while Joseph Cardinal Bernardin of Chicago reiterated that although the immediate aim of such advertising might be "good — the prevention of disease" it is unacceptable because it "questions the normativeness of heterosexual marriage as the proper context for sexual intimacy, or artificially separates the love-making and life-making dimension of marital intimacy" in the institution which cannot be questioned, heterosexual marriage (Hirsley 1988: A17). Avoiding even implicit questioning of heterosexual marriage (and information about a form of birth control within it) suffices to justify attempts to suppress the exercise of the constitutionally guaranteed right of free speech in a state constitutionally separated from the directives of any church. "Medical necessity" is an accepted rationale for intervening in the lives of stigmatized populations in the United States, but is insufficient for any initiatives which might offend the religious feelings of sex-negative Christian churches by advertising the existence or increasing the availability of prophylactics. This is a social fact. The result of subordinating the concern for effective outreach to those most at risk of HIV transmission to avoiding anything which might offend someone with the moral susceptibilities of Senator Helms's rhetoric is that

not a single piece of government-sponsored education about AIDS for young people in Canada or in the U.S. has been targeted at a gay audience. . . Government officials, school board members, public health officials, Catholic cardinals insist that AIDS education must be sensitive to "community values." But the values they have in mind are those of no existing community affected by AIDS. When "community values" are invoked, it is only for the purpose of imposing the purported values of those (thus far) unaffected by AIDS on the people (thus far) most affected (Crimp 1988: 270, 265).

Needles

AIDS has also been used to reinforce condemnation of drug users—at least low status users of street drugs. As of mid-1987 28 percent of U.S. AIDS
patients were IV drug users. After a restudy of 1982–86 drug-related deaths in New York City, the Department of Health concluded that “AIDS-related deaths involving intravenous drug users accounted for 53 percent of all AIDS-related deaths in New York City since the epidemic began [sic.: was recognized], while deaths involving sexually active homosexual and bisexual men accounted for 38 percent” (New York Times, 22 Oct. 1987, p. B1). In New Jersey, where IVDUs account for 53 percent of diagnosed cases, the mean time between diagnosis and death is only 18 days, a statistic which in itself indicates that lack of contact between IVDUs and medical services (and education). Watters, Iura and Iura (1987) found that 90 percent of San Francisco IVDUs continue to share needles. The average needle-user shared needles with thirty-seven different people a year.

In order to combat needle sharing, some public health officials proposed needle exchange programs, such as those underway in Great Britain, Australia, and the Netherlands. As with condoms, making shooting heroin safer is an unpalatable tactic even to liberal politicians. San Francisco Mayor Dianne Feinstein delivered her opinion that “it is a terrible and truly offensive idea which would put the health department in the position of aiding and abetting drug addiction” (San Francisco Chronicle, 26 July 1986).

Routine testing

If condoms and clean needles were used, transmission of HIV or whatever agent in the blood causes AIDS could probably be blocked at relatively low costs. Supposed fiscal conservatives claim that avoiding the costs of big government (especially in cases where the costs can be privatized) is one of their major concerns. Avoiding even the appearance of “condoning” private behavior of consenting adults apparently is more important than saving tax dollars or than doing anything effective in AIDS education, however, because money is appropriated for mass HIV testing. In advocating HIV testing as a routine part of marriage application, President Reagan claimed that his reason was to measure the scope of HIV’s spread through the population (New York Times, 1 June 1987). An interest in accurate numbers is spectacularly out of character for Ronald Reagan, whose administration attempted to dismantle a wide range of longitudinal data sets. Moreover, if the interest were genuine, such a self-selected sample would provide a biased estimate. Routine testing for death certificates would provide far more useful data without affecting life chances, but apparently no one in the federal government is interested in finding evidence of HIV infection in “reputable” members of the president’s own generation. Rather, marital testing is aimed at the young and at distinguishing possible “deviants.”

The rationale for military testing is just as specious: the battlefield transfusions which the Department of Defense maintained they were protecting hardly ever occur. Blood volume expanders have superceded the technology of transfusions, as the National Academy of Science (1986: 122) report noted. As Mohr (1988:179–81) suggests, the HIV antibody test is another in a long line of indicators seized upon by the American military to distinguish possible homosexuals (and secret drug users): “Knowing a soldier’s antibody status will not help the army to take better care of him. The paternalistic argument is wholly bogus. In no other area is the army suddenly concerned with the better care of its personnel.”
The sudden concern for the health of prison inmates — at the same time that nothing is done to curb prison rape or to reclassify condoms from being contraband in prisons — is similarly suspect. Then U.S. Attorney General Edwin Meese recommended to federal and state parole boards that a positive HIV antibody test be considered a reason not to parole prisoners, who gravitate to child care positions (New York Times 9 June 1987)! We find it difficult to believe that ex-cons gravitate to child care or that they would be permitted to take jobs in that sector if they sought them. Although it appears to us that this incredible concern was a passing attempt to increase parental anxiety about day care facilities (and, thus, directly part of the administration’s promotion of “traditional” families), no questions about it were raised when the news was reported.

In all these instances, the President, Secretary of Defense, and Attorney General of the United States did not even bother to concoct remotely plausible rationales for costly testing. The rationales given are transparently unrelated to the needs for epidemiological information or to protecting military personnel, prisoners, or anyone else who tests positive. It is more difficult to establish what their real motivation is, but it certainly appears likely that their aim is to ferret out and punish “secret deviants.” Suitable sacrifices reaffirm the moral order, according to Durkheim and Foucault. In this case, the death of “deserving” cases may deter experimentation with drugs or sexual adventures. An “innocent”/“deserving” distinction is at least implicit in the Reagan administration’s approach: IV drug users and male homosexuals in the late 1970s and early 1980s should have known of the risks of a yet-to-be-identified disease; unborn babies and those receiving transfusions could not. The moral status of those born black in Haiti or central Africa is not exactly clear in this theodicy, nor is it clear why “God’s punishment” of homosexuality passed over those who engage in female-female sex.

**Conclusion**

In public health thought (discourse), AIDS was immediately added to the class of exotic diseases transmitted by promiscuous sex. Although promiscuous needle use and heterosexual “promiscuity” now supplement homosexuality within the paradigm of immoral excess, the explanatory model persists among medical researchers at least in accounting for transmission of a virus believed to be the cause of AIDS, and for many non-scientists as the “real cause.” Because a syndrome was initially identified among gay men, it was obvious to medical researchers that whatever it was must be sexually transmitted. The preference for a sexual explanation persisted, obstructing consideration of drug use by those already “explained” as “homosexuals.” Between mid-1983 and late-1986, the anomaly to this explanation posed by the existence of heterosexual Haitian and African cases was avoided by assuming the Haitians were lying and the Africans were engaging in heterosexual anal intercourse (and were also probably lying). There was never any evidence that Haitians or Haitian-American men are more likely than men of other origins to conceal homosexual behavior when suffering from fatal diseases. There is no evidence that central Africans are more likely to engage in heterosexual anal intercourse.
than are North Americans. (Questions about how, when, and by whom exclusively heterosexual male African AIDS cases were anally penetrated were also begged by the extension of the anal explanatory model).

In addition to homosexuality, beginning in 1984, another “sexual deviance,” prostitution, was medicalized to account for AIDS—with no attention to prostitutes’ drug habits, or even to their sexual habits. Again, “being a prostitute” rather than behavior was the focus of attention. Given the apparent difficulty of female-to-male sexual transmission, this broader conception of “promiscuity” does not explain aetiology, but reinforces attempts to condemn and eliminate extra-marital sex. A focus on prostitutes is certainly consistent with the CDC taste (paradigm) for multiple-partner sexual transmission as an explanation of whatever they can’t explain without the help of emotional reactions to “immorality.” In American epidemiological work in central Africa, other avenues (razors and needles used for tattooing, knives used for circumcision, and the common reuse of needles in Western-style hospitals in Africa) to bloodstream (especially male ones) are not explored, while questions about visits to prostitutes and the number of sexual partners are a source of seemingly endless fascination.

The commitment to the inadequate sexual transmission theory derives from more fundamental features of American medicine than the homophobia and erotophobia of some clinicians and researchers. As has been widely noted, American doctors prefer to deal with acute diseases amenable to capital-intensive, high-tech remedies involving considerable control over patients. No such remedies are available for AIDS. A disease that kills previously healthy men in their twenties and thirties is both personally and professionally distressing. It is even a threat to the reputation of medicine in American society. We believe that doctors need to explain AIDS away as “their own fault,” quite apart from pre-existing hostility to homosexuality, prostitution, and recreational drug use, or of contempt for drug users and prostitutes. The sexual transmission of AIDS has been used by opportunistic politicians (inside and outside public health) to legitimate reinstating prohibitions of homosexual acts that are exceedingly unlikely to transmit the AIDS virus (e.g., fellatio, see Winkelstein et al. 1987b: 323). Under the guise of public health, homosexuality en toto has been remedicalized, and new extensions of social control of sexually active adults are proposed daily to protect a “public health” in which the “public” is only a righteous elect.

Notes

1. The “client” for American medicine includes the state as well as patients and families of patients.

2. An instance of possibly direct importance for federal government epidemiologists was the congressional inquiries about the failure to establish the cause of “legionnaire’s fever”: see Culliton (1976). Despite the label of a “lifestyle choice” in the name, legionnaires were not considered a menace, and their deaths were not seen as divine punishment for conventioneering in Philadelphia. Perhaps, the briefness of the outbreak spared those who died from being blamed for their illnesses.
3. For compelling analysis of sensationalism of the promiscuity paradigm to fit conventional prejudices within mass media coverage of AIDS, see Albert (1984 et seq.), Crimp (1988), and Gilman (1988:245–72). The focus of the present paper is on the conceptions, selective attention, and actions of public health professionals and organizations.

4. In 1987 New York City Department of Health reexamined 1982–86 drug-related deaths and classified many as AIDS-related, but did not extend the analysis to the late 1970s “junkie pneumonia” (Crimp 1988: 249, n11).

5. The set of labels used before the consensus on “AIDS” was achieved are listed in Murray and Payne (1988). It bears noting that GRID (gay-related immunodeficiency) was not a locution used (at least in print) by epidemiologists. It was used in the gay press, and in a clinical abstract by the discoverer of AIDS (Gottlieb 1982). An interesting contrast is the mysterious series of deaths still known as “ legionnaire’s fever.”

6. The subtext of much scientific and most popular AIDS discourse is that gay men went shopping outside conventional morality and acquired a syndrome, like acquiring a leather jacket. Presumably a celibate nun (or a monogamous, heterosexual man) injected with blood containing HIV in the 1970s was no more choosing to acquire a syndrome of infections than was a man exposed to HIV at the same time while engaging in homosexual activity, yet transfusion cases (along with children born with congenital syndromes of immunodeficiency) are often presented as “innocent victims,” although there is no difference in the ignorance about the existence and risks of AIDS, and, therefore, no difference in the degree of agentry in running the risks.

7. To avoid potential misunderstandings, we do not question that viruses, including the putative AIDS-causing virus, HIV, can be transmitted during anal intercourse. Direct transmission to the bloodstream, however, not sexual orientation nor even the number of sexual partners in itself (i.e., independent of the sexual behavior engaged in), is salient. Exposure to HIV or something else co-occurring with HIV (if HIV-infection is an indicator rather than the cause of AIDS) appears to be a necessary but insufficient condition for damage to immune functioning (see Duesberg 1987, 1988; Levy and Ziegler 1983; and “the need for a virus” section below).

8. The general public conflates cause with transmission. Some of the difficulty health and school officials have had in convincing parents that pupils with AIDS going to school with their children do not constitute a threat to their children can be attributed to the dissemination of the hepatitis analogy. This equation did not originate among the masses!
9. See Shilts 1987 on the official claims of adequate funding.

10. Bayley et al. (1985: 360) and Rodriguez et al. (1985: 1099) provide the most compelling evidence.

11. "It actively infects only 1 in \(10^4\) to \(10^5\) T cells. Under these conditions HIV cannot account for the loss of T cells, even if all infected cells die, because during the two days it takes HIV to replicate, the body regenerates about 5% of its T cells, more than enough to compensate for losses due to HIV" (Duesberg 1988: 514).

12. As one anonymous referee noted, "Research on the relationship between drug use and AIDS has continued to be hampered by moralistic focus on 'street' drugs."

13. Hessol et al. (1988) found statistically significant correlations between the progression of HIV infection to AIDS and earlier use of hallucinogens and of tranquilizers, cautioning that the correlation might be because use of these drugs is an indicator of a lifestyle of indiscriminate mixtures of recreational drugs rather than any direct effects of the specific substances.

14. Canadian and French cases linked to Haiti are not included. Detailed secondary analysis of Haitian-linked AIDS cases is contained in Murray and Payne (1989).

15. Frequency of listings in gay guidebooks is highly correlated with U.S.-Caribbean island air travel (Murray 1988b).

16. There are questions on travel to or sex with persons native to Haiti and Zaire within the previous two years in the CDC's current Multi-Area Cohort Study (MACS) questionnaire (except for West Coast cities). No rates of positive response to this question have been published. Data on the most recent two years can hardly be expected to bear on behavior prior to 1981, or indeed on Human Immunodeficient Virus (HIV) infection, given the official estimate of a 7.8 year mean incubation period it (Lui, Darrow and Rutherford 1988).

17. See the critique of the sensationalism and fictionalizations in Shilts (1987) by Crimp (1988: 238-49 ). In particular, Crimp shows how the unsubstantiated portrait of Patient Zero is made of the genre conventions of a villain seeking to destroy the innocent and the stereotype of uncontrolled homosexual male promiscuity. It was this story based on conventional American demonology that was serialized in newspapers across America and on "60 Minutes." With this focus, purporting to be "the facts" about how AIDS came to California (or America in some versions), the portrait of federal government unconcern and inaction in the book was ignored. Gaetan Dugan, not Ronald Reagan or the Department of Health Services in his administration could be blamed for the spread of AIDS. Leaving aside questions about the basis for Shilts's knowledge of what Dugan thought about whether
Kaposi's sarcoma was contagious, the time between his sexual contacts and the appearance of opportunistic infections regarded as AIDS was too short to be consistent with the current model of HIV incubation into AIDS (Moss 1988).

18. In contrast Schultz et al. (1984:296) reported a 59% drop in rates of rectal gonorrhea in Manhattan— from 485 per hundred thousand in 1980 to 201 in 1983.

19. Bayer (1989:43) had access to the communication of the findings of no distinct risk factor to Dr. Silverman from the principal CDC epidemiologist working on AIDS, William Darrow. The existence of this finding was reported in the April 1984 Coming Up! Bayer also reports that Silverman and his deputy for communicable diseases, Dean Echenberg, complained about the finding to Darrow's superiors at CDC. It is extremely difficult to imagine data showing sex clubs were a risk factor for AIDS being suppressed in an administration signally insensitive to the gay community and to civil liberties. Not issuing a report exonerating gay institutions is far more in character for the Reagan administration, its Department of Health and Human Services et al.

20. As they had left the state, the case did not go to trial. In earlier years as a homophile activist in the Society for Individual Rights, Littlejohn participated in challenging medical authority and pushing the American Psychiatric Association to remove homosexuality from the list of mental illnesses.

21. It seems that Littlejohn, Matlovich, and Shilts chose the battleground and did not attempt to see if anyone would "pay attention" to educational programs. I have heard allegations that there was another sense of no one paying attention to these men in the bathhouses that undergirded their "revenge" (see Hippler 1989:87).

22. Shilts (1987:436-41), who can be taken as an accurate reporter of the views and machinations of the Milk Club clique, details the "squeeze play" of telling gay leaders that Silverman would close the baths and Silverman that there was community support and its failure when an open meeting showed that Shilts's friends had been misrepresenting a consensus that did not exist.

23. Traditionally, clubs requiring membership have been called "private member clubs" rather than "public places." Bayer (1989) who is ostensibly concerned with the boundaries of private and public does not question the semantic sleight in Feinstein, Silverman et al. relexifying private assembly as "public" because such establishments are licensed by the county. It should be obvious that the county also issues marriage licenses without claiming that this provides a basis for regulating conduct within that institution. Building codes, public recording of deeds, etc. involve the state in homes, so that "public concern" has precedent there (as well as in hotels, a locale which the
New York Health Commissioner included within the bounds of his AIDS policy jurisdiction). The analogy of seatbelt laws and motorcycle helmet requirements is less apt in that governments build and maintain roads in addition to licensing drivers (besides which the clear medical evidence about motorcycle helmets has only intermittently led to the state protecting persons from conduct dangerous to their health and costly to the public). I can also report from personal experience that smoking was still permitted in meetings within the Department of Public Health at the time.

24. The relevance of "commercial" in this is unclear (see note 6 above). It might also be observed that the overwhelming majority of acts observed in these places were not and have not been proven dangerous. Of course, the whole safe/unsafe distinction so carefully nurtured by the Department of Public Health in San Francisco prior to 9 April 1984 was abandoned in the blanket proscription of sex in gay clubs.

25. It cannot be assumed that the sex reported by the bath sample occurred exclusively in the baths. Perhaps owing to the professional bias of psychologists for constructing personality patterns, no attempt was made to distinguish how many sex partners bathgoers had sex with in the baths from how many outside. The cherished notion of the promiscuous personality, of course, undercuts the rationale for government interference with the operations of the specific institution of the baths. Since at the time the questionnaire was prepared and distributed the official public health view was that if the baths were closed, gay men would go elsewhere, the explanation for this failure might be historical rather than occupational, i.e., the authors did not anticipate that their results would be used to justify a policy shift.

26. The persistence with which promiscuity was attacked as the problem, continuing despite the gradual shift in epidemiological discourse from number of sexual partners to particular behaviors as the mechanism of transmission (see Darrow, Jaffe and Curran 1983 for the most important statement of this revision) did not bolster confidence in "authoritative" public health pronouncements (see Murray and Payne 1989). McKusick et al. (1983:19–20) betrayed none of their informants' uncertainty about which "safe sex" policy to adopt. They were, thus, able to distinguish those (30 percent) "who have responded appropriately in terms of eliminating contact with the infective agent" (which had not at that point been identified, let alone shown to be in any particular bodily substance) and the "alarming number" (62 percent) "still engaging in high-risk behavior which, according to current [and notably unstable] epidemiological thinking [which was undergoing a paradigm shift at the time] has not removed them from danger of infection." The other eight percent so appalled McKusick et al. that they were not discussed. McKusick et al.'s key to "appropriate adaptation" is clear in their rhetoric of overcoming the "resistance" to commit to a primary relationship: doctors have prescribed monogamy; uncompliant masses have resisted.
27. In the 13 July 1984 MMWR (p. 377) slightly different preliminary figures from the San Francisco City Clinic Study were available: 25 percent (of 48) in 1980 to 65 percent (of 215) in 1984. This latter figure was used as the best estimate of HIV-infection among sexually active gay men in deliberations by Silverman and other San Francisco physicians concerned with AIDS (personal communication from a BAPHR member), although it is now regarded as an overestimate due to the biased basis for recruitment into the study (cf. Winkelstein et al. 1987).

28. This figure includes insertive as well as receptive; thirty of eighty-four reported both roles in the same night.

29. At least some justification for such an extrapolation is the earlier heightened visibility of AIDS and AIDS prevention efforts in San Francisco, including the bathhouse closure controversy. Also, the Winkelstein et al. (1987a) data from San Francisco census tracts show a similar (to the Los Angeles bathgoer sample) proportion of the gay population continuing to engage in anal intercourse without a condom.

30. Bayer (1989:61) quotes a 9 October 1985 memorandum from Director of the New York City Office of Epidemiological Surveillance and Statistics Alan Kristal to Health Commissioner David Sencer which says, “The prevalence of infection in the sexually active gay population is already so high that the environment from which one selects sexual partners has little relevance.”

31. Silverman (1986:33) also asserted that six months after the bath closure “mail from the gay community was over 60 percent in favor of closing the bathhouses.” Just how many letters he was receiving at that point is not specified. It would be surprising if there were large numbers of letters suggesting re-opening the bathhouses. The civil rights precedent was already set, although Silverman has continued to fail to understand a distinction between admiration for the bathhouses and opposition to state interference in constitutionally-guaranteed rights.

32. The same is true for the actions of the Health Commissioner of the State of New York in October 1985. David Axelrod claimed to change the state’s policy on the basis of “new evidence” rather than political pressure (New York Times, 25 October 1985, p. B3). One can hardly expect public health officials explicitly to state that they are subordinating their professional judgement to political demands.

33. “[African] patients often express a strong preference for parenteral rather than oral therapy... beli[ving] that parenteral medication is more effective... As with injections, patient expectations and medical overuse of blood transfusion may contribute to the potential spread of HIV” (Quinn et al. 1986: 959).
34. Except when one’s own son or daughter or brother or sister is implicated. An analogous widespread fantasy exists in which seduction is necessary to explain homosexuality, which then becomes irresistible, so that heterosexuality cannot compete in a free market.

35. To claims that the intent might be to protect unsuspecting women (who are presumed not to have had sexual intercourse with the men they are applying to marry), Richard Mohr (1988: 180) noted, “The legal institution of marriage is shot through with regulations, legal commitments, binding obligations, and risks affecting major life components about which the partners typically know nothing and about which, indeed, they are socially and legally encouraged to stay in ignorance.”

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(Note: For articles with more than four authors, only the first is listed)


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