Introduction: The Contemporary Historiography of AIDS

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AIDS "has stimulated more interest in history than any other disease of modern times," as we wrote in the introduction to *AIDS: The Burdens of History* in 1988.[1] This interest led many commentators to employ history, and sometimes even historians, to explain what this epidemic has in common with devastating infections in the past. Now, a decade after AIDS was first recognized, there is increasing evidence that analogies to the past can be misleading, as they usually are in the history of war or economies or anything else. In this essay we summarize and criticize the brief historiography of the epidemic and suggest research questions and methods that may lead to more valid and useful historical writing. We then introduce the essays in this volume, essays that lead us in the directions we have proposed as both necessary and useful.

The history of AIDS is a problem in contemporary history. The problem the epidemic raises for historians and for others who use historical methods is to understand the intricacies of the relationships among people and the institutions they have created in the closing decades of the twentieth century.

In the early 1980s most accounts presented AIDS as a radical break from the historical trends of the twentieth century, at least in the industrialized nations: a sudden, unexpected, and disastrous return to a vanished world of epidemic disease. Historians and most other people who paid attention to AIDS addressed it as a startling discontinuity with the past. The new epidemic seemed to bear little relationship to the diseases that absorbed the most attention and resources—the chronic diseases

of an aging population. Epidemic disease belonged to history, a history that most had comfortably forgotten. But faced with the new threat of AIDS, people felt a need to reach back into history to discover how previous epidemics had been handled: how had societies dealt with plague, cholera, and polio? We searched for analogues in the past.

We found some apparently significant parallels and some similar themes in past epidemics: themes that seemed useful. Most of the essays in *AIDS: The Burdens of History* followed this pattern, as did a set of conference papers published in *Social Research*.[2] The editor of the latter collection made explicit the analogy to past epidemics by choosing the title "In Time of Plague." Media accounts of the epidemic increasingly made use of historians' references to past plagues, and Susan Sontag drew on the work of historians for her influential *AIDS and Its Metaphors*.[3] Sontag, however, inverted the historians' argument that diseases must be understood in their social and cultural context; she wanted to strip disease of its social and cultural meanings, or metaphors, leaving behind only what she regarded as pure biology. Barbara Rosenkrantz's note of warning has largely gone unheeded: "The ordinary vices that tempt us to make simple sense of history are, not surprisingly, embedded in our culture. They offer the same temptations that we face in mounting resistance to the uncertainties of epidemic disease: the vice of 'whiggery' through which we celebrate linear progress and reassuringly demonstrate how evil is overwhelmed by good, and the vice of relativism, which separates the event from its context so we may conclude that nothing has really changed."[4]

Several aspects of the early years of the AIDS epidemic had made analogies with past epidemics seem relevant. AIDS was an infectious disease that defied cure and, for a few years, even the implication of a causal organism. More important, AIDS seemed to resonate to great historical themes—notably the victimizing and stigmatizing of helpless members of minority groups and the indifference of public officials callous to human suffering. The disease attacked gay men just a few years after they had, for the first time in modern history, been freed from the most overt oppression and, at least in major cities, had asserted a visible political presence. The disease allowed some journalists and politicians a ready opportunity to express—more accurately, to resurrect—fear and resentment toward newly visible and assertive gay communities. Moreover, the disease struck at the time when containing health costs had become a major objective of governments in the United States and Western Europe, and these governments were reluctant to recognize, let alone

deal with, the potentially devastating costs of coping with a new epidemic. The battle between a beleaguered gay community and a government apparently indifferent to the epidemic provided the dramatic point and counterpoint for Randy Shilts's *And the Band Played On*.[5] Indeed, many of the themes of early AIDS historiography dealt with the insensitivity of governments, socially and morally repressive attitudes to sexual behavior, the tendency of those in power to blame the poor or other disenfranchised groups for harboring dread diseases, and the potential threat of quarantines or other attacks on individual rights—all themes that were complaints or fears of a gay community facing an unsympathetic, indeed hostile, administration in Washington (and, by some accounts, in the capital cities of Europe).

Debates about how to respond to the epidemic reinforced the belief that AIDS was discontinuous with the recent past. Oversimply, these were arguments between alarmists on the one hand and advocates of equanimity on the other. The alarmists found analogies to the present in the great epidemics of infectious disease—notably bubonic plague, cholera, yellow fever, influenza, and polio. They urged adoption of what had become the classic repertoire of public health responses to epidemics: enhanced surveillance, mobilization of medical resources, and increased research. Advocates of equanimity used different historical parallels. They recalled times in the past when exaggeration of the severity of an outbreak of infectious disease had led to the deflection of resources from areas of greater need, the exchange of individual rights for an illusory collective good, and diminished repute for the enterprise of public health. These advocates needed to go no further back than the flu nonepidemic of 1976, although historians soon supplied them with many earlier examples.

Both the alarmists and the advocates of equanimity agreed that AIDS was a contemporary plague. They shared the belief that history was pertinent to understanding the epidemic and that the events in the past that were most pertinent were those surrounding sudden, time-limited outbreaks of infection. This agreement was the result of the shock of discontinuity in the early 1980s. Many people were unwilling to believe that a disease that had emerged (it seemed) so suddenly, and appeared to be invariably fatal, was either deeply rooted in the past or likely to become part of the human condition for the foreseeable future.

Because the history of visitations of plagues was the only history that appeared relevant to the new epidemic, most people ignored the alternative historical models that were available. For example, most of those

who used historical analogies avoided the most pertinent aspects of the histories of venereal disease and tuberculosis, emphasizing issues of surveillance and personal control policy and ignoring the problems of housing, long-term care, public education, and the financing of palliative care for people suffering from chronic infections. Tuberculosis and venereal disease had been, for many years, both endemic and intractable. For individuals, they were chronic, debilitating conditions; lifetime burdens. For the people who provided and paid for health services, these diseases were characterized by a few acute episodes and long periods when patients required no care or only supportive care. For public health officials, venereal disease and tuberculosis raised difficult problems about surveillance, public education, and the long-term control of noncompliant patients. Yet in the early years of the AIDS epidemic, people who sought historical analogies explored venereal disease and tuberculosis mainly for what they could learn about screening, contact tracing, and the restraint of patients who were dangerous to others. The history of the two leading chronic infectious diseases of modern times, that is, was used to understand a very different situation, a polity threatened by devastating plague.[6]

At the end of the first decade of what is now called the epidemic of HIV infection, the initial sense of discontinuity with the past seems ironic. For some people, especially those with the infection or close to people who have it, the psychological alternative to discontinuity is devastating. The alternative to discontinuity is admitting that the threat of disease is not transient, not a matter of a bad season or a terrible year; not, that is, like the Black Death or cholera or yellow fever. For public officials, health industry leaders, and physicians, the idea that AIDS would become another killer chronic disease, like heart disease, cancer, and stroke, has been unpalatable because it adds to the already overwhelming financial and organizational problems of health policy. Yet for all these people it is becoming increasingly plain that AIDS, like tuberculosis during most of the nineteenth century, may be, for particular populations, an endemic life-threatening condition.

By the mid-1980s concerned physicians, public officials, and gay leaders no longer had to demand attention to an unrecognized life-threatening epidemic. AIDS was institutionalized within academic medicine and the medical care establishment. The patterns of research, services, and financing of care in the 1990s have more to do with long-term strategies for responding to diseases such as cancer than with the epidemic diseases of the past. It may well be horrifying to realize that

AIDS is fitting our patterns of dealing with chronic disease, since it puts the problem into a long-term perspective. But if we assume that the rate of HIV infection will continue for the 1990s much as it did for the 1980s; if we assume that, as with cancer, most treatments will prolong life rather than cure the disease; if we assume that scientific research will continue to expand our knowledge rather than soon provide a means of prevention or cure; and if we assume that we will continue to respond to AIDS through the provision of specialized hospital units, long-term care, and other institutional services, we must also conclude that we are dealing not with a brief, time-limited epidemic but with a long, slow process more analogous to cancer than to cholera.

When, separately and together, we presented an earlier version of this argument in March 1989, it generated considerable distress and skepticism. Three months later, by June 1989, the idea that AIDS should be regarded as a chronic illness was widely accepted; in a speech at the final plenary session of the international AIDS meeting in Montreal, Samuel Broder, head of the National Cancer Institute, publicly declared that AIDS is a chronic disease and cancer the appropriate analogue for therapy.[7] Such rapid shifts in public perception illustrate how quickly things change in the world of AIDS. As contemporary perceptions of AIDS change, so too does its history; historical accounts that at one time seemed most relevant to understanding the epidemic need to be replaced by new interpretations. Such shifts in the relevance of historical texts are, of course, familiar—but in the case of AIDS, they can be especially rapid.

As a result of huge increases in funding for AIDS research and services, AIDS has now entered mainstream medicine in the United States and Western Europe. AIDS services are being financed by the existing system of private medical insurance and government programs. The costs of AIDS are being met by shifting around budgets. Today the problem of health policy is not so much to provoke a more generous official response to AIDS as to make sure that other health programs are not sacrificed to feed the swelling budgets appropriated for AIDS research and services.

Today, moreover, there is relatively little talk about quarantine, isolation, and mass testing for the disease. The immediate panicked reactions to the disease have been replaced by medical management; even if we can do little more to treat the disease than we could five years ago, we know that responsibility for its management has now passed into the hands of those who organize and control our medical care system.

The lessons of contemporary history, when they are assessed, will be different from those drawn from the epidemic diseases of the past.

The analogy between AIDS and past plagues—the argument that this epidemic constitutes a sharp break with recent history and can best be understood in relation to more distant events—is itself data for contemporary history. The insistence on discontinuity was useful, politically as well as psychologically, in the early years of the epidemic. Discontinuity was a story that many people used to comprehend dangerous, distracting, and depressing events. It was also a theme that could be used to leverage additional resources for surveillance, research, and treatment of the disease.

Professional historians were not casual bystanders in the making of a history of the AIDS epidemic as discontinuous with the recent past and best understood by examining past plagues. Many historians, including ourselves, found analogies to AIDS in time-limited visitations of infectious disease in the past. It became fashionable to make references to AIDS at the beginning and the end of historical articles and monographs ostensibly dealing with other subjects in the history of medicine or sexual behavior.[8]

Historians should not be faulted for making AIDS a minor industry or for sharing an interpretation of the past that made sense to most other people who talked and wrote about the epidemic. It is pleasant to find one's work suddenly regarded as relevant, or to have it disseminated, even if in caricature, by the media. Historians of medicine have, in general, been consulted about recent events less often than, say, our colleagues who study war and foreign affairs.

Most historians have no special knowledge about contemporary events. Their hard-won, archive-based knowledge about the past events in which they specialize may easily seduce them into arguing by analogy to their own times. Moreover, knowledge that is derived from the close reading of archival (that is, unpublished manuscript) sources is both the strength and the weakness of professional history. It is a strength because it helps to sustain scholars' resistance to reading the present backward into the past, and it provides a strong basis for dismissing stories (or models or theories) about human behavior that have no empirical basis. It is a weakness because it creates a fondness for the particular, which, carried to extremes, becomes a mindless antiquarianism that relishes facts and artifacts at the expense of explanation.

The historians who properly claim special knowledge about contemporary events may have troubled relations both with other historians

and with colleagues in adjacent disciplines. Although contemporary history flourishes, with journals, grant awards, and numerous professorial appointments, its practitioners are often on the defensive. During most of the century and a half in which some people have earned their living as historians making claims to knowledge on a scientific basis, contemporary studies have been in professional disrepute. Until the early twentieth century, studies of ancient history or of the origins of modern nation-states earned scholars more prestige from their peers. Moreover, because the analysis of archival sources properly has been the basis of historians' claims to valid and reliable knowledge, contemporary history, for which many pertinent archives are closed, has been suspect. In dealing with the distant past, historians have only the dead and each other with whom to contest their interpretations; in dealing with the recent past and the present, they must confront the living—who have memories of their experience, and who may also have powerful and perhaps partisan explanations of the same events. The political and ideological struggles over interpretations of the present are usually waged with a special intensity rarely displayed in arguments over the more distant past.

Contemporary historians have, especially in the past several decades, had equivocal relationships with colleagues in adjacent disciplines—notably political science, economics, sociology, epidemiology, anthropology, and moral philosophy. Similarly, they have had equivocal relationships with professionals, such as physicians, lawyers, managers, and policy analysts, who are often paid to make informed judgments about the recent past. *Equivocal* may be too polite a word: the methods of historical inquiry have ceased to matter to many scholars and professionals in fields in which, earlier in this century, formal historical study would have been required. This is not the place to explain this circumstance, which has complicated causes. The essential point for our argument—and the basis for this book—is that practitioners of these fields are contributing to the historiography of the epidemic of HIV infection, that they will continue to do so, and that they would benefit from alliance with contemporary historians.

People in several disciplines and professions have been notable contributors to the contemporary history of this epidemic. The most thorough analysis of the responses of public health officials and gay community leaders has been written by a political scientist.[9] Other political scientists have written about the responses of the media.[10] An economist is the principal author of the only history to date of the effective-

ness of educational measures.[11] Two policy analysts (one a professional historian) and an economist have analyzed the history of perceptions of the cost of treatment for AIDS.[12] Sociologists have synthesized the history of the responses of philanthropic foundations[13] and the history of outreach to intravenous drug users.[14] Epidemiologists have told us the most about the origins and spread of infection;[15] physicians, about treating patients;[16] ethicists, about moral dilemmas.[17] A sociolinguist has written extensively about the history of women and HIV infection.[18] Lawyers have contributed important histories of measures to control the behavior of persons perceived as dangerous to others, discrimination, and the problems of public health statutes governing the classification of disease and surveillance.[19] And policy analysts have written the only systematic comparative history of AIDS policies in Western countries.[20]

This rapidly accumulating body of secondary sources in contemporary history has had an important, but as yet unacknowledged, impact on the historiography of the epidemic. The cumulative weight of these publications has made history by analogy obsolete and, implicitly, has challenged the assumptions about discontinuity and the pertinence of the classic plague model on which it was based. These rich secondary sources make plain the continuity between the HIV epidemic and the recent past, and they demonstrate the linkage between events during the epidemic and such matters as how we have thought about disease, minority groups, women, drug users, public health law, and the organization and financing of health services.

Most of the people who have written these histories have little interest in historiography. They did not write history to test hypotheses about the past, much less to examine the validity of a discontinuity model. They wrote because they were concerned about their own disciplinary or professional agendas or about certain areas of policy or advocacy. Insofar as they are conscious of other disciplines that contribute to their practice of a social science or a policy profession, they would, typically, credit statistics or economics.

Although the displacement of history as a fundamental discipline of the social and policy sciences accounts for the relative lack of interest in historiography, it does not justify resignation among contemporary historians. Historians of our own times may find an even more receptive audience among social scientists or the policy professionals than they do among colleagues who study the more distant past. Such a potential community of scholars, like all communities, would be based on rec-

iprocity. Contemporary historians now appreciate and use the theories and methods of adjacent disciplines. The problem for contemporary historians is to convince their colleagues who do history, but only incidentally, that they could do it better with the help of historians.

The HIV epidemic provides an opportunity to demonstrate the potential reciprocity of contemporary history and studies in other disciplines and the policy professions. The problem in achieving reciprocity is that historians must make a convincing case that their theories, methods, and ways of asking questions will help other people comprehend contemporary events more profoundly and with greater practical effect.

Although contemporary historians may disagree about what stance to take on particular theoretical issues, most would, we believe, urge their colleagues in other disciplines to pay more attention to three issues. Most historians would argue that having a considered position on each of these issues would improve the ability of scholars in any discipline or profession to make claims with reasonable objectivity. The first issue is social construction: the claim that historical reality does not exist as a truth waiting to be discovered but, rather, is created by people. Some social constructionists include the data of the biological sciences in their analysis. Others, rejecting this radical relativism, would maintain that biology or at least some forms of scientific knowledge have a validity independent of the social context in which they have been produced. For contemporary history, social constructionism means an emphasis on the complex processes by which disease is negotiated, the ways in which our concepts of pathology are defined and redefined, and the ways in which these conceptions of disease in turn govern our changing social and medical responses to illness.

AIDS is a particularly good example of the social construction of disease. In the process of defining both the disease and the persons infected, politics and social perceptions have been embedded in scientific and policy constructions of their reality and meaning. Human beings make disease in the context of biological and social conditions.

A second issue for historians is skepticism about the idea of progress. Skeptical historians worry about pseudo-causal statements that substitute metaphors for data-driven analysis of why events occurred and in what direction history (reified) is tending. Pseudo-causal statements are often driven by organic metaphors ("evolve," "develop," "unfold," "mature"). Skeptics also try to look behind polite synonyms for social or medical progress ("advance" is the most common of these synonyms) and to examine instead who did what to, for, or with whom,

with what documentable results. The AIDS epidemic, or epidemic of HIV and related diseases, makes plain the danger of naive ideas about progress. At a meeting of the American Academy of Arts and Sciences in early 1988, Nobel laureate David Baltimore stated that AIDS is a medical problem; the only issue is when we will solve it. Many of the debates and much of the anger between gay activists and scientists have revolved around the idea of scientific progress or the lack of it: the accusation on the part of many activists that scientists have not lived up to the promises of progress, and the defensive reaction from scientists that an enormous amount has been learned about the disease in the time available.

A third theoretical issue is wariness about presentism; that is, distorting the past by seeing it only (or even mainly) from the point of view of our own time. Among contemporary historians presentism is often a result of using analogies from current events to interpret earlier events that are comprehended only superficially. It is the reverse of the use of analogies discussed earlier, when historians who have research-based knowledge about the past use that knowledge to project simple moral statements or conclusions about events in the present. The desire for "lessons from history," while generally welcome, must be treated with caution and laced with an awareness of the problems of extrapolating from one historical context to another.

The boundary between theory and method is somewhat artificial, since a scholar's theoretical stance often accounts for his or her choices among methods. Nonetheless, there are several methodological concerns that contemporary historians can commend to their colleagues. The most important of these is comprehensiveness, the necessity of basing a historical account on the greatest possible variety of data—on, if possible, manuscript sources, artifacts, memoirs (oral and written), printed primary sources, and a critical analysis of the theory and methods of earlier accounts of the same events. The sociologist who allegedly complained to a historian colleague that "you people read too much" either got or missed the point, depending on the level of self-irony he intended.

In particular, contemporary historians are aware that they must be skeptical of data from interviews (or, more formally, oral history) even though, in the absence of manuscript sources, they often must rely heavily on such data. The historical literature contains considerable evidence that spoken history is an account of what respondents find memorable and choose to present, using the conventions of contemporary storytelling. Such memories are notoriously fallible and often self-serving,

although they may also provide insights and information not otherwise available. Whereas journalists seek corroborating interviews (double-sourcing), historians are more comfortable checking oral accounts against documentary evidence. Journalists and contemporary historians, however, may often share the same problem when oral sources are the only ones available. Like journalists, historians may then check one person's memory against another's, with due regard for the specific context and interests of their sources. Historians usually do have more time to explore information and hypotheses in depth, being less subject to immediate deadlines; they may also be under less pressure to tailor their accounts to the views and interests of their editors. Nevertheless, there is considerable similarity between contemporary historians and investigative reporters, and both have a proper disdain for armchair commentators.

The final area in which contemporary historians can contribute to their colleagues who write historically is in helping to set the questions. Among people who write about contemporary events, historians are almost alone in asking what has been left out. Scholars in other social sciences and in the policy and advocacy professions usually write history because they already have a question to answer; they look to the past for evidence, not as a source of questions. Journalists must respond to definitions of newsworthiness that they often do not set. Historians, by contrast, have been trained to think about what is and is not known about the past, even the recent past. In the HIV epidemic it is obvious that a great deal more study could be given to the history of research on the virus, the development and testing of drugs, sexual behavior, and the behavior of particular government and private organizations.

Historians should apply their skills and training to constructing a more adequate and complete history of AIDS than can be created by the press, by activists, or by physicians and scientists. This task requires an understanding of contemporary health politics and the methods of contemporary history. Moreover, a great deal of this history should be comparative; much more, for example, is known about events in the United States than in the countries of Western Europe or Africa. The politics, policies, and practices of responding to the AIDS epidemic within different cultures and national boundaries influence not only the internal affairs of other countries but also the future shape of national and international politics. As in the United States, AIDS in the countries of the Third World must be examined as an issue of contemporary history and politics.

Historians, who usually have to deal with the scattered and often inadequate sources left by past events, have an opportunity in the AIDS epidemic to help gather more complete records of contemporary events. Historians and their archivist colleagues should be developing principles for collecting materials that will allow us to explore as fully as possible the many dimensions of this disease and our social, political, and cultural responses to its progression. Collaborators and informants—on the streets, in the clinics, and in executive boardrooms—have perspectives on the epidemic that must be documented.

Perhaps most important, the proliferation of events since the epidemic was first identified suggests that the contemporary history of science, medicine, and public health, like that of war, must be studied prospectively. Just as combat historians are identified during a conflict and follow their assigned units, so historians of fast-breaking events in health affairs could benefit from such privileged access. Prospective research on contemporary history has resulted in several superb histories of space and defense initiatives and, in Britain during World War II, of social policy.[21] There are obvious problems with giving historians privileged access to primary sources, notably those involving objectivity and potential censorship. But there is a rich literature about these problems and the ways in which people in other fields have addressed them.

The history of the epidemic of HIV infection and related diseases is now rapidly being transformed. As the contemporary history of the epidemic is being written, many people have recognized that in important aspects AIDS is continuous with the recent past and that its history is linked to our patterns of behavior, both personal and institutional. The new historiography of the epidemic creates an opportunity for reciprocity between professional contemporary historians and their colleagues in other fields, for whom history is useful but not central.

This book attempts to encourage such reciprocity. The contributors belong to what could be called, with apologies for sounding imperialistic, the Greater Historical Profession. That is, each of them uses historiography—the theory and methodology of historical studies—to explain contemporary events. As the Notes on Contributors make plain, our colleagues who are the authors of the essays in this volume have formal training and vast experience in a variety of disciplines. They represent diverse fields and professions, including epidemiology, history, law, medicine, political science, communications, sociology, social psychology, sociolinguistics, and virology. Some of the contributors use

their historical accounts as the basis for advocating particular changes in contemporary policies and practices.

The essays in Part One, "The Virus and Its Publics," explore scientific and public efforts to present and represent HIV and AIDS. Stephen S. Morse, for example, is a virologist who brings an unusually broad historical perspective to his field. Here he discusses HIV in the context of the evolutionary relationship of viral species to their human and animal hosts. He suggests that the process of viral emergence involves two major steps. In the first step, a new agent or, more commonly, an existing virus, is introduced into the human species. In the second step, the virus is disseminated in the human population. Morse develops the concepts of "viral traffic" between species and of "traffic laws" governing transmission. He provides examples of viral emergence and urges the establishment of much more systematic methods for detecting viral species. He suggests that a broader concept of environmental planning should be instituted to take into consideration the possible effects of human social behavior on viral transmission, thus enabling us to predict, and possibly prevent, the emergence of new epidemics.

Gerald M. Oppenheimer here expands his earlier study of the role of epidemiology in the social and scientific construction of AIDS.[22] Like Morse, he extends his view beyond the biological aspects of disease. He discusses the social impact of the early epidemiological characterization of AIDS by the life-style hypothesis, the definition of high-risk groups, and the analogy with hepatitis B; he then shows how the isolation of HIV led to reconceptualizing the disease in terms of a virus. He explores the continuing role of epidemiology and social science research in the process of redefining the disease and outlines the conflicts between different professional groups in the definition and management of the epidemic. The history of the epidemic, he concludes, demonstrates a dynamic process in which "different scientific specialties negotiated definitions that . . . reflected their relative power."

David C. Colby and Timothy E. Cook explore the social construction of AIDS, this time as a public problem presented through the mediation of the television nightly news. They trace the cycles of attention and inattention, of alarm and reassurance, that have been part of the logic of media attention in framing and responding to the disease. They thus explain the changing messages about AIDS that have been transmitted to the general public and show the ways in which these messages have unintentionally helped generate fearful public responses. Their es-

say provides an interesting parallel to the epidemiological construction of AIDS and helps explain some aspects of the public response to AIDS as they have been at least partially determined by the internal logic of the mass media.

The essays in Part Two address the political, legal, and ethical aspects of contemporary AIDS policies. Daniel M. Fox emphasizes the problems of financing patient care for persons with infection and disease. The heaviest financial burden continues to be borne by state and local government. This burden is increasing as HIV infection, which is now perceived as a chronic disease of lengthening duration, becomes a disease of the disadvantaged, especially of poor blacks and Hispanics. Moreover, the problems of financing health services for persons with HIV infection are inextricable from the larger policy and political issues of health care financing in the United States. Since prospects for general health care reform are modest in the political and economic climate of the early 1990s, Fox finds reason to conclude that social generosity toward persons with HIV infection will decrease.

Larry Gostin writes history as both an analyst and an advocate. His detailed synthesis of 149 legal cases of discrimination since the epidemic was recognized is solid legal history. These cases provide the only systematic data that have been collected about past, current, and potential future patterns of discrimination in education, employment, housing, and health services. Gostin also sketches the current state of antidiscrimination law, including the likely impact of the Americans with Disabilities Act, which became law in 1990 and was first enforced in 1991. But Gostin is also an advocate who detests discrimination in all its forms; his essay places historical evidence and methods in the service of legal advocacy.

Harvey M. Sapolsky and Stephen L. Boswell analyze the impact of the HIV epidemic on blood services in the United States, taking issue with conventional accounts in the medical and social science literature and in the media. Their new interpretation concurs with standard accounts in many particulars. Thus, they describe how transfusion recipients and health care personnel became subject to new risks of infection as a result of the epidemic. Though these risks are relatively small, fear of AIDS became so intense that high priority was given to efforts to reduce risk, forcing long-needed changes in medical practice and in the policies of blood collection and banking agencies. Sapolsky and Boswell differ from most other experts, however, in presenting evidence that most of the "significant improvements in the overall quality of Ameri-

can blood services . . . could have been achieved without the existence of this new health menace." They also provide an explanation, grounded in historical research, of why blood services failed to make these improvements before the HIV epidemic.

David J. Rothman and Harold Edgar compare the standards used by the federal government to judge the safety and efficacy of drugs against cancer and HIV. They undertook their inquiry in order to test the hypothesis that a chronic disease model of disease had different implications for policy than did a plague model. They conclude that, in this instance at least, the choice of a specific historical model had important policy implications. Had AZT been a drug for people with advanced cancer, the Food and Drug Administration would most likely have given much earlier approval for its use outside experimental situations. Using a plague, or infectious disease, model, however, federal scientific and regulatory officials believed that they were obligated to base their decisions exclusively on data from placebo-based, randomized clinical trials.

Ronald Bayer argues that privacy was the central political and ethical issue of the HIV epidemic in the United States in the 1980s, but that it has now been "joined, although not displaced, by the question of equity." By equity he means providing resources for "care and counseling—especially to the poor, among whom intravenous drug use plays a critical role in HIV transmission." Bayer says that he is now less pessimistic about the generosity of public policy in the United States than he was in 1988, the publication date of his important book *Private Acts, Social Consequences.*[23] In his view, there is evidence that the "culture of responsibility" may govern the United States response to the epidemic in the 1990s. By examining different kinds of evidence, Bayer thus comes to very different conclusions from those reached by Daniel Fox about the likely future of AIDS politics and policy.

The essays in Part Three deal with some of the groups most directly affected by AIDS. This section begins with a selection of photographs of women with AIDS by Ann Meredith. These are from an exhibition shown, and favorably reviewed, in cities around the United States and Europe. The photographs are accompanied by comments from the women who were interviewed about their lives and experiences.

Robert A. Padgug, a historian of sexuality turned health policy analyst, and Gerald M. Oppenheimer, a historian-epidemiologist, have previously collaborated on studies of AIDS financing; here they provide a sensitive account of the complex relationships of the gay community to

AIDS. They place AIDS in the historical context of sexual politics and practices and the construction of gay identity, as the gay community came to "own" the AIDS epidemic, at least in its early stages. In the process of taking responsibility for AIDS services and organizing around AIDS policies, the gay community and its organizations were themselves transformed. Padgug and Oppenheimer trace the political shifts of the 1980s and speculate what may happen when gay communities move beyond the stage of being consumed and defined by the AIDS crisis.

Don C. Des Jarlais and his colleagues Samuel R. Friedman and Jo L. Sotheran write about events with which they have been deeply involved: the history of the epidemic of HIV infection among intravenous drug users in New York. Des Jarlais and his colleagues have been doing research on the epidemic among intravenous drug users in New York City since 1981. Their methods have been widely emulated, and their findings have had a wide international audience. In this essay they look back on their experience and propose a "staging system," or model, of the history of the epidemic among intravenous drug users. This model is, they argue, useful for cities in which HIV infection among intravenous drug users began later than in New York or has not been as extensive. They note that, in the more recent stages of the epidemic among drug users in New York and other cities, HIV seroprevalence has stabilized.

The fourth and final section provides a sampling of perspectives on the social and scientific construction of AIDS in other nations. Virginia Berridge and Philip Strong first analyze the development of AIDS policies in the United Kingdom. They suggest three stages of AIDS policy development in their country: the first, a period of slow growth and bottom-up organizing, which developed a "policy community"; the second, a period when AIDS was treated as a national emergency; and the third, a period of normalization. They highlight the early leadership of the Department of Health, the strategy of gay groups to emphasize the possibility of heterosexual transmission, and the energetic public education campaign that followed. They stress the themes of continuity versus change in AIDS policies, provide a basis for comparing AIDS politics in the United Kingdom and other countries, and list some areas for further research.

James W. Dearing examines health policy development in Japan, a country with a small number of cases and a very distinct epidemiological profile. He thus shows how a very different society and economy